



# Medicaid Update

THE OFFICIAL NEWSLETTER OF THE NEW YORK STATE MEDICAID PROGRAM

## Increasing Colorectal Cancer Screening in New York State

All men and women aged 50-75 should be screened for colorectal cancer. Research indicates that the willingness of adults to access colorectal cancer screening tests depends on multiple factors, including physician recommendation, individual disease risk, and personal preference <sup>(1)</sup>. Discussing the importance of CRC screening tests with your patients is critically important to their use of these preventive services.

Colorectal cancer is the third most common cancer diagnosed in men and women in the United States, excluding skin cancers, and the third leading cause of cancer-related death in New York State (NYS). More than 10,000 new cases of colorectal cancer are diagnosed and approximately 3,500 men and women die from the disease each year in NYS. The five year survival rate for persons who received a diagnosis of localized colorectal cancer is 90.3%, compared with 70.4% for regional-stage cancer and 12.5% for distant-stage cancer <sup>(2)</sup>.

Colorectal cancer screening tests have been proven to reduce mortality through detection of early-stage cancer and detection of adenomatous polyps before they progress into cancer, however, in NYS, only 69.4 percent of men and women aged 50 to 75 report being up-to-date with colorectal cancer screening <sup>(3, 4, 5)</sup>. This is below the New York State Department of Health Prevention Agenda goal of 71.4 percent by December 31, 2017, <sup>(6)</sup> and well below screening rates for breast and cervical cancers.

The table below lists statewide results for the different product lines in NYS for 2011. Measure is adults 50 to 75 years of age.

Product Line	Number of Eligible Persons in Plans	Statewide average
Medicaid Managed Care	239,160	56.2%
Commercial HMO	542,186	65.4%
Commercial PPO	1,289,371	56.9%

**To increase screening, doctors, nurses and health systems can offer all recommended test options, provide information and advice about each test, and match patients with the test they are most likely to complete.**



New York State Department of Health  
**Cancer Services Program**  
 Your partner for cancer screening, support and information





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## MARCH 2014 NEW YORK STATE MEDICAID UPDATE

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#### NOTE:

Due to lack of approval from CMS, the Nursing Home transition to Medicaid managed care has been extended to June 1, 2014.

# POLICY AND BILLING GUIDANCE

–continued from cover –

Colorectal cancer screening is an essential health benefit under the Affordable Care Act, so health insurance plans must cover testing costs with no patient copayment or coinsurance. The United States Preventive Services Task Force recommends that average-risk men and women begin regular colorectal cancer screening at age 50 with any of three tests: a high-sensitivity, multi-slide fecal occult blood test (FOBT) every year using either guaiac FOBT or fecal immunochemical test (FIT); a flexible sigmoidoscopy every five years with a high-sensitivity fecal test every three years; or a colonoscopy every 10 years<sup>(3, 7)</sup>.

FOBT completed after a digital rectal examination is NOT an approved modality for colorectal cancer screening and should not be coded as such for reimbursement.

## What is FIT?

FIT is an improved FOBT with higher sensitivity and specificity when compared to guaiac FOBT.

## How does FIT compare to Guaiac FOBT?

- FIT has superior sensitivity and specificity.
- FIT uses antibodies specific for human globin and are specific for colorectal bleeding and are not affected by diet or medications, unlike the guaiac test.
- Automated development is available for some FITs which aids in the management of large numbers of tests and improves quality assurance.
- FIT has a variety of improved stool collection methods such as a brush or probe.
- New technology for FITs allows them to quantify fecal hemoglobin so that sensitivity, specificity, and positivity rates can be adjusted in screening for colorectal neoplasia<sup>(8)</sup>.

Screening patients ages 76-85 should be performed on an individual basis, as deemed necessary. Fecal testing is not recommended for those at high-risk of developing colorectal cancer. Patients with a personal or family history of colorectal cancer, history of precancerous intestinal polyps or inflammatory bowel disease, and people with a history of certain inherited diseases such as familial adenomatous polyposis and hereditary nonpolyposis colon cancer are at increased risk and may need to begin regular screening at a younger age.

Patients have strong preferences for particular colorectal cancer screening tests, but many, particularly those in minority populations, would choose FOBT/FIT when provided with objective information about test options. Evidence also indicates that patients choosing FOBT/FIT are more likely to complete the test than those who choose colonoscopy<sup>(5)</sup>.

The NYSDOH Cancer Services Program (CSP) has a seven year history of screening average-risk clients with FIT and can provide colorectal cancer risk assessment guidance for your practice. Please contact us at (518) 474-1222 or via e-mail: [canserv@health.state.ny.gov](mailto:canserv@health.state.ny.gov).

The CSP also offers a variety of free colorectal cancer and FIT patient educational materials. They can be ordered here: [www.health.ny.gov/diseases/cancer/docs/cancer\\_serv\\_prog\\_resource\\_guide.pdf](http://www.health.ny.gov/diseases/cancer/docs/cancer_serv_prog_resource_guide.pdf).

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# POLICY AND BILLING GUIDANCE

The CSP facilitates access to and provides funding for colorectal, breast and cervical cancer screening and diagnostic services for uninsured and underinsured New Yorkers. The CSP also assists eligible persons diagnosed with cancer to obtain prompt treatment through the NYS Medicaid Cancer Treatment Program, a Medicaid program for eligible uninsured persons who are in need of treatment for breast, cervical, colorectal or prostate cancer and in some cases, pre-cancerous conditions of these cancers.

Uninsured New York State residents may call the CSP toll-free referral line at (866) 442-CANCER (2262), 24 hours a day, seven days a week, to be directly connected to cancer screening services in the county in which they live or work. For more information please visit: <http://www.nyhealth.gov/cancerservicesprogram>.

## ► References:

1. Subramanian S, Klosterman M, Amonkar MM, Hunt TL. Adherence with colorectal cancer screening guidelines: a review. *Preventive Medicine*. 2004;38:536--50.
2. Howlader N, Noone AM, Krapcho M, Garshell J, Neyman N, Altekruse SF, Kosary CL, Yu M, Ruhl J, Tatalovich Z, Cho H, Mariotto A, Lewis DR, Chen HS, Feuer EJ, Cronin KA (eds). SEER Cancer Statistics Review, 1975-2010, National Cancer Institute. Bethesda, MD, [http://seer.cancer.gov/csr/1975\\_2010/](http://seer.cancer.gov/csr/1975_2010/), based on November 2012 SEER data submission, posted to the SEER web site, April 2013.
3. Whitlock EP, Lin JS, Liles E, Beil TL, Fu R. Screening for colorectal cancer: a targeted, updated systematic review for the U.S. Preventive Services Task Force. *Ann Intern Med* 2008;149:638--58.
4. Smith RA, Cokkinides V, Brooks D, Saslow D, Brawley OW. Cancer screening in the United States, 2010: a review of current American Cancer Society guidelines and issues in cancer screening. *CA Cancer J Clin* 2010;60:99--119.
5. Centers for Disease Control and Prevention [CDC] Morbidity and Mortality Weekly Report, November 5, 2013 / Vol. 62
6. Prevention Agenda 2013-2017: New York State's Health Improvement Plan [https://www.health.ny.gov/prevention/prevention\\_agenda/2013-2017/index.htm](https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm)
7. U.S. Preventive Services Task Force. Screening for colorectal cancer: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med* 2008;149:627--37.
8. Alicia Smith, Graeme P. Young, Stephen R. Cole, Peter Bampton; *Cancer* 2006;CANCER November 1, 2006 / Volume 107 / Number 9

**ATTENTION: PROVIDERS OF NURSING FACILITY SERVICES, CERTAIN HOME AND COMMUNITY BASED WAIVER SERVICES AND SERVICES TO INDIVIDUALS ENROLLED IN A MANAGED LONG TERM CARE PLAN**

## 2014 Increase to Spousal Impoverishment Income and Resource Levels

Providers of nursing facility services, home and community based waiver services and services to individuals enrolled in a managed long term care plan, are required to **PRINT** and **DISTRIBUTE** the *“Information Notice to Couples with an Institutionalized Spouse”* (pages 6-9 of this newsletter) at the time they begin to provide services to their patients.

Effective **January 1, 2014**, the federal maximum community spouse resource allowance increases to **\$117,240** while the community spouse income monthly allowance increases to **\$2,931**. The maximum family member monthly allowance increases to **\$656**.

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

### INCOME AND RESOURCE AMOUNTS

January 1, 2014

**Federal Maximum Community Spouse Resource Allowance: \$117,240**

**NOTE:** A higher amount may be established by court order or fair hearing to generate income to raise the community spouse’s monthly income up to the maximum allowance. **NOTE:** The State Minimum Community Spouse Resource Allowance is \$74,820.

January 1, 2014

**Community Spouse Minimum Monthly Maintenance Needs Allowance is an amount up to: \$2,931**  
(if the community spouse has no income of his/her own)

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

January 1, 2014

**Family Member Monthly Allowance for each family member is an amount up to: \$656**  
(if the family member has no income of his/her own)

**NOTE:** If the institutionalized spouse is receiving Medicaid, any change in income of the institutionalized spouse, the community spouse, and/or the family member may affect the community spouse income allowance and/or the family member allowance. Therefore, the local social services district should be promptly notified of any income variations.

# Information Notice to Couples with an Institutionalized Spouse

Medicaid is an assistance program that may help pay for the costs of you or your spouse’s institutional care, home and community based waiver services, or enrollment in a managed long term care plan. The institutionalized spouse is considered medically needy if his/her resources are at or below a certain level and the monthly income after certain deductions is less than the cost of care in the facility.

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

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

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

Information about resources:
Effective January 1, 1996, the community spouse is allowed to keep resources in an amount equal to the greater of the following amounts:
(1) \$74,820 (the State minimum spousal resource standard); or
(2) The amount of the spousal share up to the maximum amount permitted under federal law (\$117,240 for 2014).

For purposes of this calculation, “spousal share” is the amount equal to one-half of the total value of the countable resources of you and your spouse at the beginning of the most recent continuous period of institutionalization of the institutionalized spouse. The most recent continuous period of institutionalization is defined as the most recent period you or your spouse met the criteria listed in items 1 through 4 (under “If you or your spouse are:”). In determining the total value of the countable resources, we will not count the value of your home, household items, personal property, your car, or certain funds established for burial expenses.

# POLICY AND BILLING GUIDANCE

The community spouse may be able to obtain additional amounts of resources to generate income when the otherwise available income of the community spouse, together with the income allowance from the institutionalized spouse, is less than the maximum community spouse monthly income allowance, by requesting a fair hearing or commencing a family court proceeding against the institutionalized spouse. Your attorney or local Office for the Aging can provide you with more information.

Either spouse or a representative acting on their behalf may request an assessment of the couple's countable resources, at the beginning, or any time after the beginning of a continuous period of institutionalization. Upon receipt of such request and all relevant documentation, the local district will assess and document the total value of the couple's countable resources and provide each spouse with a copy of the assessment and the documentation upon which it is based. If the request is not filed with a Medicaid application, the local department of social services may charge up to \$25.00 for the cost of preparing and copying the assessment and documentation.

## Information about income:

### You may request an assessment/determination of:

- (1) The community spouse monthly income allowance (an amount of up to \$2,931 a month for 2014); and
- (2) A maximum family member allowance for each minor child, dependent child, dependent parent or dependent sibling of either spouse living with the community spouse of \$656 for 2014 (if the family member has no income of his/her own).

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

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

## Additional Information

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

# POLICY AND BILLING GUIDANCE

## Undue hardship occurs when:

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

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

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

## Contribution from Community Spouse

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

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





Date: \_\_\_\_\_

# Request for Assessment Form

**Institutionalized Spouse’s Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

**Community Spouse’s Name:** \_\_\_\_\_

**Current Address:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

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

- Couple’s countable resources and the community spouse resource allowance
- Community spouse monthly income allowance
- Family member allowance(s)

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

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

\_\_\_\_\_  
***Signature of Requesting Individual***

\_\_\_\_\_  
***Address and telephone # if different from above***

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Viscosupplementation of the Knee: Non-Coverage Decision

Effective April 1, 2014, for Medicaid fee-for-service (FFS) enrollees, Medicaid Managed Care (MMC) enrollees and Family Health Plus (FHPlus) enrollees, New York State (NYS) Medicaid (MA) will limit reimbursement for viscosupplementation of the knee. Specifically, NYS Medicaid will no longer cover viscosupplementation of the knee for an enrollee with a diagnosis of osteoarthritis of the knee. All other diagnoses associated with viscosupplementation will continue to be reimbursed.

**DESCRIPTION OF PROCEDURE OR SERVICE:** Viscosupplementation of the knee is a procedure in which a gel-like fluid called hyaluronic acid is injected into the knee joint. Hyaluronic acid is a naturally occurring substance found in the synovial (joint) fluid. Individuals with osteoarthritis ("wear-and-tear" arthritis) of the knee have a lower-than-normal concentration of hyaluronic acid in their joints.

**BACKGROUND:** Based on the current available evidence, NYS Medicaid will no longer cover viscosupplementation of the knee to an enrollee with a diagnosis of osteoarthritis of the knee. This coverage decision was based on research presented which included the potential harms attached to viscosupplementation (including joint infection, hematoma, and inflammation), and the fact that viscosupplementation is only marginally effective in practice.

➤ **The following CPT code is associated with the non-coverage decision:**

- CPT 20610 – Arthrocentesis, aspiration and/or injection: Major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa).

➤ **The following ICD-9 diagnoses codes are associated with the non-coverage decision:**

- ICD-9: 715.16
- ICD-9: 715.26
- ICD-9: 715.36
- ICD-9: 715.96

➤ **There will be no reimbursement provided by NYS Medicaid when the following five medication codes are reported with CPT 20610 and the ICD-9 diagnoses codes listed above:**

- J7321
- J7323
- J7324
- J7325
- J7326

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

## Expansion of Medicaid Managed Care Covered Benefits to Include HIV Resistance Testing Effective April 1, 2014

As part of MRT proposal #1458, effective April 1, 2014, Medicaid Managed Care Plans (MMCPs) will begin covering the following HIV resistance laboratory tests as prescribed by a physician:

- Genotypic testing;
- Phenotypic testing;
- HIV tropism assay.

These laboratory tests may be used in any combination to identify specific HIV strains and drug resistance in order to determine the most effective treatment. CPT codes for these tests are as follows:

CPT	Description
<b>87900</b>	Infectious agent drug susceptibility phenotype prediction using regularly updated genotypic bioinformatics.
<b>87901</b>	Infectious agent genotype analysis by nucleic acid (DNA or RNA); HIV-1, reverse transcriptase and protease regions .
<b>87903</b>	Infectious agent phenotype analysis by nucleic acid (DNA or RNA); HIV 1, through 10 drugs tested .
<b>87904</b>	Additional phenotype analysis - each additional drug tested (List separately in addition to primary procedure).
<b>87999</b>	Miscellaneous Reimbursement (Trofile co-receptor tropism assay).

MMCPs may require prior authorization for these services. For additional information, providers should direct questions to the enrollee's MMCP.

# Medicaid Breast Cancer Surgery Centers

Research shows that five-year survival increases for women who have their breast cancer surgery performed at high-volume facilities and by high-volume surgeons. Therefore, it is the policy of New York State Department of Health that Medicaid recipients receive mastectomy and lumpectomy procedures associated with breast cancer diagnosis at high-



volume facilities defined as averaging 30 or more all-payer surgeries annually over a three-year period. Low-volume facilities will not be reimbursed for breast cancer surgeries provided to Medicaid recipients. This policy is part of an ongoing effort to reform New York State Medicaid and to ensure the purchase of cost-effective, high-quality health care and better outcomes for its recipients.

The Department has completed its sixth annual review of all-payer breast cancer surgical volumes for 2010 through 2012 using the Statewide Planning and Research Cooperative System (SPARCS) database. Sixty-six low-volume hospitals and ambulatory surgery centers throughout New York State were identified. These facilities have been notified of the restriction effective April 1, 2014. The policy does not restrict a facility's ability to provide diagnostic or excisional biopsies and post-surgical care (chemotherapy, radiation, reconstruction, etc.) for Medicaid patients. Other facilities in the same region as the restricted facilities have met or exceeded the volume threshold and Medicaid patients who require breast cancer surgery should be directed to those providers.

The Department will annually re-examine all-payer SPARCS surgical volumes to revise the list of low-volume hospitals and ambulatory surgery centers. The annual review will also allow previously restricted providers meeting the minimum three-year average all-payer volume threshold to provide breast cancer surgery services for Medicaid recipients.

For more information and the list of restricted low-volume facilities, please see: [http://www.nyhealth.gov/health\\_care/medicaid/quality/surgery/cancer/breast/](http://www.nyhealth.gov/health_care/medicaid/quality/surgery/cancer/breast/).

If you have any questions, please contact (518) 486-9012.

### ► Attention Ambulance Services

# Reminder: Continue to Refer Emergency Services Abusers to the Medicaid Program

**Per New York State Penal Code §240.50(2), it is a Class A Misdemeanor to report an emergency where none exists.** Therefore, if you suspect that a Medicaid enrollee is abusing emergency ambulance services, please forward the following information to the Medicaid Transportation Policy Unit via e-mail to [MedTrans@health.ny.gov](mailto:MedTrans@health.ny.gov) or contact (518) 473-2160 and provide the following information:

- The Medicaid enrollee's name and Medicaid identification number if available, and
- Circumstances about the perceived abuse.

The Office of the Medicaid Inspector General's Recipient Fraud Unit will investigate referrals made by the Medicaid Transportation Policy Unit.

The Medicaid Transportation Policy Unit will catalogue the referral, analyze the transportation claim reports of each referred Medicaid enrollee, respond to the reports and intervene with the Medicaid enrollee as determined necessary.

Media reports describe the frustration of ambulance service providers when Medicaid enrollees dial 911 in non-emergency situations in order to get a ride to the hospital. These inappropriate calls reduce the availability of emergency responders for true emergencies that may arise, expend staff time and medical supplies, and pose undue risk of operating an emergency response vehicle.

It is the Department's intent to guide these enrollees to more appropriate modes of transportation while maintaining their right to seek emergency ambulance service when needed. With continuing intervention, enforcement, and education, we will provide necessary emergency transportation while maintaining the fiscal and programmatic integrity of Medicaid emergency services.

Questions? Please call the Medicaid Transportation Policy Unit at (518) 473-2160 or e-mail [MedTrans@health.ny.gov](mailto:MedTrans@health.ny.gov).

**Note:** Enrollee's name and Medicaid Identification Numbers are considered personally identifiable and protected health information and need to be forwarded in a secure format.

## ► Attention Transportation Vendors

# Announcement of New Fee Schedule for New York City Non-Emergency Transportation

The Medicaid program has determined that, in order to meet the transportation needs of Medicaid enrollees in New York City, a fee change is necessary to reimburse quality transportation vendors for their service. Effective **March 15, 2014**, the following fees are effective:

### Hospital Discharges (All Hospitals)

Service	Procedure Code	Fee
Ambulette (Inside Borough)	A0130/TG	\$45.00
Livery (Inside Borough)	A0100/TG	\$25.00
Ambulette (Outside Borough)	T2004/TN	\$60.00
Livery (Outside Borough)	A0100/TF	\$42.00
Ambulette Mileage*	S0209/TN	\$3.00
Livery Mileage*	S0215	\$3.00

*\*Applicable after 8.0 passenger-laden miles from mile 8.0 to the end of the passenger-laden trip. Note: tenths rounded to nearest whole mile.*

### All Medical Trips Other than Hospital Discharges (including Dialysis)

Service	Procedure Code	Fee
Ambulette (Inside CMMA)	A0130	\$33.00
Livery (Inside CMMA)	A0100	\$25.00
Ambulette (Outside CMMA)	A0130/TN	\$45.00
Livery (Outside CMMA)	A0100/TN	\$35.00
Ambulette Mileage*	S0209/TN	\$3.00
Livery Mileage*	S0215	\$3.00
Ambulette Surcharge**	A0130/SC	\$25.00
Livery Surcharge**	A0100/SC	\$25.00

*\*Applicable after 8.0 passenger-laden miles from mile 8.0 to the end of the passenger-laden trip. Note: tenths rounded to nearest whole mile.*

*\*\* To be applied at the discretion of the Department and/or its transportation manager, one per trip flat fee add-on per Medicaid passenger for one-way trips exceeding 3.0 miles in duration originating from or ending at destinations below 110<sup>th</sup> Street in Manhattan.*

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## POLICY AND BILLING GUIDANCE

As part of this new fee schedule, the Department expects that transportation vendors will adhere to the Department's standards concerning trip reroutes, i.e., if a trip cannot be accommodated, the vendor will notify the transportation manager, LogistiCare (LGTC), within 24 hours of the scheduled pickup time.

Please understand that if LGTC identifies that a transportation vendor consistently is unable to meet this and other quality standards, administrative action, possibly including cessation of trip assignment, may be pursued by the Department.

Questions? Please contact the Medicaid Transportation Policy Unit via e-mail at [MedTrans@health.ny.gov](mailto:MedTrans@health.ny.gov).

# Ambulatory Patient Groups (APGs) Rate Code Combination Edits for Incompatible Visit Types

Effective March 1, 2014, Medicaid will begin enforcing APG billing restrictions so that providers that submit multiple fee-for-service claims on the same date of service (DOS) or within the same visit/ episode of care will no longer be paid for the second claim. In order for providers to avoid having their claims denied due to these edits, they should submit a single APG claim with all the procedures rendered on that DOS or within the episode of care.

A hospital (Article 28) that bills using their National Provider Identification (NPI) containing any combination of the following APG rate codes on the claim form, will have its second claim deny:

- **1400 OPD**
- **1401 SURGERY**
- **1402 ER**
- **1489 OPD - MR/DD/TBI PATIENT ( EPISODE)**
- **1501 OPD - MR/DD/TBI PATIENT**

Similarly, a free-standing facility (Article 28) using any combination of the following APG rate codes on the claim form will have its second claim deny:

- **1407 GENERAL CLINIC**
- **1408 SURGERY**
- **1422 GENERAL CLINIC (EPISODE)**

Additionally, a free-standing ambulatory surgery center (Article 28) that bills rate code 1408 SURGERY and 1425 GENERAL CLINIC MR/DD (EPISODE) will have its second claim deny. The APG billing restrictions will also apply to out-of-state facilities for rate codes: 1413 OPD, 1416 SURGERY, 1419 ER, and 1441 OPD (EPISODE).

Questions? If you have policy questions please contact the Division of Program Development and Management at (518) 473-2160. Billing procedures and questions should be directed to the eMedNY Call Center at (800) 343-9000.



# Changes in Familial/Personal History Criteria for Medicaid BRCA Genetic Testing

Effective for dates of service on or after April 1, 2014, Medicaid is implementing changes to the BRCA coverage policy for Medicaid recipients. The coverage policy criteria is now more inclusive of ages, gender, types of cancers, and maternal/paternal family history of cancer. Physicians, nurse practitioners, physician assistants and midwives may order this laboratory test for their patients when clinically indicated and medically necessary. The expanded policy coverage criteria are listed below:

Testing for a *BRCA1* or *BRCA2* mutation may be appropriate in individuals with the following risk factors:

A personal history of **Breast cancer**:

- Diagnosed at age 45 or younger;  
Diagnosed at age 50 or younger with 1 or more close relatives\* with a diagnosis of breast cancer;
- Bilateral breast cancer or two or more primary tumors of the breast when first breast cancer diagnosis occurred at age 50 years or younger;
- Diagnosed at age 60 or younger with triple-negative breast cancer;
- Diagnosed at any age with 1 or more close relatives\* with epithelial ovarian cancer;
- Diagnosed at any age with 1 or more close male relatives with breast cancer at any age;
- Diagnosed at any age with 2 or more close relatives\* with breast cancer at any age;
- Diagnosed at any age with 2 or more close relatives\* with pancreatic or aggressive prostate cancer.
- Breast cancer in a male at any age
- Epithelial ovarian cancer at any age
- Pancreatic cancer or aggressive prostate cancer at any age, especially if 2 or more close relatives\* have been diagnosed with breast, ovarian, pancreatic or aggressive prostate cancer.

No personal history of breast or ovarian cancer, but a maternal or paternal family history of:

- Two or more close relatives with breast cancer at any age;
- One or more close relatives with breast cancer before age 50;
- One or more close relatives with triple negative breast cancer at age 60 or younger;
- One or more close male relatives with breast cancer;
- One or more close relatives with ovarian cancer;
- Two or more close relatives with pancreatic cancer or aggressive prostate cancer at any age;
- Confirmed *BRCA1* or *BRCA2* mutation in a close relative.

\* Close relative is defined as first, second, or third-degree blood relatives on the same side of the family (either maternal or paternal).

## POLICY AND BILLING GUIDANCE

\*\* In individuals without a personal history of breast or ovarian cancer and with family history only. Limitations of test result interpretation should be discussed with the patient prior to testing as part of the informed consent and genetic counseling process.

Note: Individuals who belong to ethnic groups with increased mutation prevalence, such as those of Ashkenazi Jewish descent, may be appropriate candidates for referral even if they have a less striking personal or family history of breast and/or ovarian cancer.

The criteria were developed based on a review of the National Comprehensive Cancer Network's Genetic/Familial High-Risk Assessment: Breast and Ovarian Cancer clinical practice guidelines located at [www.nccn.org](http://www.nccn.org) and [http://www.nccn.org/professionals/physician\\_gls/pdf/genetics\\_screening.pdf](http://www.nccn.org/professionals/physician_gls/pdf/genetics_screening.pdf).

Patient-specific information about cancer genetics and risk for having a *BRCA1* or *BRCA2* mutation can be found at: <http://www.health.ny.gov/diseases/cancer/genetics/index.htm>.

The reimbursement policy and coding information continue to be available on <https://www.emedny.org/ProviderManuals/Laboratory/index.aspx>

Please direct Medicaid fee-for-service questions to staff in the Bureau of Medical, Dental and Pharmacy Policy Analysis and Development at (518) 473-2160.

Please direct Managed Care questions to the specific managed care plan.

# eMedNY to Issue Electronic Prescriber Payments

To encourage the use of e-prescribing, the New York State legislature has authorized incentive payments to eligible medical practitioners for each approved ambulatory Medicaid e-prescription, plus incentives for a maximum of five refills per prescription. Incentive payments have been sent to providers for e-scripts through September 2012.

In Cycle 1907 (check dated 03/10/2014, release/mail date of 03/26/2014), the e-prescriber incentive payments for the 3rd quarter of Calendar Year 2012 through 4th quarter of Calendar Year 2013 will be issued by eMedNY, and appear as a financial transaction (lump-sum payment) on the provider's Medicaid remittance statement. Paper remittances will have an additional identifier of "LSE" to indicate an e-prescribing payment.

Questions may be directed to the eMedNY Call Center at (800) 343-9000.

# Medicaid Pharmacy Prior Authorization Programs Update

Effective April 10, 2014, the fee-for-service (FFS) pharmacy program will implement the following parameters. These changes are the result of recommendations made by the Drug Utilization Review Board (DURB) at the December 7, 2012, DURB meeting:

### Antiretroviral (ARV) Medications – Drug Interactions

- **Point of service edit for contraindicated antiretroviral/non-antiretroviral combinations.\***
- **Point of service edit for contraindicated antiretroviral/antiretroviral combinations.\***

**\*Clinical Call Center must be contacted to override the edit**

For claims that do not meet the clinical criteria, eMedNY point of service will return a rejected response "85 - Claim Not Processed", in NCPDP field 511-FB along with messaging "Call Magellan Call Center at 1-877-309-9493", in NCPDP field S26-FQ with additional details based on criteria failure. An example of this would be the new response messaging developed for the ARV drug interactions shown below:

- **75A3 - Drug Contraindication Failure**

**The pharmacist may be able to intervene by consulting the prescriber for an appropriate change in therapy to reduce the need for the prescriber to obtain PA.**

To obtain a PA, prescribers must contact the clinical call center at 1-877-309-9493. The clinical call center is available 24 hours per day, 7 days per week with pharmacy technicians and pharmacists who will work with you, or your agent, to quickly obtain a PA.

Medicaid enrolled prescribers can also initiate PA requests using a web-based application. PAXpress® is a web-based pharmacy PA request/response application accessible through the eMedNY website at: <http://www.eMedNY.org>. PAXpress® can also be accessed through Magellan Medicaid Administration at: <http://newyork.fhsc.com>.

For more detailed information on the DURB meeting, please visit:

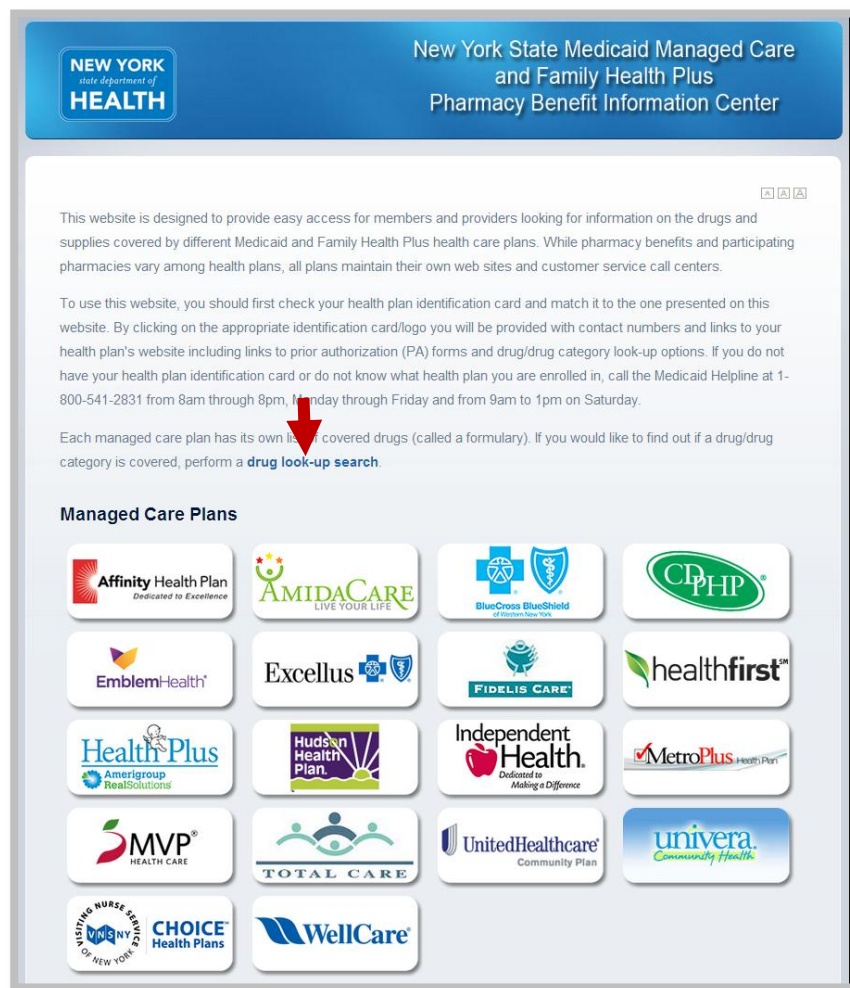
[http://www.health.ny.gov/health\\_care/medicaid/program/dur/meetings/2012/12/sum\\_1207\\_12\\_durb.pdf](http://www.health.ny.gov/health_care/medicaid/program/dur/meetings/2012/12/sum_1207_12_durb.pdf)

Below is a link to the most up-to-date information on the Medicaid FFS Pharmacy Prior Authorization (PA) Programs. This document contains a full listing of drugs subject to the Medicaid FFS Pharmacy Programs:

[https://newyork.fhsc.com/downloads/providers/NYRx\\_PDP\\_PDL.pdf](https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf)

## New York State Medicaid Managed Care and Family Health Plus Pharmacy Benefit Information Website Update

The Department of Health (NYSDOH), in partnership with the State University of New York at Stony Brook, will be releasing Phase III of The New York State Medicaid Managed Care and Family Health Plus Pharmacy Benefit Information website on March 27, 2014. Phase III will allow patients and providers to perform a Mental Health Quicklist search across Medicaid Managed Care Plans and view drug coverage across therapeutic categories related to mental health. Below is an illustration of where this additional functionality will be presented on the enhanced site.



-CONTINUED ON PAGE 15-

# PHARMACY UPDATE

**NEW YORK**  
state department of  
**HEALTH**

New York State Medicaid Managed Care and Family Health Plus  
Pharmacy Benefit Information Center

[HOME PAGE](#) [DRUG LOOK-UP](#) [FAQS](#)

Welcome to the NYS Medicaid Managed Care and Family Health Plus drug look-up page. To find out if a drug is covered, please type in the drug name and then select from the drop down menu. Then choose whether you are looking for the brand or generic formulation of the drug, or both. Lastly, select the health plan(s) you would like to compare. If you want to search a drug category please choose the category and then select from the drop down menu.

If you have questions or need a definition, please check our frequently asked questions (FAQs) page.

[Search By Name](#) [Mental Health Quicklist](#)

### Drug Look-Up

**Type**  
 All  Generic  Brand

**Plan**

<input type="checkbox"/> Affinity Health Plan	<input type="checkbox"/> Health Plus Amerigroup	<input type="checkbox"/> United Healthcare
<input type="checkbox"/> Amida Care	<input type="checkbox"/> Healthfirst	<input type="checkbox"/> VNSNY Choice Health Plans
<input type="checkbox"/> BCBS of Western NY	<input type="checkbox"/> Hudson Health Plan	<input type="checkbox"/> WellCare Health Plans, Inc
<input type="checkbox"/> CDPHP	<input type="checkbox"/> Independent Health Plan	
<input type="checkbox"/> Excellus/Univera	<input type="checkbox"/> MVP	
<input type="checkbox"/> Fidelis Care	<input type="checkbox"/> MetroPlus Health Plan	
<input type="checkbox"/> HIP/Emblem Health	<input type="checkbox"/> Total Care	
<input type="checkbox"/> <i>Select/Unselect All</i>		

**NEW YORK**  
state department of  
**HEALTH**

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[HOME PAGE](#) [DRUG LOOK-UP](#) [FAQS](#)

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[Search By Name](#) [Mental Health Quicklist](#)

### Mental Health Quicklist

- Antipsychotics - 2nd Generation
- Central Nervous System (CNS) Stimulants
- Other Agents ADHD
- Sedatives Hypnotics/Sleep Agents
- Selective Serotonin Reuptake Inhibitors (SSRIs)
- Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

*Select/Unselect All*

[Begin Look-Up](#)

## PHARMACY UPDATE

The Medicaid Managed Care and Family Health Plus Pharmacy Benefit Information website is available at: <http://pbic.nysdoh.suny.edu>.

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

**New York State Department of Health Medicaid Managed Care Page at:**

[http://www.health.ny.gov/health\\_care/managed\\_care/](http://www.health.ny.gov/health_care/managed_care/).

Click on: Medicaid Managed Care and Family Health Pharmacy Benefit Information Center

**The eMedNY home page under 'Featured Links' at:** <https://www.emedny.org/index.aspx>.

Click on: New York State Medicaid Managed Care and Family Health Plus Pharmacy Information Center .

**Redesigning New York's Medicaid Program Page under supplemental information on specific MRT proposals at:** [http://www.health.ny.gov/health\\_care/medicaid/redesign/](http://www.health.ny.gov/health_care/medicaid/redesign/)

Click on: MRT 11 & MRT 15, Pharmacy Related Proposals & then click on: Managed Care Plan Pharmacy Benefit Manager and Formulary Information.

## Medicaid Required by Federal Law to Change Electronic Remittance Delivery Date

Effective April 7, 2014, (Cycle 1911) eMedNY will no longer be permitted to make the X12 835 and the X12 820 electronic remittances available two weeks prior to release of payment. Electronic remittances will be available two days prior to the release of funds. The change is necessitated by requirements of Section 1104 of the Affordable Care Act (ACA) and the CAQH Committee on Operating Rules for Information Exchange (CORE), the authoring entity for operating rules for Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA) transactions. CORE Rule 370 requires that transmission of the 835 cannot occur more than three days prior to the availability of the EFT.

All providers receiving the 835/820 electronic remittance are affected and it is important that they assess what impact, if any, the change in the 835/820 delivery date may have on their business. The change will be implemented on April 7, 2014. Therefore, electronic remittances for cycle 1911 that would have been available on 04/07/14 will not be delivered to eXchange or FTP accounts until 04/21/14, 2 days before the Check/EFT release date. No electronic remittances will be delivered on 04/07/14 and 04/14/2014. For these two cycles electronic remittances will be released as follows:

Cycle	Payment Issue Date	Electronic Remittance Issue Date	Payment Release Date
1911	4/07/14	4/21/14	4/23/14
1912	4/14/14	4/28/14	4/30/14

**The current payment schedule will not be impacted by this change. Payments will continue to be lagged for two weeks and two days from the issue date.**

Information on the CORE Operating Rules can be found at: [http://www.caqh.org/ORMandate\\_index.php](http://www.caqh.org/ORMandate_index.php)  
Questions?

Contact the eMedNY Call Center at (800) 343-9000 or via e-mail: [eMedNYHIPAASupport@csc.com](mailto:eMedNYHIPAASupport@csc.com) .



# ALL PROVIDERS

## NY Medicaid EHR Incentive Program

The NY Medicaid EHR Incentive Program provides financial incentives to eligible practitioners and hospitals to promote the transition to EHRs. Providers who practice using EHRs are in the forefront of improving quality, reducing costs, and addressing health disparities. Since December 2011 **over \$552.8 million** in incentive funds have been distributed **within 11,850** payments to New York State Medicaid providers.

11,850+  
Payments.

NY Medicaid EHR

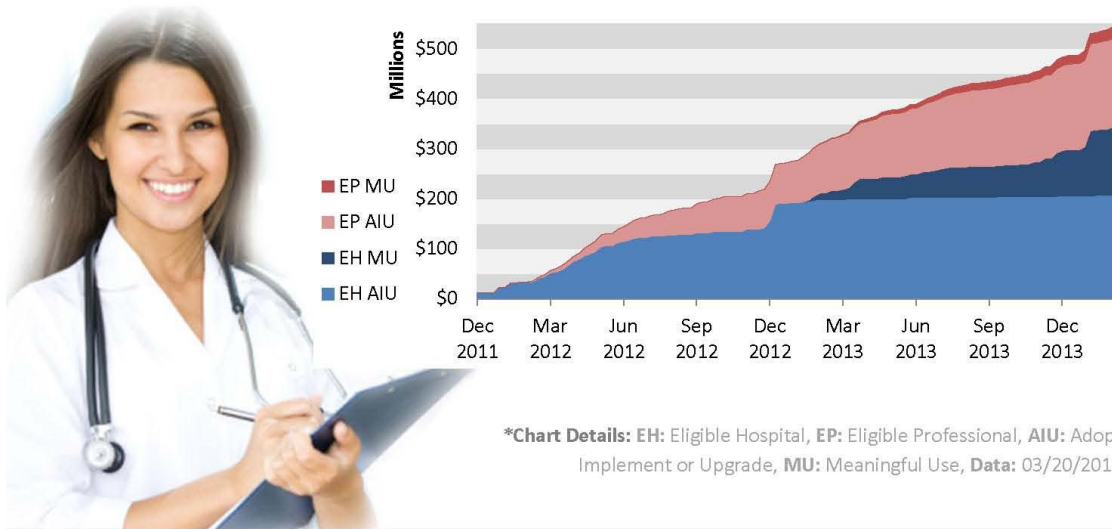
\$552  
Million Paid.

Incentive Program

Are YOU  
eligible?

[emedny.org/meipass](http://emedny.org/meipass)

### Taking a closer look: Cumulative Incentive Payments by Provider Group\*



\*Chart Details: EH: Eligible Hospital, EP: Eligible Professional, AIU: Adopt, Implement or Upgrade, MU: Meaningful Use, Data: 03/20/2014

Have Questions?

Contact [hit@health.state.ny.us](mailto:hit@health.state.ny.us) for program clarifications and details.

[www.emedny.org/meipass/](http://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](http://www.omig.ny.gov).

## **Provider Manuals/Companion Guides, Enrollment Information/Forms/Training Schedules:**

Please visit the eMedNY website at: [www.emedny.org](http://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](mailto:emednyproviderrelations@csc.com).

## **Enrollee Eligibility:**

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

## **Medicaid Prescriber Education Program:**

For current information on best practices in pharmacotherapy, please visit the following websites: [http://www.health.ny.gov/health\\_care/medicaid/program/prescriber\\_education/prescriber\\_educationprog](http://www.health.ny.gov/health_care/medicaid/program/prescriber_education/prescriber_educationprog)<http://nypep.nysdoh.suny.edu/home>

**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](http://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](mailto:medicaidupdate@health.state.ny.us).