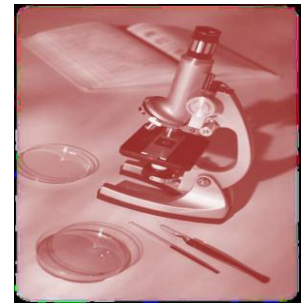




# New York State Medicaid Update

THE OFFICIAL NEWSLETTER OF THE NEW YORK STATE MEDICAID PROGRAM

## Instructions to New York Hospitals Related to Medicaid Coverage for Ebola Patients



In response to requests for clarification from New York hospital personnel, Emergency Medicaid can be granted to someone who would be eligible for Medicaid except for their immigration status. This includes undocumented immigrants or certain temporary non-immigrants (e.g., visitors, workers). Please note, an undocumented immigrant or temporary non-immigrant may receive this coverage, provided they did not enter the State for the purpose of obtaining medical care (i.e., medical visa). Eligibility for Emergency Medicaid is established prior to or during the need for emergency services. Hospitals have Certified Application Counselors who are enrolling uninsured patients through New York State of Health. This system was designed to grant Emergency Medicaid or another form of coverage, as appropriate.

In accordance with federal regulation 42 CFR 440.255, Medicaid coverage is available for emergency services (including emergency labor and delivery) required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- (a) placing the patient's health in serious jeopardy;**
- (b) serious impairment to bodily functions; or**
- (c) serious dysfunction of any bodily organ or part.**

Treatment for Ebola meets the federal definition and will be covered by Medicaid. Payment will be made to both the attending physician as well as the inpatient facility. The treating physician is responsible for certifying whether the medical treatment meets the "emergency" definition described above.

When submitting a claim to Medicaid for a patient diagnosed with Ebola, providers should report ICD-9 diagnosis code 078.89, "other specified diseases due to viruses," in the diagnosis code field. The provider must additionally document on the claim that the services were emergency in nature. The code used to indicate an emergency on a claim depends upon which method the provider has used to submit a bill. To receive timely payment for Medicaid covered services, the following procedure must be followed:

- A practitioner billing on the eMedNY 150003 paper claim form must check the "YES" box in field 16A – "Emergency Related."
- A practitioner billing electronically must enter a "Y" in the SV1-09 of the 2400 Loop in the X12 837P format.
- Inpatient hospital providers must by law bill electronically. The "Admission Type" code reported by the facility identifies if the service was related to an emergency - Admission Type code "1" = emergency.



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## SEPTEMBER 2014 NEW YORK STATE MEDICAID UPDATE

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## Policy & Billing Guidance

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Questions on payment policy may be directed to the Office of Health Insurance Programs at 518-473-2160.

Questions regarding undocumented immigrant/temporary non-immigrant eligibility for Medicaid may be directed to the Office of Health Insurance Programs at 518-474-8887.

Questions related to the billing process and performing eligibility requests on ePACES should be directed to Computer Sciences Corporation at 800-343-9000.

For more information, see the Emergency Medicaid Frequently Asked Questions at:  
[http://www.health.ny.gov/health\\_care/medicaid/emergency\\_medical\\_condition\\_faq.htm](http://www.health.ny.gov/health_care/medicaid/emergency_medical_condition_faq.htm)

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## State Department of Health to Implement Conflict-Free Evaluation and Enrollment Center (CFEEC) in Accordance with CMS Requirement

New York State's Medicaid Section 1115 Waiver Partnership Plan, Special Terms and Conditions #28 requires that the Department of Health (the Department) implement an independent and conflict-free long term supports and services (LTSS) needs determination system for newly eligible Medicaid beneficiaries. In October 2014, the Department will begin the implementation of the CFEEC to meet the 1115 waiver requirement. The goal of the CFEEC is to establish a centralized pathway for people in need of LTSS.

The Department is collaborating with MAXIMUS Health Services, Inc. to act as the CFEEC for individuals new to services. The establishment of the CFEEC will change the way people access the services they need, and especially how they enroll into a Managed Long Term Care Plan (MLTCP).

Beginning in October, the newly created CFEEC will conduct evaluations, using the Uniform Assessment System (UAS), to determine an individual's eligibility for LTSS or Community Based Long Term Care (CBLTC). This process will only apply to individuals new to CBLTC services. New enrollees will now contact the CFEEC instead of going directly to plans for enrollment. In addition, all new MLTCP enrollees will be required to have a UAS entry on record prior to enrollment.



# Policy & Billing Guidance

## CFEEC STATEWIDE IMPLEMENTATION

The Department will implement the CFEEC on a regional basis. Counties will be assigned to one of six implementation regions. During each regional implementation, MLTCPs, providers and counties will be instructed as to how and when they should adjust their business practices.

The tentative regional implementation schedule is as follows:

<u>Region/Month</u>	<u>Counties</u>
Region 1 – October 2014	New York (Manhattan) & Bronx
Region 2 – November 2014	Kings (Brooklyn), Queens, Nassau & Richmond (Staten Island)
Region 3 – February 2015	Westchester & Suffolk
Region 4 – March 2015	East Hudson (Columbia, Dutchess, Putman), Catskill (Rockland, Orange, Ulster, Greene, Sullivan), Capital (Warren, Washington, Saratoga, Fulton, Montgomery, Schoharie, Schenectady, Albany, Rensselaer), and Other (Erie, Monroe, Onondaga)
Region 5 – April 2015	Southern Tier (Tompkins, Cortland, Tioga, Broome, Chenango, Otsego, Delaware), Finger Lakes (Wayne, Ontario, Livingston, Seneca, Cayuga, Yates, Schuyler, Chemung, Steuben), and Western (Chautauqua, Cattaraugus, Allegany, Wyoming, Genesee, Orleans, Niagara)
Region 6 – May 2015	Central (Jefferson, Oswego, Lewis, Oneida, Herkimer, Madison), and Northern (St. Lawrence, Franklin, Clinton, Essex, Hamilton)

**Additional information regarding the CFEEC will be available on the Department's website at:**  
[http://www.health.ny.gov/health\\_care/medicaid/redesign/mrt\\_90.htm](http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm)

**Questions concerning the CFEEC may be e-mailed to:** [CF.Evaluation.Center@health.ny.gov](mailto:CF.Evaluation.Center@health.ny.gov)



## Policy & Billing Guidance

# Expanded Coverage for Spinal Muscular Atrophy - Prenatal Carrier Testing

### **Prenatal Testing:**

Effective October 1, 2014 Medicaid fee-for-service (FFS), and December 1, 2014 Medicaid Managed Care (MMC) and Family Health Plus (FHPlus) will begin covering prenatal carrier testing for spinal muscular atrophy(SMA), once in a lifetime, when one or more of the following criteria is met:

- There is a personal or family history of SMA or other muscular dystrophy of unknown type in a 1<sup>st</sup>\* or 2<sup>nd</sup>\*\* degree relative of either parent
- The father is a known carrier

*\*1<sup>st</sup> degree relatives: Parents, children, siblings*

*\*\*2<sup>nd</sup> degree relatives: Grandparents, aunts and uncles, nieces and nephews, and grandchildren*

Carrier screening for SMA of the male partner of a pregnancy will be covered if the pregnant female is found to be a carrier.

### **General Background:**

Spinal Muscular Atrophy is a genetic disease caused by mutations or deletions in the SMN1 gene that produces a reduction in the level of survival motor neuron (SMN) protein. This reduction destroys the nerves that control voluntary muscle movement. The muscles that are most often affected are those responsible for head and neck control, breathing, swallowing, crawling and walking. SMA is the leading inherited cause of death in infants. Although this disease is the most prevalent cause of hypotonia in girls, twice as many males are affected. African descendants exhibit a lower instance of mutations or deletions in the SMN1 gene. Carrier frequencies are estimated at 1 in 50 in the United States, with the exception of North Dakota where approximately 1 in 41 residents are affected. Carriers often exhibit no indications of the disease. To have symptoms of SMA the child must inherit two affected genes, one from each parent. If both parents are carriers, there is a 25 percent chance that the pregnancy will be affected by SMA.

The most common type of spinal muscular atrophy, Werdnig-Hoffman disease (SMA type 1), affects approximately 1 per 10,000 live births. Ninety-five percent of children with SMA type 1 don't live past 18 months of age. Most deaths related to spinal muscular atrophy are a result of respiratory complications. Severity levels are inversely associated with the age of onset. Chronic infantile (SMA type 2)



## Policy & Billing Guidance

presents between 6 and 18 months and although most children can sit unaided, their muscles are too weak to stand or walk alone. Mortality rates vary for this population. However, most children live past their 4<sup>th</sup> birthday. The onset of Kugelberg-Welander disease (SMA type 3) is after 18 months of age and can remain undiagnosed into the teenage years. Severity of symptoms varies but individuals may lose the ability to walk and swallowing and breathing difficulties arise. In both type 2 and type 3 bones usually become brittle and supports are needed for mobility. Those diagnosed with SMA type 4, which has an adult onset, have less severe hypotonia and muscles used to breathe and swallow are generally not affected. Individuals with this form of adult onset spinal muscular atrophy have a normal life expectancy.

**Reminders:**

- Diagnostic testing of individuals for SMA continues to be covered if medically necessary.
- Follow-up genetic counseling should be provided to those who test positive as a carrier of SMA.
- Prenatal testing of a fetus by amniocentesis or chorionic villus sampling should be offered in the following circumstances:
  - Following a positive SMA carrier test in the mother and the father; or,
  - Following a positive SMA test in the mother where the father is not available for testing and suspicion of the disease is high
- Consistent with existing policy, NYS Regulations at 18NYCRR Section 505.7(g)(4) requires that providers order tests individually. No payment will be made for tests ordered as groupings or combinations of tests. For more information on this and additional regulations pertaining to laboratory services please visit the following link:  
<http://w3.health.state.ny.us/dbspace/NYCRR18.nsf/b2d7d4e6cbd45bd285256546004b78bd/6665022caf89cd9f85256722007690d8?OpenDocument>

**Code:**

81401	Molecular Pathology Procedure, Level 2
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**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.**



## Policy & Billing Guidance

**Effective January 1, 2015**

# Additional Upstate Counties to be included in Transportation Carve-out for Managed Care Enrollees

To implement the Medicaid Redesign Team's (MRT) Transportation Reform Initiative #29, 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. Implementation in New York City began in January 2013. An additional 24 counties in the Finger Lakes and Northern New York moved to the NEMT manager on January 2014 (see below).

On January 1, 2015, emergency and non-emergency transportation services for all Medicaid managed care enrollees will be carved-out of the managed care benefit package for managed care enrollees in seven additional counties in Western New York.

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, 2013** – New York City

**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

**January 1, 2015** – Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Wyoming



## Policy & Billing Guidance

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

Albany	855-360-3549		Oneida	855-852-3288
Allegany	866-271-0564		Onondaga	855-852-3287
Broome	855-852-3294		Ontario	866-733-9402
Cattaraugus	866-371-4751		Orange	855-360-3543
Cayuga	866-932-7743		Orleans	866-260-2305
Chautauqua	855-733-9405		Oswego	855-733-9395
Chemung	855-733-9399		Otsego	866-333-1030
Chenango	855-733-9396		Putnam	855-360-3547
Clinton	866-753-4435		Rensselaer	855-852-3293
Columbia	855-360-3546		Rockland	855-360-3542
Cortland	855-733-9397		Saratoga	855-852-3292
Delaware	866-753-4434		Schenectady	855-852-3291
Dutchess	866-244-8995		Schoharie	855-852-3290
Erie	800-651-7040		Schuyler	866-753-4480
Essex	866-753-4442		Seneca	866-753-4437
Franklin	888-262-3975		St. Lawrence	866-722-4135
Fulton	855-360-3550		Steuben	855-733-9401
Genesee	855-733-9404		Sullivan	866-573-2148
Greene	855-360-3545		Tioga	855-733-9398
Hamilton	866-753-4618		Tompkins	866-753-4543
Herkimer	866-753-4524		Ulster	866-287-0983
Jefferson	866-558-0757		Warren	855-360-3541
Lewis	800-430-6681		Washington	855-360-3544
Livingston	888-226-2219		Wayne	855-852-3295
Madison	855-852-3286		Westchester	866-883-7865
Monroe	866-932-7740		Wyoming	855-733-9403
Montgomery	855-360-3548		Yates	866-753-4467
Niagara	866-753-4430			





## Policy & Billing Guidance

**Effective January 1, 2013, medical providers in New York City were 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 regarding the Medicaid fee-for-service transportation benefit should be directed to:**  
[MedTrans@health.ny.gov](mailto:MedTrans@health.ny.gov)



## Policy & Billing Guidance

### **Attention Family Planning Providers:**

## **Additional Clarification of Medicaid Family Planning Services for Beneficiaries Enrolled in the Family Planning Benefit Program (FPBP) and the Family Planning Extension Program (FPEP)**

The following is additional clarification of the article that was published in the [July 2014 Medicaid Update](#) regarding the recently issued [State Medicaid Director Letter #14-003](#), dated April 16, 2014, clarifying the coverage of family planning-related services, specifically the diagnosis and treatment of sexually transmitted infections (STIs). **Please note, the billing guidelines published in the July 2014 edition of the Medicaid Update have been revised (additions are in red and underlined).**

Prior to April, 16, 2014, diagnosis and treatment of an STI was only covered when provided during an initial family planning visit or a family planning follow-up visit.

**Effective April 16, 2014**, the diagnosis and treatment of an STI is a covered benefit under the FPBP and the FPEP, even **when the patient's primary reason for the medical visit is STI testing (screening) and/or STI treatment (see below)**. This is because providers will, as a matter of course, provide behavioral counseling on contraceptives in addressing the needs of a patient with an active STI. **This clarification applies to services provided to both men and women on and after April 16, 2014.**

### **Required Medicaid Claim Information**

#### **Family Planning Visit (Family Planning Service(s) with or without Treatment for Limited Medical Conditions and/or STIs)**

To bill for these services, claims **must contain:**

- A primary or secondary ICD-9CM diagnosis code in the V25 series.
- A "Y" must be sent as the Family Planning indicator when the primary diagnosis code is in the V25 series.
- The appropriate CPT-4 procedure code(s) performed from the approved follow-up procedures **(Table B)**
- The appropriate CPT-4 evaluation and management follow-up visit code **(Table E)**.
- Clinic claims must also include a clinic rate code.



## Policy & Billing Guidance

### Follow-up Visit for Treatment for Limited Medical Conditions Diagnosed During a Previous Family Planning Visit

To bill for these services, claims **must contain**:

- A primary or secondary ICD-9CM diagnosis code in the V25 series.
- A "Y" must be sent as the Family Planning indicator when the primary diagnosis code is in the V25 series.
- The appropriate CPT-4 procedure code(s) performed from the approved follow-up procedures **(Table B)**
- The appropriate CPT-4 evaluation and management follow-up visit code **(Table E)**.
- Clinic claims must also include a clinic rate code.

### Visit for Diagnosis and Treatment of Sexually Transmitted Infections (**“pursuant to” family planning services**)

To bill for these services, claims **must contain**:

- If the primary reason for the **initial visit or** follow-up visit is for **the screening, diagnosis or** treatment of an STI, the primary ICD-9 CM diagnosis code must be the STI **(Table C) and the secondary diagnosis code must be in the V25 series.**
- If the primary reason for the **initial visit or** follow-up visit is for family planning and STI **screening, diagnosis or** treatment is secondary, the primary ICD-9CM diagnosis code must be in the V25 series and the secondary diagnosis code must be the specific STI **(Table C).**
- A "Y" must be sent as the Family Planning indicator when the primary diagnosis code is in the V25 series.
- A CPT-4 procedure code for an evaluation and management visit **(Tables D and E).**
- The appropriate CPT code for the procedure(s) or medical supply **(Table A) or (Table B).**
- Clinic claims must also include a clinic rate code.

### **FPBP Transportation Benefits**

Transportation is a Medicaid covered service available through the FPBP, but not the FPEP. Medicaid will reimburse the most appropriate mode of transportation required to transport an eligible enrollee to a FPBP covered service. Providers should consult the transportation manual to obtain information regarding transportation policy guidelines, procedures and the county contact list. The manual can be viewed at: <http://www.emedny.org/ProviderManuals/Transportation/index.html>.

**Questions? Please call the Bureau of Policy Development and Coverage at (518) 473-2160.**



## Policy & Billing Guidance

**Table A**

**Approved Family Planning Procedure Codes** (items and procedures must clearly be provided or performed for family planning purposes)

00851	11982	58565	71010	77081	93307	A4268	J7301	J7307
00921	55250	58600	71015	89321	96372	A4931	J7302	S4993*
00952	55450	58615	71020	93000	A4264	J1050	J7303	
11976	58300	58670	77078	93010	A4266	J1056	J7304	
11981	58301	58671	77080	93040	A4267	J7300	J7306	

\*Please see the February Medicaid Update article, *Reimbursement Available to Family Planning Clinics Dispensing Oral Contraceptives to Medicaid Recipients at:*

[http://www.health.ny.gov/health\\_care/medicaid/program/update/2013/2013-02\\_pharmsped\\_edition.htm#rei](http://www.health.ny.gov/health_care/medicaid/program/update/2013/2013-02_pharmsped_edition.htm#rei)

**Table B**

**Procedure Codes for Treatment of Limited Medical Conditions** (conditions diagnosed during a family planning visit)

10060	56501	74000	82247	84144	85378	86780	87207	87590	88154
10140	56700	76830	82270	84146	85576	86781	87210	87591	88155
11420	56820	76856	82465	84443	85610	86900	87252	87620	88160
11421	56821	76857	82550	84703	85651	86901	87254	87621	88161
17110	57061	80048	82553	85002	85652	87015	87255	87797	88162
17111	57420	80053	82565	85004	85730	87040	87270	87798	88164
46900	57421	80061	82570	85007	86580	87070	87273	87800	88165
46922	57452	80076	82575	85013	86592	87075	87274	87801	88173
46924	57454	81000	82670	85014	86593	87077	87320	87808	88174
54050	57455	81001	82677	85018	86631	87081	87340	87899	88175
54055	57456	81002	82947	85025	86632	87086	87390	88141	88302
54056	57460	81003	82948	85027	86687	87088	87486	88142	88305
54057	57461	81007	82950	85032	86689	87102	87490	88143	88307
54060	57505	81015	82951	85045	86696	87110	87491	88147	99070
54065	57510	81025	83001	85048	86701	87164	87495	88148	J0696
56405	57511	82040	83002	85049	86702	87166	87510	88150	
56420	58100	82043	83690	85210	86703	87205	87535	88152	
56440	58340	82150	84075	85300	86762	87206	87536	88153	



## Policy & Billing Guidance

**Table C**

**ICD-9 CM Diagnosis Codes for Sexually Transmitted Infections and Abnormal Pap Smears**

054.10-054.12	054.43-054.44	054.8-054.9	078.19	090.0-099.9	<u>V01.6</u>
54.13	54.49	077.0	078.88	131.0-131.9	<u>V01.79</u>
54.19	54.6	077.98	079.4	<u>616.10</u>	<u>V65.45</u>
054.2-054.3	054.71-054.74	078.1	079.88	<u>795.00-795.02</u>	<u>V69.2</u>
054.40-054.41	54.79	078.11	079.98	<u>795.09</u>	<u>V74.5</u>

**Table D**

**Procedure Codes for Evaluation and Management Services (new patient)**

99050	99201	99203	99205	99242	99244	99384	99386
99051	99202	99204	99241	99243	99245	99385	

**Table E**

**Procedure Codes for Evaluation and Management Services (established patient)**

99050	99211	99213	99215	99242	99244	99394	99396
99051	99212	99214	99241	99243	99245	99395	



## Policy & Billing Guidance

# Reasonability Edits Have Been Established for Practitioner-Administered Drugs

New York State Medicaid fee-for-service (FFS) policy limits payment for practitioner-administered drugs to the provider's acquisition cost by invoice. This reimbursement policy applies to claims submitted by private practitioners (physicians, nurse practitioners, licensed midwives) as well as Article 28 clinics billing ordered ambulatory (Note: This does not apply to clinic APG claims). To enforce this payment policy, Medicaid maintains a maximum fee on file for each drug.

Overpayments for practitioner-administered drugs have been identified due to providers submitting their "charges" rather than the actual acquisition cost of the drugs. In order to prevent overpayment for physician-administered drugs, reasonability edits have been established.

**Effective November 1, 2014**, these reasonability edits will be turned on. If the acquisition cost submitted to FFS Medicaid for a practitioner-administered drug exceeds the cost on file for the drug, the claim will deny. This applies to drugs purchased at both 340B and non-340B prices. In order to be paid, providers must resubmit the claim reporting their actual acquisition cost as found on the invoice.

### **Claims failing the edits will have the following messages on their remittance statements:**

**Providers receiving an *electronic* remittance will see the following message:**

<b>16</b>	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.	<b>M79</b>	MISSING/INCOMPLETE/INVALID CHARGE.
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**Providers receiving a *paper* remittance or PDF file of their remittance will see the following message:**

<b>02235</b>	ACQUISITION COST REPORTED BY PROVIDER EXCEEDS PRICE ON FILE/ACQUISITION COST IS > THE GLOBAL % OF THE MAX FEE ON FILE
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## Policy & Billing Guidance

**02236** ACQUISITION COST REPORTED BY PROVIDER EXCEEDS PRICE ON FILE/ACQUISITION COST IS > PRE DESIGNATED % OF THE MAX FEE ON FILE

**02237** ACQUISITION COST REPORTED BY PROVIDER EXCEEDS PRICE ON FILE/ACQUISITION COST IS > THE GLOBAL % OF THE MAX FEE ON FILE – 340B DRUGS

**02238** ACQUISITION COST REPORTED BY PROVIDER EXCEEDS PRICE ON FILE/ACQUISITION COST IS > THE PRE DESIGNATED % OF THE MAX FEE ON FILE – 340B DRUGS

**Questions? Billing questions should be directed to the eMedNY Call Center at (800) 343-9000. Policy questions should be directed to the Division of Financial Planning and Policy at (518) 473-2160.**

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## Edits To Be Enforced When Billing Fee-for-Service Medicaid for Practitioner-Administered Drugs

The NYS Department of Health (DOH) has taken steps to enforce the eMedNY system edits in place for practitioner-administered drugs. These edits will require both practitioners and ordered ambulatory providers to report the corresponding National Drug Code (NDC) for all practitioner-administered drugs reported to the Medicaid program. Enforcement of these edits will allow the Medicaid Program to collect manufacturer rebates for practitioner-administered drugs, as required by Medicare.

**The following policy guidelines apply to practitioners and ordered ambulatory (Article 28) providers billing Medicaid for practitioner-administered J-code (and/or Q-code) drugs.**

- All practitioner-administered drug claims, including claim adjustments and Medicare/Medicaid claims, must include the corresponding NDC for each drug being billed or the “UD” modifier for each drug purchased at a 340B price. Although not required at this time, the NDC should also be reported on all 340B drug claims in addition to the “UD” modifier.



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- The number of units administered must also be included on the Medicaid claim in order for the State to collect rebates.
- Drug claims received without either the corresponding NDC or the “UD” modifier, as appropriate, will be denied.
- Practitioner-administered drugs must be billed to Medicaid at their actual acquisition cost by invoice.

**Questions? Billing questions should be directed to the eMedNY Call Center at (800) 343-9000. Policy questions should be directed to the Division of Financial Planning and Policy at (518) 473-2160.**





## Policy & Billing Guidance

# Update - Changes in Familial/Personal History Criteria for Medicaid Breast Cancer (BRCA) Genetic Testing

This Medicaid Update article replaces the [March 2014, BRCA Genetic Testing Medicaid Update](#).

Effective for dates of service on or after April 1, 2014, Medicaid implemented changes to the BRCA coverage policy for Medicaid beneficiaries. 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 breast cancer at age 50 or younger
  - 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

**AND/OR**



## Policy & Billing Guidance

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 at age 50 or younger
- One or more close relatives with triple negative breast cancer at age 60 or younger
- One or more close male relatives with breast cancer at any age
- One or more close relatives with ovarian cancer at any age
- 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).

\*\* 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).

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.**



## Pharmacy Update

# NYS Medicaid Program Pharmacists as Immunizers Fact Sheet (updated 9-8-14)

Effective October 14, 2010, the administration of select vaccines by qualified pharmacists employed by, or under contract with, Medicaid enrolled pharmacies is reimbursable under NYS Medicaid. Administration of vaccines is conducted pursuant to NYS Education Law and regulations (8NYCRR63.9) which permits licensed pharmacists who obtain additional certification to administer influenza and pneumococcal vaccinations to adults 18 years of age and older is based on a **patient-specific or non-patient specific order**.

Effective October 16, 2012, the administration of zoster (shingles) vaccine to Medicaid FFS non-dual enrollees aged 50 and older by qualified pharmacists employed by, or under contract with, Medicaid enrolled pharmacies is reimbursable under NYS Medicaid pursuant to a **patient-specific order** by a physician or nurse practitioner. Administration of vaccines will be conducted pursuant to NYS Education Law and regulations.

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 for influenza, pneumococcal and meningococcal vaccines will be based on a patient specific order or non-patient specific order. Reimbursement for zoster (shingles) vaccine is based on a 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.



## Pharmacy Update

Consistent with Medicaid immunization policy, for administration of vaccines to enrollees ages 19 and over, pharmacies will bill the administration and acquisition cost of the vaccine using the appropriate procedure codes listed below. 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. No dispensing fee or enrollee co-payment applies. Pharmacies will bill with a quantity of “1” and a day supply of “1”.

- **Billing Instructions for 19 years of age and older:** Providers must submit via NCPDP D.O, in the Claim Segment field 436-E1 (Product/Service ID Qualifier), a value of “09” (HCPCS), which qualifies the code submitted in field 407-D7 (Product/Service ID) as a Procedure code. Lastly, in field 407-D7 (Product/Service ID), enter the Procedure code. Providers may submit up to 4 claim lines with one transaction. For example, providers may submit one claim line with the Procedure code 90656 (Influenza Virus Vaccine), and another claim line for Procedure code 90471 (Immunization Administration through 19 years of age and older). For administration (age 19 and older) of multiple vaccines on the same date, code 90471 should be used for the first vaccine and 90472 indicating the additional number of vaccines administered (insert 1 or 2).
- 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 reimbursement purposes, the administration of the components of a combination vaccine will continue to be considered as one vaccine administration.
- Providers have an obligation to participate in VFC if they want to offer vaccinations to patients less than 19 years of age. Although pharmacies are not required to join the VFC program when limiting their vaccine administrations to beneficiaries 19 and older, please remember that during times of flu season, the Governor may issue an executive order allowing pharmacies to immunize patients less than 19 years of age. Vaccine administration for the VFC population is at an enhanced reimbursement fee of \$17.85. By not enrolling in the VFC program, these pharmacies **WILL NOT** be able to administer to this population.
- **VFC Billing Instructions through 18 years of age:** Providers must submit via NCPDP D.O, in the Claim Segment field 436-E1 (Product/Service ID Qualifier), a value of “09” (HCPCS), which qualifies the code submitted in field 407-D7 (Product/Service ID) as a Procedure code. Lastly, in field 407-D7 (Product/Service ID), enter the procedure code 90460 (VFC Immunization Administration through 18 years of age). For administration (through 18 years of age) of multiple VFC vaccines on the same date, code 90460 should be used for each vaccine administered.



## Pharmacy Update

**The following Procedure codes should be billed for pharmacist administration of select influenza, pneumococcal and meningococcal vaccines for age 18 and over, and zoster for age 50 and over:**

Procedure Code	Procedure Description
90656	Influenza virus vaccine, trivalent, split virus, preservative free, when administered to individuals 3 years of age and older
90658	Influenza virus vaccine, trivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use
90672	Influenza virus vaccine, quadrivalent, live, for intranasal use, for age 2 through 49 years
90673	Influenza virus vaccine, Trivalent, derived from recombinant DNA, preservative free, for intramuscular use for 18 years through 49 years for use in patients with an egg allergy. (The use in patients over the age of 50 is currently pending FDA approval, so eMedNY would indicate a maximum age of 49)
90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use
90688	Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, with preservative, for intramuscular use
90732	Pneumococcal vaccine, for intramuscular use
90733	Meningococcal polysaccharide vaccine for subcutaneous use, individuals 2 years of age and older
90734	Meningococcal conjugate vaccine, for intramuscular use, for age 11 through 55 years
90736	Zoster Vaccine
90460	Immunization <b>administration through 18 years of Age</b> via Any Route of Administration with Counseling; First or Only Component of Each Vaccine or Toxoid Administered (to be used by VFC enrolled pharmacies when administering vaccines obtained from VFC Program) <b>\$17.85</b>
90471	Immunization <b>administration ages 19 and older</b> (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid) <b>\$13.23</b>
90472	Immunization <b>administration ages 19 and older</b> (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure) <b>\$2.00</b>
90473	Immunization <b>administration ages 19 and older</b> of seasonal influenza intranasal vaccine <b>\$8.57</b>



## Pharmacy Update

**NOTE:** The maximum fees for vaccine drugs are adjusted periodically by the State to reflect the estimated acquisition cost. Insert acquisition cost per dose in amount charged field on claim form.

**For VFC enrollment information, go to:**

[http://www.health.ny.gov/prevention/immunization/vaccines\\_for\\_children.htm](http://www.health.ny.gov/prevention/immunization/vaccines_for_children.htm)

Questions regarding Medicaid reimbursement of immunizations may be directed to the Medicaid Pharmacy Program at 518 486-3209 or [PPNO@health.ny.gov](mailto:PPNO@health.ny.gov)

Additional information on influenza can be found at NYS Department of Health's website at

<http://www.health.ny.gov/diseases/communicable/influenza/>

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## Important Reminder to Prescribers Regarding Coverage of Medications for the Dual Eligible Population

It is important to remember that Medicaid will only cover OTC medications and certain prescription vitamins for beneficiaries who are covered by both Medicare Part D and Medicaid (also known as Dual Eligible beneficiaries). All other medications **must** be billed through the Medicare Part D plan.

Prior Authorization (PA) requests should not be made to the Medicaid Clinical Call Center for a participant that is a Part D beneficiary. PA's can only be requested through the beneficiary's Medicare Part D plan.

The link below will provide you with a list of the prescription medications covered by NYS Medicaid for beneficiaries who are Medicare Part D Dual eligible:

[http://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_transition/docs/2014-01-01\\_medicare\\_exempt\\_drugs.pdf](http://www.health.ny.gov/health_care/medicaid/program/medicaid_transition/docs/2014-01-01_medicare_exempt_drugs.pdf)



## Pharmacy Update

# Important Information for Prescribers to Assist in Expediting the Medicaid Prior Authorization (PA) Process

When contacting the **Clinical Call Center** to request a PA, the provider or their authorized agent will need to provide the following information:

- **Prescriber name and NPI**
- **Beneficiary's diagnoses**
- **Requested medication, quantity, number of refills and prescribing information**
- **Clinical rationale supporting the use of the requested medication**
- **Previous medication trials**

**It is very helpful to have any/all medical records available before calling to ensure that you will be able to provide the above information.**

**Please note:** If, for any reason, the PA cannot be approved by the technician, the actual prescriber (not the prescriber's agent) will be required to have a clinical discussion with the pharmacist.

## Fax Process

**When faxing a PA request to the Clinical Call Center, please ensure the following information is clearly written on the form:**

- **Beneficiary's name, date of birth and Client Identification Number (CIN)**
- **Prescriber's National Provider Identification (NPI) number, name, specialty and contact information**
- **Requested medication, quantity, number of refills and prescribing information**
- **Beneficiary's diagnoses**
- **Clinical rationale that supports the use of the requested medication**
- **Any medical trials**

**Please be sure the form is signed before faxing**

**Clinical Call Center Telephone # 877-309-9493**

**Clinical Call Center Fax #800-268-2990**



## All Providers

# eMedNY ICD-10 Provider Testing Environment is Open

Providers and vendors are again reminded that the eMedNY Provider Testing Environment (PTE) is available for submitters to begin testing Medicaid claims with ICD-10 diagnosis codes and inpatient hospital claims that utilize ICD-10 procedure codes. All New York Medicaid submitters are urged to expedite their transition from ICD-9 to ICD-10 coding and take advantage of the ICD-10 end-to-end testing provided via the PTE. Please read the information below as it will assist you with your testing efforts.

### **Date of Service Requirement**

When submitting test claims with ICD-10 codes submitters must use a date of service of July 1, 2014 or any date of service up to the date of the test submission. Future dates are not allowed. Submitters who may be testing claims with ICD-9 codes must use a date of service prior to July 1, 2014.

### **What is PTE?**

The eMedNY Provider Testing Environment is designed to enable NYS Medicaid trading partners to test batch and real-time EDI (Electronic Data Interchange) transactions using the same validation, adjudication logic, and methods as the eMedNY production environment. Test transactions submitted to the eMedNY PTE undergo processes that verify and report on data structure and content to the same degree of stringency as live transactions sent to the eMedNY production environment, and receive, in most cases, the same system responses at each step.

For similar inquiries, the response in the PTE may not be identical to the response in the production environment. For example, edits involving duplicate and near-duplicate claims, or prior authorization submissions, are not applied in PTE, so as to allow for iterative testing. Also no claim, or authorization, requests are pending in PTE.

### **PTE Access Methods**

eMedNY PTE can be accessed using any of your existing eMedNY Access Methods with a few exceptions (see below).

### **Test Indicator**

**Since existing access methods are being used for PTE access, it is critical that the test indicator is valued in the inbound/outbound transactions.**

For ASC X12 transactions: "Test Indicator" in **ISA15** is set to **"T"**





## All Providers

For NCPDP Batch 1.2/D.0 transactions: File Type (**702-MC**) field in the NCPDP Batch Header is set to **"T"**

**Important Note:** *If the appropriate indicator for a transaction is not set to Test, the transactions will be processed through the production environment.*

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# NY Medicaid Electronic Health Record (EHR) Incentive Program Update

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 \$603.7 million** in incentive funds have been distributed **within 15,028** payments to New York State Medicaid providers.

### **Taking a closer look: Public Health, Meaningful Use and the NY Medicaid EHR Incentive Program.**

One of the primary purposes of CMS Medicare and Medicaid [EHR Incentive Programs](#) is to incentivize Eligible Professionals (EPs) and Eligible Hospitals (EHs) in the meaningful use of Certified EHR Technology. The three main components of meaningful use are:

- The use of certified EHR technology for electronic exchange of health information to improve quality of health care
- The use of certified EHR technology to submit clinical quality and other measures
- The use of a certified EHR in a meaningful manner (e.g. e-prescribing)

An objective of these meaningful use components is to onboard EPs and EHs in exchanging specialized data to Public Health registries.

- In [MU Stage 1](#), EPs or EHs must submit test data to a public health registry as part of **CMS Meaningful Use Stage 1 Menu Set Objectives**.
- In [MU Stage 2](#) and beyond, EPs or EHs are required to submit immunization data to the appropriate public health registry on an ongoing basis. Additionally, providers may choose to submit data to additional public health registries within their menu objectives.



## All Providers

### Importance of Public Health and Meaningful Use:

The principal goal of Public Health Agencies is to improve the health of the populations they serve. One way Public Health does this is by studying factors that affect health, including disease and health behaviors. When EPs and EHs actively share data with public health registries, the registries are better able to identify trends and affected populations and as a result, more effectively address disease outbreaks and plan interventions.

### For more information, please visit the helpful links below:

- **NEW!** The [Public Health \(PH\) Measure Section](#).
- Public Health Measure and Onboarding [Frequently Asked Questions \(FAQs\)](#).

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

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## New Medicaid Training Schedule and Registration

- **Do you have billing questions?**
- **Are you new to Medicaid billing?**
- **Would you like to learn more about ePACES?**
- **Do you have questions on filling out forms such as Electronic Funds Transfer Authorization and Electronic Remittance Request?**

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



## All Providers

### **Web Training Available**

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

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

- **Claims** (Dental, Professional, Institutional)
- **Eligibility Verifications**
- **Claim Status Requests**
- **Prior Approval/DVS Requests**

Physician, Nurse Practitioner, Durable Medical Equipment and Private Duty Nursing claims can even be submitted in "REAL-TIME" via **ePACES**. Real-time means that the claim is processed within seconds and professional providers can get the status of a real-time claim, including the paid amount without waiting for the remittance advice.

Fast and easy registration and dates are available on the eMedNY Website at:  
<http://www.emedny.org/training/index.aspx>

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

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



## 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/presc-educationprog](http://www.health.ny.gov/health_care/medicaid/program/prescriber_education/presc-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.