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Medicaid Update

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Health and Recovery Plan (HARP) Enrollment Notices: What Providers Need to Know

Effective October 1, 2015, Medicaid Managed Care (MMC) plans will begin covering expanded Behavioral Health (BH) services for adults in New York City. Also effective October 1, 2015, Health and Recovery Plans (HARP) will begin enrollment of eligible recipients with Serious Mental Illness (SMI) and Substance Use Disorders (SUD). HARP enrollment will be phased in, beginning with current MMC adult enrollees who are system identified as HARP eligible in New York City. Providers are encouraged to refer to the July 2015 Special Edition Medicaid Update to learn more about expansion of BH services in MMC and the services available through HARP.

In August 2015, MMC plans operating in New York City began sending announcement letters to all adult enrollees informing them of the changes to the Medicaid program. On August 13, 2015, New York State's enrollment broker, New York Medicaid Choice, began sending enrollment notices on a daily basis to State-identified eligible recipients, and will continue through Fall, 2015.

It is important for providers, including Primary Care providers, to understand the BH transition process, since consumers may request assistance in understanding enrollment notices. Providers should also be familiar with their current managed care network affiliations to better assist recipients interested in HARP selection and to maintain current patient relationships.

Eligible MMC enrollees will either be passively enrolled or given an option to enroll in a HARP, depending upon current plan enrollment, as follows:

- HARP eligible enrollees in a MMC plan operated by a Managed Care Organization (MCO) that also operates a HARP product may be passively enrolled into the HARP. The enrollment notice sent by New York Medicaid Choice indicates HARP eligibility, the effective date of HARP enrollment and instructions on how to opt out of enrollment in the MCO's HARP.

- HARP eligible enrollees in MMC plans operated by a MCO not offering a HARP product may actively select and enroll in another MCO's HARP. The notice sent by New York Medicaid Choice indicates HARP eligibility, and instructions for enrollees interested in HARP enrollment and for obtaining information regarding appropriate enrollment options.

- HIV Special Needs Plans (SNP) will cover the expanded BH benefit and all HARP services for eligible enrollees, in addition to the SNP covered benefit package. The notice sent by New York Medicaid Choice indicates the member's HARP eligibility, HARP services that are available through the SNP, and instructions for enrollees interested in HARP enrollment. The notice also reminds consumers that some benefits covered by the SNP are not available through HARP enrollment.

Questions can be directed to:	*Phone*	*Email*
Division of Health Plan Contracting & Oversight	518-473-1134	omcmail@health.ny.gov
Office of Mental Health Customer Service	800-597-8481	bho@omh.ny.gov
Office of Alcoholism and Substance Abuse Services		picm@oasas.ny.gov

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Policy and Billing Guidance

FAMILY PLANNING PROVIDERS TRANSITION FROM DIAGNOSIS CODE V25 (ICD-9) TO Z30 (ICD-10)

The U.S. Department of Health and Human Services issued a rule finalizing ***October 1, 2015*** as the new compliance date for health care providers, health plans and health care clearinghouses to transition to the tenth revision of the International Classification of Diseases (ICD-10) diagnosis codes. **Effective for dates of service on and after October 1, 2015,** all Medicaid providers, including family planning providers, must use the ICD-10 diagnosis codes on all claims submitted to Medicaid.

The implementation of ICD-10 diagnosis codes does not affect Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) coding. Refer to the New York State eMedNY website for more information at ***https://www.emedny.org/icd/*****.**

Billing For Family Planning Visits

The **September 2014 Medicaid Update** article, *Additional Clarification of Medicaid Family Planning Services for Beneficiaries Enrolled in the Family Planning Benefit Program (FPBP) and the Family Planning Extension Program (FPEP),* provides instructions on submitting claims having dates of service up to and including September 30, 2015, using ICD-9 diagnosis codes. For dates of service on and after October 1, 2015, follow the instructions outlined in this Medicaid Update, using ICD-10 diagnosis codes, **Table A, *ICD-10 Diagnosis Codes for Contraceptive Management.***

Please note: Table B, *Approved Family Planning Procedure Codes,* has been updated to reflect the deletion of J1056 and the addition of 11983.

For family planning service providers this means that effective October 1, 2015, ICD-10 diagnosis codes in the Z30 series will replace the ICD-9 diagnosis codes in the V25 series. Claims for dates of service on or after October 1, 2015 for all Medicaid enrollees, including those enrolled in FPBP or FPEP, must contain an ICD-10 diagnosis code in the Z30 series. **Claims that do not contain an ICD-10 diagnosis code in the Z30 series for FPBP/FPEP enrollees will be denied.**

When billing for family planning services for a FPBP/FPEP enrollee, the visit will fall into one of three scenarios. Refer to Scenarios 1, 2, and 3 in this article for billing guidance on family planning services provided to FPBP/FPEP enrollees.

Scenario #1

Visit With or Without Treatment for a Limited Medical Condition

To bill for family planning services with or without treatment for a limited medical condition, claims **must contain:**

- a primary ICD-10 diagnosis code in the Z30 series – **Table A - *ICD-10 Diagnosis Codes for Contraceptive Management;***
- a "Y" in the Family Planning indicator field when the primary diagnosis code is in the Z30 series;
- the appropriate CPT-4 code(s) chosen from **Table B - *Approved Family Planning Procedure Codes and/or* Table C - *Procedure Codes for Treatment of Limited Medical Conditions***; and/or
- the appropriate CPT-4 code(s) chosen from **Table E - *Procedure Codes for Evaluation and Management Service***.

Scenario #2
Follow-up Visit for Treatment of Limited Medical Condition

To bill for a follow-up visit for treatment of a limited medical condition diagnosed during a previous family planning visit, claims **must contain:**

- a primary or secondary ICD-10 diagnosis code in the Z30 series – **Table A - *ICD-10 Diagnosis Codes for Contraceptive Management;***
- a "Y" in the Family Planning indicator field when the primary diagnosis code is in the Z30 series;
- the appropriate CPT- 4 code(s) chosen from **Table B - *Approved Family Planning Procedure Codes and/or* Table C - *Procedure Codes for Treatment of Limited Medical Conditions*** - follow up procedures; and/or
- the appropriate CPT- 4 code(s) chosen from **Table E** - ***Procedures for Evaluation and Management Services.***

Scenario #3
Visit for Diagnosis and Treatment of Sexually Transmitted Infections

To bill for the diagnosis and/or treatment of Sexually Transmitted Infections (STIs) pursuant to family planning services, follow the instructions below:

- If the primary reason for the visit is for the screening, diagnosis or treatment of a STI, the primary ICD-10 diagnosis code must be the STI - **Table D** - ***ICD-10 Diagnosis Codes for Sexually Transmitted Infections and Abnormal Pap Smears*** and the secondary diagnosis code must be in the Z30 series (**Table A - *ICD-10 Diagnosis Codes for Contraceptive Management).***
- If the primary reason for the visit is for family planning and STI screening, diagnosis or treatment is secondary, the primary ICD-10 diagnosis code must be in the Z30 series and the secondary diagnosis code must be the specific STI - **Table *D*** - ***ICD-10 Diagnosis Codes for Sexually Transmitted Infections and Abnormal Pap Smears.***
- The claim must contain an appropriate CPT code chosen from **Table E - *Procedure Codes for Evaluation and Management Service*** and/or the appropriate CPT code for the procedure(s) or medical supply from **Table B - *Approved Family Planning Procedure Codes*** and the item(s) and procedure(s) must clearly be provided or performed for family planning purposes and/or **Table C - Procedure Codes for Treatment of Limited Medical Conditions** (conditions diagnosed during a family planning visit).

Table A
ICD-10 Diagnosis Codes for Contraceptive Management

Z30.011	Z30.012	Z30.013	Z30.014	Z30.018	Z30.019	Z30.02	Z30.09	Z30.2	Z30.40
Z30.41	Z30.42	Z30.430	Z30.431	Z30.432	Z30.49	Z30.8	Z30.42	Z30.9	XXXX

Table B

Approved Family Planning CPT/HCPCS Codes

Items and procedures must clearly be provided or performed for family planning purposes

00851	00921	00952	11976	11981	11982	11983	55250	55450	58300
58301	58565	58600	58615	58670	58671	71010	71015	71020	77078
77080	77081	89321	93000	93010	93040	93307	96372	A4264	A4266
A4267	A4268	A4931	J1050	J7300	J7301	J7302	J7303	J7304	J7306
J7307	S4993	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX

Table C

Procedure Codes for Treatment of Limited Medical Conditions

(Limited Medical Conditions Diagnosed During a Family Planning Visit)

10060	10140	11420	11421	17110	17111	46900	46922	46924	54050	54055	54056
54057	54060	54065	56405	56420	56440	56501	56700	56820	56821	57061	57420
57421	57452	57454	57455	57456	57460	57461	57505	57510	57511	58100	58340
74000	76830	76856	76857	80048	80053	80061	80076	81000	81001	81002	81003
81007	81015	81025	82040	82043	82150	82247	82270	82465	82550	82553	82565
82570	82575	82670	82677	82947	82948	82950	82951	83001	83002	83690	84075
84144	84146	84443	84703	85002	85004	85007	85013	85014	85018	85025	85027
85032	85045	85048	85049	85210	85300	85378	85576	85610	85651	85652	85730
86580	86592	86593	86631	86632	86687	86689	86696	86701	86702	86703	86762
86780	86781	86900	86901	87015	87040	87070	87075	87077	87081	87086	87088
87102	87110	87164	87166	87205	87206	87207	87210	87252	87254	87255	87270
87273	87274	87320	87340	87390	87486	87490	87491	87495	87510	87535	87536
87590	87591	87620	87621	87797	87798	87800	87801	87808	87899	88141	88142
88143	88147	88148	88150	88152	88153	88154	88155	88160	88161	88162	88164
88165	88173	88174	88175	88302	88305	88307	99070	J0696	XXXX	XXXX	XXXX

Table D

ICD-10 Diagnosis Codes for Sexually Transmitted Infections and Abnormal Pap Smears

A50.41	A51.0	A51.1	A51.2	A51.31	A51.32	A51.39	A51.41	A51.43	A51.45	A51.46	A51.49
A51.5	A51.9	A52.00	A52.01	A52.02	A52.03	A52.06	A52.09	A52.11	A52.13	A52.14	A52.15
A52.17	A52.19	A52.2	A52.3	A52.71	A52.72	A52.74	A52.75	A52.77	A52.78	A52.79	A52.8
A52.9	A53.0	A53.9	A54.00	A54.01	A54.02	A54.03	A54.09	A54.1	A54.21	A54.22	A54.23
A54.24	A54.29	A54.31	A54.32	A54.33	A54.39	A54.40	A54.41	A54.42	A54.49	A54.5	A54.6
A54.81	A59.00	A59.01	A59.02	A59.03	A59.09	A59.8	A59.9	A60.00	A60.01	A60.02	A60.03
A60.04	A60.09	A60.1	A60.9	A63.0	A63.8	A64	A74.0	A74.81	A74.89	A74.9	B00.1
B00.2	B00.3	B00.4	B00.50	B00.51	B00.52	B00.53	B00.59	B00.81	B00.82	B00.89	B00.9
B07.8	B07.9	B33.8	B97.7	M02.30	N34.1	N76.0	N76.1	N76.2	N76.3	N76.89	R87.610
R87.611	R87.619	R87.820	Z11.3	Z20.2	Z20.5	Z20.6	Z20.828	Z71.89	Z72.51	Z72.52	Z72.53

Table E

Procedure Codes for Evaluation and Management Services

99050	99051	99201	99202	99203	99204	99205	99211	99212
99213	99214	99215	99241	99242	99243	99244	99245	99384
99385	99386	99394	99395	99396	XXX	XXX	XXX	XXX

Transportation

Medicaid will reimburse the most appropriate mode of transportation required to transport an eligible enrollee to and/or from a family planning service. Providers should consult the transportation manual to obtain information regarding transportation policy guidelines, procedures and the county contact list. The manual can be viewed at: **http://www.emedny.org/ProviderManuals/Transportation/index.html.**

FPBP Transportation Benefits

Transportation to and/or from a family planning service is a Medicaid covered service available through the FPBP only. FPEP enrollees do not have access to transportation services. Under the FPBP, only the following CPT codes are available for Medicaid reimbursement.

Table F

FPBP Transportation Procedure Codes

A0100	A0110	A0120	A0130	S0209	S0215

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Attention Rehabilitation Providers
(Occupational, Physical and Speech Therapy)
New Benefit Year Brings Change to Prior Authorization Requirement

A new benefit year began April 1, 2015 for fee-for-service (FFS) rehabilitation prior authorization (PA) requests. Rehabilitation services (physical, occupational, and speech therapy) have a 20-visit benefit limitation for specific populations. **Effective immediately,** there is no longer a requirement to obtain the authorization prior to the provision of service. System enhancements were made to the Dispensing Validation System (DVS) to permit provider requests for retroactive PAs.

Medicaid providers must still obtain PAs, but they may now obtain them prior to service, on the day of service, or after the service has been provided. The authorization must be obtained **prior to the claim submission** to Medicaid and must be included on the claim. This means that if a prior authorization was not obtained prior to the date of service, the provider must request the authorization with the DVS.

- A PA does not guarantee Medicaid payment.

- Medicaid will only pay for 20 therapy visits per therapy type (occupational, physical, and speech) per benefit year for each beneficiary that is not exempt. Additional information may be found in the Rehabilitation Services Manual online at: https://www.emedny.org/ProviderManuals/RehabilitationSrvcs/index.aspx.

- If the provider does not verify the eligibility and extent of coverage of each beneficiary each time services are requested, then the provider will risk the possibility of non-reimbursement for services provided as the State cannot compensate a provider for a service rendered to an ineligible person. Eligibility information for the beneficiary must be determined via the Medicaid Eligibility Verification System (MEVS). The MEVS Provider Manual is available online at: http://www.emedny.org/ProviderManuals/AllProviders/index.html.

INFORMATION SPECIFIC TO ARTICLE 16 CLINICS

Rehabilitation services (physical, occupational, and speech therapy) provided in an Article 16 clinic are carved out of the managed care benefit package. **Effective immediately**, Article 16 clinic providers no longer need to request manual overrides from OPWDD for the therapy PAs. **For dates of service on and after April 1, 2015**, Article 16 clinics may now obtain these PAs directly through the DVS, both retroactively and for recipients enrolled in managed care.

Reminders

There has been no change to the requirement that claim(s) contain a unique procedure code modifier for each rehabilitation service. Refer to Table 1 of this article, *Rehabilitation Procedure Code Modifiers*, for a list of modifiers. The appropriate modifiers are required on all claims for rehabilitation services, including those not requiring PA. Claims that do not contain the appropriate modifier will be denied.

Refer to Table 2 of this article, *Authorization Exemptions* for a list of enrollees, settings, and circumstances exempt from the PA requirement. Areas where there are no changes, include:

1. **20 – Visit Benefit Limit**: The 20-visit limitation on physical therapy, occupational therapy, and speech therapy is a benefit limit and remains in effect for recipients who are not exempt (Table 2) from the PA requirement. There is no means or opportunity to request an approval or an authorization for more than 20 visits to be reimbursed by Medicaid or a health plan.

2. **Benefit Year:**
   - **Medicaid FFS Enrollees:** For Medicaid FFS enrollees, the twelve-month benefit year begins on April 1st of each year and runs through March 31st of the following year.
   - **Medicaid Managed Care (MMC) Enrollees:** For MMC enrollees, the twelve-month benefit year is a calendar year, beginning January 1st of each year and running through December 31st of the same year.

3. **Requirement to use modifiers:** All providers submitting claims or PAs for physical, occupational, and speech therapy must use a procedure code modifier. The modifier identifies the therapy type and provides a mechanism for counting and matching. Without a modifier, the claim will be denied.

4. If a PA is required, it must be included on the claim at the time of submission. If no PA is on the claim and one is required, the claim will be denied.

5. There has been no change to individuals, circumstances, or settings which do not need a PA. They remain exempt from the PA requirement. Refer to Table 2 for a list of exemptions.

6. Failing to obtain rehabilitation therapy PAs, prior to or on the date of service puts the provider's reimbursement at risk. It is important for the provider to know how many of the rehabilitation therapy visits a beneficiary has already used because Medicaid will only pay for 20 therapy visits per therapy type (occupational, physical, and speech) per benefit year for each beneficiary that is not exempt. Additional information may be found in the Rehabilitation Services Manual online at: https://www.emedny.org/ProviderManuals/RehabilitationSrvcs/index.aspx.

Table 1

Rehabilitation Procedure Code Modifiers

Therapy Type	Procedure Code Modifier	Description
Physical Therapy	GP	Services delivered under an outpatient physical therapy plan of care.
Occupational Therapy	GO	Services delivered under an outpatient occupational therapy plan of care.
Speech Therapy	GN	Services delivered under an outpatient speech-language pathology plan of care.

Table 2

Authorization Exemptions

Enrollees Exempt from the PA Requirement	Settings and Circumstances Exempt from the PA Requirement
Children up to the age of 21	Rehabilitation services provided in nursing home to residents of the nursing home
Recipients with a developmental disability (R/E code 95)	
Medicare/Medicaid dually eligible recipients when Medicare pays for the rehabilitation service	Rehabilitation services provided by a certified home health agency (CHHA)
Recipients with a traumatic brain injury (R/E code 81 or a primary diagnosis on the claim in the 850 - 854 series)	Rehabilitation services provided in inpatient hospital settings

For claiming questions, please contact Computer Sciences Corporation at (800) 343-9000.
For Medicaid policy questions, please contact the Office of Health Insurance Programs at (518) 473-2160.
For MMC enrollees, please call the enrollee's health plan.

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New York State Medicaid Expansion of Coverage for Human Immunodeficiency Virus (HIV) Testing

New York State Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC) will begin reimbursement for an HIV-1/2 immunoassay capable of detecting HIV-1 antigen(s) and HIV-1 and HIV-2 antibodies (CPT 87806) in an office setting. This expansion in coverage is effective October 1, 2015 for FFS and December 1, 2015 for MMC.

The U.S. Food and Drug Administration approved test was added to the laboratory fee schedule earlier this year and is a new procedure code for 2015. This rapid test, commonly referred to as an AG/ab combo or 4th generation immunoassay, detects the presence of HIV-1 p24 antigen as well as antibodies to both HIV-1 and HIV-2, allowing for an earlier diagnosis. Early detection not only aids in patient care but also may help prevent HIV transmission.

While cases of HIV-1 are more prevalent in the United States than cases of HIV-2, both infections pose an important health risk in New York State. The appropriate course of care differs for HIV-1 and HIV-2, underscoring the importance of the ability to differentiate between HIV-1 and HIV-2 through testing.

Additional information regarding rapid HIV testing can be found on the New York State Department of Health website at the following link: http://www.health.ny.gov/diseases/aids/providers/testing/rapid/samppro.htm.

Questions regarding Medicaid FFS policy should be directed to the 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.

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Reporting of Newborn Birth Weight

Billing Reminder

Providers are reminded that pursuant to the inpatient billing procedures for All Patient Refined Diagnostic Related Groups (APR DRGs) documented in ***New York State UB-04 Billing Guidelines – Inpatient Hospital***, claims for newborns, 28 days or younger, must contain the newborn's birth weight in grams. The birth weight is reported using Value Code 54 in the Value Information segment.

The billing guidelines regarding newborns are detailed under **2.3.1.2, Rule 3 – Newborns** (https://www.emedny.org/ProviderManuals/Inpatient/PDFS/Inpatient_Billing_Guidelines.pdf).

To ensure proper payment, providers should follow these guidelines when billing Medicaid fee-for-service (MFFS) as well as billing Medicaid Managed Care (MMC) plans.

For MFFS billing guideline questions, please contact the eMedNY Call Center at 1-800-343-9000. Questions regarding MMC billing and reimbursement requirements should be directed to the enrollee's MMC plan.

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Billing for Behavioral Health Services for New York City SSI and SSI-Related Enrollees *Effective October 1, 2015*

Effective October 1, 2015 in New York City, the Medicaid Managed Care (MMC) benefit package is expanding to include certain Behavioral Health (BH) programs and services (mental health and alcohol and substance use disorder) and injectable medications (long-acting atypical antipsychotics and extended release naltrexone) for all enrollees age 21 and over. These services will no longer be covered under the Medicaid fee-for-service (FFS) program for SSI and SSI-Related enrollees, requiring these BH provider claims to be billed to the enrollee's MMC plan. Commencing July 1, 2016, this expansion will apply to the rest of the State.

While the State has made many system modifications to support this transition, system configurations continue to be made. Specifically, eligibility verification of New York City adults will incorrectly respond "**Mental Health"** carve-out for SSI consumers until all system changes are completed. This response should not deter providers from appropriately billing the enrollee's MMC plan for BH covered services. Beginning October 1, 2015, providers are required to bill the enrollee's MMC plan for such services provided on or after the October 1, 2015 implementation date.

Until the system changes are complete, providers in New York City who inappropriately bill Medicaid FFS for BH services for MMC enrollees may have their claims paid instead of denied. Please note that the New York State Department of Health (DOH) will conduct a review of BH FFS payments to identify any incorrect payments made after the BH transition implementation date. All inappropriate payments will be recovered by DOH.

The following Managed Care programs are not expanding BH services at this time and therefore are not affected by the above system changes: Managed Long Term Care - Partial Capitation, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Advantage, and Medicaid Advantage Plus.

Provider questions should be directed to the eMedNY Call Center (Provider Hotline) at 1-800-343-9000.

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Pharmacy Changes for New York City Behavioral Health Transition to Managed Care

Effective October 1, 2015, in accordance with the timeline referenced in the July Special Edition Medicaid Update, Medicaid Managed Care (MMC) plans serving New York City members will begin covering injectable atypical (second generation) long acting antipsychotics for their SSI and SSI related enrollees. MMC plans serving New York City members will also begin covering naltrexone extended release suspension (Vivitrol®). Additionally, policies that promote access to these medications and smoking cessation agents are being implemented. The following summarizes these changes.

- **Long-Acting Injectable Antipsychotics, typical and atypical**
  - MMC plans will begin covering atypical injectables for SSI and SSI-related enrollees. Previously, these were covered under fee-for-service (FFS);
  - MMC plans will cover typical and atypical long-acting injectables as both a pharmacy and medical benefit. Billing and policy guidance will be communicated to providers by the MMC plans; and
  - Prior authorization (PA) for typical long-acting antipsychotics (e.g., haloperidol decanoate and fluphenazine decanoate) will not be required.

- **Medications used for the treatment of Substance Use Disorders (SUD)**
  - Extended-release naltrexone injectable (Vivitrol®) will be covered as a pharmacy and medical benefit (previously a FFS benefit). Billing and policy guidance will be communicated to providers by the MMC plans;

- MMC plans will include medications for the treatment of SUD and/or opioid dependency on their formularies (not solely through a medical exception process);
- At least one formulation of buprenorphine and buprenorphine/naloxone will be included in plan formularies;
- Clinical criteria for buprenorphine shall also consider lengths of therapy for enrollees transitioning from long acting opioids, or who are pregnant or breast feeding; and
- Naloxone vials/prefilled syringes and/or the auto-injector and/or atomizer will be covered as a medical and pharmacy benefit.

The chart below provides guidance for determining coverage (MMC vs. FFS) for risperidone microspheres (Risperdal® Consta®), paliperidone palmitate (Invega® Sustenna®), olanzapine (Zyprexa® Relprevv™), aripiprazole (Abilify Maintena®) and naltrexone (Vivitrol®) as of 10/1/2015.

Member Qualified for Social Security Income (SSI) or is SSI Related?	**Member's Geographic Location**	**Age**	**Coverage Provided By**
No	Entire State	All Ages	MMC Plan
Yes	New York City	21 or older	MMC Plan
Yes	New York City	20 or younger	Medicaid FFS
Yes	Outside of New York City	All Ages	Medicaid FFS

- **Medications Used for Smoking Cessation**
  - Course limitations will not apply to enrollees with a SUD and/or a diagnosis of mental illness;
  - MMC plans will allow for concomitant utilization of two (2) agents, defined as: two (2) nicotine replacement therapies (NRTs); a NRT and bupropion sustained release (SR); or a NRT and Chantix.

The NYS Medicaid Managed Care Pharmacy Benefit Information Center has been updated to include therapeutic classes affected by the Behavioral Health Transition. This site also provides direct links to MMC web sites, MMC plan contact information, a "drug look-up" option, and functionality to view coverage for selected therapeutic classes; e.g., Atypical Antipsychotics, Smoking Cessation Agents etc.

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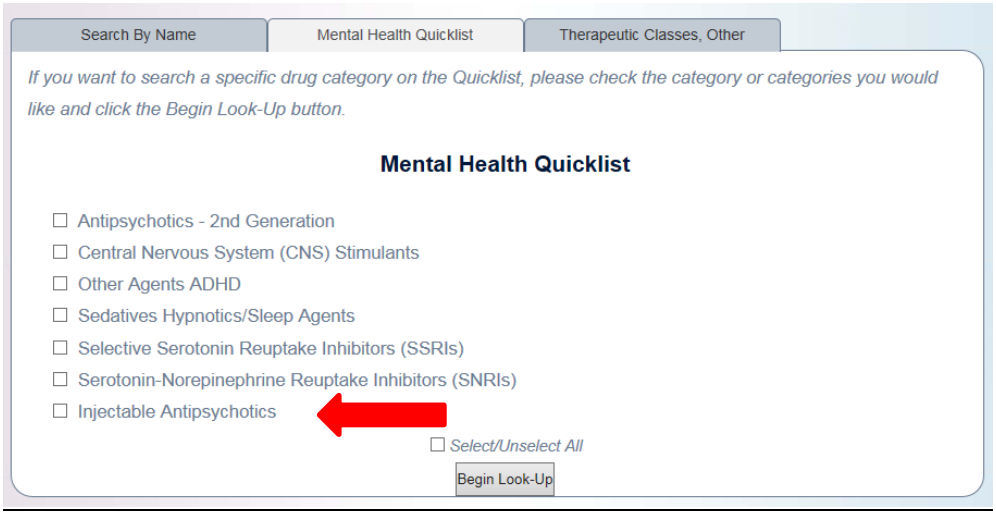
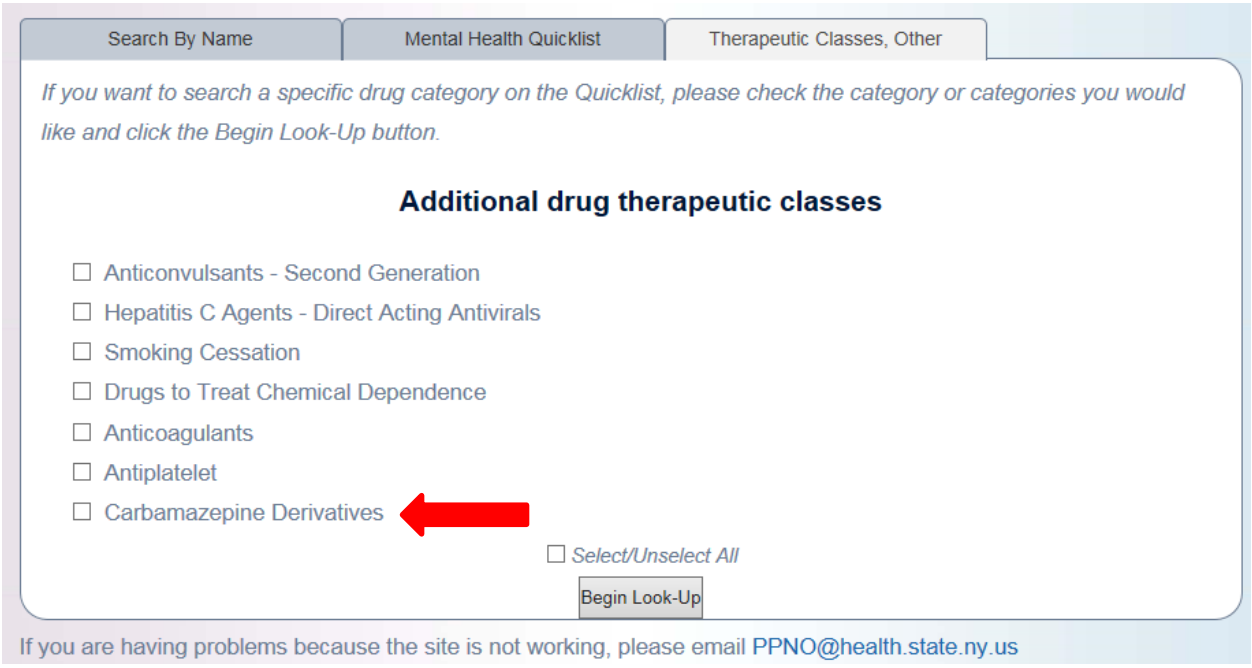
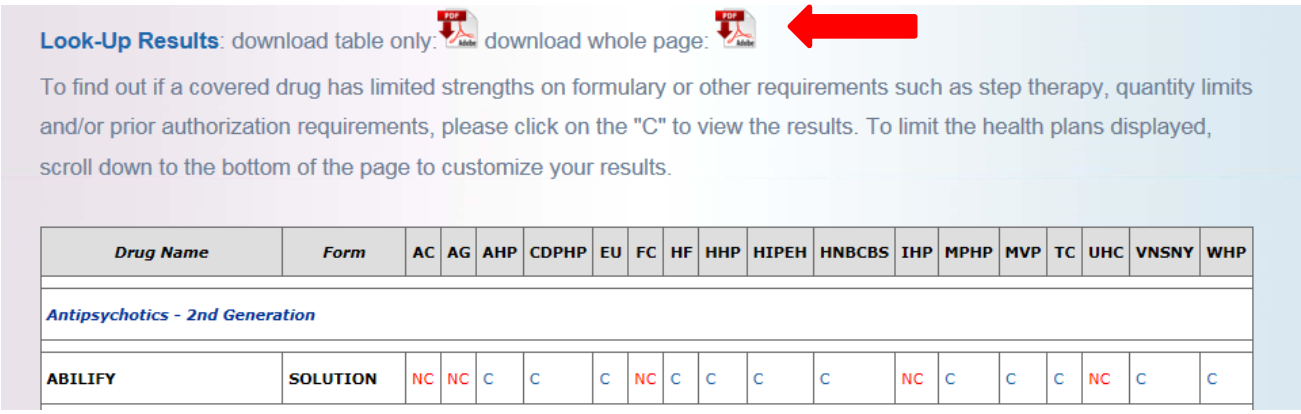
Pharmacy Update

New York State Medicaid Managed Care Pharmacy Benefit Information Website Update

The New York State Department of Health in partnership with the State University of New York at Stony Brook continue to add new drug/drug categories to the New York State Medicaid Managed Care (MMC) Pharmacy Benefit Information Website. The most recent update, occurring in August 2015, includes the addition of an **Injectable Antipsychotic** category to the ***Mental Health Quick list*** **tab** and a **Carbamazepine Derivatives** category to the ***Therapeutic Classes, Other*** **tab** on the **Drug Look-Up page.** Patients and providers will quickly be able to view drug coverage in these therapeutic categories by specific MMC plan(s) as shown below. In addition, a **download feature** has been added to the specific drug list categories. Once a drug category is selected there is an option at the top of the screen to download the **table only** or the **whole page**. This will allow providers to print out specific drug lists. Formulary coverage is subject to change. Providers should consult the website for the most current coverage.


Search By Name
Mental Health Quicklist
Therapeutic Classes, Other
If you want to search a specific drug category on the Quicklist, please check the category or categories you would like and click the Begin Look-Up button.
Mental Health Quicklist
Antipsychotics - 2nd Generation
Central Nervous System (CNS) Stimulants
Other Agents ADHD
Sedatives Hypnotics/Sleep Agents
Selective Serotonin Reuptake Inhibitors (SSRIs)
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)
Injectable Antipsychotics
Select/Unselect All
Begin Look-Up


Search By Name
Mental Health Quicklist
Therapeutic Classes, Other
If you want to search a specific drug category on the Quicklist, please check the category or categories you would like and click the Begin Look-Up button.
Additional drug therapeutic classes
Anticonvulsants - Second Generation
Hepatitis C Agents - Direct Acting Antivirals
Smoking Cessation
Drugs to Treat Chemical Dependence
Anticoagulants
Antiplatelet
Carbamazepine Derivatives
Select/Unselect All
Begin Look-Up
If you are having problems because the site is not working, please email PPNO@health.state.ny.us



Look-Up Results: download table only: download whole page:

To find out if a covered drug has limited strengths on formulary or other requirements such as step therapy, quantity limits and/or prior authorization requirements, please click on the "C" to view the results. To limit the health plans displayed, scroll down to the bottom of the page to customize your results.

Drug Name	*Form*	AC	AG	AHP	CDPHP	EU	FC	HF	HHP	HIPEH	HNBCBS	IHP	MPHP	MVP	TC	UHC	VNSNY	WHP
Antipsychotics - 2nd Generation																		
ABILIFY	SOLUTION	NC	NC	C	C	C	NC	C	C	C	C	NC	C	C	C	NC	C	C

The MMC Pharmacy Benefit Information website is available at:
http://pbic.nysdoh.suny.edu

In addition you can link to the website from the following pages:

New York State Department of Health Medicaid Managed care Page:
http://www.health.ny.gov/health_care/managed_care/
Click on Medicaid Managed Care Pharmacy Benefit Information Center

The eMEdNY home page under “Featured Links” at:
https://www.emedny.org/index.aspx
Click on New York State Medicaid Managed Care Pharmacy Benefit Information Center

Redesigning New York’s Medicaid Program Page under supplemental information on specific MRT proposals:
http://www.health.ny.gov/health_care/medicaid/redesign/
Click on MRT 11& MRT 15, Pharmacy Related Proposals & then click on Managed Care Plan Pharmacy Benefit Manager and Formulary Information

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All Providers

The Interim New York State Medicaid Management Information System (NYMMIS) Website is Open for Subscribers

In order for providers and all interested parties to stay up-to-date on process changes related to NYMMIS, all are being encouraged to sign up for the ListServ.

The ListServ will be the main source for communicating information vital to providers as NYMMIS moves forward.

Please visit: www.interimnymmis.com

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All Providers

New York State Medicaid EHR Incentive Program Update

The NY 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 $714 million*** in incentive funds have been distributed ***within 20,627*** payments to New York State Medicaid providers.

20,627 Payments	$714+ Million Paid	Are you eligible?

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

Pre-validation Services for 2015

Have you already determined your Medicaid patient volume for payment year 2015? If so, please take advantage of our pre-validation services!
An eligible professional (EP) may submit Medicaid encounter data prior to attesting. The Medicaid data will be reviewed ahead of time, which could potentially expedite the approval process when the EP submits the complete attestation in MEIPASS.

Don't delay! Pre-validation is available to both individual and group EPs.

Contact hit@health.ny.gov to request a pre-validation file for payment year 2015. Please make sure to include your NPI and patient volume method (individual or group aggregate).
Note: We cannot review Medicaid data that is within the past 90 days because this clearance period is needed for claims to be processed and finalized.

Email LISTSERV

We encourage providers and administrative staff to sign up for our email LISTSERV to receive important announcements about the Medicaid EHR Incentive Program.

- ✓ Hospital EHR Incentive Program
- ✓ Practitioner EHR Incentive Program
- ✓ Public Health

Subscribe at www.emedny.org/Listserv/EHR_Email_Alert_System.aspx

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

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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 or e-mail: emednyproviderrelations@csc.com.

Enrollee 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 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 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