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Medicaid Update

THE OFFICIAL NEWSLETTER OF THE NEW YORK STATE MEDICAID PROGRAM

Long Term Home Health Care Program (LTHHCP) New Medicaid Waiver Services and Rate Codes

The LTHHCP, a 1915(c) Home and Community Based Services (HCBS) Medicaid waiver, provides a coordinated plan of community-based care and services for individuals who would otherwise be medically eligible for placement in a nursing facility. The claiming structure for CTS (Rate Code 3144) allows the LTHHCP agency to submit one claim for the total cost of items approved by the local department of social services (LDSS). Claims with service dates prior to the effective date will be denied.

The waiver was renewed by the Centers for Medicare and Medicaid Services (CMS) for the period September 1, 2010 through August 31, 2015. With this renewal, CMS approved three new waiver services, **Assistive Technology, Community Transitional Services and Home and Community Support Services, and modification of the existing Housing Improvements waiver service.** As plans of care are developed or reassessed, LDSS and LTHHCP agency staff should consider the use of these new or modified services. These services support a Medicaid Redesign Team (MRT) proposal that supports enhanced access to services by LTHHCP participants.

NEW AND/OR MODIFIED WAIVER SERVICE DESCRIPTIONS

Assistive Technology (AT) provides items designed to improve or maintain a participant's independence, and decrease reliance on paid direct care workers with added flexibility of new technologies. This service covers medical equipment and supplies for those items **not** covered under the State Plan benefit or other third party payer, such as Medicare or private insurance. Examples of AT include a lift chair that allows the participant to rise independently to a standing position; devices to assist the hearing impaired; or sensors for alarm activation. The effective date for the use of AT was May 1, 2011.

The claiming structure for AT (Rate Code 3143) allows the LTHHCP agency to submit one claim for the total cost of items approved by the LDSS. Claims with service dates prior to the effective date will be denied. Personal Emergency Response Systems (PERS) rate codes and rates remain unchanged.

Community Transitional Services (CTS) assists waiver participants in their transition from living in a nursing home to living in the community. This service assists with the cost of first-time moving expenses and/or establishing a household, such as security deposits required to obtain a lease or utilities; purchasing essential furnishings; and health and safety assurances, such as pest removal, allergen control or one time cleaning prior to occupancy. CTS are **not** intended to assist an individual in moving from one community residence to another and are limited to one time per waiver enrollment. The effective date for the use of CTS was May 1, 2011.

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■ Provider Manual Update

Provider manuals for all provider types are frequently updated. Please see your policy manual for updated sections pertaining to 5010/D.0 transactions. In addition, refer to the Information for All Providers, General Billing section for revised timely submission guidelines. Provider manuals are available online at: <http://www.emedny.org/providermanuals/index.html>.



POLICY & BILLING GUIDANCE

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Home and Community Support Services (HCSS) is similar to LTHHCP personal care services, with the addition of oversight and supervision for the individual who has cognitive deficits and a discrete need for supervision and safety monitoring. HCSS may include cueing services and assistance with activities of daily living (ADL) and/or instrumental activities of daily living (IADL). HCSS aides must meet the same qualifications and training requirements pertaining to personal care aides. The effective date for the use of HCSS was May 1, 2011.

Environmental Modifications (E-Mods), previously known as Housing Improvements, will now cover vehicle modifications. **Housing E-Mods** may include, but are not limited to, installation of wheelchair ramps, widening of doorways, modifications to permit independent use of a bathroom, stair glides or purchase of a backup generator for critical life sustaining medical equipment. **Vehicle E-Mods** can be made only if the vehicle is the primary means of transportation for the waiver participant. Modifications to assist with access in or out of a vehicle may include, but are not limited to, a portable ramp or swivel seat.

Environmental Modifications rate codes (9998, 9995 and 9992) are retained for use with the expanded E-Mods service and should be used to claim for both housing modification and vehicle modification. The rate code claiming structure was simplified allowing the LTHHCP agency to submit one claim for the total LDSS authorized cost for the home or vehicle modification. While the rate codes are unchanged, the effective date for the use of the new claiming structure was May 1, 2011.

Note: The new rate codes will be used by all three LTHHCP Category of Service (COS) code type agencies (**COS 0388 – Nursing Home Based; COS 0284 – Hospital Based; and COS 0260 – Freestanding**). These rate codes have been loaded to all LTHHCP agency rate files in eMedNY, and may be billed immediately.

For additional guidance please contact the Office of Long Term Care, Bureau of Medicaid Waivers, Long Term Home Health Care Program at: (518) 474-5271.

The approved HCBS waiver application for the LTHHCP is available online at:
http://www.health.ny.gov/facilities/long_term_care/docs/2010-09-01_home_and_community-based_services_waiver.pdf.



Mandatory Enrollment of Seriously and Persistently Mentally Ill (SPMI) Adults and Seriously Emotionally Disturbed (SED) Children

Effective October 1, 2011, and contingent on New York State receiving the necessary federal approvals, Seriously and Persistently Mentally Ill (SPMI) adults and Seriously Emotionally Disturbed (SED) children who are not designated as SSI or SSI-related and residing in mandatory managed care counties will be required to enroll in a managed care plan.¹ Some non-SSI SPMI adults and SED children may qualify for an alternate exemption and can choose to remain in the fee-for-service program. Information on alternate exemptions for SED children and SPMI adults is available from LDSS or NY Medicaid CHOICE at (800) 505-5678.

Once enrolled, all services covered by the member's managed care plan must be accessed through participating providers. Providers who are currently treating non-SSI/SSI-related SPMI adults and SED children under the fee-for-service program are encouraged to discuss with their patients how to choose a plan that best meets their medical needs. If the patient wishes to maintain a relationship with a particular provider, he/she must choose a Medicaid managed care plan in which that provider participates.

Providers are urged to check Medicaid eligibility and managed care enrollment status *at each visit*. Please refer to the February 2011 Medicaid Update Special Edition for information about the impact of the July 2011 5010/D.0 implementation on Medicaid Eligibility Verification System (MEVS) messages.

How will non-SSI/SSI Related SPMI adults and SED children enroll in managed care?

SPMI adults and SED children who reside in mandatory managed care counties **must** choose a plan **within 30 days** of receiving a mailing that includes information about the Medicaid managed care program. Those who do not choose a health plan within the 30-day period will automatically be assigned to a plan. New enrollees, whether they choose a plan or are auto-assigned, have 90-days to switch to another plan of their choice, after which they are "locked in" with that plan for the next nine months and may only switch plans for good cause.

Individuals who need assistance enrolling, or wish to request an alternate exemption from enrollment, should contact their LDSS or call NY Medicaid CHOICE at: **(800) 505-5678**.

How will enrollment change the way beneficiaries get their Medicaid benefits?

Managed care members are eligible to receive the same Medicaid benefits as beneficiaries in the Medicaid fee-for-service program. However, members will get most of their care from the health plan's network of hospitals, physicians and clinics.

¹ SPMI adults and SED children *with an SSI or SSI-related designation* are already required to enroll in Medicaid managed care plans.



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Non-SSI/SSI-related SPMI adults and SED children will receive most of their physical health and behavioral health care through the health plan. The Medicaid managed care benefit package for SPMI/SED enrollees is described below.

The following behavioral health services are covered by the plan for non-SSI/SSI-related members and billable to Medicaid fee-for-service for members with a SSI or SSI-related designation:

- ▶ Mental health inpatient (excluding inpatient provided at State Psychiatric Centers), mental health clinic** and psychiatrist/psychologist services;
- ▶ Chemical dependence inpatient rehabilitation services.

** Clinic services provided at specialty clinics designated by the Office of Mental Health (OMH) as specializing in the provision of services to children who have a designated mental illness diagnosis and an impairment in functioning due to serious emotional disturbance are not covered by the plan and are reimbursed on a fee-for-service basis. A list of specialty clinics in each county is available on the OMH Web site.

The following services are covered by the plan for all Medicaid managed care members:

- ▶ Detoxification services, whether provided on an outpatient or inpatient basis.

The following services are billable to Medicaid fee-for-service for all Medicaid managed care members:

- ▶ Chemical dependence outpatient services provided by clinics certified by the New York State Office of Alcohol and Substance Abuse Services (OASAS), including methadone maintenance treatment programs.
- ▶ All other mental health services certified by the New York State Office of Mental Health for individuals with serious mental illness (for a list of these services, see pages 277–279 of the Medicaid Managed Care/Family Health Plus Model contract at:
http://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_and_family_health_plus_model_contract.pdf
- ▶ Risperidone microspheres (Risperdal® Consta®), paliperidone palmitate (Invega® Sustenna®) and olanzapine (Zyprexa® Relprevv™) administered during a health or mental health clinic visit or medical or psychiatric office visit.

Where can a provider get additional information about the managed care benefit package?

For a complete description of the Medicaid managed care benefit, including services billable directly to Medicaid fee-for-service, see Appendix K of the Medicaid Managed Care/Family Health Plus Model contract online at: http://www.health.ny.gov/health_care/managed_care/providers/.

For questions regarding Medicaid managed care, providers may call the Office of Health Insurance Programs, Division of Managed Care at: (518) 473-0122.



Final Notification of the 1.1% FMAP Contingency Plan

Under the FMAP 1.1% contingency law enacted in 2010 and effective for payments made for the period September 16, 2010 through March 31, 2011, the state is required to perform a reconciliation if the March 31, 2011 general fund closing balance is in excess of the general fund closing balance projected by the Division of Budget in the 2010-11 enacted financial plan. Actual general fund closing balances were below those projected in the enacted financial plan and therefore a reconciliation will not be performed.

Please e-mail your questions to: b1191@health.state.ny.us. Please include your provider name and Medicaid number on the e-mail so that questions can be reviewed and responded to in an orderly manner.

Medicaid Presumptive Eligibility (PE) for Pregnant Women

Providers that screen pregnant women for Medicaid presumptive eligibility (PE), may screen pregnant women even if they do not permanently reside in the provider's county.

For pregnant women who are screened PE eligible, the Medicaid Presumptive Eligibility for Pregnant Women Screening Checklist (LDSS-4150), as well as the completed Access NY Health Care application (DOH-4220), should be mailed to the local department of social services (LDSS) where the pregnant woman permanently resides within five business days of the PE determination.

Providers that are located in Upstate counties may send the screening checklists and Medicaid applications for New York City (NYC) residents to:

**New York City Human Resources Administration
Medical Assistance Program
330 West 34th Street, 11th Floor, PE
New York, NY 10001**

New York City providers may send the screening checklists and Medicaid applications for Upstate residents to the appropriate Upstate LDSS. The district in which the pregnant woman permanently resides will then conduct a full Medicaid eligibility determination. A listing of LDSS contact information is available online at: http://www.health.ny.gov/health_care/medicaid/ldss.htm.



Guidelines for the Blood Lead Testing of Refugee Children and Refugee Pregnant Women

Introduction

New York State Public Health Law 1370-a and implementing regulations (10 NYCRR Subpart 67-1.2(a)(1) and (3)) establish the requirements for blood lead testing of all children at one year of age and again at two, and assessment of risk for lead exposure at each well child visit and at least annually for each child six months to six years of age. Additionally, NYS regulations (10 NYCRR Subpart 67-1.2(a) (4)) authorize the Commissioner of Health to provide recommended alternative schedules for other high-risk groups.

Newly arrived refugees may have compromised nutritional status and may use imported or homemade folk remedies, spices, foods and cosmetics that contain lead. They may also lack awareness about the dangers of lead. Additionally, upon arrival to the United States, refugee children and pregnant women may be more likely to be living in older homes where the presence of lead hazards is more common. The Centers for Disease Control (CDC) has recommended a vigilant approach to the prevention and treatment of lead poisoning for refugee children². A similar approach should be utilized with refugee pregnant women to protect them and the developing fetus as well.

Recommendations for Testing All Refugee Children and All Refugee Pregnant Women for Lead Poisoning

A refugee is defined as an individual who comes to the United States because he/she faces persecution or fear of persecution in his/her home country.

1. Perform blood lead testing for all refugee children birth to 16 years old and all refugee pregnant women upon entering the United States.
2. Repeat blood lead testing of all refugee children less than 16 years of age and all refugee pregnant women three to six months after they obtain permanent residence, regardless of initial blood lead test results.
3. Perform nutritional evaluations for all refugee children and pregnant women; offer appropriate nutrition education; and provide vitamin supplements as indicated. At a minimum, the nutritional evaluation for children should include a hemoglobin/hematocrit and one or more of the following:
 - o mean corpuscular volume (MCV) combined with red cell distribution (RDW);
 - o ferritin;
 - o transferrin saturation;
 - o reticulocyte hemoglobin content.

² CDC Recommendations for Lead Poisoning Prevention in Newly Arrived Refugee Children
<http://www.cdc.gov/nceh/lead/Publications/RefugeeToolKit/pdfs/CDCRecommendations.pdf>.



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4. In addition to the requirements for newly arrived refugees, continue to perform risk assessment for lead exposure for refugee children at each well-child visit or at least annually for each child six months to six years of age. If the child is determined to be at risk of lead exposure, a blood lead test is required to be performed. Please see:

http://www.health.ny.gov/environmental/lead/exposure/childhood/risk_assessment.htm

5. A refugee woman who becomes pregnant after arrival in the United States should receive lead testing as part of prenatal care. Foreign-born status and having lived or spent any extended time outside the United States are considered risk factors for lead exposure and should prompt testing a pregnant woman for lead.

Protecting Refugee Children and Pregnant Women from Lead Exposure

Ideally, all children and pregnant women would live in lead-safe housing, especially those whose nutritional status may be compromised. Resettlement agencies and their staff are essential in helping families identify housing free of chipped or peeling paint, promoting awareness of lead hazards and offering education about reducing lead exposure. Health care providers are required to provide anticipatory guidance on lead poisoning prevention during routine well child care and prenatal care visits.

The Department of Health (DOH) has educational materials in multiple languages available free of charge to assist with lead poisoning prevention educational efforts. Please visit the DOH Web site for a list of educational materials and an order form at:

http://www.health.ny.gov/forms/order_forms/lead.pdf.

Additional information regarding lead testing was published in a July 2009 Medicaid Update article and is available online at:

http://www.health.ny.gov/health_care/medicaid/program/update/2009/2009-07_spec_edition.htm.



Medicaid Redesign Team (MRT) Proposal #11 Bundle Pharmacy into Medicaid Managed Care

Effective October 1, 2011, pharmacy benefits for the Medicaid managed care and Family Health Plus (FHPlus) beneficiaries will be “bundled into” the managed care plan (MCP) benefit package and administered by the managed care plans. This is the first of several articles intended to provide information to providers specifically regarding MRT Proposal #11.

Transition

There are approximately 3.3 million Medicaid and Family Health Plus beneficiaries enrolled in MCPs that will be affected by the bundling of the pharmacy benefit into managed care. Recognizing that a transition of this magnitude will require extensive planning to ensure continued access to medication, plans will be required to develop and implement comprehensive implementation and communication plans. The Department of Health (DOH) will review and approve transition plans according to established requirements. The transition plan, requirements and implementation timeline are available online at: http://www.health.ny.gov/health_care/medicaid/redesign/supplemental_info_mrt_proposals.htm.

For the first 90 days after implementation, in the event that the dispensing pharmacist is unable to resolve a claim denial, the MCP must provide a one-time, temporary fill of non-formulary drugs for up to a 30-day supply of medication (unless the prescription is written for less than 30 days). This would include denied claims for drugs that are on a plan's formulary and/or require prior authorization or step therapy under a MCP's utilization management rules. This 90-day timeframe assists those beneficiaries who are attempting to obtain medications from their MCP for prescriptions that had been previously covered by the Medicaid pharmacy fee-for-service program.

Communication

Beneficiaries will be notified of this change by both Medicaid and the managed care plans. Additional information and more detailed guidance will be shared with providers prior to October 1, 2011. Specific requirements for communication and outreach, and a timeline of critical activities leading up to implementation are available online at: http://www.health.ny.gov/health_care/medicaid/redesign/supplemental_info_mrt_proposals.htm.

Identification Cards and Claims Processing

Beneficiaries will be issued new identification cards by their plans and will be instructed to present their new card at the pharmacy. Network pharmacies should submit claims directly to the beneficiary's MCP, or their corresponding pharmacy benefit manager (PBM).

It is anticipated that not all beneficiaries will remember to bring their new identification cards to the pharmacy. Therefore, in a future article, we will be including detailed processing information by plan that will assist pharmacies in submitting claims. This guidance will include, but will not be limited to, the following information for each plan: Pharmacy Benefit Manager (PBM), Processor Control Number (PCN), and Batch Identification Number (BIN).

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PHARMACY UPDATES

Pharmacy Network Management

The MCPs will be responsible for enrolling, credentialing and managing their own pharmacy benefit and provider networks. Their beneficiaries will be required to fill prescriptions at pharmacies enrolled with their MCP. Medicaid enrolled pharmacies that are not currently enrolled with a MCP but would like to participate should contact those plans directly. A directory of MCPs is available online at: http://www.health.ny.gov/health_care/managed_care/pdf/cnty_dir.pdf

Plans will also be responsible for managing and auditing their pharmacy networks. If there is a suspicion of fraud or abuse, the Office of Medicaid Inspector General (OMIG) will work with the health plan to review and evaluate the situation. Managed Care Plans, Managed Care providers and Managed Care Pharmacy networks are reminded that Chapter 442 of the Laws of New York State authorize the OMIG to perform reviews and/or audits of contracts, cost reports, claims, bills and all other expenditures of medical assistance program funds to determine compliance with applicable federal and state law and regulations.

The card swipe requirement will not apply to managed care beneficiaries. The managed care plans will set policy and/or guidance regarding identity verification and/or signature requirements.

More detail regarding OMIG's role with managed care plans will be provided in future articles.

Utilization Management

MCPs will also establish their own drug utilization review programs, prior authorization processes and formularies (which must include all categories of drugs included on the [Medicaid Pharmacy List of Reimbursable Drugs](#)). New York State will oversee the MCPs with regard to access, plan formularies, and exception processes. Plans will also be required to maintain an internal and external review process for exceptions.

Coverage

The Medicaid MCP pharmacy benefit includes:

- ▶ Prescription drugs (except clotting factor)
- ▶ Over-the-counter (OTC) drugs
- ▶ Insulin and diabetic supplies
- ▶ Hearing aid batteries
- ▶ Enteral formulae
- ▶ Medical supplies

The FHPlus MCP pharmacy benefit includes:

- ▶ Prescription drugs (except clotting factor)
- ▶ Select OTC products
- ▶ Smoking cessation agents, including OTCs
- ▶ Insulin and diabetic supplies
- ▶ Hearing aid batteries
- ▶ Enteral formulae

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PHARMACY UPDATES

Two coverage categories (listed below) will remain covered under the Medicaid fee-for-service program. Pharmacies may bill Medicaid using the alpha numeric Client Identification Number (CIN) as provided on the MCP card.

- ❖ Clotting factor products (Recombinate, Novoseven, etc.)
- ❖ Family planning benefits for beneficiaries enrolled in Fidelis Care New York.

Frequently Asked Questions

Frequently Asked Questions for MRT Proposal #11 can be accessed at:

http://www.health.ny.gov/health_care/medicaid/redesign/docs/additonal_information_on_mrt11_mrt15.pdf

Additional Information

Additional information on Medicaid Managed Care can be found at the following Web sites:

Managed Care Manual: <https://www.emedny.org/ProviderManuals/ManagedCare/index.aspx>

Medicaid and Managed Care: http://www.health.ny.gov/health_care/managed_care/mamctext.htm

Managed Care by County: http://www.health.ny.gov/health_care/managed_care/mmc_counties/

Local Departments of Social Services: http://www.health.ny.gov/health_care/medicaid/ldss.htm

Beneficiary Rights: http://www.health.ny.gov/health_care/medicaid/#rights



Attention: Fee-For-Service Providers

Changes to Pharmacy Prior Authorization Requirements

Effective August 25, 2011, once a prior authorization (PA) requirement is implemented for a drug, all new prescriptions and any refills remaining on existing prescriptions will require prior authorization.

PA requirements will no longer be dependent on the date a prescription is written. New prescriptions and refills on existing prescriptions will require PA even if the prescription was written before the date the drug was determined to require a PA.

Pharmacy prior authorizations can be obtained through the Clinical Call Center at (877) 309-9493. The call center is available 24 hours a day, 7 days per week.

Additional information is available online at: <https://newyork.fhsc.com/>.

Early Fill Edit Reminder

Vacation Medication Supply

- ▶ The "03" (Vacation Supply) Submission Clarification Code-Field 420- DK, is **not** acceptable as an override for the Early Fill edit. Beneficiaries should be instructed to make alternative arrangements when a temporary absence prevents them from picking up their prescriptions.
- ▶ In cases of extenuating circumstances, the beneficiary should contact (518) 486-3209 at least seven days prior to departure. Approval **will not** be granted for controlled substances.

Lost/Stolen Medication

- ▶ The "04"(Lost/Stolen) Submission Clarification Code-Field 420-DK, is **not** acceptable as an override for the Early Fill edit. Pharmacy providers should instruct beneficiaries to contact their prescriber when medications have been lost or stolen. ***In no event will approval be granted for lost or stolen controlled substances.***
- ▶ Prescribers or their authorized agents may initiate a request for replacement of lost or stolen medication by contacting the Bureau of Pharmacy Policy and Operations at (518) 486-3209.

Long-Term Care Pharmacy Providers

- ▶ **A newly admitted resident to a long-term care facility is eligible for an early fill on their medication.** When medically necessary, a pharmacist can override edit 01642 "Early Fill Overuse" denial at the point of sale, by using a combination of the NCPDP Reason for Service Code (439-E4) 'NP', and a Submission Clarification Code (420-DK) of '02'.



e-Prescribing Incentive Reminder

The New York Medicaid e-prescribing incentive program applies only to non-facsimile electronic transmissions when compliant with Medicare Part D data standards.

e-Prescribing Incentive checks are being returned by prescribers who claim they do not e-prescribe.

PLEASE NOTE:

Electronic Prescription Definition:

New York State Pharmacy Regulations <http://www.op.nysed.gov/prof/pharm/part63.htm> recognize two distinct types of electronically-transmitted prescriptions:

- ✓ *a prescription transmitted electronically by facsimile;*
- ✓ *a prescription transmitted electronically by means other than facsimile; such non-facsimile prescriptions are required by regulation to be electronically encrypted, meaning protected to prevent access, alteration or use by any unauthorized person.*

The New York State Medicaid program accepts both types of electronically-transmitted prescriptions for standard claim reimbursement. However, pharmacies must verify a prescription is compliant with Medicare Part D data standards and requirements and NYS Pharmacy Regulations before submitting for the e-prescribing incentive.

Claims for prescriptions transmitted electronically by means other than facsimile and not Medicare Part D compliant are recognized by New York Medicaid for claim reimbursement purposes, but do not qualify for the e-prescribing incentive reimbursement.

The e-prescription must originate from the prescriber's computer system (an electronic health record, electronic medical record, or stand-alone e-prescribing software) and must be transmitted to the retail pharmacy's computer system.

Additional information is available online at:

http://www.health.ny.gov/health_care/medicaid/program/update/2009/2009-11spec.htm.

Medicaid Preferred Drug Program Update



The New York State Medicaid Pharmacy and Therapeutics (P&T) Committee recently recommended changes to the Medicaid pharmacy preferred drug program. The Commissioner of Health has reviewed these recommendations and has approved these changes effective August 25, 2011.

Prior authorization requirements will change for some drugs in the following seven PDP drug classes:

- ▶ *Corticosteroids – Intranasal*
- ▶ *Dipeptidyl Peptidase-4 (DPP-4) Inhibitors*
- ▶ *Glucagon-like Peptide-1 (GLP-1) Agonists*
- ▶ *Growth Hormones*
- ▶ *Pancreatic Enzymes*
- ▶ *Selective Serotonin Reuptake Inhibitors (SSRIs)*
- ▶ *Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)*

Changes have also been made to the preferred and non-preferred status of drugs within the **Atypical Antipsychotics*** drug class. ***Please note that non-preferred drugs in this drug class will NOT require prior authorization until December 2011. At that time, systems will be in place to allow patients stabilized on these products to continue therapy without obtaining prior authorization.**

The PDP is also expanding to include six additional drug classes. Prescriptions for non-preferred drugs in the following drug classes will require prior authorization:

- ▶ *Anti-Fungals – Topical*
- ▶ *Short Acting Opioids*
- ▶ *Topical Steroids – Low Potency*
- ▶ *Topical Steroids – Medium Potency*
- ▶ *Topical Steroids – High Potency*
- ▶ *Topical Steroids – Topical Steroids – Very High Potency*

To obtain prior authorization for a non-preferred drug in these drug classes, please contact the Clinical Call Center at **(877) 309-9493** and follow the appropriate prompts.

An up-to-date Preferred Drug List (PDL) with a full listing of preferred and non-preferred drugs for each of the drug classes can be found at: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf.

Please note that changes to the Preferred Drug List (PDL) are now communicated electronically through the Medicaid Update and the Web site mentioned above. If you wish to receive direct e-mail notification of changes, please send your request to: NYPDPNotices@magellanhealth.com.

Unless otherwise indicated on the PDL or Quick List, prescribing preferred drugs requires no further action on your part. For clinical concerns or preferred drug program questions, contact (877) 309-9493. For billing questions, contact (800) 343-9000.

Request for Medicaid Provider Documentation

The Centers for Medicare & Medicaid Services (CMS), in partnership with the New York State Office of the Medicaid Inspector General (OMIG), is measuring improper payments in the Medicaid and State Child Health Insurance programs under the Payment Error Rate Measurement (PERM) program.

CMS, their contractor, and the OMIG have the authority to collect this information under Sections 1902(a)(27) and 2107(b)(1) of the Social Security Act. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) statutes and regulations require the provision of such information upon request, and the information can be provided without patient consent.

Documentation for medical review of randomly selected claims will be requested by **A+ Government Solutions, Inc.**, the CMS contractor. If a providers' claim is selected, the CMS contractor will request documentation to substantiate claims paid in federal fiscal year 2011 (October 1, 2010 - September 30, 2011 from the provider.) Please submit the specific medical documents for the patient, as requested in the letter you receive from the CMS contractor, directly to the CMS contractor with a copy to the OMIG.

Requests for documentation began in **July 2011**.

Requests and subsequent receipt/non-receipt of documentation will be tracked. Failure to provide requested records will result in a determination of erroneous payment, and the OMIG will pursue recovery.

Questions? Please contact **PERM Project staff** at (518) 402-0066 or (518) 408-486-7153.

Mandatory Compliance Program Certification Requirement

Social Services Law (SSL) § 363-d, and Part 521 of Title 18 of the New York State Codes, Rules and Regulations (NYCRR), both entitled Provider Compliance Programs, has been actively enforced by the Office of the Medicaid Inspector General (OMIG) since 2009. This regulation requires all Medicaid providers who fall under the following categories to **certify in December of each year** that they have adopted and implemented an effective compliance program.

- ▶ *persons subject to the provisions of Articles 28 or 36 of the New York State Public Health Law;*
- ▶ *persons subject to the provisions of Articles 16 or 31 of the New York State Mental Hygiene Law;*
- ▶ *other persons, providers or affiliates who provide care, services or supplies under the Medicaid program, or persons who submit claims for care, services or supplies for or on behalf of another person or provider for which the Medicaid program is or should be reasonably expected by a provider to be a substantial portion of their business operations.*

Under 18 NYCRR § 521.2 (b), "substantial portion" of business operations means any of the following:

- ▶ *when a person, provider or affiliate claims or orders, or has claimed or has ordered, or should be reasonably expected to claim or order at least \$500,000 in any consecutive 12-month period from the medical assistance program;*
- ▶ *when a person, provider or affiliate receives or has received, or should be reasonably expected to receive at least \$500,000 in any consecutive 12-month period directly or indirectly from the medical assistance program; or*
- ▶ *when a person, provider or affiliate who submits or has submitted claims for care, services, or supplies to the medical assistance program on behalf of another person or persons in the aggregate of at least \$500,000 in any consecutive 12-month period.*

Each compliance program must contain the eight elements required under SSL § 363-d and 18 NYCRR § 521.3 (c). **Upon applying for enrollment in the medical assistance program, and during the month of December each year thereafter**, 18 NYCRR 521.3 (b) requires providers to certify to the Department and OMIG that a compliance program meeting the requirements of the regulation is in place.

The regulation, certification form, and FAQ's are available on the OMIG Web site at: <http://www.omig.ny.gov>.

Additionally, New York State's Medicaid providers are advised to review OMIG's Web site and review the Compliance Alerts that are published under the Compliance tab on OMIG's home page.

The following Compliance Alerts may be helpful to Medicaid providers as they consider their obligations under this requirement:

- ▶ *Compliance Alert 2010-02: Effectiveness of Medicaid Provider's Compliance Program;*
- ▶ *Compliance Alert 2011-01: Annual Certification 2010 and*
- ▶ *Compliance Alert 2011-05: Compliance Program Requirement for New Medicaid Providers.*

ALL PROVIDERS

Lastly, OMIG will be updating New York's Medicaid Provider Certification of Effective Compliance Program during 2011 for use during December 2011. When the new form becomes available, it will be announced in the Medicaid Update and on the OMIG's Web site. One of the new features of the 2011 certification form will be questions on whether a Medicaid provider uses the services of a Service Bureau for billing, coding and eligibility determinations. The Bureau of Compliance intends to issue a Compliance Alert during 2011 on Service Bureaus as a supplement to OMIG's Webinar #6, which is available under the Resources tab on OMIG's home page.

New York's Medicaid providers are recommended to sign up for e-mail notices from OMIG by subscribing to OMIG's listserv. Anyone can become a subscriber at no cost by signing up on OMIG's home page. The listserv is a great way to keep informed of new compliance tools and information on compliance.

Questions? Please contact the OMIG's Bureau of Compliance at (518) 473-3782 or via e-mail at: compliance@omig.ny.gov.

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 (1-877-873-7283),
or visit www.omig.ny.gov.

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

Please visit the eMedNY Web site at: www.emedny.org.

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 email: emednyproviderrelations@csc.com.

Enrollee Eligibility:

Call the Touchtone Telephone Verification System at any of the following numbers:
(800) 997-1111, (800) 225-3040, (800) 394-1234.

Address Change?

Address changes should be directed to the eMedNY Call Center at:
(800) 343-9000.

Fee-for-Service Providers: A change of address form is available at:

<http://www.emedny.org/info/ProviderEnrollment/allforms.html>.

Rate-Based/Institutional Providers: A change of address form is available at:

<http://www.emedny.org/info/ProviderEnrollment/allforms.html>.

Does your enrollment file need to be updated because you've experienced a change in ownership?

Fee-for-Service Providers please call (518) 402-7032.
Rate-Based/Institutional Providers please call (518) 474-3575.

Comments and/or Suggestions Regarding This Publication?

Please contact Kelli Kudlack at: medicaidupdate@health.state.ny.us.

Do you suspect that a Medicaid provider or beneficiary
has engaged in fraudulent activities?

PLEASE CALL: 1-877-87FRAUD

Your call will remain confidential. You may also complete
a complaint form online at: www.omig.ny.gov.

