NEW YORK STATE | Department of Health | Medicaid Program

Medicaid Update

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CAPTCHA

ePACES To Add New Feature on June 1, 2016

In an effort to make user data more secure and to improve system performance, eMedNY will be installing a new feature that will impact ePACES users when signing on to the ePACES application. This new feature, commonly called CAPTCHA, is a program that can distinguish whether the user attempting to sign-on is a human or a computer.

Effective June 1, 2016 when users attempt to sign-on to ePACES from the eMedNY website, the user will be asked to verify that he/she is a person and not a computer by selecting specific images. Once the user has successfully verified the correct images he or she will be allowed to sign into the ePACES account. If the incorrect images are selected, the user will be asked to verify another set of images before being allowed access to ePACES.

To familiarize yourself with the new verification function, please go to https://www.google.com/recaptcha/api2/demo

This new feature is widely utilized by other secure websites. Many people are familiar with it and have probably had to use it to gain access to those secure websites. The New York State Department of Health is adding this feature to help secure your data, and to prevent unauthorized computer-automated access to ePACES that could adversely impact ePACES performance.

Important Note: All users will need to have installed Internet Explorer (IE) version 10 or greater **or** any alternative browsers including Google Chrome, Mozilla Firefox, or Apple Safari. IE **versions 9 and below will not be supported.** Please be sure to coordinate with your IT department to upgrade your internet browser, if necessary, before the effective date shown above.

Questions about ePACES can be directed to the eMedNY Call Center at 800-343-9000.

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In This Issue…..

All Providers

New York Medicaid Management Information System (NYMMIS) Learning Management System and Computer-Based Trainings

Computer-based trainings (CBTs) are now available in the new NYMMIS Learning Management System (LMS). The LMS is an online repository for CBT videos and supporting materials that learners can access directly from any computer connected to the internet to learn more about NYMMIS. Webinar and in-person training classes are also available.

Registration is required to access CBTs and materials. To register, please visit: https://nymmisexternal.learnercommunity.com/account/login/secure?returnUrl=%2Fhome.

Computer Based Trainings (CBTs)

The following CBTs are currently available on the NYMMIS LMS:

- **Using the LMS** – This lesson focuses on the creation of and sign in to a user's account. It also provides information on how to navigate through courses and how to enroll in the different courses provided.
- **Introduction to NYMMIS** – The Introduction to NYMMIS training is for first-time users of the system.
- **Features and Functionality** – This training is for first-time learners of the system and explains the basic features and functionality of NYMMIS.
- **Basic and Advanced Searching** – In this lesson, learners build on their knowledge of NYMMIS by explaining the Search functions that are available in the system.
- **Introduction to Provider Enrollment** – This training is for new provider enrollments only and focuses on how to use NYMMIS to complete an electronic enrollment application.
- **Completed Provider Enrollment Applications Individual** – This course shows learners how to complete the enrollment application online for an individual provider.
- **How to Recall an Application** – This course shows the learner how to recall a Provider Enrollment application and if any additional information is required on the application for completion.
- **Check Application Status** – This course helps users determine the status of their application and understand the status of their application.

Please contact NYMMIS Training by sending an email to NYMMISTraining@xerox.com for inquiries and assistance related to these trainings.

Webinars and in-person training

NYMMIS training is also available via webinar and in-person classes. Webinars are available in these formats: Live, online educational presentations or recorded presentations you can review and playback

You can sign up to attend a NYMMIS webinar or in-person training by visiting the Training and Events Calendar on http://www.interimnymmis.com/training-and-event-calendar.

The following webinars and in-person classes are currently available:

- **Introduction to NYMMIS - Features and Functionality** - This lesson introduces the Medicaid Management Information System that is being rolled out for New York. This system is called NYMMIS, which stands for the New York Medicaid Management Information System (NYMMIS).

- **Introduction to Provider Enrollment** - This class begins with an introduction to NYMMIS and focuses on the enrollment application process.

Please contact NYMMIS Training by sending an email to NYMMISTraining@xerox.com for inquiries and assistance related to these trainings.

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All Providers

New York Medicaid EHR Incentive Program Update

The New York Medicaid Electronic Health Record (EHR) Incentive Program provides financial incentives to eligible professionals 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 $768 million*** in incentive funds have been distributed ***within 23,619*** payments to New York State Medicaid providers.

23,619 Payments	$768+ Million Paid	Are you eligible?

For more information, visit www.emedny.org/meipass

Did you know?

2016 is the last year that eligible professionals (EPs) may begin participating in the Medicaid EHR Incentive Program. EPs may receive up to $63,750 over the course of six years for the adoption and meaningful use of certified EHR technology.

Unsure if your EHR is certified? Visit the Certified Health IT Product List at http://healthit.gov/chpl to see if your EHR qualifies you for the incentive program.

2016 attestations for Adopt, Implement, or Upgrade (AIU) are available in MEIPASS. For step-by-step guidance, please review the AIU walkthrough or contact the support team at 877-646-5410 Option 2.

MEIPASS Availability

It is anticipated that MEIPASS will not be available during the summer while the system undergoes maintenance for Meaningful Use attestations for 2015 and beyond. Additional announcements about MEIPASS availability, including information about the extended deadline for 2015 Meaningful Use attestations, will be made via LISTSERV and the program website.

Questions? Contact hit@health.ny.gov for program clarifications and details.

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Policy & Billing Guidance

Billing Policy for Transfers between Hospitals for Acute Services

Reminder

Medicaid regulations provide for the ability to transfer patients between an acute care facility reimbursed under the DRG case-based payment system, to another acute care facility reimbursed under this system, to ensure the most appropriate care for the patient. In order to reimburse hospitals appropriately, a transfer payment methodology was developed by the Department of Health. This method reimburses the transferring hospital for the services provided to a patient while under their care, while the receiving hospital is also reimbursed for services they provide while the patient is under their care.

For further Information regarding the transfer policy refer to the Inpatient Manual Policy Guidelines at the following website address:
https://www.emedny.org/ProviderManuals/Inpatient/PDFS/Inpatient_Policy_Guidelines.pdf

For hospitals that undergo a merger with another hospital, the Department of Health is reminding providers that, once the individual hospitals are receiving a merged reimbursement rate that reflects a combination of the costs and statistics of the merged hospitals, transfer claims between the divisions receiving the merged rate can no longer be submitted for payment. Based on regulations, transfers between merged facilities are reimbursed as if the hospital that first admitted the patient also discharged the patient. Due to this transfer requirement, only one claim can be submitted for the merged entity which includes the diagnosis and procedure codes for the services performed at both hospitals; **both hospitals cannot submit a claim**.

If you have any questions regarding this policy, please submit an email to the Bureau of Acute and Managed Care Rate Setting at hospffsunit@health.ny.gov.

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Policy & Billing Guidance

New York State Medicaid Expansion of Allergy Testing

Effective June 1, 2016 for Medicaid Fee-For-Service (FFS) and August 1, 2016 for Medicaid Managed Care (MMC), the New York State Medicaid program will begin covering allergy testing under the parameters outlined below. Allergy testing may be necessary in the diagnosis and management of individuals with clinically significant allergic symptoms to identify the allergen(s) responsible for the symptoms.

General Background:

The most utilized types of allergy testing are *in vivo* (scratch, puncture, prick, intradermal and patch) and *in vitro* (blood-based) testing. In recognition that not all individuals are candidates for *in vivo* testing, Medicaid is expanding its allergy policy to include other methods of testing for these individuals.

Allergy testing should be performed only by licensed physicians who possess the competency to interpret results, manage possible adverse reactions and determine an appropriate course of treatment.

In vivo/In vitro Allergy Testing

Qualified physicians may now order *in vitro* allergy testing for Medicaid members where *in vivo* (skin) testing is not available for a particular allergen or for members who are unable to participate in traditional skin testing due to one or more of the following contraindications:

- Extensive skin condition, such as psoriasis, severe eczema or symptomatic dermagraphism;
- Inability to discontinue medications, such as antihistamines, that will affect test results;
- Children age 3 years and younger.

Allergy testing (*in vivo/in vitro*) may be covered only for the following conditions:

- Suspected food allergies;
- Suspected stinging insect allergies;
- Chronic rhinitis or conjunctivitis where the cause is suspected environmental allergies and the patient has been nonresponsive to avoidance and pharmacologic therapy;
- Suspected medication allergy, when no alternative is available and treatment is medically necessary;
- Suspected allergic dermatitis.

Oral Ingestion Challenge Testing

The addition of oral ingestion challenge testing may be medically necessary for those patients for whom a diagnosis of a food allergy or allergy to an oral drug has been inconclusive or inconsistent with clinical symptoms. In general, oral ingestion challenge testing should not be used as first-line testing for allergies. Oral ingestion challenge testing should only be performed in a carefully supervised allergy specialist setting, with emergency support immediately available. Oral ingestion challenge testing is a covered service when

considered medically necessary to confirm a positive *in vivo/in vitro* test result or to test for an allergic response to:

- Foods/ingested substances when *in vivo/in vitro* testing is inconclusive or inconsistent with clinical symptoms; or
- Oral medications, when all of the following are met:
    - Patient has a history of allergy to a specified drug; and
    - There is no effective alternative or equivalent drug; and
    - Patient requires treatment with the drug class.

Reminders:

- A complete physical exam and a detailed review of the patient's clinical history is expected prior to performing allergy testing.
- Testing should be performed only by licensed physicians who possess the competency to interpret results, manage possible adverse reactions and determine an appropriate course of treatment.
- Appropriate billing is the responsibility of all Medicaid providers and retrospective reviews may be conducted periodically through a Medicaid-funded utilization management contractor or the Office of the Medicaid Inspector General. The ordering physician must maintain sufficient documentation regarding the required patient history to clearly support the medical necessity of the test. In accordance with the New York Code of Rules and Regulations, 18 NYCRR 504.8 (a) (2); per 18 NYCRR 540.7 (a) (8), medical records must be maintained by providers for a period of not less than six years from the date of payment.

CPT code	Description	Number of tests eligible for reimbursement in a 5 year period (for members that meet the criteria)
95004	Percutaneous tests (scratch, puncture, prick) with allergenic. extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests	60
95017	Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests	60
95018	Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests	60

95024	Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests	40
95027	Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report by a physician, specify number of tests	40
95028	Intracutaneous (intradermal) tests with allergenic extracts, delayed type reaction, including reading, specify number of tests	40
95044	Patch or application tests(s) (specify number of tests)	40
95076	Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); initial 120 minutes of testing	As medically necessary
95079	Ingestion challenge test - each additional 60 minutes of testing (list separately in addition to code for primary procedure)	As medically necessary
86003	Allergen specific IgE; quantative or semiquantative, each allergen	30

Questions regarding Medicaid FFS policy should be directed to the Division of Program Development and Management at (518) 473-2160. Questions regarding MMC reimbursement and/or documentation requirements should be directed to the enrollee's MMC plan.

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Policy & Billing Guidance

Updated Guidance and Clarification on Use of the JW Modifier

The following article is to provide clarification and additional guidance associated with the use of the JW modifier. Directions on required documentation and how to report drug units administered are provided in the italicized print.

The JW modifier is used to report the unused portion of a drug or biologic, appropriately discarded, from a **single-use vial/package**.

Medicaid fee-for-service (FFS) will reimburse providers for the unused portion of single-use drugs or biologics, when the provider uses the JW modifier. Drug waste from multi-use vials/packages will not be reimbursed.

FFS Billing Guidance:

The provider must report both the portion of the drug that was administered along with the portion that was wasted. Payment will not exceed the maximum amount of the drug or biologic as indicated on the single-use vial or package's label. Note: The claim must include an amount that was administered in order for the wastage from the single-use vial/package to be billable.

This information should be reported on two lines:

- **Line one** – HCPCS drug code and the number of units administered. *Providers administering a portion of a unit are to round up to the nearest unit. If through rounding up to the nearest unit, the number of units reported on line one equals the total number units contained in the single-use vial/package, the JW modifier should not be reported.*

- **Line two** – HCPCS drug code appended with the JW modifier and the number of units **not** administered (discarded). *When the units discarded are reported on line one (through rounding up to the nearest unit), they should not be reported again on line two.*

Examples:

- One billing unit is equal to 10 mg of a drug. A single-use vial contains 10 mg or one unit. A 7 mg dose is administered to a patient while 3 mg is discarded. The 7 mg dose is rounded up to 10 mg (one unit) and is reported on line one. Billing another unit on line two with the JW modifier for the discarded 3 mg of drug is not permitted, because it would result in overpayment.

- One billing unit is equal to 10 mg of a drug. A single-use vial contains 20 mg or two units. A 7 mg dose is administered to a patient while 13 mg are discarded. The 7 mg dose is rounded up to 10 mg or one unit. This is reported on line one. The additional 10 mg (one unit) that was discarded is reported on line two with the JW modifier.

Providers must clearly document in the medical record the amount of the single-use vial/package that was administered, the amount that was wasted, and the total amount that the vial/package contained. Failure to include this information could result in denial of the claim.

The total number of units reported on lines one and two should not exceed the total number of units contained in the single dose vial/package.

Note: When submitting a paper claim, **multiple drug procedure codes reported for the same date of service must be submitted on separate claim forms so that the J-code is reported on the first claim line of each claim.**

For additional guidance, please see the December 2008 Medicaid Update article titled, "Billing Instructions for Physician-Administered Drugs (J-codes) Submitted on Paper Claims."

For additional guidance on use of the JW modifier, please see the August 2015 Medicaid Update article titled, "Clarification of Policy for Practitioner, Ordered Ambulatory, and APG Reimbursement *and* New Billing Instructions for Wasted Drugs Using JW Modifier."

Policy questions regarding Medicaid FFS may be directed to Office of Health Insurance Programs, Division of Program Development and Management at (518) 473-2160.

Questions regarding MMC billing and reimbursement should be directed to the enrollee's MMC Plan. Questions on billing or claims should be directed to CSC at 1-800-343-9000.

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Policy & Billing Guidance

Elective Deliveries Prior to 39 Weeks Gestation (Inductions of Labor and Cesarean Sections)

This article is an update to the June 2013, June 2014, April 2015, and April 2016 articles and supersedes all previously published guidelines.

Background:

The New York State Medicaid Redesign Team Basic Benefit Work Group's final recommendations include reducing payments for elective C-section deliveries and inductions of labor under 39 weeks gestation unless a documented medical indication is present. Evidence suggests that infants delivered prior to 39 weeks have an increased chance of complications and double the mortality rate of infants delivered at full term. Maternal concerns include an increased risk of infection, injury to reproductive and other organs and subsequent infertility, complications related to anesthesia, and difficulty with breast-feeding.

New York State Medicaid has been reducing payments for **elective** deliveries (C-section and induction of labor) less than 39 weeks gestation without an acceptable indication for Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC) enrollees.

Effective April 1 2016, claims for elective deliveries prior to 39 weeks gestation, without medical indication, were further reduced from 25% to **50%** for Medicaid FFS. This further reduction will also be applicable to MMC effective July 1, 2016**.** The increased penalty reflects the Medicaid Program's commitment to providing high quality prenatal care by ensuring appropriate delivery for both mothers and babies. This penalty also applies to GME claims submitted on behalf of MMC members.

Appendix 1 in this article contains a list of ICD-10 acceptable diagnosis codes. These codes must be reported on the medical claim in the primary position as the principal diagnosis on the claim.

Introduction:

The Medicaid program has become aware of claiming issues related to early elective deliveries resulting from the ICD-10 transition in October 2015. To address these issues, the Department is providing updated guidance, including ICD-10 procedure codes and ICD-10 diagnosis codes, for billing obstetrical deliveries. For the purpose of Medicaid billing, an obstetrical delivery occurring at less than 39 weeks gestation is considered "preterm."

Note: The ICD-10 diagnosis codes included in Appendix 1 apply to claims submitted for dates of service beginning October 1, 2015 forward.

Inpatient Hospital Claim Billing Guidance:

Elective C-sections or inductions of labor, whether prior to 39 weeks gestation or after 39 weeks gestation, require the use of a condition code (81, 82, or 83)**.** If the delivery is the result of a spontaneous vaginal delivery after 39 weeks (and does not require augmentation of labor, result in a C-section delivery, or require artificial rupture of membranes), no condition code is reported on the claim as the procedure code is not included among those that require condition codes.

Table 1 in this article contains the ICD-10 procedure codes requiring a condition code regardless of gestational age.

Note: Only obstetrical deliveries involving either an induction of labor/augmentation of labor, artificial rupture of membranes, or C-sections require the use of a condition code. All other vaginal deliveries resulting from a spontaneous labor do not require the use of a condition code.

If any of the ICD-10 procedure codes in **Table 1** are reported following spontaneous labor, please report with ICD-10 diagnosis code O60.10X0 (Preterm labor with preterm delivery, unspecified trimester, not applicable or unspecified) in the primary position as the principal diagnosis.

Note: *Do not report code O60.10X0 if procedures listed in **Table 1** have been completed as an **elective** induction of labor prior to 39 weeks gestation.*

Failure to report a **condition code** (81, 82, or 83) for those ICD-10 procedure codes included in **Table 1** will result in the claim being denied.

Condition Codes:

- **Condition code 81** - C-sections or inductions performed at **less than 39 weeks gestation for medical necessity.**
- **Condition code 82** - C-sections or inductions performed at **less than 39 weeks gestation electively.**
- **Condition code 83** - C-sections or inductions performed **at 39 weeks gestation or greater.**

Table 1: ICD-10 Procedure Codes Requiring a Condition Code

ICD-10 Procedure Code	Description
10900ZC	Drainage of amniotic fluid, therapeutic from products of conception, open approach
10903ZC	Drainage of amniotic fluid, therapeutic from products of conception, percutaneous approach
10904ZC	Drainage of amniotic fluid, therapeutic from products of conception, endoscopic approach
10907ZC	Drainage of amniotic fluid, therapeutic, from products of conception, via natural or artificial opening
10908ZC	Drainage of amniotic fluid, therapeutic from products of conception, via natural or artificial opening endoscopic
0U7C7ZZ	Dilation of cervix, via natural or artificial opening
3E030VJ	Introduction of other hormone into peripheral vein, open approach.
3E033VJ	Introduction of other hormone into peripheral vein, percutaneous approach
3E0P7GC	Introduction of other therapeutic substance into female reproductive, via natural or artificial opening
10D00Z0	Extraction of products of conception, classical open approach
10D00Z1	Extraction of products of conception, low cervical, open approach
10D00Z2	Extraction of products of conception, extraperitoneal, open approach

Practitioner Claim Billing Guidance:

Elective C-sections or inductions of labor, when reported with one of the procedure codes in **Table 2,** whether prior to 39 weeks gestation or after 39 weeks gestation, require the use of a modifier (U8 or U9)**.** If the delivery is the result of a spontaneous labor after 39 weeks (and does not require augmentation of labor or result in a C-section), no modifier is required as the procedure code is not included in **Table 2**.

Medicaid FFS *and* MMC claims submitted by *practitioners* for the obstetric delivery procedure codes included in **Table 2** *will require a modifier.*

Spontaneous labor resulting in a delivery less than 39 weeks gestation.

If the delivery occurs prior to 39 weeks gestation and the delivery (C-section or vaginal) occurs as a result of spontaneous labor, report modifier U8 and the claim will pay in full if the following ICD-10 diagnosis code is reported IN THE PRIMARY POSITION: **O60.10X0 - Preterm labor with preterm delivery**

Table 2: CPT Procedure Codes Requiring a Modifier

CPT Procedure Code	Description
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care.
59409	Vaginal delivery only (with or without episiotomy and/or forceps).
59410	Including postpartum care
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care.
59514	Cesarean delivery only.
59515	Including postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy and/or forceps).
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps).
59614	Including postpartum care
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery.
59622	Including postpartum care

Practitioner claims for obstetric deliveries, when reported with one of the procedure codes in **Table 2**, must include one of the following modifiers:

- U8 – delivery prior to 39 weeks gestation
- U9 – delivery at 39 weeks gestation or later

Failure to include a U8 or U9 modifier, as appropriate, on a claim will result in denial of the claim.

Claim Denials:

- If a practitioner and/or hospital claim is denied for payment due to lack of an appropriate condition code or modifier, please resubmit the claim with the appropriate modifier or condition code. Questions should be directed to the eMedNY Call Center at (800) 343-9000.

Appeal Process:

1.) A 50% reduction in either the hospital inpatient claim or a practitioner claim may be appealed through the following process:

2.) Medicaid FFS practitioners or hospitals may request an appeal by contacting the Division of Program Development and Management at (518) 473-2160.

3.) Medicaid FFS appeals will be referred to Island Peer Review Organization (IPRO) for review.

4.) A decision will be rendered by IPRO following clinical review. Providers will be asked to submit a written clinical justification, along with a medical record. If the appeal is upheld, no additional payment will be made. If the appeal is overturned, the claim will be re-adjudicated and payment will be restored to 100%.

A provider who wishes to appeal a payment reduction made by a MMC plan should contact the MMC plan to get details on the appeal process. Practitioners and hospitals are responsible for ensuring that the codes (and modifiers when applicable) submitted for reimbursement accurately reflect the diagnosis and procedure(s) that were reported. Post payment reviews may be conducted by the Office of the Medicaid Inspector General and/or through a Medicaid-funded utilization management contractor, as appropriate (pursuant to 18 NYCRR 504.8) on adjudicated claims. Medical records must be maintained by providers for a period of not less than six years from the date of payment.

Appendix 1: ICD-10 Acceptable Diagnosis Codes

L40.1	O29.293	O31.8X39	O35.1XX4	O35.9XX5	O36.1929	O36.5930	O40.2XX1	O41.1432	O46.093	O60.23X9
O10.03	O29.3X2	O32.0XX0	O35.1XX5	O35.9XX9	O36.1930	O36.5931	O40.2XX2	O41.1433	O46.8X2	O62.3
O10.112	O29.3X3	O32.0XX1	O35.1XX9	O36.0120	O36.1931	O36.5932	O40.2XX3	O41.1434	O46.8X3	O68
O10.113	O30.002	O32.0XX2	O35.2XX0	O36.0121	O36.1932	O36.5933	O40.2XX4	O41.1435	O60.10X0	O69.0XX0
O10.212	O30.003	O32.0XX3	O35.2XX1	O36.0122	O36.1933	O36.5934	O40.2XX5	O41.1439	O60.10X1	O69.0XX1
O10.213	O30.012	O32.0XX4	O35.2XX2	O36.0123	O36.1934	O36.5935	O40.2XX9	O42.012	O60.10X2	O69.0XX2
O10.312	O30.013	O32.0XX5	O35.2XX3	O36.0124	O36.1935	O36.5939	O40.3XX0	O42.013	O60.10X3	O69.0XX3
O10.313	O30.022	O32.0XX9	O35.2XX4	O36.0125	O36.1939	O36.62X0	O40.3XX1	O42.02	O60.10X4	O69.0XX4
O10.412	O30.023	O32.1XX0	O35.2XX5	O36.0129	O36.22X0	O36.62X1	O40.3XX2	O41.1020	O60.10X5	O69.0XX5
O10.413	O30.032	O32.1XX1	O35.2XX9	O36.0130	O36.22X1	O36.62X2	O40.3XX3	O41.1021	O60.10X9	O69.0XX9
O10.42	O30.033	O32.1XX2	O35.3XX0	O36.0131	O36.22X2	O36.62X3	O40.3XX4	O41.1022	O60.12X0	O69.4XX0
O10.43	O30.042	O32.1XX3	O35.3XX1	O36.0132	O36.22X3	O36.62X4	O40.3XX5	O41.1023	O60.12X1	O69.4XX1
O10.913	O30.043	O32.1XX4	O35.3XX2	O36.0133	O36.22X4	O36.62X5	O40.3XX9	O41.1024	O60.12X2	O69.4XX2
O11.2	O30.092	O32.1XX5	O35.3XX3	O36.0134	O36.22X5	O36.62X9	O41.02X0	O41.1025	O60.12X3	O69.4XX3
O11.3	O30.093	O32.1XX9	O35.3XX4	O36.0135	O36.22X9	O36.63X0	O41.02X1	O41.1029	O60.12X4	O69.4XX4
O12.12	O30.102	O32.2XX0	O35.3XX5	O36.0139	O36.23X0	O36.63X1	O41.02X2	O41.1030	O60.12X5	O69.4XX5
O12.13	O30.103	O32.2XX1	O35.3XX9	O36.0920	O36.23X1	O36.63X2	O41.02X3	O41.1031	O60.12X9	O69.4XX9
O12.22	O30.112	O32.2XX2	O35.4XX0	O36.0921	O36.23X2	O36.63X3	O41.02X4	O41.1032	O60.13X0	O71.02
O12.23	O30.113	O32.2XX3	O35.4XX1	O36.0922	O36.23X3	O36.63X4	O41.02X5	O41.1033	O60.13X1	O71.03
O14.02	O30.122	O32.2XX4	O35.4XX2	O36.0923	O36.23X4	O36.63X5	O41.02X9	O41.1034	O60.13X2	O75.82
O14.03	O30.123	O32.2XX5	O35.4XX3	O36.0924	O36.23X5	O36.63X9	O41.03X0	O41.1035	O60.13X3	O76
O14.12	O30.192	O32.2XX9	O35.4XX4	O36.0925	O36.23X9	O36.72X0	O41.03X1	O41.1039	O60.13X4	O77.0
O14.13	O30.193	O32.3XX0	O35.4XX5	O36.0929	O36.4XX0	O36.72X1	O41.03X2	O42.112	O60.13X5	O77.1
O14.22	O30.202	O32.3XX1	O35.4XX9	O36.0930	O36.4XX1	O36.72X2	O41.03X3	O42.113	O60.13X9	O77.8
O14.23	O30.203	O32.3XX2	O35.5XX0	O36.0931	O36.4XX2	O36.72X3	O41.03X4	O42.12	O60.14X0	O80
O14.92	O30.212	O32.3XX3	O35.5XX1	O36.0932	O36.4XX3	O36.72X4	O41.03X5	O42.912	O60.14X1	O88.212
O14.93	O30.213	O32.3XX4	O35.5XX2	O36.0933	O36.4XX4	O36.72X5	O41.03X9	O42.913	O60.14X2	O88.213
O15.02	O30.222	O32.3XX5	O35.5XX3	O36.0934	O36.4XX5	O36.72X9	O41.1220	O42.92	O60.14X3	O88.22
O15.03	O30.223	O32.3XX9	O35.5XX4	O36.0935	O36.4XX9	O36.73X0	O41.1221	O43.012	O60.14X4	O88.32
O15.1	O30.292	O32.6XX0	O35.5XX5	O36.0939	O36.5120	O36.73X1	O41.1222	O43.013	O60.14X5	O88.312
O15.2	O30.293	O32.6XX1	O35.5XX9	O36.1120	O36.5121	O36.73X2	O41.1223	O43.021	O60.14X9	O88.313

O22.52	O30.802	O32.6XX2	O35.6XX0	O36.1121	O36.5122	O36.73X3	O41.1224	O43.022	O60.20X0	O88.82
O22.53	O30.803	O32.6XX3	O35.6XX1	O36.1122	O36.5123	O36.73X4	O41.1225	O43.023	O60.20X1	O88.812
O24.02	O30.812	O32.6XX4	O35.6XX2	O36.1123	O36.5124	O36.73X5	O41.1229	O44.02	O60.20X2	O88.813
O24.012	O30.813	O32.6XX5	O35.6XX3	O36.1124	O36.5125	O36.73X9	O41.1230	O44.03	O60.20X3	O98.712
O24.013	O30.822	O32.6XX9	O35.6XX4	O36.1125	O36.5129	O36.8120	O41.1231	O44.12	O60.20X4	O98.713
O24.913	O30.823	O34.21	O35.6XX5	O36.1129	O36.5130	O36.8121	O41.1232	O44.13	O60.20X5	O98.719
O26.43	O30.892	O34.522	O35.6XX9	O36.1130	O36.5131	O36.8122	O41.1233	O45.012	O60.20X9	O98.72
O26.613	O30.893	O34.523	O35.8XX0	O36.1131	O36.5132	O36.8123	O41.1234	O45.013	O60.22X1	O99.112
O26.62	O31.8X21	O35.0XX0	O35.8XX1	O36.1132	O36.5133	O36.8124	O41.1235	O45.022	O60.22X2	O99.113
O26.832	O31.8X22	O35.0XX1	O35.8XX2	O36.1133	O36.5134	O36.8125	O41.1239	O45.023	O60.22X3	O99.12
O26.833	O31.8X23	O35.0XX2	O35.8XX3	O36.1134	O36.5135	O36.8129	O41.1420	O45.092	O60.22X4	O99.412
O29.013	O31.8X24	O35.0XX3	O35.8XX4	O36.1135	O36.5139	O36.8130	O41.1421	O45.093	O60.22X5	O99.413
O29.112	O31.8X25	O35.0XX4	O35.8XX5	O36.1139	O36.5920	O36.8131	O41.1422	O45.8X2	O60.22X9	O99.42
O29.113	O31.8X29	O35.0XX5	O35.8XX9	O36.1920	O36.5921	O36.8132	O41.1423	O45.8X3	O60.23X0	O9A.112
O29.122	O31.8X31	O35.0XX9	O35.9XX0	O36.1921	O36.5922	O36.8133	O41.1424	O46.012	O60.23X1	O9A.113
O29.123	O31.8X32	O35.1XX0	O35.9XX1	O36.1922	O36.5923	O36.8134	O41.1425	O46.013	O60.23X2	O9A.12
O29.212	O31.8X33	O35.1XX1	O35.9XX2	O36.1923	O36.5924	O36.8135	O41.1429	O46.022	O60.23X3	Q79.3
O29.213	O31.8X34	O35.1XX2	O35.9XX3	O36.1924	O36.5925	O36.8139	O41.1430	O46.023	O60.23X4	Z37.1
O29.292	O31.8X35	O35.1XX3	O35.9XX4	O36.1925	O36.5929	O40.2XX0	O41.1431	O46.092	O60.23X5	

Policy questions regarding Medicaid FFS may be directed to the Office of Health Insurance Programs, Division of Program Development and Management at (518) 473-2160.

Questions on Medicaid FFS billing or claims should be directed to CSC at 1-800-343-9000.
Questions regarding MMC billing and reimbursement should be directed to the enrollee's MMC plan.

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Transgender Related Care and Services Update

This article is an update to the June 2015 Medicaid Update article entitled, "New York State Medicaid Updates Regulations." New York State Medicaid has amended its regulations at 18 NYCRR 505.2(*l*), effective April 27, 2016, to make the following changes:

1. Gender reassignment surgery is covered for individuals 18 years and older who meet all criteria for surgery, regardless of whether the surgery will result in sterilization.

2. Psychiatric nurse practitioners have been added to the list of health care professionals who may write either the first or the second letter recommending the patient for gender reassignment surgery.

As a reminder, physicians performing gender reassignment surgery must obtain, and retain in their records, letters from two New York State licensed health professionals recommending such surgery for the patient. One letter must be written by a New York State licensed psychiatrist, psychologist, or psychiatric nurse practitioner who has an ongoing relationship with the patient. The second letter may be written by a New York State licensed psychiatrist, psychologist, physician, psychiatric nurse practitioner, or licensed clinical social worker working within their scope of practice. The recommendation for surgery in each letter must be based on an independent assessment/evaluation of the individual.

At a minimum, these letters must establish that the individual:

1. Has a persistent and well-documented case of gender dysphoria;

2. Has received hormone therapy appropriate to the individual's gender goals, which shall be for a minimum of 12 months in the case of an individual seeking genital surgery, unless hormone therapy is medically contraindicated or the individual is otherwise unable to take hormones;

3. Has lived for 12 months in a gender role congruent with the individual's gender identity, and has received mental health counseling, as deemed medically necessary, during that time;

4. Has no other significant medical or mental health conditions that would contraindicate gender reassignment surgery, or if so, that those conditions are reasonably well-controlled prior to surgery;

5. Has the capacity to make a fully informed decision and to consent to treatment.

For complete billing guidance for gender reassignment surgery, please see the Physician-Surgery provider manual.

For questions regarding Medicaid fee-for-service policy, providers should contact the Division of Program Development and Management at (518) 473-2160. For questions regarding Medicaid Managed Care (MMC), providers should contact the enrollee's MMC plan directly for implementation details.

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Pharmacy Update

Medicaid Pharmacy
Prior Authorization Programs Update

On April 27, 2016, the New York State Medicaid Drug Utilization Review Board (DURB) recommended changes to the Medicaid Fee-For-Service (FFS) pharmacy Prior Authorization (PA) programs. The Commissioner of Health has reviewed the recommendations of the Board and has approved changes to the Preferred Drug Program (PDP):

Effective May 26, 2016, PA requirements will change for some drugs in the Hepatitis C – Direct Acting Antivirals class:

- Preferred Agents: ribavirin, Daklinza, Harvoni, Sovaldi, Technivie, Viekira Pak, Zepatier
- Non-Preferred Agents: Copegus, Moderiba, Olysio, Rebetol, Ribapak, Ribasphere

In addition, the Hepatitis C – Direct Acting Antiviral clinical criteria has changed. Disease prognosis and severity has been eliminated. Remaining criteria includes:

- **FDA labeling and compendia supported use**
    - Verification of diagnosis, genotype, dosing and duration, etc.
- **Prescriber experience and training**
    - Prescribed by hepatologist, gastroenterologist, infectious disease specialist, transplant physician or health care practitioner experienced and trained in the treatment of HCV or a healthcare practitioner under the direct supervision of a listed specialist.

    AND

    - Clinical experience is defined as the management and treatment of at least 10 patients with HCV infection in the last 12 months and at least 10 HCV- related CME credits in the last 12 months.

    OR

    - Management and treatment of HCV infection in partnership (defined as consultation, preceptorship, or via telemedicine) with an experienced HCV provider who meets the above criteria.
- **Patient readiness and adherence**
    - Evaluation by using scales or assessment tools readily available to healthcare practitioners at: http://www.integration.samhsa.gov/clinical-practice/screening-tools or https://prepc.org/ to

determine a patient's readiness to initiate HCV treatment, specifically drug and alcohol abuse potential.

Effective June 30, 2016, PA requirements will change for some drugs in the following classes:

- **Non-steroidal anti-inflammatory drugs (NSAIDs) – Prescription**
- **Opioids – Long Acting**
- **Antipsychotics - Injectable**
- **Selective Serotonin Reuptake Inhibitors (SSRIs)**
- **Antibiotics - Topical**
- **Fluoroquinolones – Otic**
- **Antihistamines – Second Generation***
- **Beta-2 Adrenergic Agents – Inhaled Long-Acting**

*cetirizine OTC tablets will remain preferred due to a recent change in pricing as impacted by new Federal Upper Limits (FULs)

The PDP has also expanded to include an additional drug class. Non-preferred drugs in the following class will require PA:

- **Acne Agents – Prescription, Topical**

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 Medicaid FFS Pharmacy 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 **1-877-309-9493**. 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 a button "PAXpress" located on eMedNY.org under the MEIPASS button.

Additional information, such as the Medicaid Standardized PA form and clinical criteria are available at the following websites:

http://www.nyhealth.gov or http://newyork.fhsc.com or http://www.eMedNY.org

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Pharmacy Update

Medicaid Fee-For-Service Providers
Dispense Brand Name Drug When Less Expensive Than Generic Program

Revised

Effective 05/26/2016, the following changes will be made to the Dispense Brand Name Drug when Less Expensive than Generic Program:

- **Imitrex Kit (pens and Cartridges)** will be **added** to the program.
- **Ability Tablets*, Cymbalta and Renvela Tablets** will be **removed** from the program.

*Ability Solution remains in the program

In conformance with State Education Law which intends that patients receive the lower cost alternative, brand name drugs included in this program:

Do not require 'Dispense as Written' (DAW) or 'Brand Medically Necessary' on the prescription.
Have a generic copayment.
Are paid at the Brand Name Drug reimbursement rate or usual and customary price, whichever is lower (SMAC/FUL are not applied).
Do not require a new prescription if the drug is removed from this program.

IMPORTANT BILLING INFORMATION
Prescription claims submitted to the Medicaid program **do not require** the submission of Dispense as Written/Product Selection Code of '1'; **Pharmacies can submit any valid NCPDP field (408-D8) value.**

List of Brand Name Drugs included in this program* ***(Updated): 05/16/2016***

Ability Solution	Exelon Patch	Pulmicort Respules
Adderall XR	Focalin XR 5mg, 10mg, 15mg,20mg,30mg,40mg	Soriatane
Aggrenox	Gabitril 2mg, 4mg	Tegretol suspension
Aldara	Gleevec	Tegretol XR
Alphagan P 0.15%	Hepsera	Tobradex suspension
Astepro	**Imitrex Kit (pens and Cartridges)**	Tricor
Baraclude	Kapvay	Trilipix
Catapres-TTS	Mepron	Trizivir
Cellcept suspension	Myfortic	Valcyte
Combivir	Nasonex	Voltaren Gel
Copaxone 20ml SQ	Niaspan	Xeloda
Diastat	Patanase	Xenazine
Epivir HBV tablet	Protopic	

*List is subject to change

Please keep in mind that drugs in this program may be subject to prior authorization requirements of other pharmacy programs, promoting the use of the most cost-effective product.

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Provider Directory

Office of the Medicaid Inspector General:
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.

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

Medicaid Prescriber Education Program:
For current information on best practices in pharmacotherapy, please visit the following websites:
http://www.health.ny.gov/health_care/medicaid/program/prescriber_education/presc-educationprog
http://nypep.nysdoh.suny.edu/home

Need to change your address? Does your enrollment file need to be updated because you have experienced a change in ownership? Do you want to enroll another NPI? Did you receive a letter advising you to revalidate your enrollment?
Visit https://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.

Comments and Suggestions Regarding This Publication?
Please contact the editor, Amy Siegfried, at medicaidupdate@health.ny.gov