

State Health Department and CMS Forge Alliance to Improve Care to Dual Eligibles

The Centers for Medicare & Medicaid Services (CMS) and the New York State Department of Health (DOH) have established a federal-state partnership to implement the Medicare-Medicaid Alignment Initiative (Demonstration) that will better serve individuals eligible for both Medicare and Medicaid.



Under the partnership, DOH and CMS will contract with Fully Integrated Duals Advantage (FIDA) Plans, which are Medicare-Medicaid Plans (MMPs) that provide integrated benefits to people eligible for both Medicare and Medicaid. The FIDA plans oversee the delivery of covered Medicare and Medicaid services for enrollees who reside in New York City and the surrounding counties of Nassau, Suffolk and Westchester. The demonstration will begin July 1, 2014 and continue until December 31, 2017.

The initiative is testing an innovative payment and service delivery model to alleviate health care fragmentation, improve coordination of services for Medicare-Medicaid enrollees, and enhance the quality of care. This demonstration is an important building block in the state's move to "Care Management for all" in Medicaid.

Through FIDA, New York will provide eligible individuals with seamless access to all physical health, behavioral health, and long-term supports and services; a choice of plan and providers, with choices being facilitated by an independent broker; and care planning and coordination by patient-centered interdisciplinary teams. In addition, this demonstration will allow FIDA plans to test alternative payment arrangements with their network providers.

"We are delighted to partner with CMS to offer access to more coordinated care to Medicare-Medicaid beneficiaries with long-term care needs," said State Health Commissioner, Nirav R. Shah, MD, MPH. "Providing customized services that address each individual's medical, behavioral and social needs is critical to improving the health and well-being of this population."

Many existing managed long term care plans are expected to participate in the demonstration, which will help ensure continuity of coverage and care for individual enrollees.

A fact sheet about the CMS-DOH partnership is available at:

<http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-08-26.html>.



Andrew M. Cuomo
GOVERNOR
State of New York

Nirav R. Shah, M.D., M.P.H
COMMISSIONER
New York State DOH

Jason A. Helgerson
MEDICAID DIRECTOR
Office of Health Insurance Programs

SEPTEMBER 2013 NEW YORK STATE MEDICAID UPDATE

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Attention: Clinical Psychologists

REMINDER: Effective April 1, 2013, the following CPT procedure codes were added to the eMedNY system to enable Medicaid billing by clinical psychologists.

CPT Procedure Codes:

90791 - PSYCHIATRIC DIAGNOSTIC EVALUATION

Practitioner Non-Facility Fee is \$93.26 and Facility Fee is \$59.78

90846 - FAMILY PSYCHOTHERAPY (WITHOUT THE PATIENT PRESENT)

Practitioner Non-Facility Fee is \$52.48 and Facility Fee \$42.92

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

For policy questions you may call the Division of Program Development and Management at (518) 473-2160.



Additional Upstate Counties to be Added to Transportation Carve-out for Managed Care Enrollees Effective January 1, 2014

To implement the Medicaid Redesign Team's (MRT) Transportation Reform Initiative, the Department is phasing in a Medicaid fee-for-service non-emergency medical transportation (NEMT) management program under which transportation services are carved out of the Medicaid managed care benefit package. The first NEMT program for managed care enrollees was implemented in the Hudson Valley Region in January 2012, with additional counties in the Region moving to the NEMT manager in March and September of 2012 (see below), and implementation in New York City in January 2013.

Beginning January 1, 2014, the following transportation services will be carved-out of the managed care benefit package for managed care enrollees in 24 additional counties in the Finger Lakes and Northern New York:

- 1) emergency and non-emergency transportation services for all Medicaid managed care enrollees; and
- 2) non-emergency transportation **only** for Family Health Plus (FHPlus) enrollees aged 19 through 20.

The upstate carve-out schedule for transportation of managed care enrollees is provided below:

- *January 1, 2012* – Albany, Columbia, Fulton, Greene, Montgomery, Orange, Putnam, Rockland, Sullivan, Ulster, Warren, Washington, Westchester
- *March 1, 2012* – Broome, Cayuga, Dutchess, Oneida, Onondaga, Rensselaer, Schenectady, Schoharie
- *September 1, 2012* – Delaware, Essex, Saratoga
- *January 1, 2014* – Chemung, Chenango, Clinton, Cortland, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Ontario, Orleans, Oswego, Otsego, St. Lawrence, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne, Yates

Members and medical providers in these counties should be advised to contact Medical Answering Services, LLC (MAS), at the county-specific numbers provided on the following page:

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POLICY & BILLING GUIDANCE

Albany County	855-360-3549		Ontario County	866-733-9402
Broome County	855-852-3294		Orange County	855-360-3543
Cayuga County	866-932-7743		Orleans County	866-260-2305
Chemung County	855-733-9399		Oswego County	855-733-9395
Chenango County	855-733-9396		Otsego County	866-333-1030
Clinton County	866-753-4435		Putnam County	855-360-3547
Columbia County	855-360-3546		Rensselaer County	855-852-3293
Cortland County	855-733-9397		Rockland County	855-360-3542
Delaware County	866-753-4434		St. Lawrence County	866-722-4135
Dutchess County	866-244-8995		Saratoga County	855-852-3292
Essex County	866-753-4442		Schenectady County	855-852-3291
Franklin County	888-262-3975		Schoharie County	855-852-3290
Fulton County	855-360-3550		Schuyler County	866-753-4480
Greene County	855-360-3545		Seneca County	866-753-4437
Hamilton County	866-753-4618		Steuben County	855-733-9401
Herkimer County	866-753-4524		Sullivan County	866-573-2148
Jefferson County	866-558-0757		Tioga County	855-733-9398
Lewis County	800-430-6681		Tompkins County	866-753-4543
Livingston County	888-226-2219		Ulster County	866-287-0983
Madison County	855-852-3286		Warren County	855-360-3541
Monroe County	866-932-7740		Washington County	855-360-3544
Montgomery County	855-360-3548		Wayne County	855-852-3295
Oneida County	855-852-3288		Westchester County	866-883-7865
Onondaga County	855-852-3287		Yates County	866-753-4467

Effective January 1, 2013, medical providers in New York City are advised to contact LogistiCare, the New York City NEMT manager, at the numbers below to arrange for transportation of managed care enrollees:

Contact Information for Providers

NYC Facility Services Dept. (For facility transportation arrangements)	877-564-5925
Brooklyn facility fax	877-585-8758
Queens facility fax	877-585-8759
Manhattan facility fax	877-585-8760
Bronx facility fax	877-585-8779
Staten Island facility fax	877-585-8780
Hospital Discharge	877-564-5926

Managed care enrollees may use the numbers below to make their own transportation arrangements through LogistiCare or to register a complaint:

Contact Information for Enrollees

NYC Reservations (For enrollee reservations)	877-564-5922
NYC Ride Assist (For transportation complaints)	877-564-5923

Questions concerning the Medicaid fee-for-service transportation benefit should be directed to MedTrans@health.state.ny.us.

Coverage Guidelines for Implantable Infusion Pump for Opioid Administration for Purposes of Pain Management

Coverage Decision:

Effective on November 1, 2013, for Medicaid fee-for-service (FFS) beneficiaries, Medicaid Managed Care enrollees and Family Health Plus (FHPlus) enrollees.

Based on the current available evidence, New York State Medicaid will no longer cover implantable infusion pumps to deliver an Opioid to a patient with a non-cancer diagnosis.

Medicaid coverage of implantable infusion pumps and related supplies and drugs remains unchanged for all other indications. For those individuals who had infusion pumps implanted for ANY DIAGNOSIS prior to October 1, 2013, Medicaid will continue to cover pumps, related supplies and drugs.

BACKGROUND

DESCRIPTION OF PROCEDURE OR SERVICE:

An implantable pump is intended to provide long-term continuous or intermittent drug infusion. Possible routes of administration include intravenous, intra-arterial, subcutaneous, intraperitoneal, intrathecal, epidural, and intraventricular. The pump is surgically placed in a subcutaneous pocket under the infraclavicular fossa or in the abdominal wall, and a catheter is threaded into the desired position. A drug is infused over an extended period of time, and the drug reservoir may be refilled as needed by an external needle injection through a self-sealing septum in the infusion pump.

CRITERIA REQUIRED FOR COVERAGE:

Reimbursable ICD-9 codes used for the purpose of Opioid administration for pain management are codes in the 140-239 range.

Reimbursable CPT codes utilized in the management of cancer pain are limited to codes in the following ranges: 62350-62370, 95990-95991 and code 96522.

This policy does not apply to infusion pumps used for other indications. For example, implantable infusion pumps used to administer anti-spasmodic drugs, such as Baclofen, remain covered.

Practitioners are responsible for ensuring that the codes submitted for reimbursement accurately reflect the service(s) or procedure(s) that was provided. Post payment reviews are conducted by the Office of the Medicaid Inspector General (OMIG) 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.

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POLICY & BILLING GUIDANCE

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 fee-for-service policy should be directed to the Division of Program Development and Management at (518) 483-2160.

Questions regarding MMC/FHPlus reimbursement and/or documentation requirements should be directed to the enrollee's MMC or FHPlus plan.

Additional Low Back Pain Coverage Guidelines - Discography

COVERAGE DECISION:

Effective November 1, 2013, for Medicaid fee-for-service beneficiaries, Medicaid Managed Care enrollees and Family Health Plus (FHPlus) enrollees, the following procedures are subject to limitation, as they are considered ineffective, or experimental and investigational, for the treatment of chronic low back pain (LBP):

- 62290 Injection procedure for discography, each level; lumbar
- 72295 Discography, lumbar, radiological supervision and interpretation

Discography for the following conditions is considered not medically necessary:

- Lumbago, low back pain syndrome, lumbalgia, as represented by 2013 ICD-9 code 724.2
- Unspecified backache, vertebrogenic syndrome not otherwise specified, as represented by 2013 ICD-9 code 724.5

The decision to discontinue coverage of lumbar discography for chronic low back pain, or nonspecific LBP, is based on a lack of medical evidence, and the potential for harm. Medicaid will continue to cover discography for other indications, if medically necessary.

DESCRIPTION OF PROCEDURE OR SERVICE:

Discography, also known as discogram, disc stimulation, or provocation discography, is a diagnostic procedure used to evaluate patients with back pain thought to be discogenic in origin, who have been unresponsive to non-surgical intervention. Using radiological guidance, contrast medium is injected into the disc, to determine if the disc is the source of the pain. As a provocation test, it is liable to false positive results, and must be performed with anatomical controls to be considered valid. Therefore, the target disc, as well as adjacent disc (or discs), must be injected. The test is invasive, and carries significant risk (e.g. damage to disc or discs, nerve injury, bleeding, acute disc herniation, nucleus pulposus pulmonary embolism, inflammation or infection of disc).

Practitioners are responsible for ensuring that the codes submitted for reimbursement accurately reflect the service(s) or procedure(s) that was provided. Post payment reviews are conducted by the Office of the Medicaid Inspector General (OMIG) on adjudicated claims. Medical records must be maintained by providers for a period of not less than six years from the date of payment.

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POLICY & BILLING GUIDANCE

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 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.

Hospice Services in Mainstream Medicaid Managed Care

Effective October 1, 2013, contingent upon approval by the Centers for Medicare and Medicaid Services (CMS), mainstream Medicaid managed care and HIV Special Needs Plans will begin covering hospice services. Prior to this date, managed care enrollees received these services under the Medicaid fee-for-service (FFS) program.

Scope of Benefit

Hospice is a coordinated program of home and/or inpatient non-curative medical and support services for terminally ill persons and their families. Care focuses on easing symptoms rather than treating disease. The patient and his or her family receive physical, psychological, social and spiritual support and care. The program is available to persons with a medical prognosis of one (1) year or less to live if the terminal illness runs its normal course.

Hospice services are provided consistent with licensure requirements, and state and federal regulations. All services must be provided by qualified employees and volunteers of the hospice or by qualified staff through contractual arrangements to the extent permitted by state and federal requirements. All services must be provided pursuant to a written plan of care which reflects the changing needs of the enrollee and the enrollee's family.

For children under age 21 who are receiving hospice services, medically necessary curative services are covered in addition to palliative care.

Transition

Beginning October 1, 2013, Managed Care plans will cover the full range of Hospice services to current enrollees new to Hospice care. The transition of the benefit to managed care should not preclude the hospice providers from administering the full range of services under Article 40 of the Public Health Law. Managed care enrollees currently receiving Hospice services prior to October 1, 2013 will continue to receive these services under the FFS Medicaid program (per diem reimbursement) for the duration of their approved Hospice services.

For one year beginning October 1, 2013, managed care plans will pay the Medicaid FFS per diem rate for their enrollees receiving Hospice services during transition year. Upon completion of the one-year transition period, (September 30, 2014) Managed Care plans may negotiate different payment rates with the hospice providers.

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Provider Responsibilities

For hospice cases open prior to October 1, 2013, the hospice provider must continue to submit claims under FFS Medicaid at the per diem rate until the end of care.

For hospice cases open on or after October 1, 2013, the Hospice provider must:

- Verify Managed Care enrollment prior to performing the admission or assessment;
- Notify the managed care plan if the enrollee presents a physician order for services;
- Obtain initial authorization from the managed care plan for the provision of the hospice benefit and provide services according to a hospice plan of care approved by the managed care plan.
- If the hospice provider is not in the plan's network, the provider must obtain approval from the plan to provide services out of network. If the plan does not have a network provider, the plan must allow the member to obtain Hospice services from an out-of-network provider. However, in general, services will be provided by participating providers.

Authorization of Services

Managed Care Organizations (MCOs) will make a service authorization determination of the full array of a hospice services as fast as the enrollee's condition requires and no more than 3 business days from request as per the MMC/FHP/HIV SNP Model Contract Appendix F.1(3)(b)(i).

When the need for hospice services presents and/or an urgent referral is made by a provider during non-business hours, and the MCO is not operating in order to request authorization, the participating hospice provider will request authorization with all necessary information by the next business day. The MCO may not deny hospice services provided under these circumstances for lack of medical necessity or prior authorization, while the MCO determination is pending.

Right to Appeal

If there is a disagreement with the managed care plan determination, the provider may appeal on behalf of the enrollee. The enrollee will also have the right to a fair hearing at the state level and may be eligible for external appeal. The provider has appeal rights on their own behalf.

Optional/Suggested Claims Coding

Participating hospice providers must follow managed care plan procedures for claims processing. Managed care plans must provide specific coding guidance to providers for all hospice services.

Medicaid Coverage Guidelines for Transcutaneous Electrical Nerve Stimulation (TENS)

Policy Coverage Decision

Effective November 1, 2013, for Medicaid fee-for-service enrollees, Medicaid Managed Care enrollees and Family Health Plus (FHPlus) enrollees, New York State (NYS) Medicaid (MA) will limit reimbursement for TENS to only those enrollees diagnosed with knee pain due to osteoarthritis. This coverage determination is based on the current available medical evidence from health technology assessment studies of TENS usage outcomes in varying medical conditions.

Background

Treatment with TENS involves the transmission of electrical energy from an external stimulator to the peripheral nervous system via cutaneously placed conductive gel pads. TENS units usually have a single channel (with two electrodes) or dual channels (with four electrodes). The manner in which this energy, or current, is delivered can vary in frequency, intensity, pulse width, electrode placement and duration. The pulse forms can be exclusively positive or negative (monophasic) or bipolar (biphasic), and the frequency can be controlled.

ICD-9 CODING INFORMATION:

Reimbursable ICD-9 codes are limited to: 715.16, 715.26, 715.36, 715.86, and 715.96.

BILLING INFORMATION:

HCPCS Coding: The following codes may be used when billing for TENS provided to MA enrollees:

- A4556 Electrodes (e.g., apnea monitor), per pair
- A4557 Lead wires (e.g., apnea monitor), per pair
- A4630 Replacement batteries, medically necessary, transcutaneous electrical stimulator, owned by patient
- E0730 Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation
- Practitioners are responsible for ensuring that the codes submitted for reimbursement accurately reflect the service(s) or procedure(s) that was provided. Post payment reviews are conducted by the Office of the Medicaid Inspector General (OMIG) 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.

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POLICY & BILLING GUIDANCE

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 fee-for-service policy should be directed to the Division of Program Development and Management at (518) 483-2160.

Questions regarding MMC/FHPlus reimbursement and/or documentation requirements should be directed to the enrollee's MMC or FHPlus plan.

Limitation to Coverage for Functional Electrical Stimulation (FES)

COVERAGE DECISION

Effective November 1, 2013, for Medicaid fee-for-service beneficiaries, and effective November 1, 2013, for Medicaid Managed Care and Family Health Plus (FHPlus) enrollees, services/procedures, Durable Medical Equipment, and supplies to provide Functional Electrical Stimulation via transcutaneous, percutaneous, and implanted devices, are subject to limitation. Functional Electrical Stimulation is considered ineffective for treatment in spinal cord injury, head injury, cerebral palsy, and upper motor neuron disease.

The decision to **limit coverage of Functional Electrical Stimulation** for the above-mentioned conditions is based on a lack of medical evidence for these conditions, and the potential for harm.

Medicaid will continue to cover Functional Electrical Stimulation for other indications, if medically necessary. For those patients with electrodes and/or stimulators implanted prior to October 1, 2013, Medicaid will continue to cover the devices and supplies, and provide reimbursement to replace/revise/remove devices as medically necessary, regardless of patient diagnosis. In addition, **there is no change to the policy regarding, and no limitation to the use of:**

- Diaphragmatic/phrenic pacing device and related services and supplies (implantation of this device can be represented by CPT codes 64575, 64580, 64585, 64590, and 64595);
- Vagus nerve stimulator device and related services and supplies (implantation of this device can be represented by CPT codes 61885, 61886, 64553, 64568, 64569, 64570);
- Sacral nerve stimulator device and related services and supplies (implantation of this device can be represented by CPT codes 64561, 64581, 64590).

DESCRIPTION OF PROCEDURE OR SERVICE:

FES is a functional application of neuromuscular electrical stimulation, and is used to stimulate weak or paralyzed muscles for improvement or restoration of function. FES can be used for upper extremity and lower extremity rehabilitation. The electrical stimulus can be supplied three ways:

- Through the skin or transcutaneously (for example, the Parastep® system, the Bioness® hand rehabilitation and foot drop systems);
- Percutaneously, which requires surgery to implant leads into the muscles with an external receiver/stimulator; or
- Through fully implanted systems which require surgery to implant the stimulator and the leads.

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BILLING CLARIFICATION:

Functional Electrical Stimulation is represented by the codes in the following tables.

Table 1 – Practitioners	
HCPCS/CPT code	Code Description
A4556	Electrodes (e.g., Apnea monitor), per pair
A4557	Lead wires (e.g., Apnea monitor), per pair
E1399	Durable medical equipment, miscellaneous
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver
64555	Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)
64565	Percutaneous implantation of neurostimulator electrode array; neuromuscular
64575	Incision for implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)
64580	Incision for implantation of neurostimulator electrode array; neuromuscular
64585	Revision or removal of peripheral neurostimulator electrode array
64590	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling
64595	Revision or removal of peripheral neurostimulator pulse generator or receiver

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Table 2 – APG providers

HCPCS/CPT code	Code Description
A4556	Electrodes (e.g., Apnea monitor), per pair
A4557	Lead wires (e.g., Apnea monitor), per pair
A4558	Conductive gel or paste, for use with electrical device (e.g., TENS, NMES), per oz
A4595	Electric stimulator supplies, 2 lead, per month (e.g., TENS, NMES)
E0731	Form fitting conductive garment for delivery of TENS or NMES (with conductive fibers separate from the patient's skin by layers of fabric)
E0744	Neuromuscular stimulator for scoliosis
E0745	Neuromuscular stimulator, electronic shock unit
E0764	Functional neuromuscular stimulation, transcutaneous stimulation of sequential muscle groups of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program
E0770	Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, not otherwise specified
E1399	Durable medical equipment, miscellaneous
L8680	Implantable neurostimulator electrode, each
L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only
L8682	Implantable neurostimulator radiofrequency receiver
L8683	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver
L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension
L8686	Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension
L8689	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver
64550	Application of surface (transcutaneous) neurostimulator
64555	Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)
64565	Percutaneous implantation of neurostimulator electrode array; neuromuscular
64575	Incision for implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)
64580	Incision for implantation of neurostimulator electrode array; neuromuscular
64585	Revision or removal of peripheral neurostimulator electrode array
64590	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling
64595	Revision or removal of peripheral neurostimulator pulse generator or receiver
97014	Application of a modality to one or more areas; electrical stimulation (unattended)
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes

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For all of the services represented by the codes in Table 1 and Table 2, coverage for the conditions listed below is not medically necessary, is considered inappropriate, and not subject to reimbursement by Medicaid.

Functional Electrical Stimulation for the following conditions is considered not medically necessary:

- Spinal cord injury, as represented by ICD-9-CM codes 952.xx, 907.0-907.2, 767.4, 806.x 806.xx
- Head injury (850.11-850.12, 850.2-850.9, 851.xx, 852.xx, 853.xx, 854.xx)
- Cerebral palsy (343.0-343.9)
- Upper motor neuron diseases (Parkinson's Disease, 332.0-332.1; Late effects of Acute Poliomyelitis, 138; Anterior horn cell diseases, 335.0, 335.10-335.19, 335.20-335.29, 335.8-335.9; Multiple Sclerosis, 340; Other demyelinating diseases, 341.0-341.1, 341.8-341.9, 341.20-341.22)

Medicaid will continue to cover Functional Electrical Stimulation for other indications, if medically necessary.

Practitioners are responsible for ensuring that the codes submitted for reimbursement accurately reflect the service(s) or procedure(s) that was provided. Post payment reviews are conducted by the Office of the Medicaid Inspector General (OMIG) on adjudicated claims. Medical records must be maintained by providers for a period of not less than six years from the date of payment.

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 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.

Attention: Midwives, Nurse Practitioners, Ordered Ambulatory Providers, Pharmacists and Physicians

INFLUENZA VACCINE COVERAGE EXPANDED

For dates of service on or after August 1, 2013, the following influenza vaccine codes will be available for billing for certain age groups:

***90672** INFLUENZA VIRUS VACCINE, QUADRIVALENT, LIVE, FOR INTRANASAL USE

For beneficiaries 2 years of age to 49 years of age

90685 INFLUENZA VIRUS VACCINE, QUADRIVALENT, SPLIT VIRUS, PRESERVATIVE FREE, WHEN ADMINISTERED TO CHILDREN 6-35 MONTHS OF AGE, FOR INTRAMUSCULAR USE

For beneficiaries 6 months to 35 months only.

***90686** INFLUENZA VIRUS VACCINE, QUADRIVALENT, SPLIT VIRUS, PRESERVATIVE FREE, WHEN ADMINISTERED TO INDIVIDUALS 3 YEARS OF AGE AND OLDER, FOR INTRAMUSCULAR USE

*The administration of these vaccines to adults 18 years of age and older is also available through Medicaid enrolled pharmacies with pharmacists qualified to administer immunizations.

Questions may be referred to the Office of Health Insurance Programs Operations at (800) 342-3005.

Palivizumab (Synagis®) Practitioner Reimbursement

Medicaid reimburses for palivizumab when billed by Medicaid enrolled physicians and nurse practitioners and should be billed as follows:

- Use code 90378 – Providers should bill the Respiratory Syncytial Virus Monoclonal Antibody, recombinant with the specific vaccine code at acquisition cost. Do not add \$2.00 to the charge for the vaccine. Submit the valid 11 digit NDC, quantity, and units on the claim.
- Use code 90471 – Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections): 1 vaccine (single or combination vaccine/toxoid). Providers who do NOT qualify for the PCRI will receive \$13.23 for administration code: 90471. Providers who are eligible for the PCRI will receive an enhanced payment amount as published in the PCRI Fee Schedule which is posted on eMedNY.
- If administering palivizumab outside the guidelines, a paper claim with medical justification must be submitted.

For more information on practitioner billing, please review the Physician Provider Manual, Procedure Code and Fee Schedule, Procedure Codes Medicine and Drugs, (Section 2)- Medicine, Drugs and Drug Administration, Version 2013-1 (4/1/2013), available at:

www.emedny.org/ProviderManuals/Physician/index.html.

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

Palivizumab (Synagis®) Article 28 Clinic Reimbursement

Palivizumab is reimbursable to hospital-based and free-standing clinics and is reimbursed under Ambulatory Patient Groups (APGs) as well as ordered ambulatory for non-clinic patients.

When billing the cost and administration of palivizumab for registered clinic patients under APGs:

- For the immune globulin, use CPT procedure code 90378, respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50mg, each. This will group to APG 416, Level III Immunization.
- Submit the valid 11 digit NDC, quantity, and units on the claim.
- For the administration, use CPT 90460 Immunization administration through 18 years via any route of administration, with counseling by a physician or other qualified health care professional: first or only component of each vaccine or toxoid administration. This will group to APG 490 and will not pay at the line level.
- This immunization may be billed as a “stand alone” service even if there are no other procedure codes included on the claim.

When billed ordered ambulatory:

- If a Medicaid enrollee is referred to the Article 28 clinic by their private practitioner, the clinic should bill CPT code 90378 for the immunization as an ordered ambulatory service and report actual acquisition cost (by invoice). Additionally, providers should bill CPT code 90471 for immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular injections); 1 vaccine (single or combination vaccine/toxoid) which will pay \$13.23.

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

Palivizumab (Synagis®) Clinical Drug Review Program (CDRP) Process

As respiratory syncytial virus (RSV) season approaches, Medicaid pharmacy providers should be aware that prescriptions obtained for palivizumab are subject to Clinical Drug Review Program (CDRP) prior authorization requirements. Prior authorization requirements are intended to ensure that utilization of prescriptions written for RSV occur within the RSV season* and for children less than two years of age at the onset of the RSV season

- Prescriptions for children less than two years of age at the onset of the RSV season may be dispensed and billed (on-line) between October 16 and March 31 without prior authorization.
- Prescriptions obtained between April 1 and October 15 require prior authorization.
- Prescriptions obtained for children two years of age and over at the onset of RSV season require prior authorization.*

Prior authorizations must be initiated by the prescriber by calling (877) 309-9493 and following the appropriate prompts. Prescription refills are limited to four per patient.

The CDRP Prescriber Worksheet and Instructions provide step-by-step assistance in completing the prior authorization process.

Pharmacy providers must submit POS claims at the time of dispensing to ensure appropriate payment.

For further information about the palivizumab CDRP process including worksheet and instructions please visit: https://newyork.fhsc.com/providers/CDRP_synagis.asp

For clinical information on bronchiolitis, please visit:
http://www.health.ny.gov/health_care/medicaid/program/prescriber_education/presc-educationprog.htm

For Medicaid Pharmacy prior authorization program questions, please call (877) 309-9493. For billing questions, please call the eMedNY Call Center at (800) 343-9000.

For questions regarding prior authorization requirements for Medicaid Managed Care and Family Health Plus, please contact the enrollee's health plan.

*The Department of Health determines RSV season based on information from the CDC.

NYS Medicaid Fee-For-Service (FFS) Program **Pharmacists as Immunizers Meningococcal Vaccine**

Effective October 29, 2013, the administration of meningococcal vaccine to Medicaid FFS beneficiaries 18 years of age or older, by qualified pharmacists employed by, or under contract with, Medicaid enrolled pharmacies is reimbursable under NYS Medicaid pursuant to a patient-specific order or a non-patient specific order. Administration of vaccines must be conducted pursuant to NYS Education Law and regulations.

The following conditions apply:

- Only Medicaid enrolled pharmacies that employ or contract with NYS certified pharmacists to administer vaccines will receive reimbursement for immunization services and products. Pharmacy interns cannot administer immunizations in New York State.
- Services must be provided and documented in accordance to NYS Department of Education laws and regulations. Visit <http://www.op.nysed.gov/prof/pharm/pharmimmunizations.htm> for additional information.
- Pharmacies will only be able to bill for Medicaid fee-for-service non-dual enrollees. Medicaid managed care and Family Health Plus enrollees will continue to access immunization services through their health plans. Dual eligible enrollees will continue to access immunization services through Medicare.
- Reimbursement will be based on a patient specific order or non-patient specific order. These orders must be kept on file at the pharmacy. The ordering prescriber's NPI is required on the claim for the claim to be paid.
- Consistent with Medicaid immunization policy, pharmacies will bill the administration and cost of the vaccine using the following procedure codes. Please note that NDCs are not to be used for billing the vaccine product. Reimbursement for the product will be made at no more than the *actual* acquisition cost to the pharmacy. Amount paid for administration will be \$13.23. No dispensing fee or enrollee co-payment applies. Pharmacies will bill with a quantity of "1" and a day supply of "1".

Procedure Code	Procedure Description
90733	Meningococcal polysaccharide vaccine (any groups), for subcutaneous use, 2 years of age and older
90734	Meningococcal conjugate vaccine, serogroups A,C,Y and W-135 (tetravalent), for intramuscular use, ages 11 through 55
90471	Administration of vaccine

-continued on next page-

PHARMACY UPDATE

Reminder: Vaccines for individuals under the age of 19 are provided free of charge by the Vaccines for Children (VFC) program. Medicaid will not reimburse providers for vaccines for individuals under the age of 19 when available through the VFC program. For administration of vaccines supplied by VFC, providers are required to bill vaccine administration code **90460**. For VFC enrollment information, go to: http://www.health.ny.gov/prevention/immunization/vaccines_for_children.htm

Questions regarding Medicaid pharmacy reimbursement of immunizations may be directed to the Medicaid Pharmacy Program at 518 486-3209 or PPNO@health.state.ny.us.

Medicaid Pharmacy Prior Authorization Programs Update

On June 27, 2013, the New York State Medicaid Drug Utilization Review (DUR) Board recommended changes to the Medicaid pharmacy prior authorization programs. The Commissioner of Health has reviewed the recommendations of the Board and has approved changes to the Preferred Drug Program (PDP) within the fee-for-service pharmacy program. Effective October 3, 2013, prior authorization (PA) requirements will change for some drugs in the following PDP classes:

- Alpha Reductase Inhibitors for BPH
- Anabolic Steroids - Topical
- Anticholinergics - Inhaled/COPD Agents
- Antihistamines – Second Generation
- Anticoagulants – Injectable
- Anticoagulants – Oral
- Anticonvulsants – Second Generation
- Beta Blockers
- Corticosteroids – Inhaled
- Corticosteroids – Intranasal
- Dipeptidyl Peptidase-4 (DPP-4) Inhibitors
- Growth Hormones
- Multiple Sclerosis Agents
- Selective Serotonin Reuptake Inhibitors (SSRIs)
- Tetracyclines

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

- Gastrointestinal Antibiotics
- Gastrointestinal Preparatory Agents
- Glucocorticoids – Oral
- Topical Anti-Infectives

For more information on the above DURB recommendations, please refer to the meeting summary at: http://www.health.ny.gov/health_care/medicaid/program/dur/meetings/2013/05/sum_062713_durb_fnl_dtmtn.pdf

Please note that PA requirements are not dependent on the date a prescription is written. New prescriptions and refills on existing prescriptions require PA even if the prescription was written before the date the drug was determined to require PA.

The following is a link to the most up-to-date information on the Medicaid FFS Pharmacy Prior Authorization programs. This document contains a full listing of drugs subject to PDP, Clinical Drug Review Program (CDRP), DUR program, Brand Less Than Generic program (BLTG) and the Mandatory Generic Drug Program (MGDP): https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf

To obtain a prior authorization (PA), please call the prior authorization Clinical Call Center at (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 with an active e-PACES account can initiate PA requests through the web-based application PAXpress®. The website for PAXpress is <https://paxpress.nypa.hidinc.com/>

NY Medicaid EHR Incentive Program



NY Medicaid Electronic Health Records Incentive Program Update

The NY 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 \$431 million** in incentive funds have been distributed to **over 9,000** New York State Medicaid providers.

For more information about the EHR Incentive Program, we encourage you to visit the program website at www.emedny.org/meipass/ or attend one of the informational webinars hosted by the NYS Department of Health.

Taking a Closer Look: [Learn more about the program, attend our webinar series!](#)

Our webinar series provides a comprehensive overview of the steps healthcare practitioners need to take to successfully register and attest to the NY Medicaid EHR Incentive Program.

Healthcare Practitioner Webinar Series

1. EP Participation Year 1 (A/I/U)
2. Program Prerequisites
3. EP Participation Year 2-3 (MU1)
4. EP Participation Year 4 (MU2)

Recommended Audience

1. Healthcare Practitioners
2. Practice Managers
3. Billing / Support Staff
4. HIT Consultants

To see the complete schedule of events and webinars, please view our improved **Upcoming Event Calendar** at www.emedny.org/meipass/info/Events.aspx.

Have Questions? **877-646-5410**

Contact hit@health.state.ny.us for program clarifications and details.

www.emedny.org/meipass/



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.