



Medicaid Update

THE OFFICIAL NEWSLETTER OF THE NEW YORK STATE MEDICAID PROGRAM

NYSDOH Partners with National Healthy Mothers Healthy Babies Coalition to Promote text4baby Initiative

The New York State Department of Health (NYSDOH) has partnered with the National Healthy Mothers Healthy Babies (HMHB) Coalition to promote text4baby, the first free health text messaging service in the United States. Text4baby supports pregnant and new mothers by providing accurate, text-length health information and resources in a format that is personal and timely, using a channel they know and use. Pregnant women and new mothers who text “BABY” (or “BEBE” for Spanish) to 511411 receive weekly text messages (timed to their due date or their baby’s birth date) throughout pregnancy and up until baby’s first birthday. The text messages provide information on a variety of topics critical to maternal and child health, including developmental milestones, immunization, nutrition, mental health, safety, and more. Text4baby messages also connect women to local resources including resources for obtaining health insurance, pre-natal care providers and WIC services. The content of the messages has been developed in collaboration with government and non-profit health experts.



In order to increase health insurance enrollment for Medicaid/CHIP eligible text4baby mothers and families, text4baby and the Centers for Medicare and Medicaid Services (CMS) have partnered through CMS’ Connecting Kids to Coverage program to reach the two million Medicaid members who give birth each year. Health Insurance messages are sent in the following sequence: 1) three days after moms enroll in text4baby, they are asked their health insurance status; moms who identify as “uninsured” are provided information on Medicaid/CHIP eligibility and how to apply; 2) seven days after a mom indicates she isn’t covered by health insurance, she receives a follow-up message asking if she applied for Medicaid/CHIP; and 3) two weeks before a child’s first birthday, all text4baby users who indicated they are Medicaid/CHIP enrollees or that they had applied for Medicaid/CHIP receive a follow-up message reminding them to enroll.

Text4baby’s power lies in its ability to get the most essential health information to high-need mothers quickly and easily using a technology they regularly use and rely on. Over 81 percent of American women have a cell phone, and 72 percent of cell users send or receive text messages. Text4baby is reaching women in high-poverty areas.

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POLICY & BILLING GUIDANCE

A higher percentage of text4baby users live (or lived upon enrollment) in zip codes with the highest levels of poverty compared to the overall U.S. distribution of subscribers. In addition, it is reaching individuals early in their pregnancy. Of the users who signed up to receive pregnancy messages, over 47 percent enrolled during the first trimester (HMHB Coalition, 2012).

Recent evaluations of text4baby found the service increased 73 percent of users' knowledge of medical warning signs and helped 67 percent of users remember an appointment or immunization for them or their child (HMHB Coalition, 2012). Additional rigorous evaluations are underway, including one by Mathematica Policy Research funded by the Department of Health and Human Services.

New York State (NYS) recently entered the 2013 text4baby State Enrollment Contest, a national competition to enroll pregnant women and new mothers in the text4baby program. The states that enroll the highest percentage of pregnant women and mothers in text4baby between May 14, 2013 and October 21, 2013 will be announced and recognized during the American Public Health Association Annual Meeting in Boston, Massachusetts, in early November.

NYSDOH kicked off its efforts to win the contest on April 15 by promoting a text4baby media and marketing campaign. The campaign included the placement of posters in bus interiors and bus shelters in six high need urban areas in Erie, Monroe, Onondaga, Albany, Westchester, and Bronx counties; and a digital campaign through NYSDOH's Facebook page that targets 18- to 35-year-old women. Since the launch of the campaign 2,290 new participants have enrolled in text4baby in NYS. In addition, NYSDOH is enhancing statewide outreach by disseminating text4baby posters and palm cards to their maternal and infant health state and community-level partners. Text4baby promotional posters and palm cards are currently available by e-mailing a request to: bmchph@health.state.ny.us.

Text4baby is made possible through a broad, public-private partnership that includes government, corporations, academic institutions, professional associations, non-profit organizations, and more.

For additional information on text4baby, please contact Ann-Margret Foley via e-mail at: axf09@health.ny.gov

Percutaneous Coronary Intervention Coverage Guidelines

COVERAGE DECISION

The following coverage limitation is in response to a recommendation from the Medicaid Redesign Team (MRT) Basic Benefit Review Workgroup.

The Journal of American College of Cardiology (Vol. 59, No. 9, February 28, 2012) released new guidelines for the [Appropriate Use Criteria \(AUC\) for Coronary Revascularization](#), outlining three levels of appropriateness: “appropriate,” “sometimes appropriate,” and “rarely appropriate.” Effective July 1, 2013, New York State Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC) will disallow payment for percutaneous coronary intervention (PCI) for those patients without acute coronary syndromes or prior coronary artery bypass graft surgery who are in the “rarely appropriate” category for the procedure based on the newly released guidelines.

BACKGROUND

The New York State Department of Health (NYSDOH) Cardiac Services Program has been compiling clinical data submitted by hospitals for patients undergoing PCI. This data has been used to stratify cases into one of the three levels of appropriateness. This information regarding appropriateness of the revascularization procedures performed has been provided to hospitals for use in prioritization of case reviews and modification of clinical protocols to better reflect the AUC guidance. For those patients in the 2010 Medicaid population who had undergone PCI and could be rated (based on the criteria in the article), approximately 16% of patients without acute coronary syndromes or prior coronary artery bypass graft surgery were rated as “rarely-appropriate.”

The incorporation of these guidelines into cardiology practice will serve to improve patient outcomes, improve health care quality, and lower program costs, the “Triple Aim.”¹ Clinicians are strongly encouraged to review and apply this guidance in the treatment of their Medicaid population prior to performing PCI, to ensure that these procedures are appropriate for the patient.

PCI utilization and clinical appropriateness data from the Cardiac Services Program will be matched quarterly with Medicaid FFS and MMC PCI claims data to identify those Medicaid recipients who underwent PCI procedures deemed “rarely appropriate.” In support of the Triple Aim, **effective July 1, 2013 for both Medicaid FFS and MMC, hospital and practitioner claims for procedures that are deemed “rarely appropriate” will be subject to full payment disallowance** and funds will be taken back.

For PCI claims determined to be “rarely appropriate” with dates of service July 1, 2013, through September 30, 2013, the Department expects to begin recoupment in or after May 2014. The delay in recoupment is caused by the lag in claiming and the time involved in processing and analysis of claims data. This process will be repeated quarterly.

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¹ www.ihl.org

POLICY & BILLING GUIDANCE

18 NYCRR 504.8 indicates that “a notice of the withholding of payment shall be sent to the provider contemporaneous with withholding of payments.” This notification will be sent separately from the remittance statement, and instructions will be provided in the event that the provider needs to submit additional information in support of the claim. This policy applies to FFS Medicaid, MMC, and Family Health Plus (FHPlus).

The FFS Medicaid appeal process will be conducted through Island Peer Review Organization (IPRO), a Medicaid-funded utilization management contractor. Questions/requests for appeals should be directed to IPRO at (516) 209-5361.

For MMC and FHPlus enrollees, providers should check with the individual health plans to determine how each plan will apply this policy.

Questions regarding Medicaid FFS 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.

Elective Delivery (C-Section and Induction of Labor) < 39 Weeks without Medical Indication

In response to Medicaid Redesign Team (MRT) Initiative 5402F

BACKGROUND

The New York State (NYS) MRT Basic Benefit Work Group's final recommendations include reducing payments for elective C-section deliveries and inductions of labor under 39 weeks gestation unless a documented medical indication is present. Evidence suggests that infants delivered prior to 39 weeks have an increased chance of complications and double the mortality rate of infants delivered at full term. Maternal concerns include an increased risk of infection, injury to other organs and infertility, as well as anesthesia complications and difficulty with breast-feeding.



COVERAGE DECISION

- NYS Medicaid will reduce payment for elective deliveries (C-section and induction of labor) < 39 weeks without an acceptable medical indication.
- The following policy will be effective for fee-for-service Medicaid recipients beginning July 1, 2013. System edits may not be in place on July 1, 2013. However, policy implementation will be retroactive to the July 1, 2013 start date.
- The effective date for Medicaid Managed Care and FHPlus enrollees is October 1, 2013. The payment policy below is also applicable to all deliveries reimbursed by Medicaid Managed Care and FHPlus plans. Providers should check with each health plan for implementation details.

POLICY

All obstetric deliveries will require the use of a modifier or condition code to identify the gestational age of the fetus as of the date of the delivery. Failure to provide a modifier/condition code with the obstetric delivery procedure codes listed below will result in the claim being denied.

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PRACTITIONER CLAIMS

Effective July 1, 2013, Medicaid fee-for-service claims (October 1, 2013 for Medicaid Managed Care and FHPlus claims) submitted by **practitioners** for obstetric delivery procedure codes 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, or 59622 will require a modifier.

- *Practitioner claims for obstetric deliveries must include one of the following modifiers. Failure to include one of the two modifiers below on a claim will result in denial of the claim.*
 - **U8** - Delivery prior to 39 weeks of gestation
 - **U9** - Delivery at 39 weeks of gestation or later

Practitioner claims will be processed in the following manner:

1. Full payment – modifier included on claim, acceptable diagnosis code is documented when a delivery is <39 weeks gestation.
2. 10% reduction – modifier indicates <39 weeks gestation and an acceptable diagnosis code is not documented.
3. Claim denied – no modifier documented on claim.

System edits to deny payment for claims without a modifier or to reduce payment for medically unnecessary early deliveries will not be in place on July 1 but will be implemented at a later date. Physician claims for deliveries performed on or after July 1, 2013, will be reprocessed automatically by eMedNY when the system changes are implemented and previously paid claims will be adjusted accordingly. Physicians should use the appropriate modifiers for dates of service on or after July 1, 2013, to avoid payment denials.

HOSPITAL CLAIMS

Effective October 1, 2013, NYS Medicaid claims submitted by **hospitals** for obstetric delivery procedure codes 73.01, 73.1, 73.4, 74.0, 74.1, 74.2, 74.4, and 74.99 will require a condition code. On October 1, 2013, the National Uniform Billing Committee (NUBC) will add two new condition codes to the UB data set for hospitals to utilize when submitting inpatient institutional claims. After this date, all claims submitted by **hospitals** (institutional claim) will be required to report the appropriate condition code when submitting inpatient claims for obstetric deliveries.

Although the condition codes will not be available to hospitals until October 1, 2013, NYS Medicaid reserves the right to reduce fee-for-service payment to hospitals by 10% for deliveries on or after July 1, 2013 (October 1, 2013 for Medicaid Managed Care and FHPlus), if it is determined that the elective early delivery was not medically indicated.

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POLICY & BILLING GUIDANCE

UBC Codes effective October 1, 2013:

- 82 – Gestation less than 39 weeks, elective C-section or induction
- 83 – Gestation 39 weeks or greater

Hospital claims will be processed in the following manner:

1. Full payment – Condition code present, acceptable diagnosis code is documented when delivery is <39 weeks gestation.
2. 10% reduction – Condition code indicates <39 weeks gestation and an acceptable diagnosis code is not documented.
3. Claim denied – No condition code documented on claim.

The following payment structure will be implemented for **hospital** inpatient claims when these ICD-9 procedure codes are reported on the claim: 73.01, 73.1, 73.4, 74.0, 74.1, 74.2, 74.4, and 74.99.

- **No condition code reported** – deny claim.
 - **Condition code 82** – if this condition code is reported without an acceptable diagnosis code, reduce claim by 10%.
 - **Condition code 83** – if this condition code is reported, pay claim in full.
- Gestational age of the fetus should be determined to be at least 39 weeks. Claims submitted by practitioners and hospitals for deliveries performed at < 39 weeks gestation without an acceptable medical indication will be reduced by 10%.

Confirmation of term gestation can be determined by the following:

- An ultrasound measurement at less than 20 weeks of gestation supports gestational age of 39 weeks or greater.
- Fetal heart tones have been documented as present for 30 weeks by doppler ultrasonography.
- It has been 36 weeks since a positive serum or human chorionic gonadotropin pregnancy test result.

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Acceptable Diagnoses for Elective Delivery <39 Weeks

Indications other than those stated below may also be appropriate with clinical justification (see Appeal Process below).

Diagnoses	Code
Placenta Abruption	641.01, 641.11, 641.21, 641.31, 641.81, 641.91
Placenta Previa w/o hemorrhage	
Placenta Previa-w/hemorrhage	
Vasa Previa/complete placenta previa	663.51
Prior vertical or "T" incision cesarean section	654.21
Prior myomectomy necessitating cesarean delivery	646.81
Hypertension, complicating pregnancy, childbirth, and the puerperium.	642.01, 642.02, 642.11, 642.12, 642.21, 642.22, 642.31, 642.32,
Preeclampsia,	642.41, 642.42, 642.51, 642.52,
Eclampsia,	642.61, 642.62, 642.71, 642.72,
Chronic hypertension	642.91, 642.92.
Early Onset of Delivery, Unspecified	644.20
Early Onset of Delivery, Delivered	644.21
Early Delivery with PP	644.22
Diabetes Mellitus complicating pregnancy	648.01
Chorioamnionitis	658.41
Pre-Labor Rupture of Membranes	658.11, 658.21
Prolonged Rupture of Membranes	
Maternal Diseases/conditions, not limited to:	
Liver	646.71
Cholestasis of Pregnancy	648.51, 648.52
Congenital cardiovascular	648.61, 648.62
Other cardiovascular	646.21, 646.22
Renal Disease	646.81
Maternal malignancies	646.81
Herpes Gestationis	694.3
Antiphospholipid Syndrome	649.31, 649.32
Rare maternal trauma	646.81
Including, but not limited to:	
Maternal death	761.6
Labor, spontaneous	649.81, 649.82
Severe fetal growth restriction	656.51
Fetal Compromise	656.31
Abnormal fetal heart rate	659.71

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Acceptable Diagnoses for Elective Delivery <39 Weeks (continued)

Diagnoses	Code
Major Anomaly	
CNS malformation-deliv	655.01
Chromoso abnormality-deliv	655.11
Damage d/t virus-deliv	655.31
Damage d/t disease-deliv	655.41
Damage d/t drug-deliv	655.51
Radiat fetal damage-deliv	655.61
Abnorm nec-unspecified	655.81
Gastroschisis	756.73
Multiple gestation	
Twins	651.01
Triplet pregnancy	651.11
Quadruplet pregnancy	651.21
Other specified multiple gestation, delivered w/or without mention of antepartum condition	651.81
Oligohydramnios	658.01
Polyhydramnios	657.01
Macrosomia	656.61
Isoimmunization from other & unspec blood-group incompatibility	656.11 656.21
Malpresentation of fetus	
Unstable Lie	652.01
Multiple gestation with malpresentation of one fetus or more	652.61
Fetal Demise	656.41 (singleton still birth) 651.31, 651.41, 651.51, 651.61 (multiple gestation with one or more still birth)

CLAIM DENIALS

- If a practitioner and/or hospital claim is denied for payment due to lack of an appropriate condition code or modifier, please resubmit the claim with the appropriate modifier or condition code. Questions should be directed to the eMedNY Call Center at (800) 343-9000.
- 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.

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APPEAL PROCESS

- A 10% reduction in either the hospital inpatient claim or a practitioner claim may be appealed through the following process:
 - 1) Medicaid fee-for-service practitioners or hospitals may request an appeal by contacting the Division of Program Development and Management at (518) 473-2160.
 - 2) Medicaid fee-for-service appeals will be referred to Island Peer Review Organization (IPRO) for review.
 - 3) A decision will be rendered by IPRO following clinical review. Providers will be asked to submit a written clinical justification, along with a medical record. If the appeal is upheld, no additional payment will be made. If the appeal is overturned, the claim will be readjudicated and payment will be restored to 100%.
 - 4) If a provider wishes to appeal a payment reduction made by a Managed Care Plan, they should contact that Plan to get details on the appeal process.

- Practitioners and hospitals are responsible for ensuring that the codes (and modifiers when applicable) submitted for reimbursement accurately reflect the diagnosis and procedure(s) that were reported. Post payment reviews may be conducted by the Office of the Medicaid Inspector General (OMIG) and/or through a Medicaid-funded utilization management contractor, as appropriate (pursuant to 18 NYCRR 504.8) on adjudicated claims. Medical records must be maintained by providers for a period of not less than six years from the date of payment.

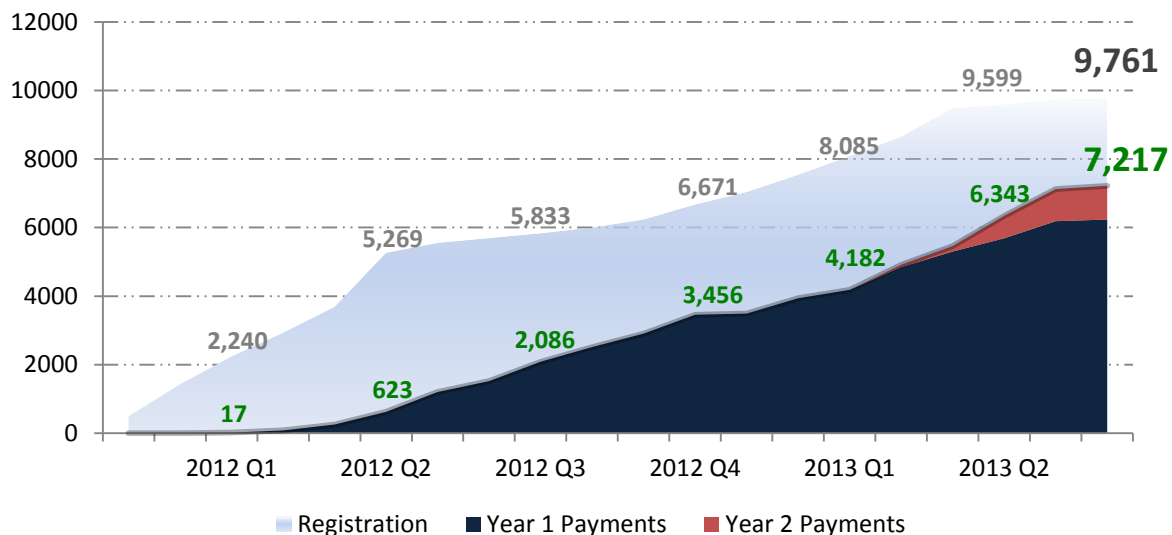
New York Medicaid Electronic Health Records Incentive Program Update

The New York Medicaid EHR Incentive Program provides financial incentives to eligible practitioners and hospitals to promote the transition to electronic health records (EHR). Providers who practice using EHRs are in the forefront of improving quality, reducing costs, and addressing health disparities. Since December 2011 over \$381 million in incentive funds have been distributed to over 7,200 New York State Medicaid providers.

For more information about the EHR Incentive Program, we encourage you to visit the program website at <https://www.emedny.org/meipass/> or attend one of the informational webinars hosted by the NYS Department of Health. To see the complete schedule of events and webinars, please view our Upcoming Event Calendar at <https://www.emedny.org/meipass/info/Events.aspx>.

Taking a Closer Look: Program Registration to Incentive Payment Highlights

<p>9,750+ registered.</p>	<p>7,200+ incentivized.</p>	<p>Are YOU on board?</p>
<p>NY Medicaid EHR</p>	<p>Incentive Program</p>	<p>emedny.org/meipass</p>



*Analysis derived from 6/10/2013 program registration data. Have Questions? Please contact hit@health.state.ny.us for program clarifications and details.

Attention Physicians: New York State Occupational Health Clinic Network

To meet the increasing demand for medical services related to the diagnosis, treatment and prevention of occupational disease, the NYS Department of Health (NYSDOH) established the **New York State Occupational Health Clinic Network (OHCN)** in 1987.

Occupational Health Clinic Locations

Albany	Occupational & Environmental Health Center of Eastern NY
Binghamton	Occupational Health Clinic Centers - Southern Tier
Canton	Occupational Health Clinical Centers – North Country
Cooperstown	New York Center for Agricultural Medicine and Health
Hudson Valley	Center for Occupational & Environmental Medicine
Long Island	Occupational & Environmental Medicine of Long Island
New York City	Bellevue/NYU Occupational & Environmental Medicine Clinic
New York City	Center for Occupational & Environmental Medicine
Rochester	Finger Lakes Occupational Health Services
Syracuse	Occupational Health Clinical Centers – Central New York

The OHCN is unique in the United States as a *public health based occupational disease clinical and preventive service* and includes eleven clinical centers, including one with statewide responsibility in the area of agricultural safety and health.

The clinics of the OHCN are a resource for health care providers treating patients with potential work-related illnesses and injuries. The clinics have diverse teams of physicians, nurses, industrial hygienists and social workers that assist providers in assessing and managing their patients' work-related conditions and, if necessary, provide worksite and social work interventions. The OHCN's board-certified occupational medicine physicians and staff are also experts in dealing with the workers' compensation system and assisting patients during the compensation process.

The OHCN clinics are open to workers, retirees and residents of New York State with potential work-related illness and injuries. Because they receive public funding, *they offer a sliding fee scale* to ensure access for uninsured and underinsured patients, and can bill directly to most major health insurance carriers.

Moreover, because of their occupational focus, the clinics are able to offer services that complement the care patients receive from their primary care physicians and other specialists. These specialty services include: **occupational illness and injury prevention education, medical surveillance examinations, respirator fit testing and clearance examinations, fit for duty examinations** and a variety of wellness programs.

Physicians in New York State are encouraged to contact the clinic in their region to determine how they can utilize the clinics' occupational health services for their patients with potential work-related conditions.

For additional information about the New York State Occupational Health Clinic in your region, please contact the NYS Department of Health at (800) 458-1158 or visit: <http://www.health.ny.gov/nysdoh/environ/occupate.htm>.

2% Across The Board Medicaid Payment Reduction Extension

The final 2013-14 state budget (Chapter 56 of the Laws of 2013) requires an extension of the 2% across the board reduction on most Medicaid payments. Such payment reductions will apply for dates of service on and after April 1, 2013. The reduction will remain in effect for dates of service through March 31, 2015.

All current agreements on the manner in which the reduction is applied to specific provider classes and/or services will be upheld unless otherwise noted. Please access the website regularly for the most updated information: http://www.health.ny.gov/health_care/state/index.



New Coverage Codes - Inpatient Hospital Claiming for Inmates and 21-64 Year Old Individuals Admitted to a Psychiatric Center

Beginning July 1, 2013, Medicaid providers will be required to submit claims through eMedNY for inpatient hospital services provided to individuals with suspend status who are incarcerated in a New York State or local correctional facility, or 21-64 years of age and residing in a New York State Office of Mental Health operated psychiatric center.

To facilitate claims payment, the following two coverage codes have been created. The new codes will be valid for dates of service beginning July 1, 2013.

- 1) **Coverage Code 25: Inpatient Hospital Only (Federally Non-Participating):** This coverage code identifies individuals who are 21-64 years old and residing in a psychiatric center. **Included:** Recipient is eligible to receive coverage for inpatient hospital services only. **Excluded:** Recipient is ineligible for enrollment in managed care.
- 2) **Coverage Code 26: Inpatient Hospital Only (Federally Participating) :** This coverage code identifies individuals who are incarcerated in a New York State or local correctional facility. **Included:** Recipient is eligible to receive coverage for inpatient hospital services only. **Excluded:** Recipient is ineligible for enrollment in managed care.

Medicaid coverage is limited to inpatient hospital services provided off the grounds of the correctional facility or psychiatric center.

ADDITIONAL INFORMATION

The ARU, POS and ePACES response messages for individuals with Coverage Code 25 and Coverage Code 26 is: Eligible Only Inpatient Services.

If you have questions, please contact Kim Ciraulo at (518) 474-8887.

Reminder: Hospice Services for Managed Care Enrollees

This is a reminder to hospice providers concerning coverage of and billing for hospice services to Medicaid Managed Care (MMC), Managed Long Term Care (MLTC), Family Health Plus (FHPlus) and Child Health Plus (CHPlus) enrollees. MMC, MLTC, FHPlus and CHPlus enrollees are eligible for hospice services when certified by a physician to be terminally ill with a life expectancy of one year or less. There is no benefit limit – regardless of how long the enrollee lives, the enrollee is eligible for the benefit as long as the enrollee requires hospice services. Enrollees under age 21 who are receiving hospice services are also eligible to receive medically necessary curative services in addition to palliative care.

Medicaid Managed Care

For MMC enrollees, hospice services are not included in the managed care plan benefit, and are billable directly to eMedNY. This includes hospice services provided in the enrollee's home or in a nursing home or hospital setting. Managed care plans remain responsible for any care provided in the home, nursing home or hospital that is unrelated to the enrollee's terminal illness. Effective October 1, 2013, hospice services will be included in the managed care benefit, contingent on approval from the Centers for Medicare and Medicaid Services (CMS).

Managed Long Term Care

For MLTC enrollees [Partial MLTC plans and Medicaid Advantage Plus (MAP)], hospice services are not included in the managed care plan benefit, and are billable directly to eMedNY. This includes hospice services provided in the enrollee's home or in a nursing home or hospital setting. Enrollees are no longer required to disenroll from their MLTC or MAP plans when hospice services are medically indicated. However, MLTC and MAP plans remain responsible for any care provided in the home that is unrelated to the enrollee's terminal illness. PACE enrollees who elect the hospice benefit must be disenrolled from PACE.

Family Health Plus and Child Health Plus

For FHPlus and CHPlus enrollees, hospice services are covered by the enrollee's managed care plan. Hospice providers are reminded that they must participate with the enrollee's managed care plan and must obtain any necessary prior approvals for admission to hospice.

End of Life Cancer Care Services at Calvary Hospital

Pursuant to Section 4406-e of the Public Health Law, managed care plans must provide acute care services for enrollees diagnosed with advanced cancer (with no hope of reversal of primary disease and fewer than sixty days to live, as certified by the patient's attending health care practitioner) with coverage for acute care services at Calvary Hospital, if the patient's attending health care practitioner, in consultation with the medical director of the facility, determines that the enrollee's care would appropriately be provided by the facility. If the plan disagrees with the admission of or, provision or continuation of care for the enrollee by the facility, the plan may not deny the admission and the plan must file an expedited external appeal. The plan is responsible for paying the facility for services provided pending the external appeal determination. Plans must reimburse Calvary Hospital at the facility's Medicare rate of payment (or for alternate level of care days, at 75% of the acute care rate) in the absence of a negotiated rate.

Billing Alert for Vision Care Providers

The Office of the State Comptroller (OSC) recently conducted an audit of certain vision care providers' Medicaid claims. The audit findings revealed that certain providers billed and received excessive payments for Medicaid clients who were dually eligible for Medicare and Medicaid coverage.

Although Medicaid pays for routine vision care services (such as eyeglasses and routine eye care exams), Medicare generally does not. Under these circumstances, Medicaid requires providers to apply the Medicaid standard fee schedule amounts when submitting claims for routine vision care services to recipients who are enrolled in both Medicaid and Medicare.



The following billing guidelines apply when billing for dually eligible recipients, which is referred to as Medicare crossover claims:

- For Medicare covered services providers are required to bill Medicare, of which the claim will automatically 'crossover' to the Medicaid payment system in order to coordinate payment of claims.
- If you know that a service is not covered by Medicare, such as routine vision care services, you can bill Medicaid directly. It is important to enter '0' (zero) approved and '0' (zero) paid amounts in the Medicare sections on the claim that you submit to Medicaid.

For more information on how to submit Medicare crossover claims, please see the General Billing Guidelines for Professionals, which is available on the eMedNY website, page 8, Section "2.4.1 Instructions for the Submission of Medicare Crossover Claims." The following web link will bring you to this information:

https://www.emedny.org/ProviderManuals/AllProviders/General_Billing_Guidelines_Professional.pdf

Please be aware that the Office of Medicaid Inspector General (OMIG) monitors claims to ensure appropriate billing and receipt of payments for Medicaid services. Inappropriate payments are subject to recovery and possible penalties.

If you have any questions you may contact a Medicaid fee-for-service policy liaison at (518) 473-2160. Billing questions? Please contact the eMedNY Call Center at (800) 343-9000 or (800) 522-5518.

Upcoming UAS-NY Milestone for Managed Long Term Care Plans

On May 13, 2013, the Division of Long Term Care (DLTC) announced a 90-day delay in the implementation of the Uniform Assessment System for New York (UAS-NY) for Managed Long Term Care (MLTC) Plans and their respective provider networks. This delay is intended to provide additional time for MLTC Plans to ensure that their staff and providers within their provider networks are operationally prepared to fully and successfully transition to the UAS-NY.

To ensure that MLTC plans and their respective networks are prepared to fully implement the UAS-NY, DLTC has established specific project milestones.

Milestone One

All HCS user accounts must be submitted to the Commerce Accounts Management Unit *no later than July 1, 2013*.

Milestone Two

Trust Level 3 assurance and UAS role assignments must be established by *no later than August 1, 2013*.

Milestone Three

All staff (assessors and support staff alike) must complete the required online training and begin using the UAS-NY in preparation for conducting assessments by **August 15, 2013**.

Milestone Four

Plans must use the UAS-NY for all new members who are scheduled to enroll effective **October 1, 2013**. This will require plans to use the UAS-NY as early as **mid-August 2013**.

Milestone Five

The UAS-NY must be used for all reassessments beginning **October 1, 2013**.

MLTC plans and their respective networks must ensure adherence to these milestones. Questions concerning this notice and the UAS-NY should be directed to the UAS-NY Project Team at uasny@health.state.ny.us or (518) 408-1021.

UAS-NY Implementation Update

Beginning **August 1, 2013**, all home and community-based long term care Medicaid programs in the following counties will begin activities to **transition** to the Uniform Assessment System for New York (UAS-NY).

Dutchess	Putnam	Sullivan
Orange	Rockland	Ulster



All organizations that manage, conduct assessments, or provide services for any of following programs will be required to use UAS-NY.

- Adult Day Health Care
- Assisted Living Program
- Care at Home I/II Waiver
- Consumer Directed Personal Assistance Program
- Long Term Home Health Care Program
- Nursing Home Transition and Diversion Waiver
- Personal Care Services Program
- Traumatic Brain Injury Waiver

Once the transition activities are completed, organizations in these counties will use the UAS-NY to conduct assessments for these programs. Organizations in these counties will achieve full implementation of the UAS-NY no later than **January 1, 2014**. Organizations that are responsible for the client assessment must ensure that any contractors are identified and notified of this change.

UAS-NY Implementation Overview Webinar

The UAS-NY Project Team will conduct an overview of the UAS-NY, the transition activities, and timeline for organizations in these counties on **July 12, 2013**. The one-hour webinar will begin at **2:00 pm**. All organizations in these counties are strongly encouraged to participate as important information about the transition activities will be presented.

To register for the event click the following link:

<https://uasny.webex.com/uasny/onstage/g.php?t=a&d=660037559>

Upon completion of your registration, you will receive an e-mail with details to access the webinar. This e-mail will include the link and password for the actual event.

Prior to the webinar, staff are encouraged to visit the Department's website for additional information concerning the UAS-NY. The website includes all previously recorded webinars and includes a summary of assessment instruments that will be replaced. Of particular importance is the January 29, 2013, UAS-NY Project Update webinar. All materials are available at:

http://www.health.ny.gov/health_care/medicaid/redesign/uniform_assessment_system/index.htm

Questions concerning the transition to and implementation of the UAS-NY may be e-mailed to uasny@health.state.ny.us.

Fee-for-Service Medicaid: Clarification of Provider Qualifications for Medicaid-Reimbursable Breastfeeding Support Services

Medicaid fee-for-service reimbursement of outpatient breastfeeding education and lactation counseling services began on **April 1, 2013**.

Medicaid Provider Qualifications

Medicaid reimbursement is available for breastfeeding education and lactation counseling services provided only by the following New York State licensed, registered, or certified health care professionals who are also International Board Certified Lactation Consultants (IBCLCs) credentialed by the International Board of Lactation Consultant Examiners (IBLCE):

- Physicians
- Nurse Practitioners (NPs)
- Midwives (MWs)
- Physician Assistants (PAs)
- Registered Nurses (RNs)

Medicaid payment is not available for breastfeeding support/lactation counseling services provided by other IBCLC licensed health care practitioners not listed above.

Medicaid Reimbursement

Code	Code Description	Benefit Limitations	Medicaid Fee
S9445	PATIENT EDUCATION, NOT OTHERWISE CLASSIFIED, NON-PHYSICIAN PROVIDER, INDIVIDUAL, PER SESSION	45 minute minimum session length - initial lactation counseling session. 30 minute minimum session length – follow-up lactation counseling session(s). Up to three (3) sessions total, within 12-month period immediately following delivery.	\$45.00
S9446	PATIENT EDUCATION, NOT OTHERWISE CLASSIFIED, NON-PHYSICIAN PROVIDER, GROUP, PER SESSION	Up to a maximum of eight (8) participants in a group session. 60 minute minimum session length. One (1) prenatal and one (1) postpartum class per recipient per pregnancy.	\$15.00

Please refer to the March 2013 Medicaid Update article on breastfeeding support for additional Medicaid billing and claiming policy. For claiming questions please contact the eMedNY Call Center at (800) 343-9000. For Medicaid policy questions, please contact the Office of Health Insurance Programs (OHIP) at (518) 473-2160. For questions about Managed Care or Family Health Plus enrollees, please contact the enrollee's health plan.

Important Information for Pharmacists Concerning Medicaid Pharmacy Prior Authorization Rejection Response Messaging

The Medicaid fee-for-service (FFS) pharmacy program provides system messaging to help guide pharmacists to appropriately submit a claim or to contact the prescriber. For claims that do not meet clinical criteria, eMedNY Point of Service (POS) will return a rejected response in (NCPDP field 511-FB) "85 - Claim Not Processed", along with an additional detailed "75" message in (NCPDP field 526-FQ).

Although there are a multitude of "75" messages that may appear, there are four in particular, listed below, for which the pharmacist may be able to intervene and reduce the need for prior authorization (PA).

- **75AT** - Step Therapy or Preferred Product Required
- **75UD** - Units Per Day or Days Supply Criteria Failure
- **75MQ** - Quantity Criteria Failure
- **75UF** - Units Per Fill or Units Per 30 Days Criteria Failure

If a rejected response on a pharmacy claim is returned with one of the above messages along with "Unable to Process a Pharmacy PA Please Call Magellan", the pharmacist can call Magellan or refer to the NYS Medicaid Pharmacy Prior Authorization Program at:

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

Additional information can be provided to the pharmacist explaining more specifically the reason for the claim rejection. The pharmacist may be able to change the days supply on the claim or limit the quantity dispensed. This may resolve the issue and eliminate the need for a PA. Here are some examples:

EXAMPLE 1:

The pharmacist submits a claim for sumatriptan, 30 tablets as a 30 day supply.

Pharmacist receives the rejection- "75UF" – "Units per Fill or Units per 30 Days Criteria Failure - Unable to Process a Pharmacy PA Please Call Magellan."

- The pharmacist can call the Magellan Clinical Call Center where they will be advised on quantity limits (in this example; 18 tablets every 30 days) or the pharmacist can refer to the NYS Medicaid Pharmacy Prior Authorization Program criteria.
- The pharmacist can then call the prescriber and discuss the quantity limit.
- The prescriber can either authorize the change or pursue a PA.

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EXAMPLE 2:

The pharmacist submits a claim for fluticasone nasal spray, 16 grams as a 30 day supply.

Pharmacist receives a rejected response “75AT” – “Step Therapy or Preferred Product Required -Unable to Process a Pharmacy PA Please Call Magellan”.

- The pharmacist can call the Magellan Clinical Call Center where they will be advised on the step or preferred product (in this example; preferred product is Nasacort AQ®) or the pharmacist can refer to the NYS Medicaid Pharmacy Prior Authorization Program criteria.
- The pharmacist can then call the prescriber and discuss preferred drug options.
- The prescriber can either pursue a PA or switch to a preferred drug.

These additional steps for the pharmacist may help patients receive their medication(s) in a timelier manner and avoid unnecessary PA's.

To obtain a prior authorization (PA) or PA criteria information, please call the prior authorization Clinical Call Center at (877) 309-9493 or visit the NYS Medicaid Pharmacy Prior Authorization Program at; https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf. 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 a PA or answer any questions you may have.

The New York State Medicaid Prescriber Education Program Drug Information Response Center

Addressing Concomitant Use of Varenicline and Nicotine Replacement Therapy

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). The NYSMPEP provides prescribers with an evidence-based, non-commercial source of the latest objective information about pharmaceuticals. In conjunction with the NYSMPEP, the Drug Information Response Center (DIRC) assists clinicians in the delivery of health care to their Medicaid patients by providing timely, evidence-based information on pharmacotherapy and serving as a resource for NYSMPEP academic educators in their outreach to prescribers. A response was prepared by the DIRC regarding the effects of combined varenicline with nicotine replacement therapy (NRT) for treatment of tobacco dependence.

The US Preventive Services Task Force and the Department of Health and Human Services (DHS) recommend varenicline and NRT, individually, as first-line agents for the treatment of tobacco dependence.^{1,2} Both organizations also recommend usage of combination therapy for treatment of tobacco dependence and describe several combinations (e.g., nicotine patch with other forms of NRT as needed, nicotine patch with bupropion). However, varenicline with NRT is not included in these recommendations. Varenicline acts as a partial agonist on the neuronal alpha-4-beta-2 nicotinic acetylcholine receptors.³ NRT acts to replace cigarettes with other sources of nicotine, including transdermal patches, gums, inhalers, nasal sprays, and lozenges.

Few studies have been published describing combined use of varenicline and NRT. One study was conducted by the manufacturer of varenicline, in which 22 patients received transdermal nicotine 21 mg/day in combination with varenicline 1 mg twice daily and 17 patients received transdermal nicotine 21 mg/day and placebo.³ The investigators compared the groups for differences in pharmacokinetic parameters and safety. Though the pharmacokinetics of nicotine were not significantly different between groups, the incidence of adverse events (including nausea, headache, vomiting, dizziness, dyspepsia, and fatigue) was greater in the combination group compared to the placebo group. Eight of 22 patients (36%) prematurely discontinued therapy in the combination group compared to 1 of 17 patients (6%) in the placebo group. No other information is available for this study. Of note, the manufacturer does not recommend either for or against the concurrent use of NRT with varenicline.

Ebbert et al. conducted a retrospective cohort study of varenicline in combination with NRT versus usual care, which consisted of NRT \pm bupropion.⁴ Data were obtained from the Mayo Clinic's Nicotine Dependence Center from 2004 through 2006 for usual care and from 2006 through 2008 for the varenicline group with no overlap. Outcomes included adverse events and smoking abstinence at 6 months. A total of 135 patients were identified in the usual care group and 104 patients in the varenicline group. During the study, at least 1 adverse event was recorded in 39% (95% confidence interval [CI] 31% to 49%) of patients in the varenicline group vs. 59% (95% CI 51% to 67%) of patients in the usual care group.⁴ Adverse events reported more frequently in the varenicline group included insomnia, nausea, vivid/disturbing dreams, depressive symptoms, gastrointestinal symptoms, and dizziness.

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PHARMACY UPDATE

Abstinence at 6 months was reported in 54% (95% CI 44% to 64%) of patients who used varenicline compared to 59% (95% CI 50% to 66%) of patients who received usual care.

No other studies evaluating the use of varenicline with NRT were found from a review of the literature. Theoretically, varenicline blocks the effects of NRT and negates its effectiveness; however, this was not shown in the single retrospective study evaluating the combination.

Based on this data, the effects of combining varenicline with NRT are inconclusive. Patients receiving the combination may be at higher risk of experiencing adverse events compared to those receiving either agent alone, though this is currently unclear.

To contact an NYSMPEP academic educator in your area, please visit <http://nysep.nysdoh.suny.edu/contactus>.

References:

1. US Preventative Services Task Force. Counseling and interventions to prevent tobacco use and tobacco-caused disease in adults and pregnant women: US Preventive Services Task Force reaffirmation recommendation statement. *Ann Intern Med.* 2009;150(8):551-555.
2. Tobacco Use and Dependence Guideline Panel. Treating Tobacco Use and Dependence: 2008 Update. Rockville, MD: US Department of Health and Human Services; 2008.
3. Chantix [package insert]. New York, NY: Pfizer, Inc.; 2012.
4. Ebbert JO, Burke MV, Hays JT, Hurt RD. Combination treatment with varenicline and nicotine replacement therapy. *Nicotine Tob Res.* 2009;11(5):572-576.

Expanding Prescriber Prevails in Medicaid Managed Care in Certain Drug Classes

Effective July 1, 2013, for Medicaid Managed Care plans, the “prescriber prevails” provision will be expanded to include medically necessary prescription drugs in the **anti-depressant, anti-retroviral, anti-rejection, seizure, epilepsy, endocrine, hematologic and immunologic therapeutic classes**,* including non-formulary drugs, upon demonstration by the prescriber, after consulting with the managed care provider, that such drugs, in the prescriber's reasonable professional judgment, are medically necessary and warranted.

This change is the result of legislation passed in the 2013-2014 Executive Budget. Once implemented, this initiative will enable the prescriber's reasonable professional judgment to prevail for the above therapeutic drug classes that are not on plan formularies or have prior authorization requirements.

Plans will continue to develop formularies and may also administer prior authorization programs for these therapeutic drug classes. Prescribers will still be required to supply plans with requested information and/or clinical documentation. As they do currently, plans will be able to provide a temporary (3 day) supply of medication when necessary.

Pursuant to federal and contractual provisions, the plans will continue to be required to meet specified turnaround times. Additionally, notices will be sent to members and prescribers for prior authorization requests where the plan is unable to make a determination due to missing information or the prescriber's reasonable professional judgment has not been adequately demonstrated. In such cases, members' rights regarding appeals and fair hearings will continue to apply. This is consistent with plans' current processes for member and provider notification.

*NOTE: Stakeholders can match affected drugs to the Medicaid fee-for-service (FFS) Preferred Drug List (PDL) for quick identification when prescribing. Please see the following crosswalk for comparison.



-continued on next page-

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2013-2014 Expanded Prescriber Prevails Classes Based on Current Medicaid FFS PDL

Hematological Agents*

Anticoagulants - Injectable

Anticoagulants - Oral

Erythropoiesis Stimulating Agents (ESAs)

Platelet Inhibitors

Central Nervous System

Seizure/Epilepsy*

Anticonvulsants- Second Generation

Benzodiazepines- Rectal

Carbamazepine Derivatives

Immunologic Agents*

Multiple Sclerosis Agents

Anti-depressants*

Selective Serotonin Reuptake Inhibitors (SSRIs)

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

Endocrine and Metabolic Agents*

Amylin Analogs

Anabolic Steroids- Topical

Biguanides

Bisphosphonates- Oral

Calcitonins- Intranasal

Dipeptidyl Peptidase- 4 (DPP-4) Inhibitors

Glucagon-like Peptide-1 (GLP-1) Agonists

Growth Hormones

Insulin- Long-Acting

Insulin- Mixes

Insulin- Rapid-Acting

Pancreatic Enzymes

Thiazolidinediones (TZDs)

Immunologic Agents*

Immunomodulators- Systemic

2013-2014 Expanded Prescriber Prevails classes *not* currently on Medicaid FFS PDL

Anti-retroviral*

Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) Agents

Anti-rejection*

Immunosuppressives - Oral

Specialty Mail Order Pharmacy in Medicaid Managed Care

The enacted SFY 2013-14 Budget includes a new provision (Section 12 of Part A of Chapter 56 of the Laws of 2013) that affects Medicaid Managed Care/Family Health Plus/HIV SNP Plans' Specialty Pharmacy Programs. Effective April 1, 2013, this new provision enables members, at their option, to obtain mail order specialty drugs at any retail network pharmacy. Medicaid Managed Care plans have procedures in place to allow their members to use any network pharmacy if that pharmacy agrees to accept a price comparable to the mail order specialty pharmacy price.



This means that if a member or provider acting on behalf of a member contacts the Managed Care Plan and requests to obtain mail order specialty medication(s) through a network retail pharmacy, and the network retail pharmacy agrees to a price that is comparable to the mail order specialty pharmacy price, the Managed Care Plan must allow the member to use the network retail pharmacy.

Managed Care plans are currently evaluating how this statutory change affects contracts with their Pharmacy Benefit Managers (PBMs) and/or their pharmacy network and will communicate any changes directly to their network pharmacies. Plans will also be responsible for notifying members and updating their websites.

Standard Prior Authorization Form in Medicaid Managed Care/Family Health Plus and Medicaid Fee-for-Service (FFS)

Effective July 8, 2013, Medicaid Managed Care/Family Health Plus and Medicaid FFS will implement a standard prior authorization (PA) request form in accordance with Section 364-j of Social Service Law, subdivision 26. This legislation authorizes the development of a standard prior authorization request form or forms to be utilized by all managed care providers for purposes of submitting a request for a utilization review determination for coverage of prescription drug benefits.

The final form was developed with stakeholder input through a series of comment periods involving the Managed Care Plans, provider and advocacy organizations, and State agencies such as the Office of Alcoholism and Substance Abuse Services and the Office of Mental Health.

The form will be available through the [NY State Medicaid Managed Care and Family Health Plus Pharmacy Benefit Information Center](http://pbic.nysdoh.suny.edu/) for Medicaid Managed Care and Family Health Plus plans at: <http://pbic.nysdoh.suny.edu/> and through Magellan Medicaid Administration for Medicaid FFS at: <https://newyork.fhsc.com/>.

Old versions of PA forms will continue to be accepted as providers transition to the new form.



Service Bureaus and Providers

Service bureaus and providers are reminded that prior to submission, claims must be reviewed by the provider of the care, services or supplies in order that the provider may correct any inaccurate claims, delete improper claims or otherwise revise the intended submission to ensure that only claims for services actually provided, due and owing are submitted.

Registration is now easier than ever!

Training Schedule and Registration

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

If you answered YES to any of these questions, you should consider registering for a Medicaid training session. Computer Sciences Corporation (CSC) offers various types of educational opportunities to providers and their staff. Training sessions are available at no cost to providers and include information for claim submission, Medicaid Eligibility Verification, Electronic Funds Transfer, Electronic/PDF Remittance Advice Form Completion, and the eMedNY website.

Web Training Available

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

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

- **Claims** (Dental, Professional, Institutional)
- **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 registration, locations, and dates are available on the eMedNY website at: <http://www.emedny.org/training/index.aspx>.

CSC Regional Representatives look forward to having you join them at upcoming meetings!

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

Note: We have recently updated the PROVIDER TRAINING pages of the website. Providers can view upcoming sessions in a calendar view, a table view, or print view.

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

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

Do you have questions about billing and performing MEVS transactions?

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

Provider Training:

To sign up for a provider seminar in your area, please enroll online at: <http://www.emedny.org/training/index.aspx>. For individual training requests, call (800) 343-9000 or e-mail: emednyproviderrelations@csc.com.

Enrollee Eligibility:

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

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.