



New York State Medicaid Update

THE OFFICIAL NEWSLETTER OF THE NEW YORK STATE MEDICAID PROGRAM

Expedited Enrollment for Ordering, Prescribing, Referring & Attending Practitioners

As explained in the April 2011 and June 2012 Medicaid Update, Section 6401(a) of the Affordable Care Act (ACA) established new requirements surrounding provider enrollment. 42 CFR, Section 455.410(b) **requires providers to be enrolled in state Medicaid programs if they continue to order or refer services reimbursed by the fee-for-service (FFS) Medicaid program.** To assist providers with compliance, a new streamlined enrollment process will be offered for **non-billing** providers.



Q: Who should complete the ordering/prescribing/referring/attending enrollment (OPRA) form?

A: Individuals credentialed in the **professions listed below** and who provide OPRA services for beneficiaries with FFS Medicaid coverage but do not bill the FFS Medicaid program directly. This includes OPRA services paid by the fee-for-service Medicaid program which are carved-out of the Medicaid managed care plan benefit and OPRA services provided by out-of-state practitioners.

Q: Who should not complete the OPRA form?

A: Individuals not credentialed in the professions listed below and individuals who are already actively enrolled in FFS Medicaid.

Q: Where can I obtain the OPRA form? What should I be careful of when completing the form?

A: The OPRA form will be available in **early April 2013** at: <https://www.emedny.org/info/ProviderEnrollment/index.aspx> within the Provider Enrollment pages. Be sure to complete all required fields, answer all questions, and provide all required documentation. Incomplete forms will be returned.

PROFESSIONS:

Audiologist	Clinical Psychologist	Nurse-LPN	Optometrist	Podiatrist
Certified Asthma Educator	Clinical Social Worker	Nurse-RN	Physician	Occupational Therapist
Certified Diabetes Educator	Dentist	Nurse Practitioner	Physician Assistant (Reg.)	Speech Pathologist
Chiropractor	Midwife/Nurse Midwife	Optician	Physical Therapist	

Questions on Provider Enrollment should be addressed to the eMedNY Call Center at (800) 343-9000.



MARCH 2013 NEW YORK STATE MEDICAID UPDATE

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Coverage of Residential Health Care Facility Services for Medicaid Managed Care Enrollees

This article provides information to assist Residential Health Care Facilities (RHCF) in avoiding non-reimbursable patient stays for non-dually eligible Medicaid managed care enrollees. Prior to accepting an enrollee for admission, the RHCF should check the eligibility status of the enrollee through eMedNY or ePACES and, if indicated, request authorization for non-permanent placement from the Medicaid managed care plan. Medicaid managed care organizations (MCOs) are responsible for all medically necessary non-permanent stays in a RHCF for their enrollees, **regardless of length of stay**. MCOs are **not** responsible for any days that an enrollee remains in an RHCF without MCO authorization for the stay OR any days after a determination has been made by the LDSS that the stay is classified as permanent and the enrollee will not be returning to the community. If the enrollee's medical condition warrants a permanent stay, the RHCF must notify the LDSS promptly of an enrollee's need for permanent placement status by DOH form LDSS-3559, "RHCF Report of Medicaid Recipient Admission/Discharge/Readmission/Change in Status". If an RHCF stay is approved by the county as a permanent stay, the enrollee is disenrolled, effective the first of the month in which the stay is determined to be permanent, and the stay will be billable to Medicaid fee-for-service.

Non-permanent Stays

MCOs are required to appropriately determine the level of care an enrollee needs and provide medically necessary services. When a Medicaid managed care enrollee is being assessed for non-permanent placement in an RHCF from a hospital or other medical facility, the MCO must be involved in the discharge plans in advance of placement. The MCO will assess the recommendations made for the enrollee and identify an appropriate placement within the plan's contracted network, or assist in locating placement outside of the plan's network, as needed. Once an RHCF is identified, the facility should contact the managed care plan and seek authorization for the stay, providing complete information that documents the need for the non-permanent stay. MCOs are required to respond to prior authorization requests within certain prescribed timeframes, and in all cases, as fast as the enrollee's condition requires.

MCOs provide a full range of medically necessary inpatient RHCF services to Medicaid managed care enrollees who are non-permanent residents of the facility. Covered services at the RHCF include: medical supervision, 24-hour per day nursing care, assistance with the activities of daily living, physical therapy, occupational therapy, speech/language pathology services and other services as specified in the New York State Public Health Law for RHCFs and AIDS nursing facilities. The MCO will authorize these services when the enrollee:

- is diagnosed by a physician as having one or more clinically determined illnesses or conditions that cause the enrollee to be so incapacitated, sick, invalid, infirm, disabled, or convalescent as to require at least medical and nursing care; and
- has assessed health care needs, in the professional judgment of the enrollee's physician or medical team that:
 - *do not require care or active treatment of the patient in a general or special hospital;*
 - *cannot be met satisfactorily in the person's own home or home substitute through provision of such home health services, including medical and other health and health-related services, as are available in or near his/her community; and*
 - *cannot be met satisfactorily in the physician's office, a hospital clinic, or other ambulatory care setting because of the unavailability of medical or other health and health-related services for the person in such setting in or near his/her community.*

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There is no benefit limit on the number of medically necessary covered inpatient RHCf days. However, the MCO may require updates from the RHCf on the enrollee's status or progress toward discharge. During these reviews, the MCO may determine at some point that the enrollee no longer meets the MCO's criteria for a non-permanent RHCf stay because, for example, the enrollee can receive an appropriate level of care at home or some other location, the enrollee is not receiving or participating in the requested skilled service, or it is not medically necessary to continue skilled services as the enrollee's condition is not expected to improve or the enrollee has met the goals needed to be discharged back into the community.

Denial of Stay

MCOs are required to notify the RHCf and the enrollee, by phone and in writing, of any decision to discontinue coverage of the RHCf stay and must work with the RHCf to identify the appropriate next level of care. The MCO notice of action must include the specific reason the requested service is being denied in sufficient detail to enable judgment as to the basis for an appeal. Where the enrollee's status is non-permanent, **if the RHCf or enrollee disagrees with the MCO's decision, the RHCf should not seek to disenroll the individual from Medicaid managed care on the basis that the individual's status has changed to a permanent stay, nor should the RHCf seek payment from FFS Medicaid, as the MCO is responsible for the non-permanent stay as long as it is medically necessary.** RHCfs should request retroactive disenrollment of an individual only when such action is appropriate to a change in the enrollee's status, and the enrollee is no longer expected to return home to a community setting.

RHCfs, on the enrollee's behalf, may appeal the MCO's decision to deny a non-permanent stay by following the appeals information provided in the MCO's denial letter. The enrollee or the enrollee's representative may also request a fair hearing. RHCfs have appeal rights on their own behalf as described in the MCO's provider manual. For denials related to lack of medical necessity, the RHCf and the enrollee may be eligible to request an independent external appeal. More information about external appeals is available at: www.dfs.ny.gov/insurance/extapp/extappqa.htm. In addition, anyone wishing to file a complaint regarding a managed care organization may contact the New York State Department of Health toll-free at (800) 206-8125 or by e-mail to managedcarecomplaint@health.state.ny.us.

Alternate Level of Care

MCOs are responsible for Alternate Level of Care (ALC) stays; these may occur when an enrollee cannot safely return to the community without an alternate level of medical care. The RHCf should work with the MCO to arrange for appropriate home-based services needed for safe discharge. It may be possible to arrange for safe discharge with MCO covered services even when the enrollee is applying for a waiver program for additional assistance. There may be circumstances where the alternate level of medical care (e.g., Assisted Living Program or home health care) is not immediately available. If this is the case, the RHCf should contact the MCO and request authorization for an ALC stay.

It is vitally important that the nursing home and MCO together establish an enrollee plan of care with clear expectations towards the ultimate goal of the individual's return to his or her home. RHCf discharge planning staff should work closely with MCO staff, starting early in the stay, to ensure that appropriate accommodations are made for a safe discharge as soon as the enrollee is medically ready. Early and active discharge planning will minimize instances of extended RHCf stays that are not medically necessary and, therefore, not reimbursable.

Family Health Plus (FHPlus)

Services provided in an RHCf to an individual who is determined by the LDSS to be in permanent status are not covered for Family Health Plus enrollees. **Family Health Plus covers only non-permanent rehabilitation stays in RHCfs.**

Questions? Contact the Medicaid Call Center at (800) 541-2831 or send an e-mail to OMCMail@health.state.ny.us.

Fee-for-Service Medicaid: Breastfeeding Support Payment for Specially Trained Lactation Counselors

Effective April 1, 2013, New York State fee-for-service (FFS) Medicaid will provide reimbursement for evidence-based breastfeeding education and lactation counseling, consistent with the United States Preventive Services Task Force (USPSTF) recommendation.

Effective May 1, 2013, Medicaid managed care and Family Health Plus (FHPlus) plans will also cover lactation counseling services.

Background

The USPSTF recommends coordinated interventions during pregnancy and after birth to promote and support breastfeeding. Additionally, the American Congress of Obstetricians and Gynecologists (ACOG) guidelines promote exclusive breastfeeding for the first six months of life. In accordance with ACOG recommendations, practitioners are strongly encouraged to provide counseling and education regarding infant feeding choices with women during prenatal visits and immediately postpartum.

The implementation of Medicaid coverage for lactation counseling services is expected to result in an increase in breastfeeding initiation, exclusivity and duration consistent with the recommendations of expert groups and the USPSTF.

Medicaid Coverage Policy

All health care professionals who care for pregnant women and/or their newborns should continue to support a woman's effort to breastfeed by providing the necessary guidance and education to the breastfeeding mother.

In an effort to encourage and promote breastfeeding, New York State Medicaid will provide reimbursement for separate and distinct breastfeeding services provided by **International Board Certified Lactation Consultants (IBCLCs)** credentialed by the International Board of Lactation Consultant Examiners (IBLCE).

Effective April 1, 2013, a separate Medicaid payment will be available for separate and distinct breastfeeding services provided by professionals who are certified as **IBCLCs** credentialed by the **IBLCE**:

- *Physicians*
- *Nurse Practitioners (NPs)*
- *Midwives (MWs)*
- *Physician Assistants (PAs)*
- *Registered Nurses (RNs)*

Lactation consultants in this program are expected to practice within the scope of practice that is appropriate to their respective discipline, as defined by the Office of the Professions, New York State Education Department.

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POLICY & BILLING GUIDANCE

Billing Medicaid Fee-for-Service

- o Lactation counseling services may be billed directly to Medicaid by physicians, nurse practitioners, or midwives who are IBCLCs (S9445 and S9446). A physician who employs an IBCLC physician assistant or registered nurse may bill Medicaid for lactation counseling provided by these health care professionals (S9445 and S9446).
- o Modifier “AF” (specialty physician), along with the appropriate “S” code from Table 1, must be reported on a claim when the physician is the provider of service.
- o Hospital outpatient departments, free-standing clinics, or Federally Qualified Health Centers (FQHCs) who have “opted into” APGs, who employ Medicaid qualified IBCLC lactation consultants can also bill for lactation counseling services. FQHCs that have “not opted into” APGs may bill their prospective payment systems (PPS) rate for **individual** lactation counseling.

Table 1: Lactation Counseling Procedure Codes

Code	Code Description	Benefit Limitations
S9445	PATIENT EDUCATION, NOT OTHERWISE CLASSIFIED, NON-PHYSICIAN PROVIDER, INDIVIDUAL, PER SESSION	The initial lactation counseling session should be a minimum of 45 minutes. Follow up session(s) should be a minimum of 30 minutes. Three sessions within 12-month period immediately following delivery.
S9446	PATIENT EDUCATION, NOT OTHERWISE CLASSIFIED, NON-PHYSICIAN PROVIDER, GROUP, PER SESSION	Up to a maximum of eight participants in a group session. 60 minute minimum session length. One prenatal and one postpartum class per recipient per pregnancy.

- o When lactation counseling services are provided by a **physician IBCLC in a hospital outpatient department** the physician can submit a separate professional claim (S9445 AF, S9446 AF) for his/her services and receive Medicaid reimbursement. The professional component for lactation counseling services provided by all other IBCLC practitioners (NPs, MWs, PAs, or RNs) is included in the APR-DRG or APG payment to the facility.
- o When lactation counseling services are provided in a diagnostic and treatment center (D&TC), the professional component for all IBCLC practitioner types, including physicians, is included in the APG payment to the facility.
- o Appropriate diagnosis codes must be utilized when billing for lactation counseling services.

In conjunction with the implementation of this program, Medicaid has established minimum specifications and updated reimbursement for breast pumps. For detailed information regarding these changes providers may visit: <https://www.emedny.org/ProviderManuals/DME/communications.aspx>.

For claiming questions, please contact the eMedNY Call Center at (800) 343-9000. For Medicaid policy questions, please contact the Office of Health Insurance Programs (OHIP) at (518) 473-2160. For questions about Managed Care or Family Health Plus enrollees, please contact the enrollee's health plan.

UAS-NY Implementation Update

Beginning **May 1, 2013**, all home and community-based long term care Medicaid programs in the following counties will begin activities to **transition** to the Uniform Assessment System for New York (UAS-NY).

- o *Allegany*
- o *Cattaraugus*
- o *Chemung*
- o *Erie*
- o *Genesee*
- o *Livingston*
- o *Monroe*
- o *Niagara*
- o *Ontario*
- o *Orleans*
- o *Schuyler*
- o *Seneca*
- o *Steuben*
- o *Wayne*
- o *Wyoming*
- o *Yates*

All organizations that manage, conduct assessments, or provide services for any of the following programs will be required to use UAS-NY.

- o *Adult Day Health Care*
- o *Assisted Living Program*
- o *Care at Home I/II Waiver*
- o *Consumer Directed Personal Assistance Program*
- o *Long Term Home Health Care Program*
- o *Nursing Home Transition and Diversion Waiver*
- o *Personal Care Services Program*
- o *Traumatic Brain Injury Waiver*

Once the transition activities are completed, organizations in these counties will use the UAS-NY to conduct assessments for these programs. Organizations in these counties will achieve full implementation of the UAS-NY no later than **October 1, 2013**. Organizations that are responsible for the client assessment must ensure that any contractors are identified and notified of this change.

UAS-NY Implementation Overview Webinar

The UAS-NY Project Team will conduct an overview of the UAS-NY, the transition activities, and timeline for organizations in these counties on **April 16, 2013**. The one-hour webinar will begin at 2:00 pm. All organizations in these counties are strongly encouraged to participate as important information about the transition activities will be presented.

To register for the event please click the following link:

<https://uasny.webex.com/uasny/onstage/g.php?t=a&d=669140063>

Upon completion of your registration, you will receive an e-mail with details to access the webinar. This e-mail will include the link and password for the webinar.

Prior to the webinar, staff are encouraged to visit the Department's website for additional information concerning UAS-NY. The website includes all previously recorded webinars and includes a summary of assessment instruments that will be replaced. Of particular importance is the January 29, 2013, UAS-NY Project Update Webinar. All materials are available at:

http://www.health.ny.gov/health_care/medicaid/redesign/supplemental_info_mrt_proposals.htm.

Questions concerning the UAS-NY transition and implementation may be e-mailed to:

uasny@health.state.ny.us.

Clarification for the Office of Mental Health (OMH) Article 31 Certified Clinics Providing Coverage of Language other than English Translation Services

The October 2012 issue of the Medicaid Update apprised providers of coverage of medical language interpretation services. This publication stated that effective October 1, 2012, Medicaid fee-for-service reimbursement is available for Article 28, 31, 32 and 16 outpatient departments, hospital emergency rooms (HERs), diagnostic and treatment centers (D&TCs), federally qualified health centers (FQHCs) and office-based practitioners to provide medical language interpreter services for Medicaid members with Limited English proficiency (LEP) and communication services for people who are deaf and hard of hearing. Providers are to bill for this service with HCPCS code T1013.

In addition, effective December 1, 2012, medical language interpreter services are reimbursed by Medicaid Managed Care and Family Health Plus plans in accordance with rates established in provider agreements or, for out-of-state network providers, at negotiated rates.

While this update is accurate for Article 28, 32 and 16 outpatient departments, it is inaccurate for Article 31 mental health clinics. The T1013 HCPCS code is not a valid code for Article 31 OMH-licensed mental health clinics. Effective October 1, 2010, Article 31 Office of Mental Health (OMH) certified clinic providers, other than FQHCs NOT using APGs, have been able to bill for 'language other than English translation services' using the U4 modifier. **(Neither the U4 modifier nor the procedure code T1013 can be billed for other OMH licensed outpatient programs, e.g., PROS, IPRT, ACT, whether the provider is free-standing or co-licensed by Article 28, 32 or 16.)** This modifier pays an additional 10% of the APG portion of payment. Billing guidelines regarding the U4 modifier can be found on the OMH website using the following web links:

http://www.omh.ny.gov/omhweb/medicaid_reimbursement/clinics/apg/modifiers.html (second item)

http://www.omh.ny.gov/omhweb/clinic_restructuring/part599/guidance.pdf (page 24)

http://www.omh.ny.gov/omhweb/clinic_restructuring/training_materials/clinic_reimbursement_updates.pdf
(slide 9)

http://www.omh.ny.gov/omhweb/clinic_restructuring/2012-12-13cpt.pdf (slide 8)

http://www.omh.ny.gov/omhweb/clinic_restructuring/clinic_faq.pdf (questions 11, 20, & 23)

Medicaid policy permits and advises Article 31 (OMH) certified clinics to continue to bill for 'language other than English translation services' using the U4 modifier and the HCPCS procedure code T1013 should not be billed by Article 31 clinics.

Questions concerning claims for Medicaid managed care and Family Health Plus (FHPlus) enrollees should be directed to the enrollee's managed care plan.

Questions? Please contact Gwen Diamond, OMH Financial Planning at (518) 474-6911 or OHIP Division of Program Development and Management at (518) 473-2160.

Medicaid Breast Cancer Surgery Centers

It is the policy of the New York State Department of Health that Medicaid recipients receive mastectomy and lumpectomy procedures associated with a breast cancer diagnosis at high-volume facilities averaging 30 surgeries or more all-payer procedures annually over a three-year period. Low-volume facilities will not be reimbursed for breast cancer surgeries provided to Medicaid recipients. This policy is part of an ongoing effort to reform New York State Medicaid and to ensure the purchase of cost-effective, high-quality health care and better outcomes for its recipients. Research shows that five-year survival increases for women having their breast cancer surgery performed at high-volume facilities and by high-volume surgeons.

The Department has completed its annual review of all-payer breast cancer surgical volumes for 2009 through 2011 and identified 73 low-volume hospitals and ambulatory surgery centers throughout New York State. These facilities have been notified of the restriction effective April 1, 2013. The policy does not affect a facility's ability to provide diagnostic or excisional biopsies and post-surgical care (chemotherapy, radiation, reconstruction, etc.) for Medicaid patients. Other facilities in the same region as the restricted facilities have met or exceeded the volume threshold and Medicaid patients who require breast cancer surgery should be directed to those providers.

The Department will annually re-examine all-payer surgical volumes to revise the list of low-volume hospitals and ambulatory surgery centers. This assessment is performed using the Statewide Planning and Research Cooperative System (SPARCS) database. The annual review will also allow previously restricted providers meeting the minimum three year average all-payer volume threshold to provide breast cancer surgery services for Medicaid recipients.

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

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

New York Medicaid Electronic Health Records Incentive Program Update

The New York State Department of Health (NYSDOH) is pleased to announce that as of March 1, 2013, the New York Medicaid Electronic Health Records (EHR) Incentive Program has now paid over \$321 million in federal incentive funds to over 5150 New York State hospitals and healthcare practitioners.

The New York Medicaid EHR Incentive Program is now accepting attestations from eligible professionals (EPs) and eligible hospitals (EHs) for both adoption/implementation/upgrade (in providers' first year of participation) and meaningful use (for providers' second participation year). EPs have until March 31, 2013, to attest in MEIPASS for Payment Year 2012 as their first or second participation year.

Important Program Dates

1/01/2013	3/31/2013	9/30/2013
EP PY2013 opens	EP PY2012 attestation deadline	EH PY2013 closes / 90 day grace period starts

If you have not yet registered for the NY Medicaid EHR Incentive Program, we encourage you to visit the **new** and **improved** website (<https://www.emedny.org/meipass/>) or attend one of the informational webinars hosted by the NYS Department of Health throughout the month of April.

Wednesday, April 3	12:00–1:00PM	Program Prerequisites
Thursday, April 4	12:00–1:00PM	EP Participation Year 1 (A/I/U)
Thursday, April 11	10:00–11:00AM	EP Participation Year 2-3 (MU1)
Tuesday, April 16	12:00–1:00PM	EP Participation Year 1 (A/I/U)
Wednesday, April 17	3:00–4:00PM	Program Prerequisites
Tuesday, April 23	3:00–4:00PM	EP Participation Year 2-3 (MU1)
Thursday, April 25	10:00–11:00AM	EP Support Documentation

The webinar schedule is subject to change based on interest levels. To see the complete schedule or to register for one of the webinars, please view the webinar schedules posted on the eMedNY.org website:

- Current Month: <https://www.emedny.org/meipass/webinar/Webinar.pdf>
- Next Month: <https://www.emedny.org/meipass/webinar/NextMonth.pdf>

Would you like to share your electronic health records or health information technology success story? Contact hit@health.state.ny.us.

Update to Enrollment of Newborns when a Mother is Enrolled in Medicaid Managed Care or Family Health Plus

What Pharmacies Need to Know

The January 2013 issue of the Medicaid Update covered information concerning the mother of an infant presenting the infant's Medicaid benefit unborn card to a pharmacy to obtain a prescription for the infant.

For clarification, the card now states "infant" rather than "unborn."
http://www.health.ny.gov/health_care/medicaid/program/update/2013/2013-01.htm

Determining a Newborn's Eligibility

- To identify a newborn's plan, pharmacists should ask the mother to present her health plan card.
- If the mother does not have her health plan card, pharmacists can confirm the newborn's enrollment information by:
 - ✓ *performing an eligibility request on ePACES.*

For questions on performing eligibility requests on ePACES, providers may contact the eMedNY Call Center at (800) 343-9000.

Attached is a poster which will assist in the process.



Attention:
MOTHERS OF NEWBORNS
WHO HAVE THIS CARD!



If you are filling a prescription for a newborn who has an infant card, you must also provide the following insurance cards to the pharmacist:

- *Mother's Medicaid Managed Care card or;*
- *Mother's Medicaid card;*
- *Any other Health Insurance card the child could be covered under.*

Keeping Kidneys Safe: Importance of Non-Steroidal Anti-Inflammatory Drug (NSAID) Avoidance in High Risk Patients

An estimated 36 million Americans use over-the-counter analgesics on a daily basis¹. These pain relievers include NSAIDs such as ibuprofen and naproxen, and are widely available in large quantities not only in pharmacies but also at wholesale stores, gas stations and convenience stores.

Patients may not disclose using NSAIDs during medication reviews since they are over-the-counter. These highly accessible medications may seem innocuous but carry a significant risk of disrupting blood flow to the kidneys, precipitating acute kidney injury (AKI). Episodes of AKI can lead to costly hospitalizations. Recently it has been recognized that episodes of AKI have long term consequences leading to new onset kidney disease or more rapid progression of existing kidney disease. Importantly, most cases of NSAID induced AKI can be avoided by recognizing high-risk patients and counseling on the appropriate use of these medications.

NSAIDS AVAILABLE IN THE UNITED STATES

GENERIC NAME	TRADE NAME
Celecoxib	Celebrex
Diclofenac	Cataflam, Voltaren, Arthrotec (combined with misoprostol)
Diflunisal	Dolobid
Etodolac	Lodine, Lodine XL
Fenoprofen	Nalfon
Flurbiprofen	Ansaid
Ibuprofen	Advil, Motrin, Tab-Profen, Vicoprofen (combined with hydrocodone), Combunox (combined with oxycodone)
Indomethacin	Indocin, Indocin SR
Ketoprofen	Orudis KT, Oruvail
Ketorolac	Toradol
Mefenamic Acid	Ponstel
Meloxicam	Mobic
Nabumetone	Relafen
Naproxen	Aleve, Naprosyn, Anaprox, Anaprox DS, Naprelan, Naprapac (packaged with lansoprazole)
Oxaprozin	Daypro
Piroxicam	Feldene
Sulindac	Clinoril

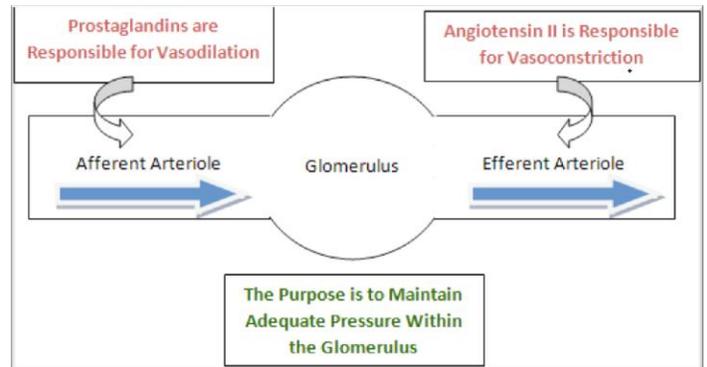
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PHARMACY UPDATE

Kidneys are at high risk for hemodynamic drug-induced injury: Adequate blood flow to the glomerulus is necessary for maintaining the pressure within the glomerulus required for filtering toxins and drugs. Vasodilation and vasoconstriction of the afferent and efferent arterioles are the main mediators of kidney blood flow.

NSAIDs reduce blood flow to the kidney by blocking prostaglandins. The effect of NSAIDs on the filtering pressure in the glomerulus is enhanced by pre-existing kidney disease and diseases associated with reduced kidney blood flow such as heart failure and liver failure (cirrhosis).

Other concomitant medications that affect blood flow to the kidney such as diuretics (decrease blood vessel volume) and ACE inhibitors or angiotensin receptor blockers (dilate efferent arteriole) increase the risk of NSAID-induced AKI. In these settings, glomerular flow's dependence on prostaglandins and angiotensin II is heightened; and, therefore, any blood flow changes from NSAIDs can have detrimental clinical consequences. This is also why not all patients develop kidney injury with NSAIDs.



NSAIDs are associated with risk of AKI that can lead to development or progression of chronic kidney disease: There is a 3 to 8 fold, progressive, age-dependent increase in the frequency of community acquired AKI in patients > 60 years old.^{2,3} Patients with AKI have hospital stays that are 3.5 days longer than other patients⁴ and an approximately 3 fold higher long term mortality risk.^{5,6,7,8} AKI is associated with higher total cost of care with an estimated increase up to \$22,000⁴ Recent data have shown that AKI predisposes some patients to developing chronic kidney disease⁷ with up to 70% elderly patients who have an episode AKI develop chronic kidney disease within 2 years.⁹ It is important to note that in otherwise healthy individuals long term usage of NSAIDs predisposes to CKD. Although uncommon, NSAIDs can also have allergic consequences affecting kidney function.

Avoiding NSAID-induced kidney injury: Counsel High-Risk Patients

- Patients with diabetes and/or hypertension, congestive heart failure or chronic liver disease;
- Patients taking ACE inhibitors, angiotensin receptor blockers and/or diuretics;
- Patients who have eGFR < 60 ml/min/1.73m² or albumin/creatinine ratio >30;
- Recommend shortest-term, lowest possible dose therapy;
- Advise high-risk patients (especially elderly) to seek medical attention within 12-24 hours if experiencing severe vomiting or diarrhea while on therapy.

On behalf of the New York State Chronic Kidney Disease Coalition with special contributions by: Amy Barton Pai, PharmD, BCPS, FASN, FCCP; Chet Fox, MD; Darren Grabe, PharmD; Katie Cardone, PharmD, BCACP, FNKF; George Cortisidis, MD; Marianne Neumann, RN, CNN; Joseph Vassalotti, MD

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The New York State Medicaid Prescriber Education Program Drug Information Response Center: Addressing Alternate Site Blood Glucose Testing

The New York State Medicaid Prescriber Education Program (NYSMPEP) is a collaboration between the New York State Department of Health (NYSDOH) and the State University of New York (SUNY), as approved by state legislation. This program was designed to provide prescribers with an evidence-based, non-commercial source of the latest objective information about pharmaceuticals. In conjunction, the Drug Information Response Center (DIRC) was developed to fulfill the mission of assisting clinicians in the delivery of health care to their Medicaid patients by providing timely, evidence-based information on pharmacotherapy to prescribers and serving as a resource for NYSMPEP academic educators in their outreach to prescribers. A recent article was prepared by the DIRC regarding alternate site blood glucose (BG) testing.

Alternate site testing (AST) of BG offers other options to patients with diabetes who dislike or may have difficulty testing on their fingers. Alternate sites include the palms, forearms, upper thighs, and calves.¹ These sites may be more desirable than the finger tips because they contain fewer nerve endings and thus may be less painful to test.² This removes a deterrent to self-monitoring of blood glucose (SMBG), which is an essential component of diabetes management.

According to a 2009 study, almost 90% of the SMBG meter market was comprised of products from four companies: Roche, LifeScan, Bayer, and Abbott.³ All of these companies manufacture at least 1 meter that allows for AST. However, according to each SMBG meter's user guide, AST is generally not recommended within 2 hours of eating a meal, injecting a rapid- or short-acting insulin dose, or exercising.⁴⁻⁷ Fingertip testing is preferred if hypoglycemia is suspected, BG may be rapidly changing, or the patient is ill. These recommendations are based on literature which demonstrates that AST BG readings are not accurate in these situations. In corroboration, the American Diabetes Association asserts that AST should only be employed when the BG is thought to be stable (e.g., during periods of fasting, immediately before meals, and near bedtime).¹

Ellison et al. conducted a study to evaluate pre- and post-meal BG concentrations in the finger, forearm, and thigh in adults with type 1 or 2 diabetes.⁸ BG measurements from the 3 locations were taken 60 minutes before and 60, 90, 120, 150, and 180 minutes after a meal. Samples from all sites were tested with the One Touch Ultra SMBG meter, and finger samples were also tested with a laboratory instrument for confirmation. A total of 42 subjects completed the study (phase 1), and of these, 38 returned approximately 14 weeks later to repeat the testing procedures (phase 2). The mean age was approximately 48 years and subjects were well balanced between type 1 and type 2 diabetes. Fingertip measurements were highly correlated with laboratory samples ($r=0.98$ for phase 1 and $r=0.97$ for phase 2). Finger sample BG concentrations peaked at 90 minutes, while forearm and thigh BG readings peaked around 120 minutes. Differences between finger sample readings and laboratory values were nearly identical at each time point, though they varied with forearm and thigh testing.

A significant difference was observed among the different sampling sites at 60 minutes post-meal during phase 1 ($p<0.05$), but differences at all other time points were not statistically significant. The authors also found greater rates of change of BG were associated with greater percent differences between finger and alternate sites ($p<0.001$ for thigh and forearm). The authors concluded that patients should use finger readings when testing BG within two hours after meals, as this is when the greatest differences between finger and alternate site readings occur. Though the authors only found a statistically significant difference in BG readings at 1 time point, clinically significant differences occurred frequently within 2 hours after meals.

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PHARMACY UPDATE

Jungheim and Koschinsky evaluated differences in BG between the forearm and finger during periods of rapidly changing BG.⁹ Patients were given glucose orally to rapidly increase BG or intravenous insulin to rapidly decrease BG. Samples were obtained and tested with 3 different SMBG meters every 15 minutes for 3-5 hours after the glucose or insulin was administered. A total of 17 patients (median age 38 years) with type 1 or 2 diabetes who were being treated with insulin participated in this study. Eight of these patients were included in a subgroup where local rubbing of the forearm was performed prior to BG sampling.

Fasting levels measured prior to administration of either agent were similar between sites. During the rapid increase in BG, fingertip values were consistently higher, with a maximal difference of 4.6 ± 1.2 mmol/L (82.8 ± 21.6 mg/dL), $p < 0.001$. During the rapid decrease in BG, fingertip values were consistently lower, with a maximal difference of 5 ± 1.0 mmol/L (90 ± 18 mg/dL), $p < 0.001$. Values for BG were delayed in the forearm by a median of 35 minutes ($p < 0.01$) compared to those obtained from the fingertip. A reduction in differences in BG values was observed with rubbing of the forearm prior to sampling, but there was large intra- and inter-individual variability. No significant differences were observed among the 3 SMBG meters used. This study demonstrated clinically and statistically significant differences between finger and forearm testing during periods of rapidly changing BG and reinforces that finger testing should be used in these situations.

AST provides less painful options to finger testing. It has been shown to be accurate under fasting conditions when BG is not changing. However, AST should not be used after a meal, after the administration of insulin, or in other circumstances where BG may be changing rapidly, as the resulting measurement may not be accurate.

To contact a NYSMPEP academic educator in your area, please visit:
<http://nypep.nysdoh.suny.edu/contactus/contactus>.

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Mandatory Compliance Program Requirement under the NYS Social Services Law OMIG's Observed Best Practices; Opportunities for Enhancement; and Insufficiencies As of September 30, 2012

Publication Notice:

The New York State Office of the Medicaid Inspector General (OMIG) recently published an update to its listing of the following compliance program reviews initiated through September 30, 2012:

- *Observed Best Practices in Compliance*
- *Observed Opportunities for Enhancement*
- *Observed Insufficiencies*

The lists are available on OMIG's website, www.omig.ny.gov. They can be accessed through the Compliance tab and are located under the Compliance Library.

The lists are composed of observations cited in OMIG's compliance program assessments for the period December 2010 up to and including September 30, 2012.

The lists do not identify specific providers or provider types, but the observations listed offer guidance to Medicaid providers on what OMIG has found to exist in compliance programs that exceed the mandatory requirements (Best Practices), that meet the mandatory requirements, but could be improved (Opportunities for Enhancement), or that do not meet the mandatory requirements (Insufficiencies).

OMIG suggests that Medicaid providers who must comply with the mandatory compliance program obligation periodically review their compliance programs, how they operate, and make improvements based upon their self-assessment. The lists referred to in this *Medicaid Update* provide insight into how OMIG may assess Medicaid providers' compliance programs.

New York's Medicaid providers are recommended to sign up for e-mail notices from OMIG by subscribing to OMIG's list serv. Anyone can become a subscriber at no cost by signing up on OMIG's home page at www.omig.ny.gov. An e-mail subscription is a great way to stay informed of new compliance tools and information on compliance. As additional compliance resources are published by OMIG on its website, e-mail subscribers will receive notices of their publication.

If you have any questions, please visit OMIG's website at www.omig.ny.gov and refer to the Compliance landing page for the Bureau of Compliance's direct contact information.

Mandatory Compliance Program Requirement under the NYS Social Services Law OMIG's Compliance Program Assessment Form (Revision date: 01/22/2013)

Publication Notice:

The New York State Office of the Medicaid Inspector General (OMIG) recently published an update to its Compliance Program Assessment Form. The form's revision date is January 22, 2013.

The form is available on OMIG's website, www.omig.ny.gov. It can be accessed through the Compliance tab and is located under the Compliance Library. The only substantive change to the form from its prior version is in the instructions on the last page of the form related to how the Bureau of Compliance would use the form when it conducts compliance program reviews.

The form is being published as guidance to Medicaid providers on the types of questions that should be asked when conducting a self-assessment of providers' compliance programs. The form is provided in MS Word format so that Medicaid providers can use it as an assessment tool. The questions track the mandatory compliance program elements and requirements that are set out in New York State Social Services Law §363-d and 18 New York Code of Rules and Regulations §521.3(c). The new instructions on the last page of the form seek the provider's identification of how their compliance programs impact each of the seven areas referred to in 18 New York Code of Rules and Regulations §521.3(a).

DO NOT SUBMIT A COMPLETED FORM TO OMIG UNLESS YOU ARE REQUESTED TO DO SO BY OMIG.

New York's Medicaid providers are recommended to sign up for e-mail notices from OMIG by subscribing to OMIG's list serv. Anyone can become a subscriber at no cost by signing up on OMIG's home page. An email subscription is a great way to stay informed of new compliance tools and information on compliance. As additional compliance resources are published by OMIG on its website, email subscribers will receive notices of their publication.

If you have any questions, please visit OMIG's website at www.omig.ny.gov and look at the Compliance landing page for the Bureau of Compliance's contact information.

Reminder: Medicaid to Cease Support of the Omni 3750 POS Card Swipe Terminals on March 31, 2013

As published in previous Medicaid Update newsletters, Medicaid will discontinue support of the Omni 3750 Point of Service (POS) terminal on March 31, 2013. Providers who currently use the Omni 3750 POS terminals to verify Medicaid eligibility or request Dispensing Validation System (DVS) prior approval must make plans to switch to one of the following real-time methods prior to the March 31, 2013 date.

- *Electronic Provider Assisted Claim Entry System (ePACES).*
- *eMedNY Simple Object Access Protocol (SOAP). SOAP does not support DVS transactions.*
- *Several large clearinghouses and service bureaus support real-time connections to eMedNY (If you require DVS, verify DVS availability with the clearinghouse prior to contracting.)*

Providers should visit www.emedny.org to determine which alternate method best meets their needs. Questions and requests for technical assistance on transitioning to an alternate access method may be forwarded via e-mail to emednyproviderservices@csc.com or providers may contact the eMedNY Call Center at (800) 343-9000.

Providers participating in the Card Swipe program who have 3750 terminals should have received a separate letter from the New York State Office of the Medicaid Inspector General (OMIG) on the status of their involvement in the Card Swipe program.

PROVIDER DIRECTORY



Office of the Medicaid Inspector General: For general inquiries or provider self-disclosures, please call (518) 473-3782. For suspected fraud complaints/allegations, call 1-877-87FRAUD (877) 873-7283, or visit www.omig.ny.gov.

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

Providers wishing to hear the current week's check/EFT amounts: Please call (866) 307-5549 (available Thursday PM for one week for the current week's amount).

Do you have questions about billing and performing MEVS transactions? Please call the eMedNY Call Center at (800) 343-9000.

Provider Training: To sign up for a provider seminar in your area, please enroll online at: <http://www.emedny.org/training/index.aspx>. For individual training requests, call (800) 343-9000 or e-mail: emednyproviderrelations@csc.com.

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

Need to change your address? Does your enrollment file need to be updated because you've experienced a change in ownership? Do you want to enroll another NPI? Did you receive a letter advising you to revalidate your enrollment?

Visit www.emedny.org/info/ProviderEnrollment/index.aspx and choose the link appropriate for you (e.g., physician, nursing home, dental group, etc.)

Medicaid Electronic Health Record Incentive Program questions? Contact the New York Medicaid EHR Call Center at (877) 646-5410 for assistance.

Do you have comments and/or suggestions regarding this publication? Please contact Kelli Kudlack via e-mail at: medicaidupdate@health.state.ny.us.