Medicaid to Discontinue Reimbursement for TASA, NBA and CONNECT Case Management Services

Effective December 1, 2011, pending federal approval, Medicaid will no longer reimburse providers for optional targeted Comprehensive Medicaid Case Management (CMCM) services, specifically for: *Teen Age Services Act (TASA), Neighborhood Based Alliance (NBA) and CONNECT programs*. However, the provision of case management services remains the responsibility of Local Districts of Social Services (LDSS), with suggested options outlined below.

TASA provides case management services for eligible pregnant and parenting teens and/or at-risk teens under the age of 21; NBA targets individuals residing in under-served and economically distressed areas, which currently operates in the Addison City School District, Steuben County and in the City of Fulton, Oswego County; and CONNECT targets women of child-bearing ages that are pregnant or parenting infants under one year of age, which is currently operating in Onondaga County only.

The basis for termination of these optional CMCM services is the availability of other case management services through a variety of vehicles, including Medicaid managed care and patient-centered medical homes – both of which are responsible for providing case management services – as well as an array of community-based programs that can serve the targeted populations.

To ensure a seamless transition for the recipient population, both the LDSS and case management providers will be notified of this change in reimbursement and will be provided with a list of public health programs in their geographic area for referral of clients, depending on client needs. Medicaid recipients receiving services through these programs will also be notified and referred to their LDSS for an appropriate referral for case management services.

This action is solely the result of a change in Medicaid policy that applies to all Medicaid recipients. It does not limit the provision of services by the LDSS, nor does it limit other Medicaid State Plan services.

Questions? Contact the Division of Policy and Planning at (518) 473-2160.

IN THIS ISSUE …

ATTENTION PROVIDERS & PHARMACISTS:
See pages 19-21 for important information
for Medicaid Managed Care and Family Health Plus beneficiaries!

Expanded Coverage of Telemedicine

Telemedicine is the use of interactive audio and video telecommunications technology to support "real time" interactive patient care and consultations between healthcare practitioners and patients at a distance. The distant site or "hub" is where the medical specialist providing the consultation or service is located. The originating or "spoke" site is where the referring health professional and patient are located.

Medicaid currently covers medically necessary physician specialist consultations provided via telemedicine to patients in Article 28 emergency rooms, hospital outpatient departments and hospital inpatient settings.

In response to a Medicaid Redesign Team (MRT) initiative, Medicaid has taken steps to expand and enhance coverage of telemedicine. The goal of this undertaking is to provide Medicaid enrollees with greater access to specialty care by reducing the barriers encountered by providers requesting and delivering care via telemedicine.

Effective for dates of service on or after October 1, 2011:

Telemedicine **"hub" sites** will include:

- Article 28 Hospitals;
- Article 28 Diagnostic and Treatment Centers (D&TCs); and
- Federally Qualified Health Centers (FQHCs) that have "opted into" APGs.

Telemedicine **originating "spoke" sites** will include:

- Article 28 Hospitals (Emergency Room, Outpatient Department, Inpatient);
- Article 28 Diagnostic and Treatment Centers (D&TCs); and
- FQHCs that have "opted into" APGs and non-FQHC School Based Health Centers (SBHCs).
  - ➢ Rate codes are being developed to permit FQHCs that have not "opted into" APGs, as well as SBHCs that are FQHCs, to bill for the administrative costs associated with telemedicine. Providers will be notified when these rate codes become active.

Practitioners, who may provide telemedicine services at the **"hub" site** will include:

- Physician Specialists (including Psychiatrists);
- Certified Diabetes Educators (CDEs); and
- Certified Asthma Educators (CAEs or A-ECs).

COVERAGE REQUIREMENTS

Telemedicine consultations are covered when medically necessary and when the following requirements are met:

- The patient must be physically present at the originating "spoke" site; the physician specialist and/or CDE/CAE is located at the "hub" site.
- The physician specialist at the "hub" site, who is performing the consult, must be licensed in New York State, enrolled in New York State Medicaid and be credentialed and privileged at both the "hub" and "spoke" site hospital and/or D&TC.
- The CDE/CAE at the "hub" site must be enrolled in New York State Medicaid as either a billing provider (i.e., MD, Nurse Practitioner, and Licensed Midwife) or a non-billing provider. CAEs and CDEs, who are non-billing providers, cannot bill Medicaid directly. They must enroll as non-billing Medicaid providers and be employed by or contracted with a billing Medicaid provider. A complete listing of professional entities that are qualified to provide CDE/CAE services is available in the October 2008 *Medicaid Update* at the following Website: http://nyhealth.gov/health_care/medicaid/program/update/2008/2008-10.htm#dia.
- The request and medical need for the telemedicine consult and the findings of the consulting physician or CDE/CAE must be documented in the patient's medical record.
- The telemedicine consultation must be "real time," and provided via a fully interactive, secure two-way audio visual telecommunication system ("store and forward" is not covered by Medicaid).

Telepsychiatry

Medicaid will reimburse for consultations provided by a psychiatrist through an audio/visual link as well as ongoing therapy provided by a psychiatrist. As with all other telemedicine services, if the originating "spoke" site is an Article 28 facility (hospital outpatient department or diagnostic and treatment center), the "spoke" site is directly responsible for all patient care, and is also required to credential and privilege the psychiatrist who is located at the distant "hub" site (see the information below on credentialing/privileging requirements). In addition to psychiatric consultations, ongoing therapy provided by the psychiatrist at the distant "hub" site may be billed to Medicaid.

Diabetes Self-Management Training (DSMT) / Asthma Self-Management Training (ASMT)

Medicaid will reimburse for CDE/CAE diabetes and asthma self-management training services provided through telemedicine. As with all other telemedicine services, if the distant "spoke" site is an Article 28 facility (hospital outpatient department or diagnostic and treatment center), the "spoke" site is directly responsible for all patient care. The decision whether a medical practitioner needs to be present to assist the patient receiving CDE/CAE services through telemedicine rests with both the practitioner at the "spoke" site as well as the CDE/CAE providing the education, e.g., it may be advantageous for a practitioner (physician, physician assistant, nurse practitioner, or RN) to be physically present with the patient when certain procedures are taught or presented such as insulin injection, use of an insulin pump, appropriate and effective use of a nebulizer, etc.

Detailed policy and billing guidance, including the appropriate diagnosis and procedure codes, for diabetes and asthma self-management training, can be found in the October 2008 *Medicaid Update*.

To view this information, please visit:
http://nyhealth.gov/health_care/medicaid/program/update/2008/2008-10.htm#dia.

CREDENTIALING AND PRIVILEGING REQUIREMENTS

Physicians

New York hospitals acting as originating telemedicine "spoke" sites are required to ensure that physicians who are providing consultations via telemedicine at distant "hub" sites are appropriately credentialed and privileged. Pursuant to previously published health department policy (see link below to access the September 22, 2006 *"Dear Chief Executive Officer"* letter), a hospital facility, including one that is acting as a telemedicine "spoke" site, may enter into a contract with an outside entity to carry out all or part of the professional application and verification process (physician credentialing). This includes activities associated with the collection and verification of information specific to credentials and prior affiliations/employment. A hospital "spoke" site may therefore enter into a contract with the "hub" site to receive and collect credentialing information, perform all required verification activities and act on behalf of the "spoke" site hospital for such credentialing purposes regarding those physicians who will be providing patient consultations via telemedicine. Such contracts must establish that the "spoke" site hospital retains ultimate responsibility for the physician credentialing.

"Spoke" site hospitals may <u>not</u> delegate, through a contract, their responsibility for peer review, quality assurance/quality improvement activities and decision making authority for granting medical staff membership or professional privileges (physician privileging).

Please see the linked Dear Chief Executive Officer letter for further details.
http://www.health.ny.gov/professionals/hospital_administrator/letters/2006/administrator/2006-09-22_mandated_credentialing_guidance.pdf

CDEs/CAEs (Verification Requirements)

The hospital, D&TC or office serving as the originating "spoke" site is responsible for ensuring that the CDE/CAE, who is providing self-management training services via telemedicine, is a New York State licensed, registered, or certified health care professional, who is also certified as an educator by the <u>National Asthma Educator Certification Board (CAE) or the National Certification Board for Diabetes Educators (CDE)</u>. Educators in this program are expected to practice within the scope of practice that is appropriate to their respective discipline, as defined by the Office of the Professions, New York State Education Department.

FACILITY/PHYSICIAN REIMBURSEMENT

Hospital OPD – "Hub" site

The "hub" site should bill Medicaid under APGs for the telemedicine consultation using the appropriate E&M consultation code or the appropriate CDE/CAE self-management training code appended <u>with</u> the "GT" modifier *(via interactive audio and video telecommunication system)*.

The physician specialist, providing the consult via telemedicine, should bill Medicaid using the appropriate E&M consultation code appended <u>with</u> the "GT" modifier *(via interactive audio and video telecommunication system)*.

Hospital OPD – "Spoke" site

The hospital OPD "spoke" site should bill Medicaid for the visit using the appropriate E&M visit code and/or CPT procedure code under APGs <u>without</u> the "GT" modifier. If the "spoke" site is not providing any medical services or care other than offering the telemedicine link to the "hub" site, the "spoke" site should bill CPT code Q3014* through APGs to recoup administrative expenses associated with the telemedicine patient encounter. The attending physician at the hospital OPD "spoke" site should bill Medicaid using the appropriate E&M visit and/or CPT procedure code <u>without</u> the "GT" modifier.

D&TC – "Hub" site

The D&TC "hub" site should bill Medicaid under APGs using the appropriate E&M consultation code or the appropriate CDE/CAE self-management training code appended <u>with</u> the "GT" modifier (*via interactive audio and video telecommunication system*).

Since the professional component for the consulting physician's services is included in the D&TC APG payment, no additional professional reimbursement will be made to the physician for the consultation.

D&TC – "Spoke" site

The D&TC "spoke" site should bill Medicaid using the appropriate E&M visit code and/or CPT procedure code under APGs <u>without</u> the "GT" modifier. If the "spoke" site is not providing any medical services or care other than offering the telemedicine link to the "hub" site, the "spoke" site should bill CPT code Q3014* through APGs to recoup administrative expenses associated with the telemedicine patient encounter.

Since the professional component for the physician's services is included in the D&TC APG payment, no additional professional reimbursement will be made to the physician for the telemedicine patient encounter.

* Under APG reimbursement, Q3014 will only be paid to "spoke" facilities when billed as a stand-alone service. If the "spoke" site is providing and billing for medical services that take place at the time of the telemedicine encounter, Q3014 will not be reimbursed. Additionally, Q3014 will not pay in APGs, even as a standalone service, until January 1, 2012.

Managed Care Coverage

Coverage of telemedicine services by Medicaid Managed Care (MMC) is optional. Please check with the enrollee's MMC Plan to determine if telemedicine services are covered and, if so, for medical necessity criteria and plan-specific billing instructions. Although optional, if telemedicine services are covered under a MMC Plan, the credentialing and privileging requirements described in this article must be met.

Questions regarding Medicaid fee-for-service policy and claiming should be sent via e-mail to the following mailbox: pffs@health.state.ny.us.

Questions regarding Medicaid Managed Care coverage should be directed to the enrollee's MMC plan.

Changes to Medicaid Managed Care Exemptions and Exclusions Categories

Effective October 1, 2011, and contingent on New York State receiving the necessary federal approvals, the following circumstances **will no longer** be sufficient reasons to be exempt or excluded from enrolling in a Medicaid managed care plan in mandatory counties. These changes are needed in order to enroll additional populations into Medicaid managed care or other care coordination programs over the next three years.

- o Residents of Mental Health family care homes.
- o Persons with a relationship with primary care providers not participating in any managed care plans (effective 7/1/11).
- o Geographic accessibility-Persons without a choice of primary care provider in a plan within 30 miles-30 minutes.
- o Individuals temporarily living outside of their home district (e.g., college students).
- o Pregnant women with prenatal providers not participating in any managed care plans. Women in their second trimester may continue to see their existing prenatal care provider through 60 days postpartum (this also includes Nurse Midwives). Please refer to the June 2011 *Medicaid Update* article, Prenatal Care Providers Update, for more information.
- o Persons living with HIV (Exemption now ended statewide).
- o Non-SSI, Seriously and Persistently Mentally Ill (SPMI) adults, and Non-SSI, Seriously Emotionally Disturbed (SED) children. Please refer to the July 2011 *Medicaid Update* article, Mandatory Enrollment of SPMI Adults and SED children, for more information.
- o Individuals who cannot be served due to a language barrier.
- o Persons with chronic medical issues with specialist providers not participating in any managed care plans.*

Individuals newly enrolled in a Medicaid managed care plan who are undergoing a course of treatment may be eligible for transitional care. **Non-participating** providers are required to provide transitional care for a period of up to 60 days from date of enrollment. For persons with an already approved course of treatment such as home care or personal care services, **participating** providers are required to provide transitional care until the health plan's approved treatment plan is in place.

Information on exemptions and exclusions as well as information on how to apply for another exemption not listed above is at NY Medicaid Choice at (800) 505-5678 or from the Local Departments of Social Services (LDSS).

The Medicaid Redesign Team (MRT) and legislative initiatives require most Medicaid recipients to transition and be enrolled in a managed care plan by April 2013. As a result, all providers are strongly encouraged to enter into contractual arrangements with Medicaid managed care plans in the provider's service area in order to continue to provide needed services to members once they transition into a Medicaid managed care plan.

For a list of managed care plans by county, please visit:
http://www.nyhealth.gov/health_care/managed_care/pdf/cnty_dir.pdf

For more information on the Medicaid Redesign Team initiatives now being implemented, please visit:
http://nyhealth.gov/health_care/medicaid/redesign/.

* Individuals with chronic medical issues who have had a relationship for at least six months with a specialist provider not participating in any managed care plans are allowed one exemption limited to six month duration. This exemption will defer enrollment into a Medicaid managed care plan for up to six months, and is limited to persons who are in active treatment at the time of the exemption request.

Changes in the Enrollment Processing into Mandatory Managed Care

Effective October 1, 2011*, Medicaid applicants residing in counties that have implemented mandatory managed care will be required to choose a Medicaid managed care plan at the point of application for Medicaid eligibility. This procedure will allow for a more expedited enrollment in a managed care plan once Medicaid eligibility is determined.

If an applicant chooses a managed care plan on the Medicaid application form, the effective date of enrollment into the plan of choice will generally be the first of the month following the full Medicaid eligibility determination. Failure to choose a plan on the Medicaid application will result in the state assigning the consumer into a plan effective the first day of the month after determination of Medicaid eligibility unless the consumer is otherwise exempt or excluded from managed care enrollment.

New Medicaid cases for Supplemental Security Income (SSI) recipients who automatically receive Medicaid when Social Security opens their SSI cash assistance cases and current Medicaid recipients will have 30 days to choose a health plan.

Once enrolled, all medical services covered by the member's managed care plan must be accessed through participating providers. Providers who are currently treating Medicaid recipients under the fee-for-service program are encouraged to discuss with their patients how to choose a plan that best meets their medical needs. If the patient wishes to maintain a relationship with a particular provider, he/she must choose a Medicaid managed care plan in which that provider participates.

The Medicaid Redesign Team and legislative initiatives require most Medicaid recipients to transition and be enrolled in a managed care plan by April 2013. As a result, all providers are strongly encouraged to enter into contractual arrangements with Medicaid managed care plans in the provider's service area in order to continue to provide needed services to members once they transition into a Medicaid managed care plan.

For a list of managed care plans by county, please visit:
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For more information on the Medicaid Redesign Team initiatives now being implemented, please visit:
http://nyhealth.gov/health_care/medicaid/redesign/.

* Contingent upon approval from the Centers for Medicare and Medicaid Services (CMS).

Childcare, ICF-DD, Inpatient, Residential Health and Home Health Providers

IMPORTANT NOTICE ON EDIT 02068:
'PROVIDER RATE FOUND WITHOUT MATCHING ZIP/LOCATOR CODE.'

Institutional providers were notified in the **March 2011** *Medicaid Update* of the Department's initiative to ensure accurate reporting of where a service was performed, which is critical for correct reimbursement and program compliance.

From **April-July 2011**, claims that failed Edit 02068 were placed on a schedule of **payment holds** to assist providers in identifying billing errors. This schedule has resulted in significant improvement in compliance with accurate service location reporting. Some providers continue to report a nine-digit zip code that is not a recognized service location. A common error is use of the pay-to address instead of the nine-digit zip code of the service location(s).

During **October 2011**, the Department will begin changing the status of Edit 02068, meaning **claims will deny** when the nine-digit zip code is not found as a service location on enrollment records. Providers will be notified through their eMedNY Provider Type listserv regarding their specific implementation schedule.

To sign up for the eMedNY listserv (Provider Type and General), please visit:
https://www.emedny.org/listserv/emedny_email_alert_system.aspx.

Questions? Please contact the eMedNY Call Center at (800) 343-9000.

The New York State Medicaid Prescriber Education Program Announces Free Online CME

The New York State Department of Health (NYSDOH) in conjunction with the State University of New York (SUNY) has developed a free, online, accredited continuing medical education (CME) program: *"The Role of Palivizumab in RSV Bronchiolitis."* The sessions cover epidemiology, virology, and prevention of respiratory syncytial virus (RSV), associated morbidity and mortality, and the economic impact of RSV. The module also includes an interactive algorithm to guide providers in making evidence-based treatment decisions. After viewing this CME program, participants should be able to:

- Discuss the incidence of RSV hospitalization and death among infants.

- Recognize the signs/symptoms of RSV bronchiolitis.

- Identify the season/months during which RSV infection peaks.

- Define the role of palivizumab in the prevention of RSV bronchiolitis hospitalization/complications.

- Identify high-risk populations and assess who should and who should not receive RSV prophylaxis based upon current AAP guidelines and primary literature references.

- Design a palivizumab regimen for RSV prophylaxis in a high-risk patient.

The program takes about 45 minutes to complete and is accredited for 0.75 AMA PRA Category 1 credits.

Please visit http://nypep.nysdoh.suny.edu/rsvintroduction for more information and to register and complete the online offering.

Important Notice to Pharmacies

New York Medicaid Pharmacy Services Signature Requirement

18 NYCRR 504.3 (e) states that a duty of the Medicaid provider is "to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons."

In an effort to strengthen the Medicaid pharmacy program and prevent improper payments, effective **October 1, 2011,** pharmacy providers must obtain a signature from the beneficiary or their designee confirming receipt of the pharmacy service(s).

This policy applies to all pick-ups, home deliveries and facility deliveries. Claim submission is not proof that the prescription or fiscal order was actually furnished.

Provisions of this signature requirement at time of pick up include:

- The signature documentation must also include the prescription number and date the prescription/fiscal order was picked up. If multiple prescriptions are being picked up at one time, a single signature verifying receipt will be sufficient for all of the patient's prescriptions/fiscal orders.
- Electronic signatures for receipt are permitted only if retrievable upon audit and kept on file by the pharmacy.
- Obtaining a signature to confirm receipt of prescriptions/fiscal orders can be part of a counseling log.
- The signature confirmation must be maintained by the dispensing pharmacy for six years from the date of payment and must be retrievable upon audit.

Provisions of this signature requirement for facility delivery include:

- A signature is required at the time of delivery.
- The signature documentation must also include the list of prescription number(s) and date the medication(s) was/were delivered. A single signature verifying receipt will be sufficient for all of the medications in the delivery.
- Electronic signatures for receipt or electronic tracking slips for delivery are permitted only if retrievable on audit.
- A waiver signature form is not an acceptable practice, and such forms will not serve as confirmation of delivery. Waiver signature forms are defined by delivery industry standards.
- Confirmation of the delivery must be maintained by the pharmacy for six years from the date of payment and must be retrievable on audit. Delivery industry tracking receipts that contain a signature (e.g., FedEx tracking receipts) qualify as a signature for receipt of delivery.

Additional information on the Home Delivery policy is outlined in the January 2011 *Medicaid Update*. Please visit: http://nyhealth.gov/health_care/medicaid/program/update/2011/2011-01.htm#pha.

Questions? Please contact the Office of Health Insurance Programs at (518) 486-3209.

Medicaid Benefits to Change for Medicare/Medicaid Dual Eligibles

Effective October 1, 2011, the Medicaid program will no longer cover drugs in the following drug classes when billed for full benefit Medicare/Medicaid dual eligibles:

- Atypical antipsychotics;
- Antidepressants;
- Antiretrovirals used in the treatment of HIV/AIDS; and
- Antirejection drugs used for tissue and organ transplants.

Drugs in these classes must be billed directly to the Medicare/Medicaid enrollee's Part D plan, or when applicable, to Medicare Part B. Prior authorization or exception requests may be required by the Part D plan.

The New York State Medicaid Program will continue to cover certain drugs which are excluded from the Medicare Part D benefit, such as barbiturates, benzodiazepines, some prescription vitamins and some non-prescription drugs. These drugs may continue to be billed directly to Medicaid.

We strongly encourage prescribers and pharmacists to work with Medicare Part D plans prior to October 1, 2011, to obtain coverage of these drugs and avoid interruption in their patients' drug therapy.

Please contact Medicare at 1-800-MEDICARE for information regarding Medicare drug benefits. Questions pertaining to Medicaid drug coverage may be directed to (518) 486-3209.

Free Medscape CME and Checklist: New Tools for Safe Injections

Providers in New York State and across the nation now have two important new tools to help them and staff members make sure that every medical injection performed at their facility is a safe injection.

The Centers for Disease Control and Prevention has released a Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care. This guide is accompanied by a checklist that can be used to assess infection control and prevention practices.

In addition, the Safe Injection Practices Coalition (SIPC) has announced the release of a free Medscape continuing medical education (CME) activity on safe injection practices, titled Unsafe Injection Practices: Outbreaks, Incidents, and Root Causes. The CME is now "live" on Medscape's Website. It will educate healthcare providers about safe injection practices, help to dispel common myths and emphasize basic infection control methods that can be applied to any healthcare setting.

Free CME
Unsafe Injection Practices: Outbreaks, Incidents, and Root Causes

Learn More

Brought to you by the Safe Injection Practices Coalition

Medscape EDUCATION

According to the Safe Injection Practices Coalition (CDC is a member), in the last decade, more than 130,000 patients in the United States have been notified of potential exposure to hepatitis B, hepatitis C, and HIV due to lapses in basic infection control practices. Many of these lapses involved healthcare providers reusing syringes, resulting in contamination of medication vials or containers which were then used on subsequent patients.

New York is a "partner state" in the SIPC's "One & Only Campaign," whose slogan is: "One Needle, One Syringe, Only One Time."

**Please visit the following site for more information:
http://oneandonlycampaign.org/content/healthcare-provider-information**.

Important Information for Cardswipe Providers

The Office of the Medicaid Inspector General (OMIG) would like to remind cardswipe providers to take all necessary steps to ensure sensitive information obtained through the use of the Medicaid cardswipe terminal remains confidential. You may be in violation of the Health Insurance Portability & Accountability Act (HIPAA) should this information become public knowledge.

For more information on HIPAA regulations, please visit: www.HHS.gov, and click on Regulations.

For additional information on the Card Swipe Program please visit the Office of the Medicaid Inspector General's Website at http://omig.ny.gov/data/. Click on the "Resources" tab, and choose "Landline Units" or "Mobile Units".

Questions? Please contact (518) 402-1470.

Prepare for ICD-10 Today

After the successful implementation of the 5010/D.0 project, eMedNY has initiated analysis and planning for the implementation of International Classification of Diseases, 10th Edition (ICD-10). Providers are strongly encouraged to initiate their planning soon. Compliance for ICD-10 begins October 1, 2013. ICD-10 will replace the ICD-9 medical code sets currently used for coding diagnoses and inpatient hospital procedures, by adopting ICD-10-CM (Clinical Modification) for diagnosis coding and ICD-10-PCS (Procedure Coding System) for inpatient hospital procedure coding.

ICD-10 compliance will be date-of-service driven. Therefore, eMedNY expects that entities covered under the Health Insurance Portability and Accountability Act (HIPAA) sending fee-for-service (FFS) claims for dates of service after September 30, 2013 will utilize the ICD-10 code sets.

For rate-based claims that span past the October 1, 2013 implementation date, eMedNY expects the charges to be split in two (2) separate claims: one for Dates of Service before October 1, 2013, which will use ICD-9, and another claim for dates of service after September 30, 2013, using ICD-10. For Inpatient claims the Discharged Date will determine the ICD version.

The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used after September 30, 2013. Atypical transactions, while not HIPAA-covered, will still need to report the appropriate ICD Diagnosis Code.

Please inform your billing and coding staff of these changes. eMedNY will require claims submitted for dates of service after September 30, 2013 to use ICD-10 in order to receive payment.

Reminder: HIPAA 5010/D.0 Compliance Date is January 1, 2012

New York Medicaid is 5010 Compliant, Are You?
On July 21, 2011, New York State Medicaid implemented system enhancements that provided eMedNY with the capability to accept and process HIPAA 5010/D.0 transactions. The implementation was in response to a January 15, 2009, final rule released by the federal Department of Health and Human Services (DHHS) requiring use of the 5010/D.0 transactions standards by January 1, 2012. The July 21 implementation date was important to ensure providers/vendors had sufficient time to understand the 5010 changes and update their billing systems accordingly to ensure they would be able to support the 5010/D.0 transactions by the January 1, 2012 compliance date.

Since the July 21 implementation only a small number of submitters, outside of those who use ePACES, have converted to the 5010 format. January 1, 2012 is less than four months away and we are concerned that providers/vendors may be underestimating the magnitude of required billing systems changes and the need to conduct successful testing with eMedNY. Please take the necessary steps to ensure your billing system will be 5010 compliant by January 1, 2012.

Provider Testing Environment Available
eMedNY offers a Provider Testing Environment (PTE) that will accept and process 5010 HIPAA X12 and NCPDP D.0 transactions from trading partners who wish to test their program changes with eMedNY. It is strongly recommended that all providers and vendors submitting electronic transactions test their submissions using the PTE.

Information about testing with eMedNY is available in the Standard Companion Guide – Trading Partner Information available on the eMedNY Website at:
https://www.emedny.org/hipaa/5010/transactions/eMedNY_Trading_Partner_Information_CG.pdf.

Providers who utilize the services of a vendor or billing service are urged to contact those entities to ensure their systems will be prepared to submit electronic transactions in the 5010 format by the January 1, 2012 compliance date.

Version 5010 Electronic Remittances
Providers receiving electronic remittances (835/820) should notify eMedNY when they are ready to begin receiving their electronic remittances in 5010 format in test and/or production by completing and submitting the form available at:
https://www.emedny.org/info/ProviderEnrollment/Provider%20Maintenance%20Forms/5010_Electronic_Remittance_Request_Form.pdf.

All electronic remittances produced by eMedNY after January 1, 2012 will be in the 5010 format.

Additional Information: Please visit the eMedNY HIPAA Support page at:
http://www.emedny.org/HIPAA/5010/index.html.

Questions? For technical support regarding connectivity or for assistance in troubleshooting rejected transactions, please contact the eMedNY Call Center at (800) 343-9000. Or e-mail emednyproviderservices@csc.com or emednyhipaasupport@csc.com.

ALL PROVIDERS

eMedNY Provider Test Environment 5010/D.0 Testing

Consistent with a mandate issued by the Office of the Secretary of the Department of Health and Human Services (DHHS), eMedNY will require that all providers send electronic transactions in the new **5010/D.0 format by January 1, 2012**. Electronic remittances will only be offered in 5010 format following this date.

In order to assist providers in the transition to the new requirements, the eMedNY Provider Testing Environment (PTE) is open to all NYS Medicaid trading partners to test batch and real-time Electronic Data Interchange (EDI) transactions using the same validation and adjudication logic methods as the production environment. The Provider Testing Environment accepts and processes 5010 HIPAA X12 and NCPDP D.0 transactions.

eMedNY PTE will support batch file submission and subsequent processing for ASC X12 transactions (versions 4010 and 5010), and NCPDP transactions (versions 1.1/5.1 and 1.2/D.0). Trading Partners may also conduct real-time testing (only supported transactions) in eMedNY PTE. **Note:** If the test transaction is submitted in version 4010 or 5.1, the response should be expected in the same version. Similarly, if the test transaction is submitted in version 5010 or D.0, you should expect the response returned in version 5010 or D.0 respectively.

Trading partners may utilize any of their existing eMedNY access method(s) to submit test files into the eMedNY PTE. Testing in eMedNY PTE will be supported via FTP (batch dial-up or VPN), CPU to CPU (real-time), PC-to-Host (real-time), eMedNY eXchange (batch), and eMedNY SOAP (real-time or batch).

PC-to-Host and CPU-to-CPU testing in PTE will have limited availability. CPU-to-CPU users will be scheduled for testing, by eMedNY, on an individual basis. All test transactions undergo the same processes to verify data structure and content as if they were submitted to the production environment. Responses, for the most part, will mirror a production response.

The only difference between transactions to be routed to the Provider Test Environment or those sent to the eMedNY production environment is the value of a test indicator in the transaction. For ASC X12 transactions, Data Element ISA15, the Usage Indicator, will be a T to indicate a test transaction as shown below.

**(4010 transaction) ISA*00* *00* *ZZ*1234 *ZZ*EMEDNYBAT
*110504*1428*U*00401*000000485*0*T*:~**

**(5010 transaction) ISA*00* *00* *ZZ*1234 *ZZ*EMEDNYBAT
*110504*1428*^*00501*000000485*0*T*:~**

For NCPDP D.0 transactions, Field 702 in the Batch Transmission Header Record will be T to indicate a test transaction as shown below.

ØØT123456789Ø123456789Ø22229876747199412Ø11632T12ABCDEFGHYTEWQASDXZAQ1234

Questions? Please contact the eMedNY Call Center at (800) 343-9000 or via e-mail to: emednyproviderservices@csc.com or emednyhipaasupport@csc.com.

Provider Seminar Schedule for October-December 2011 Now Available

With the implementation of changes for HIPAA 5010 compliant submissions, including ePACES, CSC has scheduled an extensive list of educational seminars for the October-December, 2011 period. The list includes seminars on new ePACES screens and functionality, new providers and eMedNY Website enhancements.

ePACES is the electronic Provider Assisted Claim Entry System which allows enrolled providers to submit the following type of transactions:

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

Physician, Nurse Practitioner, DME and Private Duty Nursing claims can 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 seminar registration, locations, and dates are available on the eMedNY Website at:
http://www.emedny.org/training/index.aspx

CSC Regional Representatives look forward to meeting with you at upcoming seminars!

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.

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 any of the following numbers:
(800) 997-1111, (800) 225-3040, or (800) 394-1234.

Address Change?
Address changes should be directed to the eMedNY Call Center at (800) 343-9000.

Fee-for-Service Providers: A change of address form is available at:
http://www.emedny.org/info/ProviderEnrollment/allforms.html.

Rate-Based/Institutional Providers: A change of address form is available at:
http://www.emedny.org/info/ProviderEnrollment/allforms.html.

**Does your enrollment file need to be updated because you've experienced a change in
ownership?** Fee-for-service providers please call (518) 402-7032.
Rate-Based/Institutional providers please call (518) 474-3575.

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

Do you suspect that a Medicaid provider or beneficiary has
engaged in fraudulent activities?

PLEASE CALL: 1-877-87FRAUD

Your call will remain confidential. You may also complete
a complaint form online at: www.omig.ny.gov.

ATTENTION: PROVIDERS AND PHARMACIES
*Please assist us in notifying beneficiaries of this upcoming program change
by displaying this poster and Frequently Asked Questions (FAQs) document
in your practice. Feel free to copy and distribute.*

EFFECTIVE OCTOBER 1, 2011

MEDICAID MANAGED CARE AND FAMILY HEALTH PLUS BENEFICIARIES

THIS NOTICE PROVIDES INFORMATION ABOUT UPCOMING CHANGES TO YOUR MANAGED CARE BENEFIT.

▶ You <u>must</u> use your <u>health plan card</u> to receive your prescriptions, <u>not</u> your Medicaid benefit card, effective October 1, 2011.

▶ During August 2011, your health plan sent you information about your pharmacy benefit and what drugs are included under your health plan. If you have any questions, please contact your health plan directly.

▶ Health plans each have their <u>own</u> list of drugs. If a drug is not on your health plan's list, you or your pharmacist may need to talk to your doctor about changing to a drug on your health plan's list, or your doctor can ask the plan to let you continue taking the same drug. Information regarding what drugs are on your health plan's list were sent to you by your health plan at the end of August.

▶ If you are taking a drug that is not on your plan's list and you are unable to contact your doctor to change to a covered drug, your health plan will allow a one-time only fill of your medication.

▶ You must use a pharmacy that takes your health plan. If your pharmacy does not take your health plan, you may need to obtain new prescriptions from your doctor to bring to a plan pharmacy. More information regarding your plan's participating pharmacies will be sent to you at the end of August.

▶ Your co-payments for drugs will not change.

Effective October 1, 2011, your pharmacy benefits will be provided by your health plan.

Contact your health care plan if you have any questions about this change.

NEW YORK
state department of
HEALTH

ATTENTION:
MEDICAID MANAGED CARE AND FAMILY HEALTH PLUS MEMBERS
EFFECTIVE OCTOBER 1, 2011,
PHARMACY BENEFITS WILL BE PROVIDED BY YOUR HEALTH PLAN

Frequently Asked Questions (FAQ)

Q1.   What has changed about the Medicaid Pharmacy benefit?
ANSWER: Beginning October 1, 2011, members enrolled with Medicaid and Family Health Plus managed care plans will have their pharmacy benefit paid for by their health plans instead of the Medicaid program directly. This means that members will need to work with their physicians and health plans to make certain the drugs they use are covered.

Q2. How do I know if the medications I am currently taking will be covered by my health plan?
ANSWER: You should have received a letter from your plan with information about which drugs are included on its formulary (list of covered drugs). If you did not receive this letter or have questions, please contact your health plan. You may also contact the NYS Medicaid helpline at (800) 541-2831 for assistance.

Q3.   How can I obtain a list of the medications my plan covers?
ANSWER: You should contact your health plan directly to obtain its formulary or list of covered drugs. You may also contact the NYS Medicaid helpline at (800) 541-2831 for assistance.

Q4.   Which card do I need to use at the pharmacy?
ANSWER: Effective October 1, 2011, Medicaid managed care and Family Health Plus beneficiaries must use their health plan card (not their Medicaid/CBIC card) at the pharmacy.

Q5. What if I do not have a health plan card?
ANSWER: You must contact your managed care plan and ask them to issue a new health plan card. All plans have help lines. Please visit your plan's Website or contact the NYS Medicaid helpline at (800) 541-2831 to obtain your plan's number.

Q6. What if I do not know what health plan I have chosen?
ANSWER: To find out what plan you currently have, please contact the New York State Medicaid helpline at (800) 541-2831.

Q7. Will my co-payment change?
ANSWER: Co-payments for drugs will remain the same in both Medicaid and Family Health Plus with one exception; there will be no co-payments for supplies if you are in a Medicaid Managed Care Plan.

Q8. I do not see my drug on my plan's formulary or list of covered drugs and I've been on this drug for a while; can I stay on it?
ANSWER: If you've been on the drug for a while, you may be able to stay on that drug. For example, many plans will continue to cover antipsychotics, immunosuppressants, antiretroviral therapy, anticonvulsant and antidepressant drugs for their members that are already on these drugs. You should contact your plan to find out if the drug you are on is one that your plan will continue to cover for you, even though it may not be on their list of covered drugs.

Q9. My drug is not covered by my plan; can I get a temporary supply?
ANSWER: Between October 1, 2011 and December 31, 2011, you can get a ***one-time*** temporary fill of up to 30 days for each drug you are currently taking that is not available through your plan.

Q10. I received a one-time fill and I need my medication again. What should I do? ANSWER: You need to contact your doctor. The doctor may decide to change to a drug covered by your health plan or your doctor can ask the plan to make an exception to their formulary rules.

Frequently Asked Questions (FAQ)

Q11. What if my drug is not covered and no other medication will work for me?
ANSWER: Your doctor needs to contact your plan and ask them to make an exception to their formulary rules and let you continue taking the drug.

Q12. What if the plan still won't pay for my medication after my doctor asks for an exception?
ANSWER: You can appeal your plan's denial to internal and external reviewers. Contact your plan for information about their appeal process. You can also call the Community Health Advocates Hotline at (888) 614-5400 for assistance, or the NYS Medicaid helpline at (800) 541-2831 for help with contacting your plan.

Q13. Can I also ask for a fair hearing?
ANSWER: Yes, you can ask for a fair hearing with aid continuing so that you can continue to receive the drug while you wait for the hearing. For help in requesting a fair hearing, you can call the Fair Hearings Hotline at (800) 342-3334 or call the Community Health Advocates Hotline at (888) 614-5400.

Q14. Will I be able to use the same pharmacy and doctor?
ANSWER: You can continue with the same pharmacy and doctor, as long as they participate with your managed care plan. Ask your pharmacy and doctor to check to make sure they are participating.

Q15. I cannot find a pharmacy in my neighborhood that accepts my health plan. What do I do?
ANSWER: You should contact your health plan for assistance in locating a neighborhood pharmacy that accepts your health plan.

Q16. I have Hemophilia (Bleeding disorder), how will I get my blood products (clotting factor)?
ANSWER: Clotting factor products will continue to be covered by Medicaid fee-for-service benefit for a limited period of time. When billing for these items the pharmacy can use your Client Identification Number (CIN) on the health plan card to bill Medicaid.

Q17. My managed care or Family Health Plus plan is Fidelis Care New York. How will I get my family planning prescriptions after the October 1 change?
ANSWER: You will continue to get your family planning items from Medicaid. Your pharmacy should bill Medicaid for these services using the alpha numeric Client Identification Number (CIN) on your Fidelis card.

Q18. When I used my Medicaid to get medications, I had no problems. Why can't I just continue to use my Medicaid card?
ANSWER: A new state law requires that these changes be made to your Medicaid benefit. The law and/or regulation(s) that allow us to do this are Social Services Law (SSL) Sections 365-i and 369-dd, as repealed by L. 2011, ch. 59, Pt. H, Section 5 (Medicaid managed care pharmacy benefit change); SSL Section 369-ee(1)(e)(v) and 369-ee(2-b) (FHP pharmacy benefit change).

Q19. Can I switch managed care plans if I do not like the pharmacy benefits?
ANSWER: If you are within the first 90 days of joining the health plan, then you may leave and join another plan. However, once the first 90 days are over, you are "locked in" to that plan for the rest of the year (the next nine months). After the 9 month "lock-in" you may switch plans at any time. However, the lock-in applies after the first 90 days of enrollment every time you switch plans. For help making a decision about which plan to join, you can call the State's Enrollment hotline at (800) 505-5678.