



Medicaid Update

THE OFFICIAL NEWSLETTER OF THE NEW YORK STATE MEDICAID PROGRAM

Medicaid Beneficiaries Cannot Be Billed

■ This is a reminder to all hospitals, free-standing clinics and individual practitioners about the requirements of the Medicaid program related to requesting compensation from Medicaid beneficiaries, including Medicaid beneficiaries who are enrolled in a Medicaid managed care or Family Health Plus (FHPlus) plan, or who have been found to be presumptively eligible for Medicaid or the Family Planning Benefit Program (FPBP).



By enrolling in the Medicaid program, a provider agrees to accept payment under the Medicaid program as payment in full for services rendered. A provider may not make a private pay agreement with a beneficiary to accept a Medicaid fee for a particular covered service and then provide a different upgraded service (usually a service that is beyond the scope of the Medicaid program) and agree to charge the beneficiary only the difference in fee between two services, in addition to billing Medicaid for the covered service. It is an unacceptable practice to knowingly demand or collect any reimbursement in addition to claims made under the Medicaid program, except where permitted by law.

ACCEPTANCE AND AGREEMENT

- *When a provider accepts a Medicaid beneficiary as a patient, the provider agrees to bill Medicaid for services provided or, in the case of a Medicaid managed care or Family Health Plus (FHPlus) enrollee, the beneficiary's managed care plan for services covered by the contract.*
- *The provider is prohibited from requesting any monetary compensation from the beneficiary, or their responsible relative, except for any applicable Medicaid co-payments.*
- *The provider is prohibited from requesting any monetary compensation from pregnant women or children who have been found to be presumptively eligible for Medicaid or beneficiaries found presumptively eligible for FPBP.*
- *A provider may charge a Medicaid beneficiary, including a Medicaid or FHPlus beneficiary enrolled in a managed care plan, only when both parties have agreed prior to the rendering of the service that the beneficiary is being seen as a private pay patient.*
- *This agreement must be mutual and voluntary. It is suggested that providers keep the beneficiary's signed consent to be seen as a private pay patient on file.*
- *If, for example, a provider sees a beneficiary, and advises them that their Medicaid card or health plan card is valid, eligibility exists for the date of service and treats the individual, the provider may not change their mind and bill the beneficiary for that service or any part of that service.*

A provider who participates in Medicaid fee-for-service may not bill Medicaid fee-for-service for any services included in a beneficiary's managed care plan, with the exception of family planning services, when a provider doesn't provide such services under a contract with the recipient's health plan.



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FEBRUARY 2014 NEW YORK STATE MEDICAID UPDATE

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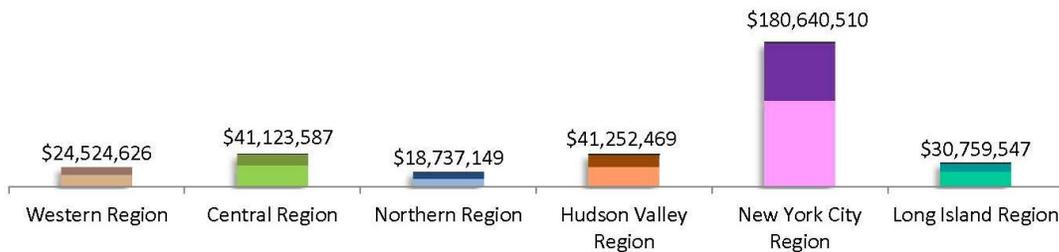
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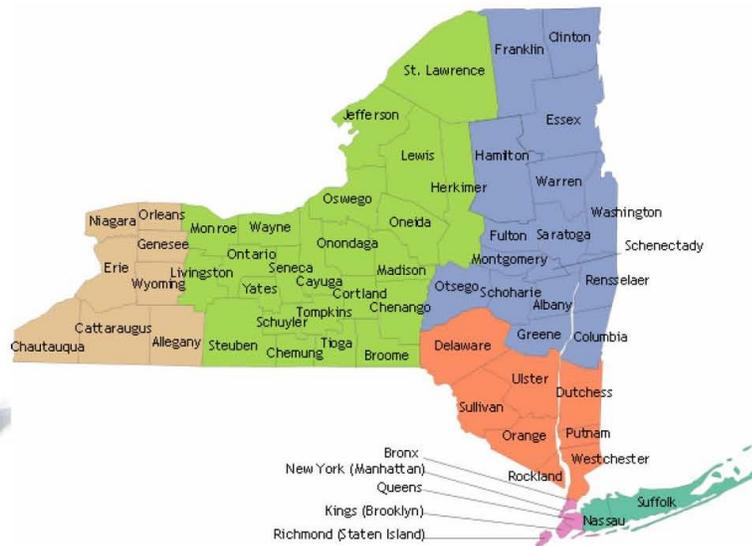
NY Medicaid EHR Incentive Program

The New York Medicaid Electronic Health Record (EHR) Incentive Program provides financial incentives to eligible practitioners and hospitals to promote the transition to EHRs. Providers who practice using EHRs are in the forefront of improving quality, reducing costs, and addressing health disparities. Since December 2011, **over \$535.4 million** in incentive funds have been distributed **within 12,600** payments to New York State Medicaid providers.

Taking a closer look: Incentive Payments Paid to Hospitals by Region*



* Hospital incentive payments for Year 1 (light shade), Year 2 (dark shade) and Year 3 as of February 07, 2014 by HEAL Grant Region.



Have Questions?

Contact hit@health.state.ny.us for program clarifications and details.

www.emedny.org/meipass/

Medicaid Beneficiaries Cannot Be Billed –continued–

A provider who does not participate in Medicaid fee-for-service, but who has a contract with one or more managed care plans to serve Medicaid managed care or FHPlus members, **may not bill Medicaid fee-for-service** for any services. Nor may any provider bill a beneficiary for services that are covered by the beneficiary's Medicaid managed care or FHPlus contract, unless there is prior agreement with the beneficiary that they are being seen as a private pay patient as described previously. The provider must inform the beneficiary that the services may be obtained at no cost from a provider that participates in the beneficiary's managed care plan.

Note: Due to the requirement that PRIOR agreement be made for reimbursement, Medicaid beneficiaries may never be charged for services rendered in an Emergency Room (except applicable Medicaid co-payments).

CLAIM SUBMISSION

Providers are strongly encouraged to confirm eligibility and the appropriate payor every time a patient is seen and before rendering services. Providers of long term services and supports are encouraged to confirm eligibility on the 1st and 15th of each month, and, as applicable, promptly contact a recipient's new managed care plan to ensure continued service authorization.

The prohibition on charging a Medicaid or FHPlus recipient applies:

- *When a participating Medicaid provider or a Medicaid managed care or FHPlus participating provider fails to submit a claim to Computer Sciences Corporation (CSC) or the recipient's managed care plan within the required timeframe; or*
- *When a participating Medicaid provider or a Medicaid managed care or FHPlus participating provider submits a claim to CSC or the recipient's managed care plan, and the claim is denied for reasons other than that the patient was not eligible for Medicaid or FHPlus on the date of service.*

COLLECTIONS

A Medicaid beneficiary, including a Medicaid managed care or FHPlus enrollee, **must not be referred to a collection agency** for collection of unpaid medical bills or otherwise billed, *except for applicable Medicaid co-payments*, when the provider has accepted the enrollee as a Medicaid or FHPlus patient. Providers may, however, use any legal means to collect applicable unpaid Medicaid co-payments.

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Medicaid Beneficiaries Cannot Be Billed –continued–

EMERGENCY MEDICAL CARE

A hospital that accepts a Medicaid beneficiary as a patient, including a Medicaid or FHPlus recipient enrolled in a managed care plan, accepts the responsibility for making sure that the patient receives all medically necessary care and services. *Other than for legally established co-payments*, a Medicaid or FHPlus recipient should never be required to bear any out-of-pocket expenses for:

- *Medically necessary inpatient services; or,*
- *Medically necessary services provided in a hospital-based emergency room (ER).*

This policy applies regardless of whether the individual practitioner treating the beneficiary in the facility is enrolled in the Medicaid program. When reimbursing for ER services provided to Medicaid managed care or FHPlus enrollees, health plans must apply the:

- *Applicable federal and state law and regulation;*
- *Provisions of the Medicaid Managed Care/FHPlus Model Contract; and*
- *Department Directives.*

To avoid payment delays, hospitals are encouraged to query MEVS for a patient's current eligibility status and appropriate payor, before preparing an emergency Medicaid application.

CLAIMING PROBLEMS

If providers find a problem with a claim submission, they must first contact the CSC Call Center at (800) 343-9000. If the claim is for a service included in the Medicaid managed care or FHPlus benefit package, the enrollee's managed care plan must be contacted.

Questions? Please call the Office of Health Insurance Programs at (518) 473-2160.

Nursing Home Population and Benefit Transition to Medicaid Managed Care

Pending Centers for Medicaid and Medicare Services (CMS) approval, beginning April 1, 2014, all eligible individuals age 21 and older in need of long term placement in a nursing facility will be required to join a Medicaid Managed Care Plan (MMCP) or a Managed Long Term Care Plan (MLTCP). The MMCP benefit package will also expand to include long term nursing home services as this is already a benefit in MLTCPs.

The steps toward this transition require that Managed Care Organizations (MCOs), providers and the State ensure that individuals in need of long term care services receive care in the most integrated and least restrictive setting by developing a patient centered care plan. For the purpose of this article, MCO means a MMCP and a MLTCP.

Current long term placed beneficiaries residing in a Medicaid certified skilled nursing facility (nursing home) on a permanent basis at the time of this transition will remain in fee-for-service Medicaid and will not be required to enroll in a MCO.

Transition of Benefit

Beginning April 1, 2014, the nursing home benefit will be included in the MMCP benefit package for plans operating in New York City, Nassau, Suffolk, and Westchester counties. Medicaid managed care enrollees entering a nursing home for long term placement after the applicable implementation date will receive the benefit through their current MMCP. Enrollees will select a nursing home for long term placement from the plan provider network. In addition, individuals residing in New York City, Nassau, Suffolk and Westchester counties in need of long term nursing home services will be required to enroll in a MCO. The transition of the benefit and population will phase into additional counties beginning October 2014 for both dual and non-dual eligible populations, with all counties phased in by December 2014 (see revised phase-in schedule below).

Beginning October 1, 2014, the State will allow beneficiaries residing in a nursing home on a long term basis prior to April 1, 2014 in New York City, Nassau, Suffolk and Westchester counties to enroll in a MCO on a voluntary basis. Individuals residing in a nursing home in the remaining counties will be allowed to enroll in a MCO on a voluntary basis beginning January 1, 2015.

MCOs are required to reimburse contracted nursing homes at either the benchmark rate (fee-for-service) or a negotiated rate that is agreed to by both parties. This reimbursement arrangement will extend until April 1, 2017 for Phase 1 counties and until January 1, 2018 for the rest of state.



POLICY AND BILLING GUIDANCE

Authorization of Services Post Transition

The recommendation for long term placement in a nursing home is made by the nursing home physician or clinical peer, based upon medical necessity, functional criteria, and the availability of services in the community, consistent with current practice and regulation. Following the appropriate assessments, the MCO is responsible for reviewing all documentation and approving or adjusting the care plan to ensure the needs of the enrollee are appropriately met. The nursing home and the MCO must follow authorization procedures as outlined in the provider agreement.

For plan enrollees, MCOs are responsible for authorizing long term placements in nursing homes and paying the nursing home for authorized services while long term financial eligibility is established by the local district. After long term placement, MCOs continue to be responsible for authorizing non-residential health services, such as non-emergency hospital inpatient or specialty services.

Eligibility Determination

For individuals in need of long term placement in a nursing home, the local department of social services (LDSS) will determine Medicaid eligibility using institutional rules, including a review of assets for the 60 month look-back period and the imposition of a transfer penalty, if applicable. If a transfer penalty period is imposed, the individual is ineligible for coverage of nursing home care. Otherwise eligible individuals and individuals who are not subject to a transfer penalty period will have eligibility determined by the LDSS under chronic care budgeting rules to determine the Net Available Monthly Income (NAMI) amount that the nursing home or MCO will need to collect from the individual. The LDSS must notify both the MCO and the nursing home of the eligibility determination, and any penalty period and NAMI amount. Nursing homes will continue to be allowed to retroactively bill fee-for-service Medicaid for care provided by the nursing home for any period prior to managed care enrollment, as long as the beneficiary is determined to be eligible for coverage of nursing home care.

For current Medicaid managed care enrollees in need of long term placement, the nursing home and the MCO will assist the enrollee in submitting documentation for Medicaid eligibility to the local district in a timely manner. The MCO is responsible for working with the nursing home to collect the NAMI amount. If long term eligibility is not approved or a penalty period is identified, the MCO must recoup payment from the nursing home for any period of ineligibility.

Plan Selection Process

For new managed care enrollment, individuals will have 60 days from the date long term Medicaid eligibility is established to select a MCO for enrollment. New York Medicaid Choice will assist with education, plan selection and enrollment in a MCO contracting with the nursing home in which the beneficiary resides. If the individual does not select a plan, he or she will be auto-assigned to a MCO contracting with the nursing home in which the individual resides.

POLICY AND BILLING GUIDANCE

Lock-In rules will be suspended for managed care enrollees who wish to transfer to a nursing home that is not in the current plan provider network.

Access to Services

The MCO is responsible for assessing the long term care needs of the enrollee using the state-required Uniform Assessment System bi-annually and whenever there is a change in the enrollee's condition. The MCO must implement a patient centered care plan and assist the enrollee in accessing authorized services.

The MCO network must provide enrollees requiring long term services with a choice of at least two participating nursing homes with available beds to address the needs of the enrollee.

The nursing home, hospital and the MCO must respond to an enrollee's request for services to be provided in a less restrictive setting in a timely manner, and as clinically appropriate for the enrollee.

Right to Appeal

In case of a disagreement with the MCO determination, the enrollee or enrollee's designee may file an appeal to the plan. A provider may file an appeal on behalf of an enrollee with appropriate consent. The enrollee will also have the right to a State fair hearing and may be eligible for external appeal. The provider also has appeal rights on his or her own behalf.

Phase-In Schedule

Nursing Home Transition Phase-In Schedule	
Month	County
April 1, 2014 Phase 1	New York City - Bronx, Kings, New York, Queens, Richmond Nassau, Suffolk, Westchester
October 1, 2014	For the above counties - voluntary enrollment in Medicaid managed care becomes available to individuals residing in nursing homes who are in fee-for-service Medicaid
October 1, 2014 Phase 2	Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chenango, Clinton, Columbia, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Jefferson, Lewis, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Orange, Oswego, Otsego, Putnam, Rensselaer, Rockland, St. Lawrence, Saratoga, Schenectady, Schoharie, Steuben, Sullivan, Ulster, Warren, Washington
November 1, 2014 Phase 3	Chemung, Cortland, Schuyler, Seneca, Tioga, Yates
December 1, 2014 Phase 4	Genesee, Livingston, Ontario, Orleans, Tompkins, Wayne, Wyoming
January 1, 2015	All remaining counties – voluntary enrollment in Medicaid managed care becomes available to individuals residing in nursing homes who are in fee-for-service Medicaid

Questions regarding the transition can be directed to the Division of Health Plan Contracting and Oversight at (518) 473-1134 or the Division of Long Term Care at (518) 474-6965 or e-mail to omcmail@health.state.ny.us.

Billing for Clients enrolled with Medicaid Coverage: (Medicare Coinsurance and Deductible Only)

Providers should be aware that when rendering services for Medicaid clients enrolled with Medicare Coinsurance and Deductible Only coverage, that Medicaid will only consider reimbursement of Medicare Coinsurance and Deductible amounts after Medicare. This means that Medicare must have made a payment on the claim, then patient responsibility amounts of Deductible and/or Coinsurance would be due from Medicaid. If Medicare did not cover the claim, then the secondary claim submitted to Medicaid will be denied for claims Edit 01027 (Medicaid Coverage code 09 - Medicare Approved Amount Missing).

How to identify clients who have coverage: (Medicare Coinsurance and Deductible Only):

When verifying eligibility, the HIPAA response will return a literal: MEDICARE COINSURANCE DEDUCTIBLE ONLY. When a generic Service Type Code of “30” is entered on the request, the eligibility response will return the Generic Service Type Codes applicable to the Service Type Description. The following will be returned:

SERVICE TYPE CODE	SERVICE TYPE DESCRIPTION
1	Medical Care
33	Chiropractic
35	Dental Care
47	Hospital
48	Hospital Inpatient
50	Hospital - Outpatient
86	Emergency Services
88	Pharmacy
98	Professional (Physician) Visit - Office
AL	Vision (Optometry)
MH	Mental Health
UC	Urgent Care

Providers may also enter an explicit Service Type on the eligibility inquiry transaction to determine if their services will be covered for Medicare deductible and coinsurance amounts.

Questions? Please contact the eMedNY Call Center at (800) 343-9000.

Providers Urged to Submit Correct Coordination of Benefits (COB) Information to Medicaid

Recent reviews of COB claims submitted to Medicaid have uncovered persistent misreporting of information, impacting the appropriate payment of these claims. It is imperative that COB claims submitted to Medicaid after Medicare or other Third Party adjudication contain all information as provided in the Remittance Advice, in accordance with Section 1.4.1.1 (COB Models) of the HIPAA 837 Claims Implementation Specifications or Technical Reports. The information is to include the Claim Adjustment Group Codes (CAGCs) and Claim Adjustment Reason Codes (CARCs) received from the previous payer(s).

It is also important to forward the information at the same level that it was received, claim-level to claim-level and line-level to line-level. In cases when the COB claim being sent to eMedNY is produced from a paper/proprietary remittance, providers are required to properly crosswalk the proprietary code(s) to appropriate CAGCs and CARCs, and if one is not found the provider must assess whether using CARC 192 - non -standard adjustment code from paper remittance and a suitable CAGC is appropriate. eMedNY's claims adjudication depends on the nationally set standards to correctly process the claims.

The misreporting of information on COB claims may at times result in inappropriate payments to a provider. Providers are reminded that both federal and state laws specify that providers participating in the Medicaid program must not retain any inappropriate payments. Knowingly retaining inappropriate payments violates the Fraud Enforcement and Recovery Act (FERA) which amended the federal False Claims Act.

In addition, effective May 22, 2010 the Affordable Care Act (ACA) amended the Social Security Act (SSA) to include a variety of Medicare and Medicaid program integrity provisions. A new section under SSA, [§1128J\(d\)](#), requires providers of Medicare or Medicaid services or supplies to notify the program and return any inappropriate payments to the program(s) within sixty (60) days of identifying the overpayment.

Providers who may need technical assistance complying with COB claims submission requirements should contact eMedNYHIPAASupport@csc.com.



Mandatory Prospective Drug Utilization Review (Pro-DUR) and how it relates to Drugs Subject to Medicaid Pharmacy Prior Authorization Programs

Medicaid enrolled pharmacies are required to perform prospective drug utilization review on all pharmacy claims. The Department of Health oversees this review within its ProDUR Program through the Medicaid Eligibility Verification System (MEVS).

Medicaid's point-of-sale system allows pharmacists to perform on-line, real-time eligibility verifications, electronic claims capture and adjudication (ECCA), and Prior Authorization (PA) messaging. In addition, it helps to reduce Medicaid beneficiaries' risk of drug induced illnesses through point-of-sale clinical editing.

Under ProDUR, in order to receive payment for services rendered, all pharmacies must enter their transaction using the National Council for Prescription Drug Programs (NCPDP) formats via one of the MEVS access methods. NCPDP format specifications can be found at:

https://www.emedny.org/ProviderManuals/Pharmacy/ProDUR-ECCA_Provider_Manual/index.aspx

All enrolled pharmacies, **including long term care, MUST** participate in the mandatory ProDUR Program to receive reimbursement.

- For drugs identified as having utilization management PA requirements* (such as Step Therapy, Frequency/Quantity/Duration etc.), **claims must be submitted as a real-time transaction** (date of adjudication/submission = date of service). When a PA is required, the prescriber must contact the clinical call center and should consider a different product, units/day, etc. **PA will not be issued retroactively for patients eligible on the date of service.**
- If upon claims submission the patient is determined ineligible the Pro-DUR transaction will adjudicate. If a PA message is received that states: "UNABLE TO PROCESS A PHARMACY PA PLEASE CALL MAGELLAN"; the prescriber must take action to consider a different product, units/day, etc. since a retroactive PA request will not be considered. **A PA will not be issued by the clinical call center or a patient who is ineligible.**

*Drugs identified on the eMedNY formulary file with a PA code = G,

<https://www.emedny.org/info/formfile.aspx>

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Exceptions:

- If on the date of service the patient is not enrolled in Medicaid and therefore does not have an identification number to submit, a retroactive PA can be requested for the Department to review (i.e. a Medicaid identification number is assigned and the patient's eligibility is added to the eMedNY system retroactively involving the date of service in question).

An automated claim review is performed via the pharmacy claims point-of-sale (POS) system. This entails system editing that applies specific clinical rules, which have been established by the Medicaid Drug Utilization Review Board (DURB) prior to payment of the pharmacy claim. **If the clinical rules are met for the drug requested, a PA is generated within the system regardless of eligibility and therefore no additional action should be required by the prescriber.**

The following is a link to the most up-to-date information on the Medicaid Fee-for-Service (FFS) Pharmacy Prior Authorization programs. This document contains a full listing of drugs subject to the Preferred Drug Program (PDP), Clinical Drug Review Program (CDRP), Drug Utilization Program (DUR), Brand Less than Generic program (BLTG), the Mandatory Generic Drug Program and the Dose Optimization Program: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf.

Update on Pharmacy Billing Procedures for Compounded Prescriptions

Per Medicaid policy, in order for Medicaid to consider a compound reimbursable, the compounded prescription **MUST** meet one of the following conditions:

- It must be a combination of any two or more legend drugs found on the List of Medicaid Reimbursable Drugs, or
- It must be a combination of any legend drug(s) included on the List of Medicaid Reimbursable Drugs (see link below) and any other item(s) not commercially available as an ethical or proprietary product, or
- It must be a combination of two or more products which are labeled "Caution: For Manufacturing Purpose only."

For example: The combination of Aquaphor® and Hydrocortisone Cream 2.5% is **NOT** considered a compound, since it does not meet any of the above requirements. The reconstitution of a commercially available product is **NOT** considered compounding. All ingredients of a compounded prescription **MUST** be submitted to Medicaid regardless of reimbursement.

When billing a compound via National Council for Prescription Drug Programs (NCPDP) D.0 transaction, providers **MUST** submit a minimum of two ingredients (NDC's) in the Compound Segment, field 489-TE-(Compound Product ID). Providers are able to submit up to 25 ingredients (NDC's) using this field. Providers **MUST** also submit a compound code of "2" in field 406-D6-(Compound Code) in the Claim Segment.

The information above provides more specific billing details to support the compound drug billing instructions listed in the February 2011 Medicaid Update 5010 Special Edition http://www.health.ny.gov/health_care/medicaid/program/update/2011/feb11mu_special.pdf.

A Medicaid list of reimbursable drugs can be found at: <https://www.emedny.org/info/formfile.aspx>.

Please contact the eMedNY Call Center at (800) 343-9000 for questions regarding this billing requirement, or any billing issue.

Medicaid Pharmacy Prior Authorization Programs Update

Effective March 20, 2014, the fee-for-service (FFS) pharmacy program will implement the following parameters. These changes are the result of recommendations made by the Drug Utilization Review Board (DURB) at the December 12, 2013 DURB meeting:

Long Acting Opioids

- Point of service (POS) edit for any long acting opioid prescription for opioid naïve patients. Absence of evidence of recent opioid use in patient’s claim or medical history will require prescriber involvement.
 - Exemption for diagnosis of cancer or sickle cell disease.
- POS edit for any additional long acting opioid prescription for patients currently on long acting opioid therapy. Override will require prescriber involvement.
 - Exemption for diagnosis of cancer or sickle cell disease.

Antiretroviral Therapy

- Confirmation of diagnosis for FDA or compendia supported uses. Absence of covered diagnosis will require prescriber involvement.

Benzodiazepine Therapy

- Confirmation of diagnosis for FDA or compendia supported uses.
- POS edit for initiation of concurrent opioid and benzodiazepine prescriptions.
- POS edit for additional oral benzodiazepine prescriptions for patients currently on benzodiazepine therapy.
- POS edit for a benzodiazepine prescription for patients currently being treated with oral buprenorphine.
- Step Therapy for Generalized Anxiety Disorder or Social Anxiety Disorder:
 - Require trial with a Selective-Serotonin Reuptake Inhibitor (SSRI) or a Serotonin-Norepinephrine Reuptake Inhibitor (SNRI) prior to initial benzodiazepine prescription.
- Step Therapy for Skeletal Muscle Spasms:
 - Require trial with a skeletal muscle relaxant prior to a benzodiazepine.
- For Panic Disorder:
 - POS edit requiring concurrent therapy with an antidepressant (SSRI, SNRI, or tricyclic antidepressants (TCA)).

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- Duration limit for insomnia or panic disorder of 30 consecutive days.

Note: Override for the above recommendations will require prescriber involvement.

For more detailed information on the DURB, please refer to:

http://www.health.ny.gov/health_care/medicaid/program/dur/index.htm.

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

https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf.

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

Medicaid enrolled prescribers can also initiate PA requests using a web-based application. PAXpress® is a web based pharmacy PA request/response application accessible through the eMedNY website at:

<http://www.eMedNY.org>. PAXpress® can also be accessed through Magellan Medicaid Administration at: <http://newyork.fhsc.com>.

For additional questions on the Medicaid Primary Care Rate Increase (PCRI) program, please e-mail:

PCRI-L@listserv.health.state.ny.us.

PHARMACY UPDATE



Coverage of Compounded Prescriptions for the Dual Eligible Population

Only drugs that are excluded by law from being covered by the Medicare Part D plans, such as select prescription vitamins and over-the-counter drugs are covered by NYS Medicaid for dual eligible patients (Medicare/Medicaid). **NYS Medicaid does not provide dual eligible patients with coverage of compounded prescriptions.**

Effective March 20, 2014, Medicaid will enforce editing on compounded prescriptions for dual eligible patients. Patients and providers should consult the appropriate Medicare Part D prescription drug plan or Medicare Advantage Prescription Drug Contracting (MAPD) plan for coverage of compounded prescriptions for medically accepted indications.

NYS Medicaid continues to cover compounded prescriptions for NYS Medicaid beneficiaries who are not Medicare eligible.

Important Information on Ketamine use in Compounded Prescriptions

Effective March 10, 2014, Medicaid fee-for-service (FFS) **will no longer** reimburse for ketamine bulk powder used in compounding prescriptions. Ketamine is **not** FDA approved or Compendia supported for use as a compounded topical preparation. Furthermore, the American Academy of Neurology guidelines state that topical use of ketamine is not recommended.

Providers should consider alternative drugs that are FDA approved or Compendia supported for use, based on the patient's diagnosis. A complete list of reimbursable drugs can be found at: <https://www.emedny.org/info/formfile.aspx>.

Medicaid and ICD-10 Implementation

CMS LINKS FOR ASSISTANCE

CMS has provided many resources and guidance in regards to ICD-10. NYS Medicaid encourages you to utilize these free resources.

CMS resources: www.cms.gov/icd10.

CMS ICD-10 Industry Email Updates:

http://www.cms.gov/Medicare/Coding/ICD10/CMS_ICD-10_Industry_Email_Updates.html.

NY MEDICAID

New York State Medicaid and Computer Sciences Corporation (CSC), its fiscal contractor, are working aggressively to ensure coding and programming changes required by the transition to ICD-10 are completed well in advance of the October 1, 2014, compliance date.

CLAIMS PROCESSING

Claims with dates of service prior to 10/01/2014 must be submitted with ICD-9 codes. Claims with dates of service on or after 10/01/2014 must be sent with ICD-10 codes. Retroactive claims will be processed based on the date of service.

The following claim types cannot be split and must be submitted using ICD-10 when the discharge date or end date of service is on or after October 1, 2014, regardless of the Statement Begin Date:

- Inpatient DRG claims
- Inpatient GME claims
- Inpatient Psychiatric
- Clinical APG Episode of Care
- CHHA Episodic claims

The following electronic claims and **all paper claims** must be split. Separate claims will be required with ICD-9 codes for dates of service prior to October 1, 2014 and for ICD-10 for dates of service on or after 10/01/2014:

- Inpatient non-DRG claims
- Professional claims
- Nursing Home claims

NOTE: Claims that contain ICD code versions that do not match the above criteria will be rejected during pre-adjudication editing. A 277CA will be returned for the electronic claims and will not appear on the provider's remittance advice. Paper claims submitted with errors will result in a denial.

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ALL PROVIDERS

Claims that contain a combination of ICD-9 and ICD-10 coding will fail in the business edits or with a paper denial.

TESTING ENVIRONMENT

The Provider Testing Environment (PTE) will be available for ICD-10 testing on **July 28, 2014** for electronic transactions only. New York State Medicaid will not mandate ICD-10 testing, but trading partners are urged to test early and test as soon as PTE is available. The PTE is designed to support end-to-end testing, allowing trading partners to submit test transactions and receive responses.

For testing purposes eMedNY, will be utilizing a compliance date of **October 1, 2014**. Claims in PTE with a date of service prior to October 1, 2014 will contain ICD-9 codes; claims with a date of service of October 1, 2014 or after will contain ICD-10 codes. For ICD-10 testing purposes, future dates of service will be allowed in PTE.

Please refer to the eMedNY Trading Partner Information Standard Companion Guide available at: <https://www.emedny.org/HIPAA/5010/transactions/index.aspx> for complete details on trading partner testing.

NOTE: ICD-10 test files cannot contain more than 50 claims per file and there is a file limit of two files per user/per day. These limits will be enforced.

MEDICAID ICD-10 RESOURCES

Medicaid Update: Future articles will provide ICD-10 updates and requirements.

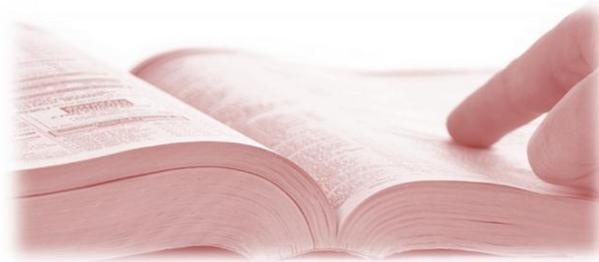
eMedNY website: Main menu page contains link to ICD-10 information.

eMedNY listserv: Will be utilized to email pertinent ICD-10 updates to subscribers. Providers who have not subscribed to the listserv are urged to do so.

FAQ: Responses to a list of key ICD-10 questions, posted at www.emedny.org.

eMedNY Call Center: (800) 343-9000. Only for questions related to the information in the FAQs.

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 listen to the current week's check/EFT amounts:

Please call (866) 307-5549 (available Thursday PM for one week for the current week's amount).

Do you have questions about billing and performing MEVS transactions?

Please call the eMedNY Call Center at (800) 343-9000.

Provider Training:

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

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.