New York State
Medicaid Update

Information for Medical Practitioners and Facilities
Transportation Management Initiative Covers Four New York City Boroughs

As of September 1, 2012, the Department and its contractor LogistiCare Solutions have implemented non-emergency medical transportation management services for New York City Medicaid fee-for-service enrollees *(i.e., those not in a managed care plan)* who are receiving Medicaid covered services in Manhattan and the Bronx. LogistiCare is currently managing non-emergency transportation services in Brooklyn and Queens.

All trips must be pre-arranged and confirmed by LogistiCare Solutions:

o Requests for routine services must be pre-arranged 72 hours (three days) in advance.
o Requests for urgent (same day or next day) care are arranged any time.

Key Transportation Telephone Numbers

Medical Facility Services Department	877-564-5925	Monday – Friday 7a.m. – 6 p.m.	Medical providers may call this number to speak to one of our specialists and request a standing order or episodic transport for an enrollee.
Medical Facility Services Department Fax	877-585-8758 (Brooklyn) 877-585-8759 (Queens) 877-585-8760 (Manhattan) 877-585-8779 (Bronx)	24/7	Case managers or social workers may fax the 2015 Medical Justification Form or the Standing Order Request forms to this number.
Hospital Discharge	877-564-5926	24/7	Hospital discharges are handled quickly and efficiently.
"Where's My Ride"	877-564-5923	24/7	Providers may call this number if there is a service issue or complaint, or when the enrollee needs to be picked up.
Reservation Number for Enrollee Use	877-564-5922	Monday – Friday 7a.m. – 6 p.m.	This is the number a Medicaid fee-for-service enrollee can call to request transportation.

IN THIS ISSUE …

AUGUST 2012 NEW YORK STATE MEDICAID UPDATE

Transportation Management Implementation Schedule for Rest of City

Staten Island	October 1, 2012
Managed Care Plan Members (other than long term care plans members)	January 1, 2013

Can Members Request Transportation to Medical Appointments?

Medicaid members are now allowed to request their own trips to and from their medical practice. This may relieve providers of the administrative task of arranging every trip required by members.

Prior to May 2012, providers were required to arrange for a Medicaid member's livery, ambulette and stretcher transport. Now, all that is required is the Medicaid Transportation Justification Request (Form 2015) to document the need for transportation via livery, ambulette and ambulance. This document is maintained by LogistiCare. When a patient requests a trip, we will verify the necessary mode and assign your preferred transportation provider to the appointment. If the documentation is not on file, LogistiCare will contact you directly and ask you to submit the Medicaid Transportation Justification Request.

This form, along with all other forms and policy material, is available online at: NYCMedicaidRide.net. The form may be saved electronically, and maintained as part of your electronic record. Any questions for LogistiCare may be e-mailed to: nyc@LogistiCare.com.

Questions? Please e-mail MedTrans@health.state.ny.us, or contact us via telephone at (518) 473-2160.

Orthodontia Covered by Managed Care Plans Beginning October 1

As of October 1, 2012, Medicaid managed care plans will begin covering the orthodontic benefit for enrolled children under the age of 21. Individuals who received prior approval for orthodontic treatment prior to October 1, regardless of enrollment status, will continue to be covered under the Medicaid fee-for-service (FFS) program for the duration of their approved treatment and retention. On and after October 1, managed care plans will be responsible for prior approval of new orthodontic cases as well as monitoring treatment progress, quality of care and reimbursing orthodontists for services provided to members whose treatment they prior approve.

Cases Authorized Under Medicaid Fee-for-Service Prior to October 1

The state will continue to reimburse claims for all Medicaid managed care cases approved prior to October 1 for the duration of treatment and retention. For these cases, orthodontists should send requests for continuation of treatment to the State's Dental Prior Approval Program and claims for services (including claims for placement of appliances and quarterly follow-up visits) to eMedNY.

The state will accept requests for prior approval of orthodontic treatment for Medicaid managed care members through September 4, 2012. For the period September 5 through September 28, only emergency cases should be submitted to the state. All non-emergency requests for prior approval for Medicaid managed care members should be pended for submission to the patient's managed care plan on or after October 1. All procedures remain the same for individuals who are not enrolled in Medicaid managed care. These cases will continue to be handled by the state.

Cases Authorized by Managed Care Plans on and After October 1

Requests for prior approval of orthodontic treatment for Medicaid managed care members must be sent to the member's managed care plan beginning October 1, 2012. Orthodontists must participate in the provider network of the member's Medicaid managed care plan to receive payment for services provided to an enrolled patient. Out-of-network orthodontists may treat an enrolled individual only with approval from the member's managed care plan or during the transitional care period (see below).

Medicaid managed care plans must use the same guidelines for approval of orthodontic services that are used by the Medicaid FFS program. Requirements for documenting prior approval requests, treatment progress and quality of care, as well as procedures for submission of claims, may vary by plan. Claims should be submitted to the member's managed care plan of record as of the date of service.

Eligibility Changes during Treatment and Transitional Care

Medicaid managed care members are allowed to switch plans for "good cause" at any time, and may switch plans for any reason when they are not in their "lock-in" period[i]. When an enrollee changes plans after appliances are placed and active treatment has begun, transitional care policies will apply if the orthodontist does not participate with the enrollee's new health plan. Under the transitional care policy, Medicaid managed care plans must permit a new enrollee to continue an ongoing course of treatment with an out-of-network orthodontist during a transitional period of up to sixty days. If the out-of-network orthodontist wishes to continue treating the enrollee during the transition period, the orthodontist must agree to accept the new plan's reimbursement as payment in full and adhere to that plan's policies and procedures. The enrollee will be switched to a network orthodontist at the end of the transitional care period.

If a Medicaid managed care enrollee loses eligibility for Medicaid services after appliances are placed and active treatment has begun, the enrollee will be disenrolled from Medicaid managed care and will be entitled to a maximum of six months of treatment reimbursed via eMedNY (FFS Medicaid). Providers must check eligibility at every visit, as enrollment status and Medicaid eligibility status may change at any time.

Prohibition on Direct Billing

The Medicaid fee-for-service or Medicaid managed care plan payment for orthodontic services represents payment in full for the full treatment protocol, regardless of the type of appliances used. Separately billing the patient for any portion of orthodontic treatment is prohibited and could result in the provider being terminated from the Medicaid program. Orthodontists must offer Medicaid members the same treatment options offered to the majority of patients in the provider's practice with similar treatment needs (e.g., orthodontists may not restrict Medicaid patients to metal brackets if non-Medicaid patients are routinely provided other types of devices, such as: bonded "clear" brackets; "Damon®" brackets; "Invisalign™" appliances; bite plates or removable appliances), and may not charge Medicaid members for the use of these other techniques and/or devices.

Family Health Plus Members

This change does not apply to Family Health Plus (FHPlus) members. Orthodontia remains a non-covered service under the FHPlus program.

Questions regarding managed care may be e-mailed to OMCMail@health.state.ny.us.

Fee-for-service questions may be e-mailed to: Ortho@health.state.ny.us.

---

[1] Medicaid managed care members may switch plans within ninety days of enrolling in a plan. If they do not choose to switch during this period, they are "locked in" to that plan for the following nine months except for good cause.

New York Medicaid Electronic Health Records Incentive Program Update

The Department is pleased to announce that as of August 10, 2012, the New York Medicaid Electronic Health Records (EHR) Incentive Program has now paid over $169 million in federal incentive funds to over 2150 New York State hospitals and healthcare practitioners.

The Department is continuing to review applications for Payment Year 2011 incentive payments that were submitted prior to the April 29, 2012 deadline, and applications for Payment Year 2012 are currently being accepted from providers who are new to the incentive program. Applications for providers' second incentive payment (including Meaningful Use attestation) will be accepted starting in the fourth quarter of calendar year 2012.

If you have not yet registered for the NY Medicaid EHR Incentive Program, we encourage you to visit the eMedNY.org website (https://www.emedny.org/meipass/) or attend one of the informational webinars hosted by the NYS Department of Health throughout the month of September.

Wednesday, Sept. 5	3:00–4:00PM	EP Participation Year 1 (AIU)
Thursday, Sept. 6	12:00–1:00PM	Program Prerequisites
Tuesday, Sept. 11	10:00–11:00AM	EP Support Documentation
Wednesday, Sept. 19	12:00–1:00PM	Program Prerequisites
Thursday, Sept. 20	12:00–1:00PM	EH Participation Year 2 (MU)
Tuesday, Sept. 25	10:00–11:00AM	EP Participation Year 1 (AIU)
Thursday, Sept. 27	3:00–4:00PM	EP Participation Year 2 (MU)

The webinar schedule is subject to change based on interest levels. To see the complete schedule or to register for one of the webinars, please view the webinar schedules posted on the eMedNY.org website:

- Current Month: https://www.emedny.org/meipass/webinar/Webinar.pdf
- Next Month: https://www.emedny.org/meipass/webinar/NextMonth.pdf

OMH Residential Treatment Facility Prescription Drug Carve-Out

Effective September 1, 2012, reimbursement of prescription drugs for residents of the Office of Mental Health (OMH) Residential Treatment Facilities (RTF) will be covered as a Medicaid fee-for-service (FFS) benefit and billed directly to Medicaid by the dispensing pharmacy. There are currently 19 facilities statewide, with a total of 554 certified beds.

This change only affects prescription drugs. Physician administered drugs, commonly referred to as J-code drugs, and over-the-counter (OTC) drugs, medical supplies, immunization services (vaccines and their administration), nutritional supplies, sick room supplies, adult diapers, and durable medical equipment (DME) will not be carved out of the RTF rate and will remain the responsibility of the facility.

The NYS Medicaid FFS program only provides reimbursement for prescription drugs included on the NYS Medicaid Pharmacy List of Reimbursable Drugs, and is available online at: http://www.emedny.org/info/formfile.html.

Once this change takes effect, RTF providers will no longer purchase prescription drugs for the children and youth in their programs. Prescriptions must be written on the Official New York State Prescription Form (ONYSRx), with only one medication permitted per form. Prescriptions must then be dispensed and billed by a Medicaid enrolled pharmacy, using the child's individual Medicaid Client Identification Number (CIN). These children do not have Medicaid benefit cards; therefore, the OMH RTF will provide the CIN to the pharmacy.

Pharmacy Enrollment Information

Pharmacies that supply prescription drugs to OMH RTFs must be enrolled in the Medicaid program in order to submit claims for reimbursement. No other entity may function as a billing agent for a LTC pharmacy.

Enrollment information can be found at the following websites:

- **o**   Pharmacy Enrollment Packet:

    http://www.emedny.org/info/ProviderEnrollment/FFS%20Enrollment%20Packets/4090-Pharmacy%20Enrollment%20Packet/4090-Pharmacy.pdf.

- **o**   Additional information to be submitted by out-of-state pharmacies:

    http://www.emedny.org/info/ProviderEnrollment/FFS%20Enrollment%20Packets/4020-Out%20of%20State%20Pharmacy/4020-Out%20of%20State%20Pharmacy%20Applicants.pdf

Prior Authorization Programs

The Medicaid program requires prior authorization for certain drugs through the Preferred Drug Program (PDP), Mandatory Generic Drug Program (MGDP), Clinical Drug Review Program (CDRP), and the Brand When Less Than Generic Program (BLTG). The prescriber may need to obtain prior authorization for certain drugs. General information on prescription drug prior authorization may be found on the Magellan Medicaid Administration website at: https://newyork.fhsc.com

Note: If a prior authorization number has not been obtained by the prescriber and the pharmacist is unable to reach the prescriber, the pharmacist may obtain a prior authorization for up to a 72 hour emergency supply of a multi-source brand-name or non-preferred drug, subject to state laws and Medicaid restrictions. Once a 72 hour supply prior authorization number is given and a 72 hour supply is dispensed, the prescription is no longer valid for the remaining quantity and refills. The pharmacist is expected to follow-up with the prescriber to determine future needs.

Pharmacy Program information is available on the Medicaid Pharmacy Program website at: http://www.health.ny.gov/health_care/medicaid/program/pharmacy.htm.

Information on the specific prior authorization programs as well as FQD/Step Therapy requirements can be found at the following websites:

o   Preferred Drug Program
     https://newyork.fhsc.com/providers/PDP_about.asp

o   Mandatory Generic Drug Program
     https://newyork.fhsc.com/providers/MGDP_about.asp

o   Clinical Drug Review Program
     https://newyork.fhsc.com/providers/CDRP_about.asp

o   Brand When Less Than Generic Program
     http://nyhealth.gov/health_care/medicaid/program/docs/bltg.pdf

o   Step Therapy (ST) Program
     http://www.health.ny.gov/health_care/medicaid/program/dur/docs/step_therapy.pdf

o   Frequency/Quantity/Duration (F/Q/D) Program
     http://www.health.ny.gov/health_care/medicaid/program/dur/docs/fqd_program.pdf

Questions?

Additional information regarding the Medicaid prior authorization programs is available online at: https://newyork.fhsc.com/ or by calling (877) 309-9493. For pharmacy billing questions, please call (800) 343-9000.

OMH Residential Treatment Facility Prescription Drug Carve-Out FAQ's

Q1) What is included in the OMH RTF carve out?

A1) Only prescription drugs listed on the Medicaid Pharmacy List of Reimbursable Drugs, available online at: http://www.emedny.org/info/formfile.html

Q2) How do I know which drugs on the Medicaid Pharmacy List of Reimbursable Drugs require a Prior Authorization (PA)?

A2) The Medicaid Pharmacy List contains a "PA CD" field. PA code of "0" indicates PA not required; PA code of "N" indicates PA required; and PA code of "G" indicates PA required/may be required.

Q3) Are emergency supplies of prescription drugs requiring PA permitted?

A3) Yes, if a prior authorization number has not been obtained by the prescriber and the pharmacist is unable to reach the prescriber, the pharmacist may obtain a prior authorization for up to a 72 hour emergency supply of a multi-source brand-name or non-preferred drug, subject to State laws and Medicaid restrictions. Once a 72 hour supply prior authorization number is given and a 72 hour supply is dispensed, the prescription is no longer valid for the remaining quantity and refills. The pharmacist is expected to follow-up with the prescriber to determine future needs. Additional information is available online at: https://newyork.fhsc.com/providers/PA_forms.asp.

Q4) What is not included in the OMH RTF carve-out?

A4) Items not included are physician administered drugs (commonly referred to as J-code drugs), over the counter drugs, medical supplies, immunization services (vaccines and their administration), nutritional supplies, sick room supplies, adult diapers, and durable medical equipment (DME). These items remain the responsibility of the facility.

Q5) Are over-the-counter medications included in the carve-out?

A5) No, over-the-counter medications are not included in the carve-out and the cost of these items will remain in the RTF daily rate.

Q6) Are over-the-counter drugs listed on the Preferred Drug List (PDL) also covered as a pharmacy benefit for OMH RTF?

A6) No, over-the-counter drugs are not included in the OMH RTF carve-out. They will remain the responsibility of the OMH RTF.

-continued-

Q7)   Is a newly admitted resident eligible for an early fill on their drugs?

A7)   Yes, when medically necessary, a pharmacist can override edit 01642 "Early Fill Overuse" denial at the point of sale, by using the following combination:

- ✓ National Council for Prescription Drug Programs (NCPDP) Reason for Service Code (439-E4) of 'NP'(New Patient Processing);
- ✓ A valid Result of Service Code (441-E6), and
- ✓ Submission Clarification Code (420-DK) of '02'.

Q8)   Will OMH RTF residents be responsible to pay their co-pays?

A8)   No, residents of an OMH RTF are exempt from Medicaid co-pays.

Q9)   When using the client's Medicaid number to obtain prescription medications, what Medicaid sequence number should be placed on the pharmacy claim?

A9)   A sequence number is not required on the pharmacy claim for these clients.

Reporting of the National Drug Code (NDC) is now required for all Physician Administered Drugs for Medicaid Managed Care and Family Health Plus (FHPlus) Plans

Effective September 20, 2012, Medicaid Managed Care and Family Health Plus (FHPlus) plans will require network providers to report the NDC on the claim when billing for physician administered drugs in accordance with guidance originally set forth in the June 2008 Medicaid Update.

Medicaid Managed Care and Family Health Plus plans are communicating the specific requirement to their provider network.

Attention: Medicaid Fee-for-Service Providers

Dispense Brand Drugs When Less Expensive Program

Effective August 30, 2012, Uroxatral will be **removed** from the Dispense Brand Drugs When Less Expensive Program *and* **Symbyax, Ziagen tablet and Catapres-TTS** will be **added** to the Dispense Brand Drugs When Less Expensive Program in conformance with State Education Law which intends that patients receive the lower cost alternative, brand name drugs included in this program:

- o do not require 'Dispense as Written' (DAW) or 'Brand Medically Necessary' on the prescription;
- o have a generic copayment;
- o will be paid at the Brand Name Drug reimbursement rate or usual and customary price, whichever is lower (neither the SMAC nor FUL will be applied)

IMPORTANT BILLING INFORMATION

Prescription claims submitted to the Medicaid program **do not require** the submission of Dispense As Written/Product Selection Code of '1'; and **pharmacies can submit any valid NCPDP field (408-D8) value.**

Current list of Brand name drugs included in this program* (Date Revised 8/30/2012):

Adderall XR	**Epivir**
Arixtra	**Kadian**
Astelin	**Lexapro**
Carbatrol	**Lovenox**
Catapres-TTS	**Nasacort AQ**
Combivir	**Symbyax**
Concerta	**Valtrex**
Diastat	**Ziagen tablet**
Geodon	

* List is subject to change

Please keep in mind that drugs in this program may be subject to prior authorization requirements of other pharmacy programs; again promoting the use of the most cost-effective product.

NYS Medicaid Pharmacy Prior Authorization Programs Update

The NYS Medicaid Pharmacy Prior Authorization Program is excited to introduce a new Preferred Drug List (PDL) format this month. The new format offers a centralized location for information on the Preferred Drug Program (PDP), Clinical Drug Review Program (CDRP) and the Drug Utilization Review Program (DURP).

Specific prior authorization and coverage parameters are now included in the new format:

- o Clinical Criteria
- o Frequency/Quantity/Duration Limits
- o Step Therapy Requirements

Please see below for a snapshot of the new PDL:

NYS Medicaid Preferred Drug List

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
Central Nervous System (CNS) Stimulants[F/Q/D]		

Adderall XR®
amphetamine salt combo immediate-release
Concerta®
dexmethylphenidate
dextroamphetamine
Focalin XR®
Metadate ER®
Methylin®
Methylin ER®
methylphenidate
methylphenidate SR 10 mg, 20 mg (tablet)
Vyvanse®
	Adderall®
	amphetamine salt combo extended-release
	Daytrana®
	Desoxyn®
	Dexedrine Spansule®
	dextroamphetamine SR
	Focalin®
	Metadate CD®
	methamphetamine
	methylphenidate ER 18 mg, 27 mg, 36 mg, 54 mg
	methylphenidate ER 20 mg, 30 mg, 40 mg (capsule)
	Nuvigil® cc
	Procentra®
	Provigil® cc
	Ritalin®
	Ritalin LA®
	Ritalin SR®
		CLINICAL CRITERIA (CC)
		➢ patient-specific considerations for drug selection include treatment of excessive sleepiness associated with shift work sleep disorder or as an adjunct to standard treatment for obstructive sleep apnea.
		FREQUENCY/QUANTITY/DURATION (F/Q/D)
		➢ quantity limits based on daily dosage as determined by FDA labeling
		➢ quantity limits for patients less than 18 years of age to include:
		  – Short-acting CNS stimulants, not to exceed 3 dosage units daily with maximum of 90 days per strength (for titration)
		  – Long-acting CNS stimulants, not to exceed 1 dosage unit daily with maximum of 90 days
		➢ quantity limits for patients 18 years of age and older to include:
		  – Short-acting CNS stimulants, not to exceed 3 dosage units daily with maximum of 30 days
		  – Long-acting CNS stimulants, not to exceed 1 dosage unit daily with maximum of 30 days
		➢ diagnosis is required for patients age 18 and older when prescribing greater than 30 day supply

Multiple Sclerosis Agents		
Avonex® Copaxone® Betaseron® Rebif®	Extavia® Gilenya™	

To access the complete PDL, please visit the following link:

https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf

If prior authorization (PA) is required, please contact the clinical call center at 1-877-309-9493 for assistance. The clinical call center is available 24 hours per day, 7 days per week with pharmacy technicians and pharmacists who will work with you, or your agent, to quickly obtain PA.

For additional information on the Medicaid Pharmacy Prior Authorization Programs, please visit the following websites: http://www.nyhealth.gov or http://newyork.fhsc.com or http://www.eMedNY.org

PHARMACY UPDATE

Effective August 30, 2012

Prior Authorization Changes to PDP Classes

On June 15, 2012, the New York State Medicaid Pharmacy & Therapeutics Committee recommended changes to the Medicaid pharmacy prior authorization programs. The NYS Commissioner of Health has reviewed the recommendations of the committee and has approved changes to the Preferred Drug Program (PDP) within the fee-for-service pharmacy program.   Effective August 30, 2012, prior authorization (PA) requirements will change for some drugs in the following PDP classes:

- o   Alpha Reductase Inhibitors (for BPH)
- o   Anabolic Steroids – Topical
- o   Antihistamines - Ophthalmic
- o   Beta Blockers
- o   Beta Blockers + Diuretics
- o   Cholesterol Absorption Inhibitors
- o   Dipeptidyl Peptidase-4 (DPP-4) Inhibitors
- o   Fluoroquinolones – Oral
- o   Opioids – Long-Acting
- o   Opioids – Short-Acting
- o   Pancreatic Enzymes
- o   Phosphate Binders/Regulators
- o   Prostaglandin Agonists - Ophthalmic
- o   Steroids, Topical – Medium Potency
- o   Steroids, Topical – Very High Potency
- o   Sulfasalazine Derivatives

The PDP has also expanded to include additional drug classes. Non-preferred drugs in the following drug classes will require PA:

- o   Antibiotics - Ophthalmic
- o   Antibiotic/Steroid Combinations - Ophthalmic

Please note that PA requirements are not dependent on the date a prescription is written. New prescriptions and refills on existing prescriptions require PA even if the prescription was written before the date the drug was determined to require PA. The Preferred Drug List (PDL) and additional information, such as updated PA forms and clinical criteria for the PDP and Clinical Drug Review Program (CDRP) are available at the following websites:

http://www.nyhealth.gov or http://newyork.fhsc.com or http://www.eMedNY.org

To obtain a PA, please contact the prior authorization clinical call center at (877) 309-9493. The clinical call center is available 24 hours per day, 7 days per week and staffed with pharmacy technicians and pharmacists who will work with you, or your agent, to quickly obtain a PA.

If you have any questions, wish to obtain additional information regarding the PDP or would like to receive the PDL, please contact the clinical call center at (877) 309-9493. Thank you for your continued support of our efforts to maintain a quality pharmacy program for Medicaid fee-for service beneficiaries.

New Website Portal Available to Initiate Fee-for-Service Pharmacy Prior Authorization Requests

Effective September 6, 2012, Medicaid enrolled prescribers can initiate prior authorization (PA) requests using a web-based application.* **PAXpress®** is a web-based pharmacy PA request/response application maintained by Health Information Designs (HID) and is accessible through a new button "PAXpress" located on eMedNY.org under the MEIPASS button.

- Prescribers must have an active e-PACES account. To enroll in e-PACES, please visit https://www.emedny.org/selfhelp/index.aspx.

- The website for PAXpress® is https://paxpress.nypa.hidinc.com/, which can also be accessed from the eMedNY website at https://www.emedny.org as well as Magellan's website at https://newyork.fhsc.com/.

- A user manual, designed specifically for prescribers, is available on the site, and provides information for using the PAXpress® application:

    o Logging in;
    o Requesting a PA;
    o Understanding PA request.

    Results in each section include screen shots, field definitions, and instructions on how to perform the various tasks. If you encounter trouble logging into the PAXpress® or if you have any questions regarding navigation of the application, please contact the eMedNY Call Center at (800)343-9000.

- The PAXpress® websites provides a single point of entry for prescriber access to announcements, documents and quick links to important program information.

Prior authorization will also continue to be available through the Magellan Clinical Call Center at (877)309-9493.

Please Note: Prior authorization requests through PAXpress® that do not meet clinical criteria will require that prescribers call Magellan.

Medicaid Fee-for-Service Pharmacy Actual Acquisition Cost and Cost of Dispensing Survey

In accordance with legislation passed in April 2011, the Department of Health is undertaking a comprehensive survey of Medicaid enrolled pharmacies to identify drug actual acquisition costs (AAC) and associated costs of dispensing (COD). The overall goal of this initiative is to create a cost-based pharmacy reimbursement methodology that is valid, transparent, timely and sustainable. All enrolled NY Medicaid fee-for-service pharmacies located in the State of New York are required to complete both surveys.

The pilot survey for AAC/COD is in process. The data received will be analyzed and survey processes are being reviewed. Some proposed changes to the survey process have resulted from the initial review and from input by participants that have completed the pilot surveys.

The Department is preparing to issue the initial AAC and COD surveys to all Medicaid enrolled fee-for-service pharmacies. Both the AAC survey and the COD survey will be issued in the fall of 2012.

- o For the initial AAC survey, providers will be required to submit invoice pricing for each drug (NDC level) that was purchased in the month prior to issuance of the survey. Also, total monthly drug purchase costs, net rebates and surcharges for each of the preceding 12 months will be required. All Medicaid enrolled pharmacy providers will be required to participate in the initial AAC survey. Each month thereafter, a random subset of pharmacies will be selected to submit pricing data for a one month period.

- o For the COD survey, providers will be required to report specific business costs for the most recently completed annual or fiscal year. The COD survey will be issued annually and all Medicaid enrolled pharmacy providers are required to participate.

All Providers Must Obtain a Health Commerce System Medical Professions Account

One consistent issue encountered during the pilot study was that many pharmacies are still not affiliated with the Health Commerce System (HCS).

- o All enrolled Medicaid fee-for-service pharmacies are required to have an active Medical Professions HCS account for this project. If you have an active HCS account, it may not be a Medical Professions account. Please contact HCS to ensure that you have the correct account type.

- o To set up an account, please send an e-mail to camuout@health.state.ny.us with the pharmacy name, the pharmacy's NYSED registration number, and a contact phone number.

- o The HCS has the tools necessary to securely transmit the files via the 'Secure File Transfer' tool and, for pharmacies reporting on a single NPI, the COD online survey tool is also located on the HCS.

Participation

All Medicaid enrolled fee-for-service pharmacy providers are required by regulation to participate in the AAC and COD surveys.

> *18 NYCRR 505.3 (f) (4) Each pharmacy enrolled in the Medicaid program shall provide the department, in such manner, for such periods, and at such times as the department may require, with the drug acquisition cost, as defined in paragraph 505.3(a)(3), of prescription drugs.*

Survey Tools

Providers are required to use the survey tools that are issued by the Department. No changes may be made to the survey tools; this includes changing formulas or formats, adding or deleting survey fields, or inserting attributes not already included in a defined field. Data should be reported in established fields that best define the data. If you have any questions as to where to report something, send an e-mail to medpharmpricing@health.state.ny.us for clarification. Surveys that are altered in any way will be returned for correction and resubmission.

Detailed Instruction Guidebook

The Department is developing a step-by-step instruction guide to assist providers in the preparation and submission of the AAC and COD surveys. The instruction guide and a letter explaining the AAC/COD project will be mailed to enrolled independent pharmacy providers prior to issuance of the initial surveys. The instruction guide for chain pharmacies will be sent electronically.

Wholesaler Involvement

Providers are required to submit pricing data directly; however, the Department is working closely with several servicing wholesalers in an effort to make the data collection process easier for providers. If you would like Department staff to reach out to your wholesaler to provide information regarding the format in which data must be submitted, send contact information for your wholesaler(s) and we will do so. Information should be submitted via e-mail to: medpharmpricing@health.state.ny.us.

Timelines

Providers will be permitted eight weeks to complete each survey. The COD and AAC survey time periods may overlap. Please be aware that it will take you at least 8 hours to complete each survey. The Department strongly advises providers to start preparing the required information on the survey start date to ensure compliance on the required submission date. Extensions will only be granted in cases where extenuating circumstances exist.

Any questions related to the AAC or COD surveys should be emailed to: medpharmpricing@health.state.ny.us.*****

* Please note - this is not a secure email and should not be used to submit pricing or COD data.

ATTENTION MIDWIVES, NURSE PRACTITIONERS, ORDERED AMBULATORY PROVIDERS, PHARMACISTS and PHYSICIANS

INFLUENZA VACCINE COVERAGE EXPANDED

For dates of service on or after September 1, 2012, the following influenza vaccine codes will be available for billing for certain age groups:

90654   INFLUENZA VIRUS VACCINE, SPLIT VIRUS, PRESERVATIVE FREE, FOR INTRADERMAL USE

For beneficiaries 18 years of age to 64 years of age.

90662   INFLUENZA VIRUS VACCINE, SPLIT VIRUS, PRESERVATIVE FREE, ENHANCED IMMUNOGENICITY VIA INCREASED ANTIGEN CONTENT, FOR INTRAMUSCULAR USE

For beneficiaries 65 years of age and older.

Questions? Please contact the Office of Health Insurance Programs at (800) 342-3005.

Medicaid to Require Electronic Funds Transfer (EFT) for Provider Payments and Electronic Remittance Advice (835) or PDF Version of Paper Remittances

As reported in previous Medicaid Update publications, during the upcoming months Medicaid will begin to phase-in both EFT and ERA (835s) or PDF version paper remittances. These new requirements will better align the Medicaid program with health care industry standards of practice and achieve greater administrative and financial efficiency.

In addition to the cost savings associated with eliminating the production, processing and mailing of paper, this initiative is better for the environment and in line with the "GO GREEN" movement. Providers still receiving checks and/or paper remittances are urged to act now and convert to EFT and the 835. Additional information and applications are available at www.emedny.org or click the "Go Green" icon above.

Providers who do not wish to purchase software to interpret the HIPAA-compliant ERA (835) may elect to have remittances delivered in PDF format to an eMedNY eXchange in-box. The PDF version is an exact copy of the paper remittance but delivered two weeks in advance of payment release. To establish an eXchange in-box providers must be a registered ePACES user.

Enroll in ePACES today by calling the eMedNY Call Center at (800) 343-9000.

OMIG's Self-Disclosure Update

The New York State Office of the Medicaid Inspector General (OMIG) originally issued self-disclosure guidance to Medicaid providers on March 12, 2009. OMIG developed this self-disclosure guide in consultation with health care providers and industry professionals to offer providers an easy-to-use method for disclosing overpayments.

OMIG developed this approach to encourage providers to investigate and report matters that they identify through self-review, compliance programs or internal controls that affect the state's Medicaid program, such as possible fraud, waste, abuse or inappropriate payment of funds. This guide is designed to help providers through the process, point out advantages of self-disclosure, offer a user-friendly mechanism, and make providers aware of regulatory compliance requirements.

Since its inception, the Self-Disclosure program has successfully and extensively been utilized by providers. As a result of the OMIG's Self-Disclosure Unit's experience and feedback, the agency made enhancements and added resources to the process.

The function is now supplemented by utilizing the OMIG/HMS PORTal, a web-based site maintained by OMIG's contracted agent, HMS, Inc. The PORTal is an online mechanism used by OMIG/HMS to conduct various projects and to process recoveries in a simple, effective, and user-friendly electronic medium. This guide has been revised to reflect the consolidation of the self-disclosure function within OMIG to better serve providers and the New York State Medicaid program. Manual submissions may still be submitted directly to OMIG.

Accordingly, the self-disclosure guidelines found on the OMIG website at www.omig.ny.gov have been revised. Please check the self-disclosure section on the web page for the most up-to-date guidelines before submitting any new self-disclosure documents, whether via the PORTal or on a manual basis.

Additionally, OMIG staff is in the process of developing a webinar to introduce and explain the features of the revised OMIG self-disclosure process and online PORTal mechanism. Questions or comments may be submitted via e-mail to: omig.sm.selfdisclosures@omig.ny.gov.

Once the webinar is scheduled, OMIG will announce the date via its website, the OMIG listserv, OMIG's Twitter feed (#NYSOMIG), and the Medicaid Update. To subscribe to the OMIG listserv, please visit www.omig.ny.gov and follow the subscription instructions.

Medicaid to Discontinue Use of the Omni 3750 Point of Service (POS) Device

Effective in early 2013 eMedNY will no longer support the Omni 3750 POS Device. The exact date of the discontinuance will be provided in future Medicaid Update articles. Providers who currently use the Omni 3750 POS Device to verify Medicaid eligibility or request Dispensing Validation System (DVS) prior approval should make plans immediately to switch to one of the alternate methods listed.

Real Time Options

ePACES
- Internet access, free, easy-to-use
- Supports a variety of transactions
  - MEVS eligibility; DVS; Claim status for any of your claims; Institutional, Professional, and Dental claims; prior authorizations.

eMedNY Simple Object Access Protocol (SOAP)- Real Time
- Internet accessible; provides the capability of integrating with your current system uses an already existing FTP or ePACES user ID; supports MEVS eligibility (does not support DVS.)

Batch Options(do not support DVS)

eMedNY eXchange
- Internet accessible; easy-to-use – works like an e-mail mailbox; no special scripting or software necessary to upload or download files; files retained for 28 days after submission; ePACES user ID is used to access your eMedNY eXchange mailbox; able to receive 835/820 Electronic Remits, PDF Remits, PA Rosters.

FTP (Dial-up)
- For those without high speed Internet access; login and file transmission is fully scriptable able to receive 835/820 Electronic Remits.

eMedNY Simple Object Access Protocol (SOAP) - Batch
- Internet accessible; Provides the capability of integrating with your current system; eMedNY SOAP is an XML based protocol which enables applications to exchange information over Hyper Text Transfer Protocol (HTTP); uses an already existing FTP or ePACES user ID.

Several large clearinghouses and service bureaus maintain direct real-time connections to eMedNY. Providers should check with their clearinghouse/service bureau vendor to see if they can support the real time transactions that you utilize on the Omni 3750.

At some point eMedNY may no longer be able to support POS devices. Providers currently using one of these devices are encouraged to consider one of the listed alternate methods. If the alternate methods listed are not feasible providers may wish to purchase the Verifone Vx570 POS Device. Questions and requests for technical assistance transitioning to an alternate access method may be forwarded via e-mail to emednyproviderservices@csc.com or providers may contact the eMedNY Call Center at (800) 343-9000.

New Training Schedule and Registration

- o **Do you have billing questions?**
- o **Are you new to Medicaid billing?**
- o **Would you like to learn more about ePACES?**

If you answered YES to any of these questions, consider registering for a Medicaid training session. eMedNY offers various types of educational opportunities to providers and their staff. Training sessions are available at no cost to providers and include information for claim submission, Medicaid Eligibility Verification, and the eMedNY website.

Web Training Now Available

You may also register for a webinar. Training will be conducted online and you will be able to join the meeting from your computer and telephone. After registration is completed, just log in at the announced time. No travel involved.

Many of the sessions planned for the upcoming months offer detailed instruction about Medicaid's free web-based program ePACES, the electronic Provider Assisted Claim Entry System that allows enrolled providers to submit the following type of transactions:

- o **Claims**
- o **Eligibility Verifications**
- o **Claim Status Requests**
- o **Prior Approval/DVS Requests**

Physician, Nurse Practitioner, DME and Private Duty Nursing claims may even be submitted in "REAL-TIME" via ePACES. Real-time means that the claim is processed within seconds and professional providers can get the status of a real-time claim, including the paid amount without waiting for the remittance advice.

Fast and easy registration, locations, and dates are available on the eMedNY website at: http://www.emedny.org/training/index.aspx.

eMedNY representatives look forward to having you join them at upcoming meetings!

If you are unable to access the Internet to register or have questions about registration, please contact the eMedNY Call Center at (800) 343-9000.

PROVIDER DIRECTORY
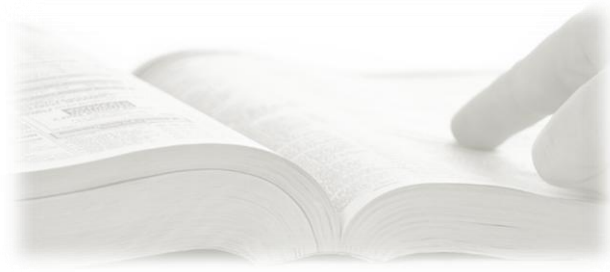
Office of the Medicaid Inspector General: For general inquiries or provider self-disclosures, please call (518) 473-3782. For suspected fraud complaints/allegations, call 1-877-87FRAUD (1-877-873-7283), or visit www.omig.ny.gov.

Provider Manuals/Companion Guides, Enrollment Information/Forms/Training Schedules: Please visit the eMedNY website at: www.emedny.org.

Providers wishing to hear 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 or e-mail: emednyproviderrelations@csc.com.

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

Need to change your address? Does your enrollment file need to be updated because you've experienced a change in ownership? Do you want to enroll another NPI? Did you receive a letter advising you to revalidate your enrollment?
Visit www.emedny.org/info/ProviderEnrollment/index.aspx and choose the link appropriate for you (e.g., Physician, Nursing Home, Dental Group, etc.)

Do you have comments and/or suggestions regarding this publication? Please contact Kelli Kudlack via e-mail at: medicaidupdate@health.state.ny.us.