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Medicaid Update

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New York State Medicaid Coverage of Hepatitis C and Syphilis Screening

Hepatitis C and syphilis screening testing are mandated in New York State (NYS) Public Health Law (PHL) §2171(1)(2), NYS PHL §2500-L, and NYS PHL §2308(1). In 2023, the statute was amended, and the law requires that hepatitis C and syphilis screening be offered to/ordered for the groups of individuals outlined below. **Effective immediately**, for both fee-for-service (FFS) and Medicaid Managed Care (MMC), NYS Medicaid coverage of hepatitis C and syphilis screening tests align with this amendment.

Hepatitis C Screening

Hepatitis C Testing Law is extended to 2030 (previously 2026) to align with the New York State Hepatitis C Elimination Plan, **effective immediately**. The New York State Hepatitis C Elimination Plan can be found on the NYS Department of Health (DOH) "New York State Hepatitis C Elimination" web page.

NYS PHL §2171(1)(2) requires a **hepatitis C screening be offered to individuals eighteen years of age and older (or younger than eighteen years of age if there is evidence or indication of risk activity)**. NYS PHL §2500-L requires **practitioners to order a hepatitis C virus (HCV) screening test for ALL pregnant persons**.

If the hepatitis C screening test of the member is reactive, a hepatitis C virus (HCV) ribonucleic acid (RNA) test must be performed on the same specimen, or a second specimen collected at the same time as the initial HCV screening test specimen must be used, to confirm diagnosis of current infection.

The provider must either offer all persons with a detectable HCV RNA diagnostic test follow-up HCV care and treatment or refer the individual to a provider who can provide such follow-up care.

Exemptions from screening requirements are as follows:
- the individual is being treated for a life-threatening emergency;
- the individual has previously been offered, or has received, a hepatitis C screening test (except that a test shall be offered if otherwise indicated); *and/or*
- the individual lacks capacity to consent to a hepatitis C screening test.

Syphilis Screening for Pregnant Individuals

According to NYS data, reported congenital syphilis cases increased more than 240 percent over the last five years, with 2022 marking the highest number of reported diagnoses in NYS in the last 20 years. For pregnant individuals who screen negative for syphilis at the time of their first exam, a third trimester screen will ensure adequate time for persons who seroconvert during their pregnancy to be appropriately treated prior to delivery.

Additional information may be found in the *New York State 2021 Sexually Transmitted Infections Surveillance Report*. NYS PHL §2308(1) requires **practitioners to order a syphilis screening test for pregnant individuals during their third trimester of pregnancy, in addition to testing at the time of their first exam, and again at delivery.**

Questions and Additional Information:
- FFS coverage and policy questions should be directed to the Office of Health Insurance Programs (OHIP) Division of Program Development and Management (DPDM) by telephone at (518) 473-2160 or by email at FFSMedicaidPolicy@health.ny.gov.
- FFS billing/claim questions should be directed to the eMedNY Call Center at (800) 343-9000.
- Medicaid Managed Care (MMC) reimbursement, billing, and/or documentation requirement questions should be directed to the specific MMC Plan of the enrollee. MMC Plan contact information can be found in the eMedNY *New York State Medicaid Program Information for All Providers – Managed Care Information* document.

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All Providers

Reminder: Sign Up for eMedNY Training Webinars

eMedNY offers several online training webinars to providers and their billing staff, which can be accessed via computer and telephone. Valuable provider webinars offered include:
- ePACES for: *Dental, Durable Medical Equipment Supplier (DME), Free-Standing and Hospital-Based Clinics, Home Health, Institutional, Physician, Private Duty Nursing (PDN), Professional (Real-Time), Transportation,* and *Vision Care*
- *ePACES Dispensing Validation System (DVS) for DME*
- *eMedNY Website Review*
- *Medicaid Eligibility Verification System (MEVS)*
- *New Provider / New Biller*
- *Pharmacy - New Provider / New Biller*
- *Provider Enrollment Portal - Practitioner*

Webinar registration is fast and easy. To register and view the list of topics, descriptions and available session dates, providers should visit the eMedNY "Provider Training" web page. Providers are reminded to review the webinar descriptions carefully to identify the webinar(s) appropriate for their specific training needs.

Questions
All questions regarding training webinars should be directed to the **eMedNY Call Center** at (800) 343 9000.

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New York State Department of Health Telehealth Provider Survey

The New York State (NYS) Department of Health (DOH) is conducting the *Telehealth Provider Survey* for all health care providers to complete in order to gain knowledge of their experiences using telehealth during the Coronavirus 2019 (COVID-19) Public Health Emergency (PHE), as well as their plans to continue to use telehealth. NYS DOH will use the results of this five-minute survey to inform telehealth policy development.

All NYS providers whether they have used telehealth services or not, are encouraged to complete the survey, which will close on Monday, October 2, 2023. To access the survey, use the direct link provided above or visit the NYS DOH Information for Providers web page.

Questions
Questions regarding the *Telehealth Provider Survey* should be sent to NYS DOH at Telehealth.Policy@health.ny.gov.

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Policy and Billing

Reminder: Medicaid Requires Coordination of Benefits

Medicaid is always the payor of last resort and federal regulations require that all other available resources be used before Medicaid considers payment. Accordingly, New York State (NYS) Medicaid providers are required to bill applicable third parties that may be liable for a claim before billing NYS Medicaid. The *Reminder: Medicaid Requires Coordination of Benefits* article published in the April 2022 issue of the *Medicaid Update* affirms this requirement by directing providers to exhaust all existing benefits prior to billing NYS Medicaid. Providers should always ask the NYS Medicaid member if they have other third-party coverage to ensure the proper coordination of benefits.

All claims submitted for NYS Medicaid members with Medicare and/or other third-party insurance must accurately reflect payments, adjustments and denials received from other insurers to allow correct calculation of NYS Medicaid reimbursement amounts. The Explanation of Benefits (EOB), along with other documentation supporting Medicare and/or third-party insurance including third-party reimbursement amounts, must be kept for a period of six years from the date of payment, and made available upon request for audit or inspection by the NYS Department of Health (DOH), the Office of the Medicaid Inspector General (OMIG), the Office of the State Comptroller (OSC), or other state or federal agencies responsible for audit functions.

Additionally, for any claims submitted to NYS Medicaid with zero-fill reimbursement from Medicare or third-party insurers, providers must retain evidence that the claims were initially billed to Medicare and/or third-party insurers and then were denied ***before*** seeking reimbursement from NYS Medicaid. The only exception to this policy is for services and items that are statutorily not covered by Medicare. Providers are responsible for providing the statutory exemptions from Medicare for audit or inspection.

Please note: When submitting an EOB, or other member-related data, providers must ensure they are only submitting data relevant to the NYS Medicaid member. All other patient information ***must be redacted*** prior to submission. It is important to ensure that providers are ***not*** submitting Personally Identifiable Information (PII) or Protected Health Information (PHI) of non-NYS Medicaid members to NYS Medicaid.

Questions and Additional Information:
- Fee-for-service (FFS) coverage and policy questions should be directed to the Office of Health Insurance Programs (OHIP) Division of Program Development and Management (DPDM) by telephone at (518) 473-2160 or by email at FFSMedicaidPolicy@health.ny.gov.
- FFS billing/claim questions should be directed to the eMedNY Call Center at (800) 343-9000.
- Medicaid Managed Care (MMC) reimbursement, billing, and/or documentation requirement questions should be directed to the specific MMC Plan of the enrollee.
- MMC Plan contact information can be found in the eMedNY *New York State Medicaid Program Information for All Providers – Managed Care Information* document.

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Reimbursement Changes for Dental Services

Providers should be aware of the following reimbursement changes for dental services:
- Reimbursement and billing guidance for Current Dental Terminology (CDT) procedure codes **"D9230"** (*Inhalation of Nitrous Oxide/Analgesia, Anxiolysis*) and **"D9248"** (*Non-Intravenous Conscious Sedation*).
- Reimbursement and billing guidance for dental care performed in the Ambulatory Surgery Centers (ASCs) setting, using CPT code **"41899"**, which allows billing multiple units based on time for a recipient with exception (RE) code **"81"** or RE code **"95"** (OPWDD/Managed Care Recipient Exemption Code).
- 20 percent fee enhancement to private practitioners for care provided to New York State (NYS) Medicaid members and Medicaid Managed Care (MMC) enrollees with a RE code **"81"** (*TBI Eligible*) or RE code **"95"** (*OPWDD/Managed Care Recipient Exemption Code*).

Billing for Nitrous Oxide Analgesia, Anxiolysis, and Non-Intravenous Conscious Sedation in the Dental Setting

Effective for dates of service on or after July 1, 2023, for NYS Medicaid fee-for-service (FFS) providers and MMC Plans, CDT code **"D9230"** (Inhalation of Nitrous Oxide/Analgesia, Anxiolysis) and CDT code **"D9248"** (Non-Intravenous Conscious Sedation) will be separately reimbursable for NYS Medicaid members and MMC enrollees through 20 years of age (inclusive) with documentation of clinical necessity and in conjunction with covered dental services. For NYS Medicaid members and MMC enrollees 21 years of age and older, CDT codes **"D9230"** and **"D9248"** will be separately reimbursable for NYS Medicaid members and MMC enrollees identified with an RE code of **"81"** (Traumatic Brain Injury Eligible) or an RE code of **"95"** (OPWDD/Managed Care Recipient Exemption Code) with documentation of clinical necessity and in conjunction with covered dental services.

Only a single CDT code for anesthesia may be billed in a single encounter on a single day. **"D9230"** or **"D9248"** are not billable when another billable method of anesthesia/analgesia/sedation (i.e., **"D9222"**, **"D9223"**, **"D9239"** and **"D9243"**) is used during an encounter when **"D9230"** and **"D9248"** are used together, only one is reimbursed.

FFS Billing
Prior authorization (PA) is not required; however, written documentation for **"D9248"** should indicate the specific anesthetic agent administered and the method of administration. For purposes of the NYS Medicaid program, conscious sedation is reimbursable only when provided by a qualified dental provider who has the appropriate level of certification in dental anesthesia by the NYS Education Department (NYSED). Additional information may be found on the NYSED "Dental Anesthesia/Sedation Certification" web page.

Billing for Dental Procedures in an ASC Setting

Effective for dates of service on or after July 1, 2023, for NYS Medicaid FFS providers and MMC Plans, NYS Medicaid will increase the billable limits for ASCs for dental surgery services rendered to NYS Medicaid members and MMC enrollees with intellectual and/or developmental disabilities (I/DD), identified by the presence of a RE code **"81"** or RE code **"95"** on their NYS Medicaid eligibility response. For this specific population, NYS Medicaid will allow hospital-based and free-standing ASCs to bill up to a maximum of four units of CPT code **"41899"** to compensate for the multiple services, extra time, sophisticated equipment, and extra personnel that may be required to treat NYS Medicaid members with an I/DD. An ASC may bill NYS Medicaid for a maximum of one unit of CPT code **"41899"** for NYS Medicaid members who are not identified with either of the above-referenced RE codes.

The ASC **must** check the eligibility of the NYS Medicaid member, prior to the provision of NYS Medicaid services via the Medicaid Eligibility Verification System (MEVS), to verify the presence of either RE code **"81"** or RE code **"95"**. A provider who does not verify eligibility prior to the provision of services will risk the possibility of non-payment for those services. Information regarding the utilization of MEVS can be found in the *eMedNY Medicaid Eligibility Verification System (MEVS) and Dispensing Validation System (DVS) Provider Manual*.

FFS Billing
An ASC should submit an Ambulatory Patient Group (APG) claim to NYS Medicaid and indicate the number of units on the claim line for CPT code **"41899"**. The number of units submitted is based on the duration of the encounter up to a maximum of four units. ASCs submitting more than one unit for CPT code **"41899"** must check the eligibility of the NYS Medicaid member via MEVS and verify the presence of either RE code **"81"** or RE code **"95"** on the enrollment file of the NYS Medicaid member.

The ASC should submit Healthcare Common Procedure Coding System (HCPCS) modifiers **"U1"** and **"U2"** on the CPT code **"41899"** claim line. Modifiers **"U1"** and **"U2"** must appear consecutively, in this order, on the claim line when seeking reimbursement for CPT code **"41899"** greater than one unit. Failure to include these modifiers will result in non-payment. The chart provided below shows the encounter duration and corresponding number of units that are allowed to be billed:

Duration of Service	Billable Units
Less than 68 minutes	One unit
69 to 128 minutes	Two units
129 to 186 minutes	Three units
186 minutes or longer	Four units

At this time, facilities are advised to bill using CPT code **"41899"** (not CDT codes). The treating dentist may also submit a separate professional claim to NYS Medicaid for their professional services rendered in an outpatient hospital-based or free-standing ASC, using appropriate CDT coding. These services will receive a 20 percent increase when provided to NYS Medicaid members with an RE code of **"81"** or **"95"**.

Increase in Reimbursement for Private Practice Dentists Serving the I/DD Population with RE code "81" or "95"

Effective for dates of service on or after July 1, 2023, for NYS Medicaid FFS members with an RE code of **"81"** or **"95"** NYS Medicaid FFS private practitioners will be reimbursed 20 percent over the base fee schedule for all dental services provided to the I/DD population who are enrolled in FFS. This enhanced payment rate is intended to incentivize practices to increase access to care for NYS Medicaid FFS members with I/DD and compensate for the additional time necessary to care for these members.

Please note: Although this enhancement is **effective July 1, 2023**, additional reimbursement will be delayed until systems changes are complete. As a reminder, clinics billing using APG methodology have a 20 percent enhancement added to the APG base rate for services provided to the I/DD population, using rate codes **"1501"**, **"1489"**, **"1435"** and **"1425"**. Additional information can be found in the *Ambulatory Patient Groups (APGs) Medicaid Fee-for-Service Provider Manual – Policy and Billing Guidelines*.

Questions and Additional Information:
- FFS claims reimbursement and/or provider enrollment questions should be directed to the Computer Sciences Corporation (CSC), or CSRA Inc. at (800) 343-9000.
- FFS dental coverage and policy questions should be directed to the Office of Health Insurance Programs (OHIP) Division of Program Development and Management (DPDM) by telephone at (518) 473-2160 or by email at dentalpolicy@health.ny.gov.
- MMC reimbursement, billing, and/or documentation requirement questions should be directed to the specific MMC Plan of the enrollee. MMC Plan contact information can be found in the eMedNY *New York State Medicaid Program Information for All Providers – Managed Care Information* document.

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Updated New York State Medicaid Drug Testing Policy

Effective July 1, 2023, for New York State (NYS) Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC), the drug testing policy guidance titled *New York State Medicaid Drug Testing Policy* published in the August 2021 issue of the *Medicaid Update*, has been amended to align with the Centers for Medicare and Medicaid Services (CMS) implementing National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits.

As a reminder, NYS Medicaid drug testing policy follows a two-step testing process/structure that consists of the use of screening (presumptive) tests then confirmatory (quantitative) tests. Presumptive drug class tests using Common Procedural Terminology (CPT) codes **"80305"**, **"80306"**, or **"80307"** are the first step in the process. Only substances that return positive results or are inconclusive on presumptive tests or results on presumptive tests that are inconsistent with clinical presentations are reimbursable for quantitative testing using CPT codes **"80321"** through **"80377"** listed on the fee schedule. **Definitive or direct confirmation tests** using CPT code **"G0480"** are only reimbursable when no screening methods for the substances are available.

CMS implemented NCCI PTP edits for CPT codes **"80305"**, **"80306"**, and **"80307"** for presumptive test(s), and CPT code **"G0480"** for definitive test(s). Currently, these edits cannot be bypassed using an NCCI modifier; however, CMS will allow the use of a modifier to bypass the edits in those circumstances when billing these codes together is allowable, **retroactive to July 1, 2023**. If you have denied NYS Medicaid claims with edit **"00715"**, with dates of service between July 1, 2023, and October 1, 2023, you may submit a claim adjustment with modifier **"59"** (separate procedures or distinct procedural services).

Please note: NYS Medicaid requires that claims be initially submitted within 90 days from the date of service to be valid and enforceable unless the claim is denied due to circumstances outside of the control of the provider. All such claims submitted after 90 days must be submitted within 30 days, from the time submission came with control of the provider, with the appropriate numeric delay reason (DR) code. If the original claim was submitted within 90 days from the date of service, and the claim is denied for a reason unrelated to timely filing, and follow up is timely, then DR code **"9"** may be used.

Questions and Additional Information:
- FFS coverage and policy questions should be directed to the Office of Health Insurance Programs (OHIP) Division of Program Development and Management (DPDM) by telephone at (518) 473-2160 or by email at FFSMedicaidPolicy@health.ny.gov.
- FFS billing/claim questions should be directed to the eMedNY Call Center at (800) 343-9000.
- MMC reimbursement, billing, and/or documentation requirement questions should be directed to the specific MMC Plan of the enrollee. MMC Plan contact information can be found in the eMedNY *New York State Medicaid Program Information for All Providers – Managed Care Information* document.

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Update to NYRx, Medicaid Pharmacy Prior Authorization Programs

On May 18, 2023, the New York State (NYS) Medicaid Drug Utilization Review (DUR) Board recommended changes to the NYS Medicaid pharmacy prior authorization (PA) programs. The Commissioner of Health (COH) has reviewed the recommendations of the DUR Board and approved changes to the Preferred Drug Program (PDP) within the NYS Medicaid fee-for-service (FFS) pharmacy program. **Effective August 3, 2023**, PA requirements will change for some drugs in the following PDP classes:
- Angiotensin Receptor Blockers
- Angiotensin Receptor Blocker Combinations
- Triglyceride Lowering Agents
- Anticonvulsants, Other
- Selective Serotonin Reuptake Inhibitors
- Psoriasis Agents, Topical
- Dipeptidyl Peptidase-4 (DPP-4) Inhibitors
- Glucagon Agents
- Glucagon-like Peptide-1 (GLP-1) Agonists
- Proton Pump Inhibitors
- Erythropoiesis Stimulating Agents
- Immunosuppressives, Oral
- Antihistamines, Ophthalmic
- Urinary Tract Antispasmodics
- Anticholinergic / COPD Agents
- Antihistamines, Second Generation
- Beta2 Adrenergic Agents, Inhaled, Long Acting

Additional information can be found on the NYS Department of Health (DOH) "Drug Utilization Review (DUR)" web page. Providers should refer to the *NYRx, the Medicaid Pharmacy Program Preferred Drug List*, for up-to-date information on NYRx. The *NYRx, the Medicaid Pharmacy Program Preferred Drug List* contains a listing of drugs/classes that may be subject to NYRx pharmacy program-specific criteria. Not all agents covered by NYRx are listed on the Preferred Drug List (PDL). For a complete list of NYRx-covered drugs, providers should refer to the eMedNY "Medicaid Pharmacy List of Reimbursable Drugs" web page.

To obtain a PA, providers must contact the clinical call center at (877) 309-9493. The clinical call center is available 24 hours per day, seven days per week, with pharmacy technicians and pharmacists who will work with prescribers, or their authorized agent, to quickly obtain a PA.

Questions and Additional Information:
- NYRx claim questions should be directed to the eMedNY Call Center at (800) 343-9000.
- NYRx coverage and policy questions should be directed to the Medicaid Pharmacy Policy Unit by telephone at (518) 486-3209 or by email at NYRx@health.ny.gov.
- Additional information on NYRx can be found on the NYS DOH "Welcome to NYRx, the Medicaid Pharmacy Program" web page and the Magellan Rx Management, LLC, "NYRx, the Medicaid Pharmacy Program" web page.
- Additional information on NYS Medicaid FFS practitioner administered drug policy and billing guidance, as well as NYS Medicaid FFS *Clinical Criteria Worksheets*, can be found on the NYS DOH "New York State Medicaid Fee-for-Service Practitioner Administered Drug Policies and Billing Guidance" web page.

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Pharmacy Program Integrity Spotlight

The Pharmacy Program Integrity Spotlight is a monthly series intended to share program integrity information with providers and reinforce pharmacy program requirements.

Reminder: Submitting for Prior Authorization of Non-Preferred Drugs

Prior authorization (PA) requests for non-preferred drugs must be submitted by the prescriber or by an authorized agent of the prescriber. An authorized agent of the prescriber is considered an employee of the prescribing practitioner and has access to the patient's medical records (i.e., nurse, medical assistant).

When presented with a prescription for a non-preferred drug that requires PA, the pharmacist must notify the prescriber that PA is required and notify the patient once the prescriber has obtained the PA. If the pharmacist is unable to reach the prescriber and a PA number has not yet been obtained by the prescriber, the pharmacist may initiate a PA for a 72-hour emergency supply only.

Pharmacists are **not** authorized to submit for a PA nor enter into an agreement with a prescriber to effectuate PAs and appeals on the prescriber's behalf (except for the 72-hour emergency supply mentioned above or when employed by a prescriber). Such conduct is contrary to the official rules and regulations of the New York State (NYS) Department of Health (DOH) and violates §1902 [42 United States code (U.S.C.) 1396a] (a) (23) of the Social Security Act, and NYS Public Health Law (PHL) Article 2-A Title 1 §273 (3) and (5). Providers found to be engaging in such conduct may be subject to criminal, civil, or administrative actions, including exclusion from the NYS Medicaid program.

For more information on NYS Medicaid drug program PA policy and guidelines, providers should refer to the *NYRx, NY Medicaid Pharmacy Program Pharmacy Manual - Policy Guidelines*, located on the eMedNY "Pharmacy Manual" web page.

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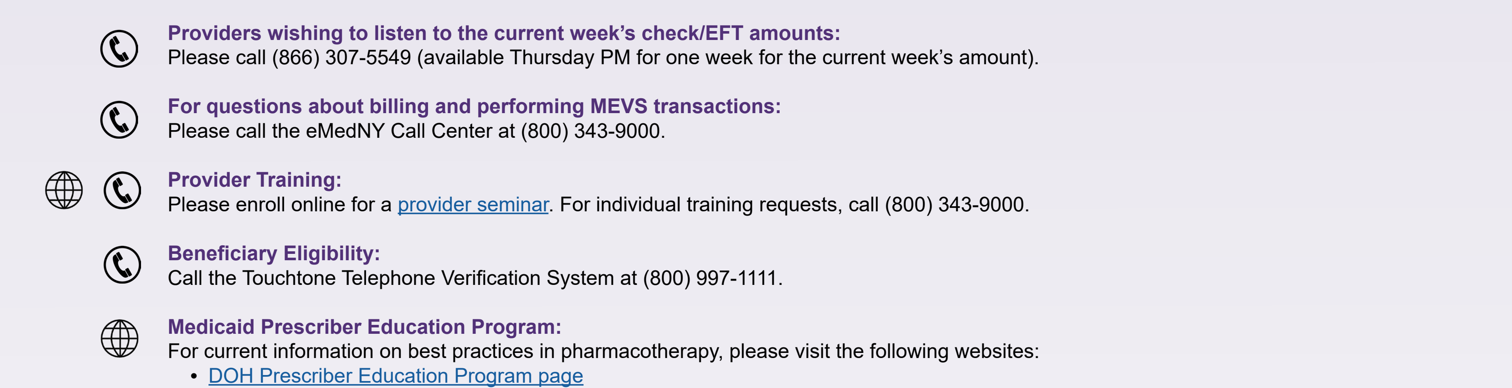

Provider Directory

Office of the Medicaid Inspector General:
For suspected fraud, waste or abuse complaints/allegations, call 1-877-87FRAUD, (877) 873-7283, or visit Office of Medicaid Inspector General (OMIG) web site.

Provider Manuals/Companion Guides, Enrollment Information/Forms/Training Schedules:
Please visit the eMedNY website.

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).

For questions about billing and performing MEVS transactions:
Please call the eMedNY Call Center at (800) 343-9000.

Provider Training:
Please enroll online for a provider seminar. For individual training requests, call (800) 343-9000.

Beneficiary 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:
- DOH Prescriber Education Program page
- Prescriber Education Program in partnership with SUNY

eMedNY
For a number of services, including: change of address, updating an enrollment file due to an ownership change, enrolling another NPI, or revalidating an existing enrollment, please visit eMedNY's Provider Enrollment page and choose the appropriate link based on provider type.

Comments and Suggestions Regarding This Publication
Please contact the editor, Angela Lince, at medicaidupdate@health.ny.gov.

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