New Legislation Regarding Provision of the Pertussis (Whooping Cough) Vaccine By Article 28 Hospitals

Pertussis, or whooping cough, is a highly contagious bacterial disease that causes uncontrollable, violent coughing. The coughing can make it difficult to breathe. A deep "whooping" sound is often heard when the patient tries to take a breath. When an infected person sneezes or coughs, tiny droplets containing the bacteria move through the air, and the disease is easily spread from person to person. [1]

Since the 1980s, cases of whooping cough in infants younger than five months old have increased more than 50 percent. Infants under the age of 12 months may become seriously ill as a result of whooping cough, and are more likely to develop complications and be hospitalized than people in other age groups. [2]

Effective January 18, 2013, based on changes to Public Health Law, general hospitals with newborn nurseries or providing obstetric services will now be required to offer the pertussis vaccine to every parent, person in parental relation or other individual who is reasonably anticipated to be a caregiver of a newborn being treated in the hospital.

If the individual declines the hospital's offer or wishes to defer the vaccine, the hospital must provide information on where the individual may go to be vaccinated. The hospital is not required to provide the vaccine to parents and caregivers who have already had the vaccine or to those for whom it is medically inappropriate.

New York State Medicaid covers the pertussis vaccine. The following CPT code should be used when billing for the pertussis vaccine for parents/caretakers.

90715   **TETANUS, DIPHTHERIA TOXOIDS AND** *ACELLULAR PERTUSSIS VACCINE* **(TDAP), WHEN ADMINISTERED TO INDIVIDUALS 7 YEARS OR OLDER, FOR INTRAMUSCULAR USE**

IN THIS
ISSUE

JANUARY 2013 NEW YORK STATE MEDICAID UPDATE

POLICY & BILLING GUIDANCE

(continued from cover)

New Legislation Regarding Provision of the Pertussis (Whooping Cough) Vaccine by Article 28 Hospitals

If the parent, parental relation or other individual anticipated to care for the infant receives fee-for-service Medicaid and wishes to have the pertussis vaccine Medicaid will reimburse the hospital for administering the vaccine. The vaccine and vaccine administration should be billed by the hospital as ordered ambulatory services. Fee-for-service billing instructions can be found at the following link:

https://www.emedny.org/ProviderManuals/communications/H-052-10842_att1_Change_In_Billing_for_Vaccine_Administration_12-6.pdf

When billing for individuals enrolled in Medicaid Managed Care (MMC) or Family Health Plus (FHPlus), hospitals should contact the enrollee's managed care plan for specific billing instructions.

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

Questions regarding billing and claiming issues should be directed to the eMedNY Call Center at (800) 343-9000.

Reference:

[1] www.ncbi.nlm.nih.gov/pubmedhealth/PMH0002528
[2] www.babycenter.com/0_whooping-cough_10911.bc

Enrollment of Newborns When a Mother Is Enrolled in Medicaid Managed Care or Family Health Plus

Newborns born to women receiving medical assistance on the date of birth are automatically eligible for Medicaid for one year. If the mother is enrolled in a Medicaid Managed Care plan (MMCP), the newborn will be enrolled in the same plan from the date of birth. Women who receive Family Health Plus (FHPlus) at the time they give birth are treated in the same manner as women who receive Medicaid for purposes of hospital reporting and the infant's Medicaid eligibility. If the mother's FHPlus plan also participates in Medicaid Managed Care (MMC), the newborn will be automatically enrolled in that MMCP. If the mother's FHPlus plan does not participate in MMC the mother will be asked to select a MMCP for the unborn child. The mother in FHPlus may subsequently transfer the newborn to another health plan if other children in the household are in a different health plan. The only exceptions to the automatic enrollment of a newborn into the same MMCP as the mother are when the newborn receives comprehensive third party health insurance (TPHI). In this case, the child will be disenrolled to fee-for-service Medicaid.

WHAT PHARMACIES NEED TO KNOW

When the mother of an infant presents the infant's Medicaid benefit unborn card to the pharmacy to obtain a prescription for the infant, the pharmacy should know that **the infant is guaranteed eligibility through the mother's MMCP or, if the mother is not enrolled in an MMCP, through Medicaid fee-for-service (FFS).** The pharmacist should ask the mother if she is enrolled in Medicaid FFS or MMC to verify which insurance they should bill the infant's prescription to. If the mother of the infant is enrolled in Medicaid FFS, the pharmacist should bill Medicaid FFS for the infants' prescription. If the mother is enrolled in a MMCP, the pharmacist should ask her to present her MMCP card, as the infant will be enrolled in the same MMCP (see paragraph below for exceptions to this rule). The claim should then be processed through the mother's MMCP (after any available third party health insurance is billed). If the claim cannot be processed because the infant is not found in the MMCP's system, the pharmacist should contact the MMCP (not the plan's pharmacy benefits manager) to report the infant's information. The MMCP will add the information into the system to allow for an on-line adjudication. If the mother is enrolled in an MMCP, the pharmacy should NOT process the claim through the Medicaid FFS (eMedNY) system, as the infant's eligibility file may not be updated for plan enrollment, and the resulting erroneous payments will be subject to audit and recoupment.

EXCEPTION: If the mother lives in *Essex or Franklin County*, and is enrolled in Excellus Health Plan's FHPlus program, her infant will be enrolled in either Medicaid fee-for-service or Fidelis Care. If the mother lives in *Clinton County*, and is enrolled in Excellus Health Plan's FHPlus program, the infant will be enrolled in Medicaid fee-for-service, Fidelis Care or United Healthcare. The pharmacist should ask the mother which plan she chose for her infant.

POLICY & BILLING GUIDANCE

HOSPITAL RESPONSIBILITIES

Hospitals must report live births to women who receive Medicaid/FHPlus to the State Department of Health, or its designee, within five business days of the birth. Hospitals may face a financial penalty of up to $3,500 per occurrence for each birth it fails to report within the established five-day timeframe. Hospitals also must notify each mother, in writing upon discharge, that her newborn is deemed to be enrolled in the Medicaid program and that she may access care, services and supplies available under the Medicaid program for her baby, provided that she was covered under Medicaid or FHPlus at the time of the birth. Infants born to women enrolled in FHPlus are also entitled to one year of "automatic" Medicaid eligibility. Since July 1, 2000, births have been reported by hospitals through an electronic birth certificate process.

Current state regulations require hospitals and all approved Medicaid providers to conduct a Medicaid eligibility verification (eMedNY) clearance on each presenting Medicaid recipient to determine Medicaid eligibility status and medical coverage. Under this policy, hospitals must also determine the newborn's managed care status by checking the mother's status on eMedNY. The hospital must check:

o *Medicaid eligibility status;*

o *Medical coverage - Eligible PCP or FHPlus and an insurance code indicate enrollment in managed care or FHPlus plan and the specific managed care or FHP provider; and*

o *MEVS eligibility responses no longer include scope of benefits information for managed care plans. Providers must contact the health plan to determine plan covered services. Service type codes are used to identify carved-out services, where possible.*

It is possible that a pregnant managed care enrollee may present herself at an out-of-network hospital and need to be admitted for delivery. In this case, that hospital must notify the MMCP promptly and bill the MMCP for the newborns and mother's inpatient costs associated with the birth. MMCPs will reimburse the hospital at the Medicaid rate or at another rate if agreed to between the MMCP and the hospital. The hospital should not bill the eMedNY system. If a hospital bills eMedNY and is paid, the state will recover the erroneous FFS payment. The MMCP may not deny inpatient hospital costs for untimely billing or notification if the claim is made within 15 months of the date of service, except as otherwise provided by contractual agreement between the plan and the hospital. MMCPs are not required to pay claims for delivery and newborn services submitted more than two years after the date of service, where the hospital failed to report the birth to the Department of Health.

Providers must continue to determine whether the newborn and/or mother are enrolled in a MMCP. If either is enrolled and the service to be provided is a covered service by the MMCP, the provider should contact the plan before rendering service, except in an emergency.

Note: HIV Special Needs Plans (SNPs) are MMCP specifically for Medicaid recipients with HIV or AIDS. The policy for enrollment of infants whose mothers are HIV SNP enrollees is generally the same as for other MMCPs. If the newborn's mother is enrolled in an HIV SNP at the time of his/her birth (and the child does not receive TPHI), the newborn will be enrolled in the mother's plan, effective the first day of the child's month of birth. If the mother wants the child to be in a plan other than the one she is enrolled in, the child may be transferred to another plan prospectively, at the mother's request.

Questions regarding Medicaid managed care may be referred to the Consolidated Call Center at (800) 541-2831. Questions regarding FHP or Medicaid eligibility for newborns may be referred to the toll-free Newborn Helpline at (877) 463-7680.

Attention: <u>**ALL**</u> Dentists

A revised "Dental Policy and Procedure Code Manual" and "Dental Fee Schedule" are available on the eMedNY website at: www.emedny.org/ProviderManuals/Dental.

The new manuals are effective for dates of service on or after January 2, 2013.

The major revisions are in compliance with changes that were made to the 2013 CDT and include the <u>removal</u> of procedure codes:

- o **D0360** (cone beam CT) - *use procedure code D0367 instead*;

- o **D1203** (topical fluoride application for beneficiaries under 21) – *use procedure code D1208 instead*;

- o **D1204** (topical application of fluoride for beneficiaries 21 and over) – *use procedure code D1208 instead*;

- o **D6970** (post and core in addition to fixed partial denture retainer, indirectly fabricated) – *use procedure code D2952 instead*; and,

- o **D6972** (prefabricated post and core in addition to bridge retainer) – *use procedure code D2954 instead*.

The <u>addition</u> of procedure codes:

- o **D0367** (cone beam CT capture);

- o **D0502** (other oral pathology procedures) – only available for enrolled oral pathologist;

- o **D1208** (topical application of fluoride);

- o **T1013** (sign language and oral interpretive services).

The 2013 "Dental Policy and Procedure Code Manual" and "Dental Fee Schedule" <u>must</u> be referenced for full details as well as a complete listing of all the changes.

Orthodontists

Authorizations for the initiation of orthodontic treatment (D8070, D8080 or D8090) that were issued through the "New York City Orthodontic Rehabilitation Program (NYCORP)" **prior to January 1, 2012,** and treatment has not begun will not be honored without a re-assessment of the **current** needs of the patient case. A **new prior approval** must be submitted and reviewed and a new determination made by the benefit administrator (either fee-for-service or managed care) for that patient. If benefits are administered through fee-for-service, the request and all supporting documentation will need to be submitted to eMedNY following the instructions in the "Dental Policy and Procedure Code Manual" which is available at: www.emedny.org/ProviderManuals/Dental.

If only **interceptive treatment** was authorized by either Albany or NYCORP without an authorization for any comprehensive treatment and comprehensive treatment is now being requested, this represents a new phase of treatment with a different treatment plan. A **new prior approval** will need to be submitted and reviewed and a new determination made by the benefit administrator (either fee-for-service or managed care) for that patient.

Beginning February 1, 2013, authorizations for de-banding and retention (D8680) for patients whose orthodontic benefit is administered through the fee-for-service program will require the submission of a prior approval to eMedNY. The submission of documentation directly to the Dental Unit will no longer be accepted.

For orthodontic cases where **orthognathic surgery** is required and the patient is enrolled in a managed care plan, **the plan is responsible for the surgical component** of treatment even if the orthodontic phase is administered through the fee-for-service program. Regardless of any approvals or authorizations issued through NYCORP, the orthodontist and surgeon must coordinate treatment with the plan to obtain any approvals or authorizations for treatment that the plan may require for the orthognathic surgery.

Dental Clinics

The following pre-diagnostic procedure codes will be added to APG's **for dates of service on or after April 1, 2013**:

o D0190 (screening of a patient) – only available for treatment programs approved by the Bureau of Dental Health (BDH**)**;

o D0191 (assessment of a patient) - only available for academic dental centers (ADCs).

Any questions should be directed to the Division of OHIP Operations, Dental Prepayment Review Unit at (800) 342-3005 (option #2), or (518) 474-3575 (option #2) or by e-mail to: dental@health.state.ny.us.

New York Medicaid Electronic Health Records Incentive Program Update

The New York State Department of Health (NYSDOH) is pleased to announce that as of January 11, 2013, the New York Medicaid Electronic Health Records (EHR) Incentive Program has now paid more than $271 million in federal incentive funds to more than 3,950 New York State hospitals and healthcare practitioners.

The New York Medicaid EHR Incentive Program is now accepting attestations from eligible professionals (EPs) and eligible hospitals (EHs) for both adoption/implementation/upgrade (in providers' first year of participation) and Meaningful Use Attestation (MUA) (for providers' second participation year).

Hospitals participating in both the Medicare and Medicaid EHR Incentive programs will be required to complete their MUA for the Medicare EHR Incentive Program using the CMS Registration & Attestation System prior to attesting in the New York Medicaid EHR Incentive Program Application Support Service (MEIPASS).

EPs have until March 31, 2013, to attest in MEIPASS for Payment Year 2012 as their first or second participation year. EHs have until January 31, 2013, to attest in MEIPASS for Payment Year 2012 as their first or second participation year. New York Medicaid encourages all providers to attend our revised participation year 1 and 2 webinars to view enhancements recently made in the MEIPASS application.

All providers are encouraged to make sure they have maintained all program prerequisites and eligibility requirements prior to attesting. This includes being enrolled as a fee-for-service Medicaid provider, having an active ePACES login and calculating Medicaid eligibility requirements.

If you have not yet registered for the New York Medicaid EHR Incentive Program, we encourage you to visit the **new** and **improved** website (https://www.emedny.org/meipass/) or attend one of the informational webinars hosted by the NYSDOH throughout the month of February.

Wednesday, Feb. 6	12:00 – 1:00PM	Program Prerequisites
Thursday, Feb. 7	12:00 – 1:00PM	EP Participation Year 1 (A/I/U)
Thursday, Feb. 14	10:00 –11:00AM	EP Participation Year 2 (MU)
Tuesday, Feb. 19	12:00 – 1:00PM	EP Participation Year 1 (A/I/U)
Wednesday, Feb. 20	3:00 – 4:00PM	Program Prerequisites
Thursday, Feb. 21	12:00 – 1:00PM	EH Participation Year 2 (MU)
Tuesday, Feb. 26	12:00 – 1:00PM	EP Participation Year 2 (MU)
Thursday, Feb. 28	10:00 –11:00AM	EP Support Documentation

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 at:

o   Current Month: https://www.emedny.org/meipass/webinar/Webinar.pdf

o   Next Month: https://www.emedny.org/meipass/webinar/NextMonth.pdf

POLICY & BILLING GUIDANCE

ATTENTION: PROVIDERS OF NURSING FACILITY SERVICES, CERTAIN HOME AND COMMUNITY-BASED WAIVER SERVICES AND SERVICES UNDER A PACE PROGRAM

2013 Spousal Impoverishment Income and Resource Levels Increase

Providers of nursing facility services, home and community-based waiver services and services under a PACE program, are required to PRINT and DISTRIBUTE the *"Information Notice to Couples with an Institutionalized Spouse"* (pages 8-12 of this newsletter) at the time they begin to provide services to their patients.

Effective January 1, 2013, the federal maximum community spouse resource allowance increases to **$115,920** while the community spouse income allowance increases to **$2,898.** The maximum family member monthly allowance remains **$631** until the federal poverty levels for 2013 are published in the *Federal Register*.

This information should be provided to any institutionalized spouse, community spouse or representative acting on their behalf so as to avoid unnecessary depletion of the amount of assets a couple can retain under the spousal impoverishment eligibility provisions.

INCOME AND RESOURCE AMOUNTS

January 1, 2013

FEDERAL MAXIMUM COMMUNITY SPOUSE RESOURCE ALLOWANCE: **$115,920**
NOTE: A higher amount may be established by court order or fair hearing to generate income to raise the community spouse's monthly income up to the maximum allowance. NOTE: The state minimum community spouse resource allowance is $74,820.

January 1, 2013

COMMUNITY SPOUSE MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE IS AN AMOUNT UP TO: **$2,898**
(if the community spouse has no income of his/her own)
NOTE: A higher amount may be established by court order or fair hearing due to exceptional circumstances that result in significant financial distress.

January 1, 2013

FAMILY MEMBER MONTHLY ALLOWANCE FOR EACH FAMILY MEMBER IS AN AMOUNT UP TO: **$631**
The maximum family member monthly allowance of $631 (if the family member has no income of his/her own) is subject to change when the Federal Poverty Levels for 2013 are published in the *Federal Register*. NOTE: If the institutionalized spouse is receiving Medicaid, any change in income of the institutionalized spouse, the community spouse, and/or the family member may affect the community spouse income allowance and/or the family member allowance. Therefore, the social services district should be promptly notified of any income variations.

Information Notice to Couples with an Institutionalized Spouse

Medicaid is an assistance program that may help pay for the costs of you or your spouse's institutional care, home and community-based waiver services or Program of All-inclusive Care for the Elderly (PACE) program. The institutionalized spouse is considered medically needy if his/her resources are at or below a certain level and the monthly income after certain deductions is less than the cost of care in the facility.

Federal and state laws require that spousal impoverishment rules be used to determine an institutionalized spouse's eligibility for Medicaid. These rules protect some of the income and resources of the couple for the community spouse.

If you or your spouse are:
(1) In a medical institution or nursing facility and are likely to remain there for at least 30 consecutive days; or
(2) Receiving home and community-based services provided pursuant to a waiver under section 1915(c) of the federal Social Security Act and is likely to receive such services for at least 30 consecutive days; or
(3) Receiving institutional or non-institutional services under a PACE program as defined in sections 1934 and 1894 of the federal Social Security Act; AND
(4) Married to a spouse who does not meet any of the criteria set forth under (1) through (3), these income and resource eligibility rules for an institutionalized spouse may apply to you or your spouse.

If you wish to discuss these eligibility provisions, please contact your local department of social services. Even if you have no intention of pursuing a Medicaid application, you are urged to contact your local department of social services to request an assessment of the total value of you and your spouse's combined countable resources. It is to the advantage of the community spouse to request such an assessment to make certain that allowable resources are not depleted by you for your spouse's cost of care. To request such an assessment, please contact your local department of social services or mail the attached completed "Request for Assessment Form." New York City residents may contact the Human Resources Administration (HRA) Infoline at (718) 557-1399.

Information about resources:
Effective January 1, 1996, the community spouse is allowed to keep resources in an amount equal to the greater of the following amounts:
(1) $74,820 (the state minimum spousal resource standard); or
(2) The amount of the spousal share up to the maximum amount permitted under federal law ($115,920 for 2013).

For purposes of this calculation, "spousal share" is the amount equal to one-half of the total value of the countable resources of you and your spouse at the beginning of the most recent continuous period of institutionalization of the institutionalized spouse. The most recent continuous period of institutionalization is defined as the most recent period you or your spouse met the criteria listed in items 1 through 4 (under "If you or your spouse are"). In determining the total value of the countable resources, we will not count the

value of your home, household items, personal property, your car, or certain funds established for burial expenses. The community spouse may be able to obtain additional amounts of resources to generate income when the otherwise available income of the community spouse, together with the income allowance from the institutionalized spouse, is less than the maximum community spouse monthly income allowance, by requesting a fair hearing or commencing a family court proceeding against the institutionalized spouse. Your attorney or local office for the aging can provide you with more information.

Either spouse or a representative acting on their behalf may request an assessment of the couple's countable resources, at the beginning, or any time after the beginning of a continuous period of institutionalization. Upon receiving such a request and all relevant documentation, the local district will assess and document the total value of the couple's countable resources and provide each spouse with a copy of the assessment and the documentation upon which it is based. If the request is not filed with a Medicaid application, the local department of social services may charge up to $25 for the cost of preparing and copying the assessment and documentation.

Information about income:
You may request an assessment/determination of:
(1) The community spouse monthly income allowance (an amount of up to $2,898 a month for 2013); and
(2) A maximum family member allowance for each minor child, dependent child, dependent parent or dependent sibling of either spouse living with the community spouse remains $631 (if the family member has no income of his/her own) until the 2013 federal poverty levels are published in the *Federal Register*.

The community spouse may be able to obtain additional amounts of the institutionalized spouse's income, due to exceptional circumstances resulting in significant financial distress, than would otherwise be allowed under the Medicaid program, by requesting a fair hearing or commencing a family court proceeding against the institutionalized spouse. Significant financial distress means exceptional expenses which the community spouse cannot be expected to meet from the monthly maintenance needs allowance or from amounts held in resources. These expenses may include, but are not limited to: recurring or extraordinary non-covered medical expenses (of the community spouse or dependent family members who live with the community spouse); amounts to preserve, maintain, or make major repairs to the home; and amounts necessary to preserve an income-producing asset. Social Services Law 366-c.2(g) and 366-c.4(b) require that the amount of such support orders be deducted from the institutionalized spouse's income for eligibility purposes. Such court orders are only effective back to the filing date of the petition. Please contact your attorney or local office for the aging for additional information.

If you wish to request an assessment of the total value of you and your spouse's countable resources, a determination of the community spouse resource allowance, community spouse monthly income allowance, or family member allowance(s) and the method of computing such allowances, please contact your local department of social services. New York City residents should call the Human Resources Administration (HRA) Infoline at (718) 557-1399.

Additional Information

For determining Medicaid eligibility for the institutionalized spouse, a community spouse must cooperate by providing necessary information about his/her resources. Refusal to provide the necessary information shall be reason for denying Medicaid for the institutionalized spouse because Medicaid eligibility cannot be determined. If denial of Medicaid would result in undue hardship for the institutionalized spouse and an assignment of support is executed or the institutionalized spouse is unable to execute such assignment due to physical or mental impairment, Medicaid shall be authorized. However, if the community spouse refuses to make such resource information available, then the Department, at its option, may refer the matter to court.

POLICY & BILLING GUIDANCE

Undue hardship occurs when:
(1) A community spouse fails or refuses to cooperate in providing necessary information about his/her resources;
(2) The institutionalized spouse is otherwise eligible for Medicaid;
(3) The institutionalized spouse is unable to obtain appropriate medical care without the provision of Medicaid; and
(a) The community spouse's whereabouts are unknown; or
(b) The community spouse is incapable of providing the required information due to illness or mental incapacity; or
(c) The community spouse lived apart from the institutionalized spouse immediately prior to institutionalization; or
(d) Due to the action or inaction of the community spouse, other than the failure or refusal to cooperate in providing necessary information about his/her resources, the institutionalized spouse will be in need of protection from actual or threatened harm, neglect, or hazardous conditions if discharged from appropriate medical setting.

An institutionalized spouse will not be determined ineligible for Medicaid because the community spouse refuses to make his or her resources in excess of the community spouse resource allowance available to the institutionalized spouse if:

(1) The institutionalized spouse executes an assignment of support from the community spouse in favor of the social services district; or
(2) The institutionalized spouse is unable to execute such assignment due to physical or mental impairment.

Contribution from Community Spouse

The amount of money that we will request as a contribution from the community spouse will be based on his/her income and the number of certain individuals in the community depending on that income. We will request a contribution from a community spouse of 25% of the amount his/her otherwise available income that exceeds the minimum monthly maintenance needs allowance plus any family member allowance(s). If the community spouse feels that he/she cannot contribute the amount requested, he/she has the right to schedule a conference with the local department of social services to try to reach an agreement about the amount he/she is able to pay.

Pursuant to Section 366(3)(a) of the Social Services Law Medicaid MUST be provided to the institutionalized spouse, if the community spouse fails or refuses to contribute his/her income towards the institutionalized spouse's cost of care. However, if the community spouse fails or refuses to make his/her income available as requested, then the Department, at its option, may refer the matter to court for a review of the spouse's actual ability to pay.

DOH
STATE OF NEW YORK
DEPARTMENT OF HEALTH

Date:

Request for Assessment Form

Institutionalized Spouse's Name:

Address:

Telephone Number:

Community Spouse's Name:

Current Address:

Telephone Number:

I/we request an assessment of the items checked below:

[   ] Couple's countable resources and the community spouse resource allowance

[   ] Community spouse monthly income allowance

[   ] Family member allowance(s)

Check [   ] if you are a representative acting on behalf of either spouse. Please call your local department of social services if we do not contact you within 10 days of this request.

NOTE: If an assessment is requested without a Medicaid application, the local department of social services may charge up to $25 for the cost of preparing and copying the assessment and documentation.

_____
Signature of Requesting Individual

_____
_____
_____
Address and telephone # if different from above

Spousal Impoverishment Income and Resource Amounts

Federal Maximum Community Spouse Resource Allowance

$115,920 – January 1, 2013

NOTE: A higher amount may be established by court order or fair hearing to generate income to raise the community spouse's monthly income up to the maximum allowance.

NOTE: The State Minimum Community Spouse Resource Allowance is $74,820.

Community Spouse Minimum Monthly Maintenance Needs Allowance

is an amount up to: $2,898 – January 1, 2013

if the community spouse has no income of his/her own.

NOTE: A higher amount may be established by court order or fair hearing due to exceptional circumstances that result in significant financial distress.

Family Member Allowance

for each family member is an amount up to: $631 – January 1, 2013

if the family member has no income of his/her own.

NOTE: The maximum family member allowance is subject to change when the Federal Poverty Levels for 2013 are published in the *Federal Register*.

If the institutionalized spouse is receiving Medicaid, any change in income of the institutionalized spouse, the community spouse, and/or the family member may affect the community spouse income allowance and/or the family member allowance. Therefore, the social services district must be promptly notified of any income changes.

Important Reminder to Pharmacies and Durable Medical Equipment (DME) Providers

Prescription drugs, over-the-counter products (OTCs), medical/surgical supplies and durable medical equipment (DME) items can be picked up at the pharmacy/DME provider or can be delivered to the Medicaid recipient's home or current residence including facilities and shelters. Pharmacy/DME providers must obtain a signature from the Medicaid recipient, or the recipient's caregiver or designee to confirm the receipt of care, services and supplies, including these prescription drugs, OTC products, medical/surgical supplies and DME items. Delivery is an optional service and pharmacies/DME dealers that choose to provide delivery are required to implement and operate a distribution and delivery system. As stated in the June 2000 and November 2003 *Medicaid Updates*:

- o the recipient or caregiver or designee must be contacted to confirm the need for delivery and the confirmation shall be maintained in the recipient's patient record;

- o the recipient, caregiver or designee must receive the delivery;

- o electronic signatures are only permitted if retrievable upon audit and kept on file by the pharmacy/DME provider; and

- o automatic refills are not permitted.

Additional home delivery criteria is outlined in the January 2011 *Medicaid Update*. Also, see the September 2011 *Medicaid Update* for additional signature criteria for pick up and facility delivery.

Q1.   Why is signature and back-up documentation required?

A1.   To ensure the prescription, OTC product, supply or DME item is needed prior to dispensing and delivering and that the order had not been discontinued or is no longer necessary and to document that the recipient, or the recipient's caregiver or designee received the prescription, OTC product, supply or DME item.

To show compliance with legal requirements as well as the pharmacy/DME provider's certification that it complies with all Medicaid policies and applicable federal and state laws and regulations when submitting claims to the Medicaid program for care, services and supplies it furnished or caused to be furnished to the Medicaid recipient.

See *eMedNY/Certification Statement for Provider Billing Medicaid.*
https://www.emedny.org/info/ProviderEnrollment/Provider%20Maintenance%20Forms/Certification%20Statement-Cert%20Instructions%20for%20Existing%20ETINs.pdf

To comply with the regulatory requirement that the provider prepare, maintain and furnish to the Department upon request, contemporaneous records demonstrating its right to receive payment from the Medicaid program and also to fully disclose the nature and extent of care, services and supplies that it provided to the Medicaid recipient (18 NYCRR 504.3(a)). To show that the provider has submitted claims for payment "only for services actually furnished"(18 NYCRR 504.3).

Q2.   Why are signatures required?

A2.   To confirm/document receipt of the care, services or supplies, (including prescription drugs, OTC products, medical/surgical supplies and DME items) by the recipient, caregiver or designee.

Q3. **Who should sign to confirm the item(s) were provided to the recipient?**

A3. The recipient or the recipient's caregiver or designee should sign to confirm the item(s) were received

Q4. **What is the signature requirement for multiple prescriptions, OTC products, medical/surgical supplies and DME items that are delivered to a recipient's home on a single date of delivery – or when multiple deliveries are made to the same recipient on a single date?**

A4. The recipient's, caregiver's or designee's signature is required on an itemized delivery receipt. The signature should be maintained by the pharmacy provider and retrievable upon audit. The signature needs to reference all prescriptions, OTC products, medical/surgical supplies and DME items delivered for that date of delivery.

For example:

- o   If the delivered items are listed on separate delivery receipts/pages, each receipt/page must be signed.
- o   If one signed delivery receipt/page is stapled to one or more unsigned delivery receipts/pages, **only** the signed delivery receipt/page is considered valid.
- o   If there are multiple deliveries on one date, a signature is required for each delivery on that date.

An electronic signature is acceptable only if retrievable upon audit and kept on file by the pharmacy provider. Delivery industry tracking receipts that contain a signature (e.g., FedEx tracking receipts) qualify as a signature for receipt of delivery. "Waiver of Signature" forms are **not allowed/not acceptable**.

Q5. **When a provider is unable to provide or deliver the ordered care, service or supply, at what point must the provider reverse the claim submitted to Medicaid?**

A5. Medicaid providers are required to certify that the claim being submitted is for care, services or supplies that have been furnished to the recipient. Claims for any Medicaid reimbursed service or supply including prescriptions, OTC products, medical/surgical supplies and DME items not received by the intended recipient should be promptly reported, reversed, and returned no later than within 60 days from the date the overpayment was identified . (See Affordable Care Act of 2010 §6402(a)). Such repayment is also a mandatory part of New York's compliance programs under 18 NYCRR Part 521.

Q6. **How long is a provider required to maintain signature and other supporting claims documentation?**

A6. At a minimum, this documentation must be retained by all providers for six years from the date the care, services, or supplies were furnished as required by 18 NYCRR §504**.**3(a); and by fee-for-service providers, for six years from the date the care, services or supplies were furnished or billed, whichever is later, as required by 18 NYCRR § 517.3(b)(1) to ensure compliance with Medicaid program requirements, or longer as otherwise required by contract, law, Medicaid policy or regulation.

Additionally, providers who are licensed, registered, or certified under state education law *must retain records in accordance with the laws and regulations that apply to their profession*. All professionals must be aware of the standards that apply to their professions.

PHARMACY UPDATE

Office of Mental Health Residential Treatment Facility Prescription Drug Carve-Out

UPDATED:

As of September 1, 2012, reimbursement of prescription drugs for children and youth who are residents of the Office of Mental Health (OMH) residential treatment facilities (RTF) are covered as a Medicaid fee-for-service (FFS) benefit. Claims should be billed directly to Medicaid by the dispensing pharmacy beginning with the 91st day of residency. The cost of medications provided to the Medicaid-eligible child during the first 90 days of stay are the responsibility of the RTF. There are currently 19 facilities statewide, with a total of 554 certified beds.

The FFS benefit only impacts 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) are not carved out of the RTF rate and 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.

UPDATED:

RTF providers are only responsible for purchasing prescription drugs for the children and youth in their programs for the first 90 days of stay. Beginning on day 91 of the stay, the dispensing pharmacy will bill the Medicaid formulary for these medications. Prescriptions billed directly to Medicaid 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 can function as a billing agent for a LTC pharmacy.

Enrollment information can be found at the following websites:

Pharmacy Enrollment Packet:

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

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

- o 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 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 can 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 can be found on the Medicaid pharmacy program web page located 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:

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

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

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

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

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

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.

PHARMACY UPDATE

FREQUENTLY ASKED Q&As

Q1. **What is included in the OMH RTF carve out?**

A1. Only prescription drugs listed on Medicaid Pharmacy List of Reimbursable Drugs, which can be found 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/downloads/providers/NYRx_PA_emergency_supply_pharmacy_worksheet.docx

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 OTC drugs listed on the preferred drug list (PDL) also covered as a pharmacy benefit for OMH RTF?**

A6. No. OTC drugs are not included in the OMH RTF carve-out. They will remain the responsibility of the OMH RTF.

FREQUENTLY ASKED Q&As (continued)

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

A7. **Updated** Early fill should not be an issue, since the RTF is responsible for prescription drugs during the first 90 days of the child's residency.

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.

Q10. **Added** Can prescription drugs be billed by a dispensing Medicaid-enrolled pharmacy directly to Medicaid for a child who currently Medicaid-eligible, and recently admitted to the OMH RTF?

A10. No. The OMH RTF is responsible for purchasing prescription drugs for their residents for the first 90 days of their stay. The dispensing Medicaid-enrolled pharmacy may bill Medicaid directly beginning on day 91 of the stay.

THE NEW YORK STATE MEDICAID PRESCRIBER EDUCATION PROGRAM DRUG INFORMATION RESPONSE CENTER

Addressing Metformin Efficacy in the Elderly Population

The New York State Medicaid Prescriber Education Program (NYSMPEP) is a collaboration between the New York State Department of Health (NYSDOH) and the State University of New York (SUNY), as approved by state legislation. This program was designed to provide prescribers with an evidence-based, non-commercial source of the latest objective information about pharmaceuticals. In conjunction, the Drug Information Response Center (DIRC) was developed to fulfill the mission of assisting clinicians in the delivery of health care to their Medicaid patients by providing timely, evidence-based information on pharmacotherapy to prescribers and serving as a resource for NYSMPEP academic educators in their outreach to prescribers. A recent article was prepared by the DIRC regarding metformin efficacy in the elderly.

Current evidence indicates metformin is effective in the treatment of type 2 diabetes mellitus (T2DM) in elderly patients. The American Diabetes Association (ADA) and American Geriatrics Society (AGS) issued a consensus report of treatment of T2DM in older adults.[1] Metformin is considered to be first-line therapy in most patients with adequate renal function. The drug is associated with a low risk for hypoglycemia and there is little evidence for in increased risk of lactic acidosis. In patients with decreased renal function (estimated glomerular filtration rate [eGFR] 30 to 60 mL/min) the dose should be reduced. The efficacy of metformin may be considered to be reduced in these patients because it generally exhibits a dose-response relationship.[2] Patients with an eGFR <30 mL/min should not use metformin.[1] Healthcare providers should be aware the ADA guidelines for management of hyperglycemia recommend individualized goals based on patient-specific factors.[3] Elderly patients, who are more likely to have risk factors and a shorter life expectancy compared to younger patients, will likely have a less stringent glycemic goal.

Ito et al. conducted a retrospective study evaluating the efficacy and safety of metformin in Japanese geriatric patients.[4] The investigators analyzed 568 patients, 180 of whom were ≥65 years of age at the time of metformin initiation. The age range for the elderly patients was 65 to 85 years and the mean duration of diabetes for these patients was 10.9 ± 9.3 years. The mean hemoglobin A1C (HbA1C) was 8.0 ± 1.6%. Patients received metformin dosed at 250 to 750 mg/day. (Of note, the maximum recommended dosage of metformin in Japan is 1000 mg/day). Glycemic control improved over the study period (1 year) in both non-elderly and elderly patients, independent of age, gender, obesity and concomitant drug use. For the 34 patients aged ≥75 years, significant reductions in HbA1C were observed, from 7.9 ± 1.1% at baseline to 7.2 ± 0.7% at 12 months. Based on these results, the authors concluded that metformin is efficacious in elderly patients.

Roussel et al. conducted a study of the effect of metformin on mortality in patients with diabetes and atherothrombosis.[5] The investigators reviewed data from 19,691 patients with diabetes and established atherothrombosis participating in the Reduction of Atherothrombosis for Continued Health (REACH) registry who had been treated with (7457) or without (12234) metformin. Of the patients who received metformin, the mean age was 67.1 years (SD 9.3). The two-year mortality rate was found to be lower in patients receiving metformin (hazard ratio [HR] 0.76, 95% CI: 0.65 to 0.89).

PHARMACY UPDATE

Interestingly, the reduction in mortality with metformin use was consistent among subgroups, including those with congestive heart failure (HR 0.69, 95% CI: 0.54 to 0.90), patients older than 65 years of age (HR 0.77, 95% CI: 0.62 to 0.95), and patients with creatinine clearance (Clcr) of 30 to 60 mL/min/1.73 m^2 (HR 0.64, 95% CI: 0.48 to 0.86). The authors concluded that metformin may decrease mortality in patients with diabetes as a means of secondary prevention, including subsets of patients in whom its use is not routinely recommended.

In an older study, Gregorio et al. assessed the efficacy of metformin compared to increasing sulfonylurea dosage in elderly patients with T2DM.[6] Patients were required to be over 70 years of age with well-preserved renal function (Clcr >100 mL/min and/or serum creatinine <1 mg/dL), HbA1C ≥9%, and fasting blood glucose of ≥200 mg/dL at enrollment. Patients were randomized to receive a sulfonylurea increased to its maximum dose (n=85) or fasting blood glucose of ≤7.8 mmol/L (140mg/dL) or receive metformin in addition to their current sulfonylurea therapy (n=89). Groups were well balanced at baseline, with an average age of approximately 75.5 years and mean duration of T2DM of about 15 years. In the metformin group, 5 patients received 850 mg/day, 28 patients received 1275 mg/day, and 56 received 1700 mg/day. After 18 months, HbA1C had decreased from 10.32% at baseline to 8.60% in the sulfonylurea group and 10.33% at baseline to 8.59% in the metformin group. The authors concluded metformin was an effective treatment option in the elderly who have poorly controlled T2DM and preserved renal function.

These studies illustrate that metformin is effective in treating T2DM in the elderly population. However, it is important to monitor renal function and adjust the dose accordingly to minimize the risk of lactic acidosis. A perceived decrease in efficacy may be due to lower doses being used. Additionally, during the literature search, no studies were found specifically designed to compare metformin efficacy in elderly patients vs. a younger population.

To contact a NYSMPEP academic educator in your area, please visit
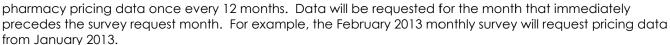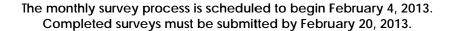http://nypep.nysdoh.suny.edu/contactus/contactus.

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1. Kirkman MS, Briscoe VJ, Clark N, et al. Diabetes in older adults. *Diabetes care.* Dec 2012;35(12):2650-2664.

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3. Inzucchi SE, Bergenstal RM, Buse JB, et al. Management of hyperglycemia in type 2 diabetes: a patient-centered approach: position statement of the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD). *Diabetes care.* Jun 2012;35(6):1364-1379.

4. Ito H, Ohno Y, Yamauchi T, Kawabata Y, Ikegami H. Efficacy and safety of metformin for treatment of type 2 diabetes in elderly Japanese patients. *Geriatrics & gerontology international.* Jan 2011;11(1):55-62.

5. Roussel R, Travert F, Pasquet B, et al. Metformin use and mortality among patients with diabetes and atherothrombosis. *Archives of internal medicine.* Nov 22 2010;170(21):1892-1899.

6. Gregorio F, Ambrosi F, Manfrini S, et al. Poorly controlled elderly Type 2 diabetic patients: the effects of increasing sulphonylurea dosages or adding metformin. *Diabetic medicine : a journal of the British Diabetic Association.* Dec 1999;16(12):1016-1024.

Fee-for-Service Pharmacy Pricing Survey Update

The initial Average Actual Acquisition Cost (AAC) survey has been completed. The Department of Health (DOH) has begun verification and analysis of data submitted, with results expected to be released in March 2013. The Department may contact pharmacies if there are any questions on the data submitted.

As a reminder, all enrolled Medicaid fee-for-service pharmacy providers were required to complete the initial AAC survey. Each month, a subset of pharmacies will be randomly selected from the full pool of pharmacy providers and required to complete the pricing survey. This will result in each enrolled provider having to provide pharmacy pricing data once every 12 months. Data will be requested for the month that immediately precedes the survey request month. For example, the February 2013 monthly survey will request pricing data from January 2013.

The monthly survey process is scheduled to begin February 4, 2013.
Completed surveys must be submitted by February 20, 2013.

The AAC survey tool and instruction guide may be downloaded from the Department website: http://www.health.ny.gov/health_care/medicaid/program/pharmacy.htm.

Providers still experiencing problems due to Hurricane Sandy and who are unable to complete the survey should e-mail DOH at the address below with the pharmacy name, NPI and reason for exemption request.

Questions may be e-mailed to medpharmpricing@health.state.ny.us. Technical assistance is also available by calling (518) 486-3209.

Medicaid Pharmacy Prior Authorization Programs Update

The New York State Medicaid Pharmacy & Therapeutics Committee recently recommended changes to the Medicaid pharmacy prior authorization programs. The Commissioner of Health has reviewed these recommendations and has approved changes to the Preferred Drug Program (PDP) and Clinical Drug Review Program (CDRP) within the fee-for-service (FFS) pharmacy program.

Effective February 21, 2013, prior authorization (PA) requirements will change for some drugs in the following PDP classes:

- o Carbamazepine Derivatives
- o Growth Hormones
- o Other Agents for ADHD
- o Second Generation Anticonvulsants

In addition, the CDRP will expand to include the following:

- o Anabolic Steroids
- o Central Nervous System Stimulants for patients age 18 years and older
- o Truvada for Pre-Exposure Prophylaxis (PrEP)

A summary of the Pharmacy & Therapeutics Committee meeting and final determinations are available at the following website:

http://www.health.ny.gov/health_care/medicaid/program/ptcommittee/meetings/2012/11/ptsummary11-15-12_with_comm_final_determi.pdf

Below is a link to the most up-to-date information on the Medicaid FFS Pharmacy Prior Authorization Programs including a full listing of drugs subject to PDP, CDRP, the Drug Utilization Review Program (DUR), the Dispense Brand Name Drug when Less Expensive than Generic Program (BLTG) and the Mandatory Generic Drug Program (MGDP):

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

To obtain a PA, please call the prior authorization clinical call center at 1-877-309-9493. 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.

Medicaid enrolled prescribers can also initiate PA requests using a web-based application. PAXpress® is a web based pharmacy PA request/response application accessible through a new button "PAXpress" located on eMedNY.org under the MEIPASS button.

Additional information, such as updated PA forms and clinical criteria for the PDP and CDRP, are available at the following websites:

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

ATTENTION: PHARMACISTS AS IMMUNIZERS

Change in Medicaid Billing for Vaccine Administration for Dates of Service on and After January 1, 2013

Adult Vaccine Administration:

Effective January 1, 2013, for pharmacist administration of select vaccines for ages 18 and over, including influenza and pneumococcal, and age 50 and over for zoster, providers will be required to bill under the procedure codes below.

- o   Providers must continue to bill the specific vaccine code at acquisition cost.
- o   G0008 & G0009 will no longer be reimbursed, use the appropriate codes below.

Note:

- o   For administration of multiple vaccines on the same date beginning January 1, 2013, code 90471 will be used for the first vaccine and 90472 for ANY other vaccines administered on that day. One line will be billed for 90472 indicating the additional number of vaccines administered (insert 1 or 2).
- o   The administration fee remains $13.23 for each vaccine. The intranasal code 90473 administration fee remains $8.57.

90471	IMMUNIZATION ADMINISTRATION (INCLUDES PERCUTANEOUS, INTRADERMAL, SUBCUTANEOUS, OR INTRAMUSCULAR INJECTIONS); 1 VACCINE (SINGLE OR COMBINATION VACCINE/TOXOID)	$13.23
90472	IMMUNIZATION ADMINISTRATION (INCLUDES PERCUTANEOUS, INTRADERMAL, SUBCUTANEOUS, OR INTRAMUSCULAR INJECTIONS); EACH ADDITIONAL VACCINE (SINGLE OR COMBINATION VACCINE/TOXOID) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE))	$13.23
90473	IMMUNIZATION ADMINISTRATION BY INTRANASAL OR ORAL ROUTE; ONE VACCINE (SINGLE OR COMBINATION VACCINE/TOXOID)	$8.57

Questions:

Medicaid Billing Assistance: (800) 343-9000 or Medicaid Pharmacy Policy: (518)486-3209.

Providers Urged to Join the eMedNY LISTSERV ®

New York State Medicaid has a LISTSERV® system that allows providers, vendors and other partners to instantly receive eMedNY related information and notifications. The LISTSERV® e-mail system runs on a free, wide-open platform and enrolling is as simple as visiting www.eMedNY.org. The LISTSERV® button is located on the right side of the homepage. Any number of individuals in your office may sign up for this free service.

The LISTSERV® is used to alert providers and submitters about many topics such as:

- o *Alerts for upcoming changes to claims and other transaction editing;*
- o *Announcements about special web meetings being offered;*
- o *Provider type specific changes in policy and submission requirements;*
- o *ePACES changes and enhancements.*

Since its inception the eMedNY LISTSERV® has become a primary medium for the dissemination of eMedNY related information and today it has more than 37,000 subscribers. It is imperative that all providers subscribe to the LISTSERV® to ensure they receive the most up-to-date eMedNY information. You may subscribe for as many categories as you like. Consider signing up today.

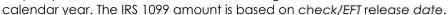Questions? Please contact the eMedNY Call Center at (800) 343-9000.

IRS Form 1099

Computer Sciences Corporation (CSC), the eMedNY contractor for the Department of Health, issues IRS (Internal Revenue Service) Form 1099 to providers at the beginning of each year for the previous year's Medicaid payments. The 1099s are issued with the individual provider's social security number or for businesses, with the Federal Employer Identification Number (FEIN) registered with New York Medicaid.

As with previous years, please note that the IRS 1099 amount **is not** based on the date of the checks/EFTs; rather, it is based on the date the checks/EFTs were released to providers.

Due to the two-week check lag between the date of the check/EFT and the date the check/EFT is issued, the IRS 1099 amount will not correspond to the sum of all checks/EFTs issued for your provider identification number during the calendar year. The IRS 1099 amount is based on *check/EFT release date*.

The IRS 1099 that will be issued for the year 2012 will include the following:

- o   Check dated 12/19/11 (Cycle 1791) released on 01/04/2012 through,
- o   Check dated 12/10/12 (Cycle 1842) released 12/26/12.

Additionally, each year, CSC receives calls from individual providers who are issued 1099s for funds the practitioner is unaware of. In order for group practice providers to direct Medicaid payments to a group NPI and corresponding IRS 1099 for the group, group practices must submit the group NPI in the appropriate field on the claim (paper or electronic). Claims that do not have the group NPI entered will cause payment to go to the *individual* provider and his/her IRS 1099. Regardless of who deposits the funds, the 1099 will be issued to the individual provider when the funds have been paid to the individual provider's NPI.

It is imperative that providers keep their addresses current. An incorrect address will impact the provider's ability to receive their 1099 form in a timely manner.

Please note that 1099s are not issued to providers whose yearly payments are less than $600.00.

IRS 1099s for the year 2012 will be mailed no later than January 31, 2013.

The above information is provided to assist providers with reconciling the IRS 1099 amount. Any questions should be directed to 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 (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.)

Medicaid Electronic Health Record Incentive Program questions? Contact the New York Medicaid EHR Call Center at (877) 646-5410 for assistance.

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