



Medicaid Update

The Official Newsletter of the New York State Medicaid Program

August 2016

Volume 32 | Number 8

Postpartum Maternal Depression Screening

Updated Billing Guidance

This article supersedes the billing guidance for postpartum maternal depression screening that was published in the July 2015 *Medicaid Update*. Effective September 1, 2016 for Medicaid Fee-for-Service (FFS) and effective November 1, 2016 for Medicaid Managed Care (MMC) Plans, the New York State Medicaid program will allow providers of infant healthcare to bill for postpartum maternal depression screening under the infant's Medicaid identification number. Also, the current CPT code used for maternal depression screening (99420) will be replaced with the following:

- G8431 (with HD modifier) – Screening for clinical depression is documented as being positive and a follow-up plan is documented
- G8510 (with HD modifier) – Screening for clinical depression is documented as negative, a follow-up plan is not required

Postpartum maternal depression screening using a validated screening tool may be reimbursed up to three times within the first year of the infant's life. This reimbursement is in addition to the payment for an Evaluation and Management (E&M) service. Screening can be provided by the mother's healthcare provider and/or by the infant's healthcare provider following the birth of the baby. This service can be integrated into the well-child care schedule.

If the mother screens positive for depression, then she must be further evaluated for diagnosis and treatment. Medical practices that do not have the capacity to evaluate and treat mothers who screen positive for depression must have a referral process in place for these beneficiaries. Women with current depression or a history of major depression warrant particularly close monitoring and evaluation. The current standard of care for pregnant women requires that all pregnant women receive depression screening as part of their routine antepartum care. Maternal depression screening that occurs antepartum is considered to be included in the payment for the E&M service.

A maternal healthcare provider is defined as a: physician, midwife, nurse practitioner, physician assistant, or other healthcare practitioner acting within his or her lawful scope of practice. The infant's healthcare provider is defined as a: physician, nurse practitioner, physician assistant, or other healthcare practitioner acting within his or her lawful scope of practice.

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The Medicaid Update is a monthly publication of the New York State Department of Health.

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Screening and Referral Tools

There are multiple, validated depression screening tools available for use. These tools usually can be completed in less than 10 minutes. Some examples of recommended screening tools include the Edinburgh Postnatal Depression Scale (EPDS) and the Patient Health Questionnaire-9 (PHQ-9). Additional information is available on validated screening tools for maternal depression.

Please refer to the following links for helpful referral information:

- https://www.health.ny.gov/community/pregnancy/health_care/perinatal/maternal_depression/providers/additional_resources.htm
- [Directory of Office of Mental Health Facilities](#)
- [Postpartum Resource Center of New York/Emergency Resources](#)

Billing Guidance

If maternal depression screening is provided postpartum by the maternal healthcare provider, the service can be reimbursed in addition to the E&M visit. Effective September 1, 2016 for FFS and November 1, 2016 for MMC, providers should bill for this service using CPT code G8431 in conjunction with the "HD" modifier for a positive depression screen of the mother and G8510 in conjunction with the "HD" modifier when the screening returns a negative result. These two new "G" series codes replace CPT code 99420 (The Administration and Interpretation of Health Risk Assessment Instrument - Health Hazard Appraisal) currently being used for maternal depression screening. Upon the effective date outlined above, the CPT code 99420 will no longer be active in the Medicaid billing system.

If maternal depression screening is performed on the same day as the infant's primary care visit (E&M) by the infant's healthcare provider, one claim can be submitted for both services using the appropriate "G" series code (G8431/G8510) with the HD modifier under the infant's Medicaid identification number. Alternatively, providers may bill this service separately under the mother's Medicaid identification number.

Reminders

- New York State Medicaid record-keeping requirements apply to all services offered and provided to beneficiaries.
- HIPAA-compliant consent to treat and share information necessary for treatment is the responsibility of all providers. Medical providers who have additional questions on requirements should consult with their own counsel.

Medicaid FFS policy questions may be directed to the Office of Health Insurance Programs' Division of Program Development and Management at (518) 473-2160. Questions regarding MMC reimbursement and/or documentation requirements should be directed to the enrollee's MMC plan.

eMedNY 2017 ICD-10 Update Testing Opening September, 2016

On September 6, 2016, eMedNY's Provider Testing Environment (PTE) will be available for submitters to begin testing their Medicaid claims with updated 2017 ICD-10 diagnosis codes and their inpatient hospital claims that utilize updated 2017 ICD-10 procedure codes. **Test claims must be submitted for dates of service on or after September 1, 2016, up to the date of the test submission**, in order to be adjudicated with the ICD-10 updates provided by CMS. Future dates of service are not allowed.

What is PTE? The eMedNY PTE allows New York State Medicaid trading partners to test batch and real-time Electronic Data Interchange transactions against the same validation and adjudication logic as the eMedNY production environment. In order to allow for iterative testing, PTE does not apply edits involving duplicate and near-duplicate claims, nor prior authorization submissions. Additionally, no claim or prior authorization requests are pended in PTE.

How to Use the eMedNY Provider Testing Environment

- All submitters must use an active ETIN when submitting transactions to PTE.
- Most existing eMedNY access methods may be used **except** ePACES, VeriFone POS, Audio Response Unit (ARU), and paper.
- For all ASC X12 inbound and outbound PTE transactions, "Test Indicator" in ISA15 must be set to "T", otherwise they will be processed through the production environment.
- **Only 2 files per day, per user with a maximum of 50 claims on a file are allowed.**
- The PTE weekly adjudication cycle ends on Fridays and remittances are delivered the following week according to the submitter's/provider's production settings.

More information about ICD-10 changes may be found at www.emedny.org/icd. Questions may be directed to the eMedNY Call Center at 800-343-9000 or via email to eMedNYHIPAAsupport@csra.com.

All Providers

New York Medicaid EHR Incentive Program Update

The New York Medicaid Electronic Health Record (EHR) Incentive Program provides financial incentives to eligible professionals and hospitals to promote the transition to EHRs. Providers who practice using EHRs are in the forefront of improving quality, reducing costs and addressing health disparities. Since December 2011 **over \$783 million** in incentive funds have been distributed **within 24,261** payments to New York State Medicaid providers.

24,261
Payments

\$783+
Million Paid

**Are you
eligible?**

For more information, visit www.emedny.org/meipass

Did you know?

2016 is the last year that eligible professionals (EPs) may begin participation in the New York Medicaid EHR Incentive Program. An EP may receive up to \$63,750 over the course of six years, which includes a lump sum payment of \$21,250 for the first participation year wherein the EP can demonstrate adopt, implement, or upgrade to certified EHR technology. Thereafter, the EP may receive \$8,500 for each of the remaining five years for demonstrating meaningful use.

Visit <https://ehrincentives.cms.gov/hitech/login.action> to register for the program. The provider's registration must match the enrollment information with New York Medicaid. Upon successful registration, the provider must then submit an attestation to the New York Medicaid EHR Incentive Program in order to be considered for the incentive payment. 2021 will be the last year of the program.

MEIPASS Availability

The New York Medicaid EHR Incentive Program Administrative Support Service (MEIPASS) is currently closed due to important maintenance being performed on the system for meaningful use attestations for payment year 2015 and beyond. It is anticipated that MEIPASS will reopen in early fourth quarter of calendar year 2016. Announcements will be made via LISTSERV and the program website. Program support will continue to be available by phone at 877-646-5410.

Questions? Contact hit@health.ny.gov for program clarifications and details.

Change to Medicaid Reimbursement of Medicare Part C Copayment and Coinsurance Liabilities

This Article Supersedes the Article Published in the July 2016 *Medicaid Update*

Effective July 1, 2016, an amendment to New York State Social Services Law* changes Medicaid reimbursement of Medicare Part C (Medicare Advantage or Medicare managed care) copayment and/or coinsurance liabilities for outpatient services provided to dually eligible Medicaid beneficiaries. Dually eligible beneficiaries are those individuals having both Medicare and Medicaid coverage.

Presently the Medicaid program pays the full copayment or coinsurance amounts for Medicare Part C claims. **Retroactively to July 1, 2016**, Medicaid will reimburse at the rate of eighty-five percent (85%) of the Medicare Part C copayment or coinsurance amount.

The Department is in the process of making the necessary eMedNY System changes to enable the implementation of the new payment policy. Implementation will be applied retroactively pending System support. Paid claims will then be adjusted automatically to reflect the new cost-sharing limits.

This change will affect **institutional claims and professional claims** when submitting claims for Medicaid reimbursement of a Medicare Part C copayment or coinsurance. **This change will also apply to pharmacy claims for drugs and supplies when submitted via a NCPDP transaction or as a professional claim.**

There is no change to the current reimbursement methodology of Medicare Part C copayment/coinsurance amounts for ambulance providers and psychologists. Medicaid will continue to reimburse these providers in the full Medicare Part C copayment/coinsurance amounts.

Note: A provider of a Medicare Part C benefit cannot seek to recover any copayment, or coinsurance amount from Medicare/Medicaid dually eligible beneficiaries. The provider is required to accept the Medicare Part C health plan payment and any Medicaid payment as payment in full for the service. The Medicaid beneficiary may not be billed for any Medicare Part C copayment/coinsurance amount that is not reimbursed by Medicaid.

Providers will be notified by a future *Medicaid Update* article prior to claim adjustments being made.

Questions? Please contact the Office of Health Insurance Programs, Division of Program Development and Management at (518) 473-2160.

*A new subparagraph (iv) was added to paragraph (d) of subdivision 1 of Section 367-a of the Social Services Law.

Policy & Billing Guidance

Physician Signature - Billing Update for Home Health Care Providers

A recent change to New York Codes, Rules & Regulations (NYCRR), Title 10, Sections 763.7 & 766.4 now allows certified home health agencies (CHHAs), long term home health care programs (LTHHCPs), and licensed home care services agencies (LHCAs) up to 12 months to obtain a physician's signature on orders for services, including verbal and telephone orders. The regulations can be found at:

http://www.health.ny.gov/regulations/recently_adopted.

Home care providers cannot submit claims for Medicaid Fee-for-Service beneficiaries until the signed physician order is obtained. In order to accommodate the provisions of the revised regulation, the 90-day timely filing requirement found in NYCRR Title 10, Section 540.6 has been extended to exempt appropriately submitted home care claims from certain timely filing edit denials.

Home care providers must submit their claims within 30 days of the date of the signed physician order. **No Delay Reason Code should be included with these claims.**

In cases where a claim is returned to a provider due to data insufficiency or claiming errors (rejected or denied), it must be corrected and resubmitted within 60 days of the date of notification to the provider. Claims not correctly resubmitted within 60 days, or those continuing to not be payable after the second resubmission, are neither valid nor enforceable.

All claims must be **finally** submitted to the fiscal agent and be payable within two years from the date the care, services or supplies were furnished in order to be valid and enforceable.

Billing questions should be directed to the eMedNY Call Center at 1-800-343-9000.

Policy & Billing Guidance

Incontinence Supply Management Program September 1, 2016

As announced in the [June 2016 Medicaid Update](#), beginning September 1, 2016, all adult and youth sized diapers dispensed to all Medicaid beneficiaries must meet minimum product specifications established by the Department of Health. These minimum standards apply to all adult and youth sized products dispensed to Medicaid beneficiaries residing in community settings by Fee-for-Service, Managed Care and Managed Long Term Care Medicaid providers.

The Department has awarded a preferred vendor supply contract to Twin Med, LLC for incontinence products to be purchased by Medicaid providers. Medicaid providers who purchase incontinence supplies from Twin Med will receive competitive pricing and a formulary that has been approved by the Department as meeting the new minimum quality standards. Medicaid providers are not required to verify incontinence product quality standards if the products are purchased from Twin Med, LLC. To set up an account with Twin Med, please visit the preferred vendor's New York website at www.twinmedny.com or contact Twin Med by phone at 1-844-886-3639.

The preferred vendor purchase pricing and formulary are as follows:

New York State Incontinence Supply Contracted Purchase Price by HCPCS Code (HCPCS codes denoted with an asterisk are subject to minimum quality standards)

HCPCS CODE	BRIEF DESCRIPTION	CONTRACTED PRICE
A4554	<i>Disposable Underpads</i>	\$0.15
T4521 *	<i>Disposable Adult Small Diaper</i>	\$0.25
T4522 *	<i>Disposable Adult Medium Diaper</i>	\$0.25
T4523 *	<i>Disposable Adult Large Diaper</i>	\$0.34
T4524 *	<i>Disposable Adult Extra Large Diaper</i>	\$0.41
T4529	<i>Disposable Pediatric Small/Medium Diaper</i>	\$0.16
T4530	<i>Disposable Pediatric Large Diaper</i>	\$0.28
T4533 *	<i>Disposable Youth Diaper</i>	\$0.32
T4535	<i>Disposable liners/pads</i>	\$0.15
T4537	<i>Reusable Underpad, Bed Size</i>	\$7.00
T4539	<i>Reusable Diaper, any size</i>	\$6.00
T4540	<i>Reusable Underpad, Chair size</i>	\$3.95
T4543 *	<i>Disposable Bariatric Diaper (waist/hip >62")</i>	\$0.65

New York State Incontinence Supply Program
Twin Med, LLC Approved Product Formulary as of 8/1/2016

HCPCS	Products
T4521 *	First Quality Prevail Briefs, Small, (20"-31") 96/CS
	Covidien Quilted Briefs, Small, (20"-31") 96/CS
T4522 *	First Quality Procare Brief, Medium, (34"-44") 96/CS
	Nu-Fit Briefs Medium, (34"-44") 96/CS
	First Quality Procare Underwear, Medium (34"-46") 80/CS
	First Quality Procare Plus Underwear, Medium, (34"-46") 100/CS
	Covidien Quilted Briefs, Medium, (34"-44"), 100/CS
	Covidien Surecare Underwear, Medium, (34"-48") 80/CS
T4523 *	First Quality Procare Briefs, Large, (45"-58") 72/CS
	First Quality Nu-Fit Briefs, Large, (45"-58") 72/CS
	First Quality Procare Underwear, Large, (46"-58") 72/CS
	First Quality Procare Plus Underwear, Large, (46"-58")
	Covidien Simplicity Quilted Briefs, Large, (45"-58") 72/CS
	Covidien Surecare Underwear, Large, (44"-54") 72/CS
T4524 *	First Quality Procare Briefs, X-Large, (59"-64") 60/CS
	First Quality Nu-Fit Briefs, X-Large, (59"-64") 60/CS
	First Quality Procare Underwear, X-Large, (58"-68") 56/CS
	First Quality Procare Plus Underwear, X-Large, (58"-68") 100/CS
	Covidien Simplicity Quilted Brief, X-Large, (59"-64") 60/CS
	Covidien Surecare Underwear, X-Large, (48"-66") 56/CS
T4533 *	First Quality Prevail Briefs, Youth, (15"-22") 96/CS
	First Quality Prevail Extra Underwear, Youth/Small, (20"-34") 88/CS
T4543 *	First Quality Procare Briefs, 2-XL, (62"-73") 48/CS
	First Quality Prevail Extra Underwear, 2-XL (68"-80") 48/CS
	Covidien Surecare Underwear, 2-XL (60"-80") 48/CS
A4554	ProCure Fluff Underpad, (23"-36") 150/CS
	Covidien Tendersorb Fluff Underpad (23"-36") 150/CS
	First Quality Procare Fluff Underpad, (23"-36") 150/CS
T4529	First Quality Cuties Baby Diapers – Newborn 169/CS
	First Quality Cuties Baby Diapers – Size 1 200/CS
	First Quality Cuties Baby Diapers – Size 2 168/CS
	First Quality Cuties Baby Diapers – Size 3 144/CS

New York State Incontinence Supply Program
Twin Med, LLC Approved Product Formulary as of 8/1/2016

T4530	First Quality Cuties Baby Diapers – Size 4 124/CS
	First Quality Cuties Baby Diapers – Size 5 108/CS
	First Quality Cuties Baby Diapers – Size 6 92/CS
	First Quality Cuties Baby Diapers – Size 7 80/CS
	First Quality Cuties Boy Training Pants – Size 2 104/CS
	First Quality Cuties Boy Training Pants – Size 3 92/CS
	First Quality Cuties Boy Training Pants – Size 4 76/CS
	First Quality Cuties Girl Training Pants – Size 2 104/CS
	First Quality Cuties Girl Training Pants – Size 3 92/CS
	First Quality Cuties Girl Training Pants – Size 4 76/CS
T4535	ProCure Premium Absorbent Liners 4" x 10" 200/CS
	ProCure Premium Absorbent Liners 7" x 17" 200/CS
	First Quality Prevail Moderate Pads 9.25" 180/CS
	First Quality Prevail Moderate Long Pads 11" 144/CS
	Covidien SureCare Bladder Control Pads 4" x 10" 132/CS
	Covidien SureCare Bladder Control Pads 4" x 14" 168/CS
T4537	ProCure Reusable Bed Pad, Twill 30" x 36" 24/CS
	ProCure Reusable Bed Pad, Twill 34" x 36" 24/CS
	ProCure Reusable Bed Pad, Plaid 30" x 36" 24/CS
	ProCure Reusable Bed Pad, Plaid 34" x 36" 24/CS
T4539	ProCure Products Reusable Diaper, Medium 60/CS
	ProCure Products Reusable Diaper, Large 60/CS
	ProCure Products Reusable Diaper, X-Large 60/CS
	ProCure Products Reusable Diaper, 2XLarge 60/CS
	ProCure Products Reusable Fitted Brief, Medium, 24/CS
	ProCure Products Reusable Fitted Brief, Large, 24/CS
	ProCure Products Reusable Fitted Brief, X-Large, 24/CS
	ProCure Products Reusable Fitted Brief, 2XLarge, 24/CS
T4540	ProCure Products Reusable Chair Pad, Twill 60/CS
	ProCure Products Reusable Chair Pad, Plaid, 60/CS

Providers will continue to be able to purchase incontinence products from alternative suppliers as long as the products provided meet the established minimum quality standards. Medicaid providers who choose to purchase incontinence supplies from an alternative supplier, however, are responsible for ensuring that any product dispensed meets the minimum product specifications established by the Department and will be responsible for obtaining independent testing results for these products (even if they are the same as or similar to products on the approved formulary). Only products purchased from Twin Med, LLC are exempt from the documentation requirement.

The Department will incorporate review of incontinence product minimum quality specifications into routine pre-payment and post-payment reviews and other routine audit processes. Providers must maintain independent testing documentation for a six-year period following reimbursement for any product not purchased from Twin Med, LLC and have the ability to produce such documentation upon audit or claims review. The Department will also investigate any complaints received from Medicaid beneficiaries or other parties concerning Medicaid providers dispensing incontinence products which do not meet the established minimum product specifications.

For questions about the Incontinence Supply Management Program, contact the Bureau of Medical Review by telephone at 1-800-342-3005 or by email at OHIPMEDPA@health.ny.gov.

Policy & Billing Guidance

Change in Reimbursement Policy for Compounded Alpha-Hydroxyprogesterone Caproate (17-P)

This Article Supersedes All Previously Published Billing Guidance

New York State Medicaid will no longer reimburse for the compounded version of the drug 17 alpha-hydroxyprogesterone caproate (17-P) unless the U.S. Food and Drug Administration (FDA) approved product is unable to meet the medical needs of an individual patient. This policy applies to both Medicaid Fee-for-Service and Medicaid Managed Care. This coverage policy is consistent with the recommendations of the FDA regarding compounded versions of drugs. The FDA approved version of this drug, Makena®, will continue to be reimbursed by Medicaid.

Background:

The FDA approved Makena® in February 2011 to reduce the risk of preterm delivery for women currently with a singleton pregnancy and for women who have had at least one prior singleton spontaneous preterm birth. Makena® is not intended for use in women who have a multiple pregnancy, such as a twin pregnancy, or other risk factors for preterm birth. Prior to the FDA's approval of Makena®, the compounded version of hydroxyprogesterone caproate was available and reimbursed by New York State Medicaid.

In June 2012 the FDA released an [updated statement](#) and [Q&A](#) on compounded versions of hydroxyprogesterone caproate (the active ingredient in Makena®).^{1,2} The [FDA website](#) recommends "using a FDA-approved drug product, such as Makena, instead of a compounded drug except when there is a specific medical need (e.g., an allergy) that cannot be met by the approved drug. Under section 503A of the Federal Food, Drug, and Cosmetic Act (FDCA), a pharmacist may not compound regularly or in inordinate amounts any drug products that are essentially copies of Makena. In addition, under section 503B, an outsourcing facility may not compound any drug that is essentially a copy of an approved drug."³

New York State Medicaid regulations at [18 NYCRR section 505.3 - Drugs \(a\)\(1\)](#) provide a definition of a compounded prescription that is reimbursable within the Medicaid pharmacy program. Additional clarification regarding compounded prescriptions is available in the [Medicaid Pharmacy Manual Policy Guidelines](#).⁴

Professional Guidance:

Preterm birth is the leading cause of neonatal mortality in the United States, and infants born prematurely have increased risks of mortality and morbidity throughout childhood. It is estimated that in 2014, between 20,973 and 25,511 infants (8.8% - 10.7%) were born prematurely in New York State.^{5,6,7} Recent analysis of New York State Medicaid data from 2014 – 2015 reveals that the percentage of eligible women (i.e., women with a singleton pregnancy and at least one prior singleton spontaneous preterm birth) who received 17-P ranges from 17-26%. Both the [American College of Obstetricians and Gynecologists](#) and the [Society for Maternal-Fetal Medicine \(SMFM\)](#) recommend the use of hydroxyprogesterone caproate to prevent preterm birth in women with a singleton gestation and a prior singleton spontaneous preterm birth.^{8,9}

Medicaid Fee-for-Service (FFS) Billing Guidance:

In general, New York State Medicaid covers drugs administered by intramuscular methods in the physician's office when medically necessary, for purposes consistent with FDA and Compendia-supported indications. See the New York State Medicaid Program [Physician-Procedure Codes Section 2-Medicine, Drugs and Drug Administration](#) for more information.¹⁰

Physician Office Billing:

- It is no longer necessary to bill Makena® on paper with an invoice attached.
- Makena® should be billed to Medicaid using code J1725 via an electronic claim; include the actual invoice amount of the drug dose administered to the patient on the claim.
- In the event that a patient has a medical need for the compounded version of hydroxyprogesterone caproate, providers should bill Medicaid using code J1725, reporting the actual invoice amount of the drug components used to compound the drug.
- For audit purposes, providers must keep a copy of the paid invoice on file.

Note: Single-dose preservative-free vials of hydroxyprogesterone caproate injection are now available to providers. The single-dose vials are priced per dose at the same price-point as the price per dose of the 5 mL multi-dose vial. The single-dose vials are delivered in a 4-pack, and each vial has its own NDC so the provider can bill for each vial used. Providers billing for either Makena® single-dose vials (NDC 64011-0247-02) or multi-dose vials (NDC 64011-0243-01), must report the same code - J1725 - for both. Each single-dose vial has an extended shelf life allowing for a long term storage option.

Article 28 Clinic Billing:

Makena® is carved out of APG payment methodology and should be billed as an ordered ambulatory service when provided in an Article 28 Clinic setting. Please see the ordered ambulatory fee schedule at the following link: <https://www.emedny.org/ProviderManuals/OrderedAmbulatory/index.aspx>

Medicaid FFS policy questions may be directed to the Office of Health Insurance Programs' Division of Program Development and Management at (518) 473-2160. Questions regarding Medicaid Managed Care (MMC) reimbursement and/or documentation requirements should be directed to the enrollee's MMC plan.

References:

¹U.S. Food and Drug Administration (FDA). Updated FDA statement on compounded versions of hydroxyprogesterone caproate (the active ingredient in Makena). FDA website. <http://www.fda.gov/newsevents/newsroom/pressannouncements/ucm308546.htm>. Published June 15, 2012. Accessed July 6, 2016.

²U.S. Food and Drug Administration (FDA). Questions and answers on updated FDA statement on compounded versions of hydroxyprogesterone caproate (the active ingredient in Makena). FDA website. <http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm310215.htm>. Updated June 29, 2012. Accessed July 6, 2016.

³U.S. Food and Drug Administration (FDA). Hydroxyprogesterone caproate (17P). FDA website. <http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/PharmacyCompounding/ucm402614.htm>. Updated December 9, 2014. Accessed July 6, 2016.

⁴New York State Medicaid Program Pharmacy Manual Policy Guidelines. Version 2015-1. eMedNY website. https://www.emedny.org/ProviderManuals/Pharmacy/PDFS/Pharmacy_Policy_Guidelines.pdf. Updated November 2015. Accessed July 6, 2016.

⁵Vital Statistics of NYS 2014. Table 11b: Live births by clinical estimate of gestation and resident county New York State – 2014. NYSDOH website. http://www.health.ny.gov/statistics/vital_statistics/2014/table11c.htm. Revised April 2016. Accessed July 6, 2016.

⁶Vital Statistics of NYS 2014. Table 11b: Live births by gestation and resident county New York State – 2014. NYSDOH website. http://www.health.ny.gov/statistics/vital_statistics/2014/table11b.htm. Revised March 2016. Accessed July 6, 2016.

⁷New York State Prevention Agenda Dashboard – State Level. Promote healthy women, infants, and children. NYSDOH website. https://apps.health.ny.gov/doh2/applinks/ebi/SASSStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard. Revised May 2016. Accessed July 6, 2016.

⁸Committee on Practice Bulletins – Obstetrics, the American College of Obstetricians and Gynecologists. Practice Bulletin no. 130: Prediction and prevention of preterm birth. *Obstet Gynecol*. 2012 Oct;120(4):964-73.
http://www.mhpa.org/_upload/ACOGPracticeBulletinNo130_PredictionandPreventionofPretermBirth_Oct2012.pdf.

⁹Society for Maternal-Fetal Medicine Publications Committee, with assistance of Vincenzo Berghella. Progesterone and preterm birth prevention: translating clinical trials data into clinical practice. *Am J Obstet Gynecol*. 2012 May;206(5):376-86.
[http://www.ajog.org/article/S0002-9378\(12\)00291-8/fulltext](http://www.ajog.org/article/S0002-9378(12)00291-8/fulltext).

¹⁰ New York State Medicaid Program Physician Manual-Procedure Codes Section 2-Medicine, Drugs and Drug Administration. Version 2016. eMedNY website. https://www.emedny.org/ProviderManuals/Physician/PDFS/Physician_Procedure_Codes_Sect2.pdf. Accessed July 6, 2016.

Policy & Billing Guidance

Medicaid Reimbursement to Article 28 Clinics for Oral Assessments by Dental Hygienists with Collaborative Practice Agreements

Information for Clinic Dental Directors:

Changes to State Education Law now permit registered dental hygienists who provide dental services in facilities organized under Article 28 of the Public Health Law to enter into a collaborative practice agreement with a licensed and registered dentist who has a formal relationship with the same facility. **In order to constitute a “formal” relationship, the collaborating dentist must either be employed by the Article 28 facility or have a contract to provide services within the Article 28. In the case of a dental hygienist practicing in a School Based Health Center, the collaborating dentist must either be employed or have a contract to provide services in either the School Based Health Center or the Article 28 with whom the School Based Health Center is affiliated.**

Effective September 1, 2016, Medicaid will reimburse Article 28 clinics for oral assessments provided by a registered dental hygienist in accordance with a collaborative practice agreement. In addition, Medicaid will reimburse the clinic for a follow up visit with a dentist for an oral exam or treatment. Medicaid Managed Care plans are required to implement this change effective November 1, 2016.

A registered dental hygienist providing services pursuant to a collaborative arrangement shall:

1. Only provide those services that may be provided under **general supervision**, provided that the physical presence of the collaborating dentist is not required for the provision of such services;
2. Instruct individuals to visit a licensed dentist for comprehensive examination or treatment;
3. Possess and maintain certification in cardiopulmonary resuscitation; and
4. Provide collaborative services only pursuant to a written agreement that is maintained in the practice setting of the dental hygienist and collaborating dentist. Such written agreement shall include:
 - a) Provisions for:
 1. Referral and consultation;
 2. Coverage for emergency absences of either the dental hygienist or collaborating dentist;
 3. Resolution of disagreements between the dental hygienist and collaborating dentist regarding matters of treatment, provided that, to the extent a disagreement cannot be resolved, the collaborating dentist's treatment shall prevail;
 4. The periodic review of patient records by the collaborating dentist; and
 5. Such other provisions as may be determined by the dental hygienist and collaborating dentist to be appropriate; and
 - b) Protocols, which may be updated periodically, identifying the services to be performed by the dental hygienist in collaboration with the dentist and reflecting accepted standards of dental hygiene. Protocols shall include provisions for:
 1. Case management and care coordination, including treatment;
 2. Appropriate recordkeeping by the dental hygienist; and
 3. Such other provisions as may be determined by the dental hygienist and collaborating dentist to be appropriate.

Collaborative arrangements shall not supersede any law or regulation which requires identified services to be performed under the personal supervision of a dentist.

General Billing Information for Clinic Billing Staff:

For institutional claims submitted for a dental hygienist's services (offsite):

A dental hygienist screening of a patient should be billed using D0190. The clinic should bill for any other procedures provided by the hygienist within their scope of practice (e.g., prophylaxis). These claims will be identified by the D0190 code to indicate that a dental hygienist performed the services provided. Please note that D0190 should only be billed for screening performed by a dental hygienist. Claims billed with a screening for a patient using D0190 will not include a capital add-on.

For institutional claims submitted for a dentist's services (patient previously seen by dental hygienist):

The clinic is permitted to bill for any services rendered by the dentist with the exception of D0190. Please note, do not report D0190 for services provided by a dentist. Current policy remains in place for frequency limitations for procedures. Please refer to the [dental policy manual](#) for details.

Patient seen in an Article 28 facility by a dentist & dental hygienist on the same date of service:

Only one claim should be submitted when a patient is seen by a dentist and a dental hygienist on the same date of service. All services provided should be reported on the claim. D0190 should not be billed since the patient will be seen by a dentist providing an oral exam.

Federally Qualified Health Center (FQHC) Billing:

Please see the following chart for billing guidance based on the location where services are provided:

Satellite Site (SBHC, etc.)	Host site	How to Bill
Dental Hygienist at a non-FQHC (Billing APGs)	Dentist at an FQHC	Satellite may bill through APGs per guidance above. Host site may bill PPS rate.
Dental Hygienist at an FQHC	Dentist at a non-FQHC (Billing APGs)	Satellite site may only bill PPS rate. Host site may not bill.
Dental Hygienist at an FQHC	Dentist at an FQHC	Satellite or Host site may only bill one PPS rate.

Questions regarding Medicaid Fee-for-Service policy should be directed to the Division of Program Development and Management at (518) 473-2160. Questions regarding Medicaid Managed Care (MMC) reimbursement and/or documentation requirements should be directed to the enrollee's MMC plan.

Policy & Billing Guidance

Direct Admit for Observation Services

This is to clarify that New York State Medicaid, including Medicaid managed care plans, provides payment for hospital Observation services for patients who are directly admitted.

General Observation Billing Guidelines and Requirements:

General billing guidelines for Observation services published in prior *Medicaid Updates* are applicable:

- May 2011 *Medicaid Update*- Medicaid Begins Coverage for Hospital Emergency Room Observation Services:
http://www.health.ny.gov/health_care/medicaid/program/update/2011/2011-05.htm
- February 2012 *Medicaid Update*- Health Department Regulations Adopted for Observation Unit Operating Standards:
http://www.health.ny.gov/health_care/medicaid/program/update/2012/2012-02.htm
- May 2013 *Medicaid Update* – Observation Services Legislation and Medicaid Payment:
http://www.health.ny.gov/health_care/medicaid/program/update/2013/2013-05.htm

Billing for Direct Admit for Observation:

In order to bill under Ambulatory Patient Groups (APGs) for Direct Admit for Observation (DAO), the provider must be sure to include the following two procedure codes with the number of units and type of unit modifier indicated as follows:

- G0379 Direct Referral Hospital Observation (see full list of Direct Referral codes below)
AND
- G0378 Hospital Observation per hour, number of units (minimum of 8), and “UC” modifier if the service is provided in a designated Observation unit.

Direct Referral Hospital Observation Codes

HCPCS	HCPCS Description	HCPCS	HCPCS Description
99217	Observation care discharge	99226	Subsequent observation care
99218	Initial observation care	99234	Observ/hosp same date
99219	Initial observation care	99235	Observ/hosp same date
99220	Initial observation care	99236	Observ/hosp same date
99224	Subsequent observation care	G0379	Direct refer hospital observ
99225	Subsequent observation care		

If both codes are present on the claim as well as an appropriate primary diagnosis, the Direct Referral Hospital Observation Code (which initially groups to APG 492) will automatically regroup to one of the following three medical APGs based on the primary diagnosis provided.

- APG 500- Direct Admission for Observation - Obstetrical
- APG 501- Direct Admission for Observation - Other Diagnoses
- APG 502- Direct Referral for Observation- Behavioral Health

Additional Billing Guidance:

Facilities that do not have an emergency room rate code can use their clinic rate code for billing. Facilities with both rate codes available for billing must use the emergency rate code.

Payment for Direct Admit for Observation:

The remittance will show the number of units and payment on the Direct Referral Hospital Observation (G0379) line and the Observation Per hour (G0378) will package as follows:

Procedure Code	Procedure Code Description	Modifier	Units of Svce	Expected APG	APG Description	Payment Action	Pymt %	Allowed Weight	Full APG Pymt	Add-on Pymt	Total Pymt
G0379	Direct refer hospital observ		15	501	Direct Admission for Observation- Other	Full Pymt	100%	1.8756	\$370.21	\$68.76	\$438.97
G0378	Hospital observation per			450	Observation	No Pymt	0%	0.0000	\$0.00	\$0.00	\$0.00
Total Paid											\$438.97

Questions should be referred to the Office of Health Insurance Programs, Division of Program Development and Management at (518) 473-2160.

Policy & Billing Guidance

Medicaid Coverage of Allergen Immunotherapy Services

Updates

Allergen Immunotherapy Services:

New York State Medicaid Fee-for-Service (FFS) will be making changes to the fee schedules for Allergen Immunotherapy services beginning on September 1, 2016. Updated policy and billing guidance related to allergen immunotherapy is provided below. In addition, information is provided regarding procedure codes that are scheduled to be end-dated.

Policy and Billing Guidance - Coverage of Allergen Immunotherapy:

Allergen immunotherapy is a treatment program for individuals who are hypersensitive to one or more allergens (antigens). The objective of the therapy is to lessen or diminish symptoms when the individual is exposed to the allergen in the future. Immunotherapy consists of injections that contain progressively larger amounts of allergen until the individual reaches and is able to continue on a maintenance dose level.

The major risk of allergen immunotherapy is anaphylaxis. Allergen immunotherapy should, therefore, be administered by professionals who can recognize early signs and symptoms of anaphylaxis and administer emergency medications when necessary. In addition, immunotherapy should be administered only in facilities equipped to treat anaphylaxis.

- New York State Medicaid reimburses for both the administration component and preparation component of all allergen immunotherapy.
- Evaluation and Management (E&M) office visit codes may be used in addition to allergen immunotherapy, if both of the following criteria are met:
 - There is a significant, separate and identifiable E&M service provided during the same visit as the allergen immunotherapy (administration and/or preparation).
 - Documentation clearly reflects allergen immunotherapy (administration and/or preparation) was a separate and identifiable service from the E&M office visit.

Note: Modifier 25 must be used to append the E&M code for proper adjudication of the claim.

**Current Procedural Terminology (CPT) Codes Associated with
Allergen Immunotherapy Services
Effective September 1, 2016 (FFS)**

Administration – Physician and/or Nurse Practitioner:

CPT 95115 – Professional services for allergen immunotherapy, not including provision of allergenic extracts; single injection.

CPT 95117 - Professional services for allergen immunotherapy, not including provision of allergenic extracts; two or more injections.

- CPT codes 95115 and 95117 cannot be billed together on the same date of service.
- Only one unit is to be billed with each code.

Preparation of Non-Venom Doses – Physician Only:

CPT 95144 – Professional services for the supervision of preparation and provision (supply) of antigens for allergen immunotherapy, **single dose vial(s)** (specify number of vials.)

- CPT code 95144 is used to report **single dose vials** of antigen only. Bill only if the physician providing the antigen is providing it to be injected by some other entity.
- Report regular antigens, other than stinging insect.
- If CPT code 95144 is billed with CPT code 95115 or 95117, payment for 95144 will be Discounted.

CPT 95165 – Professional services for the supervision of preparation and provision (supply) of antigen(s) for allergen immunotherapy; single or multiple antigens (Specify number of doses.)

- Use CPT code 95165 when preparing multi-dose vials.
- Bill when preparing the antigen to administer in your office, or when preparing the antigen and supplying to another entity who will be administering the antigen.
- One dose equals 1 mL aliquot removed from a single multi-dose vial.
- Bill for the total number of mLs prepared.
- Code does not include the injection of antigen(s); injection of antigen(s) is separately billable by reporting CPT 95115 or CPT 95117 as appropriate.

New York State Medicaid does not reimburse for diluted doses.

Code 95165 Billing Exceptions:

If the antigens, e.g., mold and pollen, cannot be mixed together, the practice expense (PE) for mixing a multi-dose vial of antigens is based on the following observed practice method:

- Physicians usually prepare a 10 mL vial and remove aliquots with a volume of 1 mL.
- Ten (10) 1 mL aliquot doses equal the entire PE component for the service.
- Size or number of aliquots removed does NOT alter the PE for the service.

Preparation of Venom Antigens – Physician Only:

CPT 95145 – Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); single stinging insect venom.

CPT 95146 – Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); two single stinging insect venoms. One dose means getting some of two venoms.

CPT 95147 – Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); three single stinging insect venoms. One dose means getting some of three venoms.

CPT 95148 – Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); four single stinging insect venoms. One dose means getting some of four venoms.

CPT 95149 – Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); five single stinging insect venoms. One dose means getting some of five venoms.

CPT 95170 – Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; whole body extract of biting insect or other arthropod (specify number of doses.)

- Venom doses are prepared in separate vials and not mixed together except in the case of a three vespid mix (white and yellow hornets and yellow jackets). In multi-venom therapy, the physician provides a portion of each venom amount.
- For billing purposes, the combined antigen amounts extracted from multiple vials is equal to one (1) unit. An example is provided as follows:

Patient is allergic to white-faced hornet, yellow-faced hornet, yellow jacket, and honey bee. The first three venoms can be mixed together in one vial (vial #1). A separate vial (vial #2) of the honey bee venom is prepared. Seven doses have been prepared for the patient – vial #1 has seven doses for the first three venoms and vial #2 has seven doses of the second venom. CPT 95148 is the appropriate code to bill for this patient as 4 different venoms have

been prepared. When billing, specify 7 as the number of doses. Since this code includes all four bees, consider the doses in both vials as one unit for billing. The patient receives two injections. Providers should bill procedure code 95117 for administration (see previous section on Administration).



**White-faced Hornet
Yellow-faced Hornet
Yellow Jacket
Antigen**



**Honey Bee
Antigen**

The above vials include seven (7) doses each of the assigned antigens and are drawn up separately for administration at the same office visit to the same person. The combination of the four antigens will equal one (1) dose and one (1) unit for billing purposes.

Desensitization Procedure:

CPT 95180 – Rapid desensitization procedure, each hour (e.g., insulin, penicillin, equine serum). One unit equals one hour of procedure time.

End-Dated Procedure Codes:

The following procedures codes will be end-dated effective September 1, 2016 (FFS):

- 95120
- 95125
- 95130 – 95134 (combination codes)

Questions regarding Medicaid FFS policy should be directed to the Division of Program Development and Management at (518) 473-2160. Medicaid Managed Care (MMC) plans are required to cover the scope of each covered service as established by the New York State Medicaid Program and as set forth in the applicable New York State Medicaid Provider Manual(s). Questions regarding MMC reimbursement and/or documentation requirements should be directed to the enrollee's MMC plan.

Pharmacy Update

Medicaid Fee-for-Service Prescription Drug Coverage for “Emergency Services Only” Category of Eligibility

Reminder

Attention Pharmacists...

Medicaid fee-for-service (FFS) coverage is available for a limited list of drugs for beneficiaries of “Emergency Services Only” coverage, category of eligibility (COE) 07.

Coverage criteria based on federal regulations at 42 CFR 440.255(c) and a list of covered medications for Emergency Services Only, category of eligibility 07 can be found at:

http://www.health.ny.gov/health_care/medicaid/redesign/mrt_phase_3.htm. Medications not on the list for this coverage category will reject (depending on your software) with “recipient ineligible.” **Please note that obtaining a clinical prior authorization from the Magellan Call Center does not supersede the requirement to obtain approval from Medicaid for each drug not included on the covered medications list.**

Pharmacies should not attempt to override “recipient ineligible” rejections on their own, including any overrides in the submission clarification code field. All non-approved overrides are subject to recovery of payment. Requests for drugs systematically denied for this category of service must be formally submitted to and approved by the Department of Health. Submission of such a request does not guarantee approval.

If an “Emergency Services Only” request is approved by the Department of Health, a Department staff member will contact the beneficiary’s preferred pharmacy to advise as to what specific drug is approved, the duration of approval, and how to process the claim. Additionally, a notice on official letterhead will be faxed to the pharmacy as documentation to support the approved use of the override code for the specifically approved medication(s). **It is expected that the pharmacy will maintain the notice in its files for a period of six (6) years as documentation in the event of an audit. The absence of documentation to support the exception/override may result in the recovery of payments.**

For policy questions, please e-mail the New York State Medicaid Pharmacy mailbox at: ppno@health.ny.gov, or call (518) 486-3209. For questions on performing eligibility requests on ePACES, providers may contact the eMedNY Call Center at 1-800-343-9000 or the Medicaid Eligibility Verification System staff at (800) 997-1111.

Pharmacy Update

New Legislation Enacted for Drugs Used for Detoxification or Maintenance Treatment of Opioid Addiction for Medicaid Fee-for-Service & Medicaid Managed Care Beneficiaries

As a result of changes to Social Services Law section 364-j, and Public Health Law section 273, Medicaid Fee-for-Service and Medicaid Managed Care cannot require prior authorization for initial or renewal prescriptions for preferred or formulary buprenorphine or injectable naltrexone when used for detoxification or maintenance treatment of opioid addiction. The Food and Drug Administration and Compendia supported frequency, quantity and/or duration limits may continue to be applied.

To obtain preferred/formulary drug listings and plan limitations please see the following websites:

Medicaid Fee-for-Service Preferred Drug List and Pharmacy Prior Authorization Programs:

<https://newyork.fhsc.com/>

Medicaid Managed Care Pharmacy Formulary and Benefit Information:

<http://mmcdruginformation.nysdoh.suny.edu/>

Medicaid Managed Care to Implement an Opioid Fill Limit of Four Prescriptions Every 30 Days

As a result of the enactment of Social Services Law section 364-j(26-a), effective October 1, 2016, Medicaid Managed Care providers must require prior authorization for prescriptions of opioid analgesics in excess of four prescriptions in a thirty-day period. Prior authorization will not apply to prescriptions for patients receiving hospice care, prescriptions for patients with a diagnosis of cancer or sickle cell disease, or any other condition or diagnosis for which the Commissioner of Health determines prior authorization is not required.

Medicaid Fee-for-Service previously implemented such a limit, as reported in the December 2011 [Medicaid Update](#).

Provider Directory

Office of the Medicaid Inspector General:

For suspected fraud complaints/allegations, call 1-877-87FRAUD, (877) 873-7283, or visit www.omig.ny.gov.

Provider Manuals/Companion Guides, Enrollment Information/Forms/Training Schedules:

Please visit the eMedNY website at: www.emedny.org.

Providers wishing to listen to the current week's check/EFT amounts:

Please call (866) 307-5549 (available Thursday PM for one week for the current week's amount).

Do you have questions about billing and performing MEVS transactions?

Please call the eMedNY Call Center at (800) 343-9000.

Provider Training:

To sign up for a provider seminar in your area, please enroll online at:

<http://www.emedny.org/training/index.aspx>. For individual training requests, call (800) 343-9000.

Beneficiary Eligibility:

Call the Touchtone Telephone Verification System at (800) 997-1111.

Medicaid Prescriber Education Program:

For current information on best practices in pharmacotherapy, please visit the following websites:

http://www.health.ny.gov/health_care/medicaid/program/prescriber_education/presc-educationprog

<http://nypep.nysdoh.suny.edu/home>

Need to change your address? Does your enrollment file need to be updated because you have experienced a change in ownership? Do you want to enroll another NPI? Did you receive a letter advising you to revalidate your enrollment?

Visit <https://www.emedny.org/info/ProviderEnrollment/index.aspx> and choose the link appropriate for you (e.g., physician, nursing home, dental group, etc.).

Medicaid Electronic Health Record (EHR) Incentive Program questions?

Contact the New York Medicaid EHR Call Center at (877) 646-5410 for assistance.

Comments and Suggestions Regarding This Publication?

Please contact the editor, Amy Siegfried, at medicaidupdate@health.ny.gov