



# Medicaid Update

The Official Newsletter of the New York State Medicaid Program

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## Medicaid Pharmacy Prior Authorization Programs Update

On April 26, 2018, the New York State Medicaid Drug Utilization Review (DUR) Board recommended changes to the Medicaid 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) within the fee-for-service (FFS) pharmacy program. **Effective August 2, 2018**, PA requirements will change for some drugs in the following PDP classes:

- Cephalosporins – Third Generation
- Anti-infectives - Topical
- Steroids, Topical – Medium Potency
- Steroids, Topical – High Potency
- Dipeptidyl Peptidase-4 (DPP-4) Inhibitors
- Sodium Glucose Co-Transporter 2 (SGLT2) Inhibitors
- Anticoagulants - Injectable
- Antihistamines - Ophthalmic
- Leukotriene Modifiers

For more detailed information on the above DUR Board recommendations, please refer to the meeting summary at: [http://www.health.ny.gov/health\\_care/medicaid/program/dur/meetings/2017/04/summary\\_durb.pdf](http://www.health.ny.gov/health_care/medicaid/program/dur/meetings/2017/04/summary_durb.pdf).

Please note that PA requirements are not dependent on the date a prescription is written. New prescriptions and refills on existing prescriptions require PA even if the prescription was written before the date the drug was determined to require PA.

The following 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 PDP, Clinical Drug Review Program (CDRP), DUR Program, Brand Less than Generic Program (BLTG), Dose Optimization Program and the Mandatory Generic Drug Program (MGDP): [https://newyork.fhsc.com/downloads/providers/NYRx\\_PDP\\_PDL.pdf](https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf).

To obtain a PA, please call the PA clinical call center at 1-877-309-9493. The clinical call center is available 24 hours per day, seven days per week with pharmacy technicians and pharmacists who will work with you, or your agent, to quickly obtain a PA.

Medicaid-enrolled prescribers with an active e-PACES account can initiate PA requests through the web-based application PAXpress®. The website for PAXpress is <https://paxpress.nypa.hidinc.com/>. The website may also be accessed through the eMedNY website at <http://www.eMedNY.org>, as well as Magellan Medicaid Administration's website at <http://newyork.fhsc.com>.

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# Policy & Billing Guidance

## Skin Substitutes in the Office Setting

The following billing guidance is for professional providers of fee-for-service (FFS) Medicaid using skin substitutes in the office setting. For clinic billing, please refer to: [www.health.ny.gov/health\\_care/medicaid/rates/apg/index.htm](http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm). Professional providers must refer to the Fee Schedules found on [www.emedny.org](http://www.emedny.org).

If there is a specific “Q” code on the Fee Schedule for the skin substitute, the provider must bill using that “Q” code. If there is not a “Q” code listed for the skin substitute, providers should use CPT 99070: Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or material provided).

All skin substitutes require medical review and must be billed on the New York State eMedNY-150003 paper claim form with supporting medical documentation and invoice attached.

Questions regarding Medicaid FFS billing or paper claim form submission should be directed to eMedNY Provider Services at (800) 343-9000. Questions regarding Medicaid FFS policy may be directed to the Office of Health Insurance Programs, 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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## Timely Billing Webinar

The Bureau of Medical Review, Pended Claims Unit will be conducting a webinar on August 9, 2018 at 10:00 a.m. for all providers regarding the Department’s timely filing edits and procedures. Topics that will be discussed include:

- Use of Adjustments vs. Voids in Claims Correction
- Use of Delay Reason codes
- Specific instances where delay reason Codes are not needed for Claims processing

There will be time available at the end of the presentation to take questions from participants. The webinar will be limited to 150 participants and advanced registration is required. To enroll for the webinar, please click on the following link: <https://csra.webex.com/csra/k2/j.php?MTID=t65447092fb5e4fea96c21e0ed9eb567b>.

**Due to an overwhelming response to the announcement on eMEDNY.org of this webinar, the August 9, 2018 is full. At this time, we are working with CSRA to schedule another session later in August that will accommodate more people who wish to attend the webinar. Please look for notification of the next scheduled date announcement through the eMEDNY.org listserv for all providers.**

For more information, please contact the Bureau of Medical Review, Pended Claims Unit at 1-800-342-3005 (option 3).

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# Provider Training Schedule and Registration

Do you have billing questions? Are you new to Medicaid billing? Would you like to learn more about ePACES? If you answered "yes" to any of these questions, consider registering for a Medicaid training session. eMedNY offers various types of educational opportunities to providers and their staff. Training sessions are available at no cost to providers and include information for claim submission, Medicaid Eligibility Verification, the eMedNY website, and ePACES.

**Seminars** are a valuable opportunity to meet personally with CSRA's eMedNY Regional Representatives in your area. Seminars are in-person training sessions with groups of providers and billing staff conducted at locations throughout NYS. For seminars offered at a location near you, please check the eMedNY website at: <http://www.emedny.org/training/index.aspx>.

**Webinar Training Also Available** - You may also register for a webinar. Webinar training sessions will be conducted online and you will be able to join the meeting from your computer and telephone. After registration is completed, you will receive an email with instructions to join the online meeting and then just log in at the announced time. **No travel is involved.**

Many sessions offer detailed instruction about Medicaid's free web-based program ePACES, the electronic provider assisted claim entry system that allows enrolled providers to submit the following types of transactions:

- Claims
- Eligibility Verifications
- Claim Status Requests
- Prior Approval/DVS Requests

Fast and easy registration, locations and dates are available on eMedNY website at: <http://www.emedny.org/training/index.aspx>. The website is updated quarterly with new sessions. eMedNY Regional Representatives look forward to having you join them at upcoming training sessions. If you are unable to access the internet to register or have questions about registration, please contact the eMedNY Call Center at (800) 343-9000.

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## Pharmacy Update

### Update on Medicaid FFS Pharmacy Billing Instructions for Coordination of Benefits Submission

**Effective July 26, 2018**, the NYS Department of Health (DOH) will implement system enhancements to improve the submission of Medicaid fee-for-service (FFS) pharmacy claims when the patient has other third-party coverage. These changes are being made to ensure that all values in specified fields are recognized and function appropriately, other patient responsibility amounts are accepted, and other third-party insurance billing is validated when the claim is not covered. This is an update to previous guidance on this topic issued in the [May 2014 Medicaid Update](#).

Coordinating benefits ensures the correct party pays first. **Medicaid is always the payor of last resort; federal regulations require that all other available resources be used before Medicaid considers payment.** If there is a responsible third-party that should be paying for the patients' health benefits, such as a health insurance provider, the responsible third-party should pay first.

Medicaid pays the lesser of Patient Responsibility (PR) or the Medicaid fee, regardless of the PR amount. For pharmacy, this rule applies to all PR, which includes deductible, co-insurance, copay, and other patient responsibility.

The list of values reported in field 308-C8 (Other Coverage Code) below are considered acceptable. This field is used by the pharmacy to indicate whether the patient has other insurance coverage or is enrolled in a Medicare Managed Care Organization (MCO).

#### Valid entries for field 308-C8 are:

- 0 = Not Specified
- 1 = No Other Coverage Identified
- 2 = Other Coverage Exists, Payment Collected
- 3 = Other Coverage Exists, This Claim Not Covered
- 4 = Other Coverage Exists, Payment Not Collected

**The updates below will be made to the specified values submitted in field 308-C8 when the Other Coverage Code of "3" is submitted. The following codes *will not* be accepted in NCPDP field 472-6E, 'Other Payer Reject Codes' and *will not* be allowed to be returned on a claim.**

#### Invalid Entries for field 472-6E are:

- 75 (Prior Authorization Required)
- 39 (M/I Diagnosis Code)
- 76 (Plan Limitations Exceeded)
- 80 (Drug - Diagnosis Mismatch)
- 79 (Refill too Soon)
- 88 (DUR Reject Error)
- MR (Product Not on Formulary)

A pre-adjudication edit was developed for this field and will return the NCPDP Reject Code (DE 3988) '6E - M/I Other Payer Reject Code' if one of these values are used.

**The Provider must work with the primary insurance to obtain coverage for the member. This could involve prior authorization requirements, appeal processes, or changes to medications ordered to align with the primary plans formulary products, etc.** If all attempts for coverage have been exhausted and coverage has not been granted from the primary insurer, DOH may consider the denial under special

circumstances. The medication in question would still be subject to any editing requirements under the Medicaid FFS program.

Contact the eMedNY Call Center at (800) 343-9000 for questions regarding Coordination of Benefits billing or any billing issue.

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## Pharmacy Coverage for Children in Foster Care Facilities

Most of the medication costs for children residing in Foster Care facilities or group homes are covered by the Medicaid per diem paid to the facility. There are times, however, where the cost of the medication exceeds a cost sustainable by the per diem. The list of drugs that are carved out of the per diem rate has been updated and posted on the Department of Health website. **Effective August 1, 2018**, drugs on this list can be billed directly to Medicaid fee-for-service.

This list is subject to change due to ongoing market activity and will be reviewed regularly. Coverage of high-cost drugs not included on this list will be considered on a case-by-case basis. The agency should send such requests to the Office of Children and Family Services. All claims will be subject to fee-for-service [Preferred Drug List \(PDL\)](#) criteria and prior approval process if applicable.

Preferred agents in the following classes on the PDL

- Anticholinergics / COPD Agents
- Antipsychotics – Second Generation
- Antipsychotics, Injectable
- Anti-Virals – Topical
- Benzodiazepines – Rectal
- Biguanides
- Central Nervous System (CNS) Stimulants
- Corticosteroid/Beta2 Adrenergic Agent (Long-Acting) Combinations – Inhaled
- Corticosteroids – Inhaled
- Epinephrine, Self-injected
- Growth Hormones
- Hepatitis C Agents – Direct Acting Antivirals
- Immunomodulators – Topical
- Insulin – Mixes
- Insulin – Rapid-Acting
- Other Agents for Attention Deficit Hyperactivity Disorder (ADHD)
- Pancreatic Enzymes
- Pulmonary Arterial Hypertension (PAH) Oral Agents, Other

Individual Drugs Listed Below

- Chlorpromazine
- Lupron Depot
- Onfi
- Prograf
- Pulmicort Respule
- Synagis

Antiretroviral Drugs Used for HIV

- Includes any antiretroviral drug indicated to treat HIV infection

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# All Providers

## Menu Labeling Campaign Can Help Patients Eat Healthier

**Effective May 7, 2018** under new Food and Drug Administration (FDA) regulations, all restaurants and similar retail food establishments that are part of a chain with 20 or more locations are required to post the number of calories contained in standard items on menus/menu boards. Additionally, businesses must also provide, upon request, written nutrition information for standard menu items on total calories, total fat, saturated fat, trans fat, cholesterol, sodium, total carbohydrates, sugars, fiber and protein.

To promote healthy weight and calorie awareness, the NYS Department of Health has launched the iChoose600® campaign, running from June through September 2018. While people’s caloric needs vary, the average adult needs about 2,000 calories a day. By choosing meals with 600 calories or less, people can choose to be healthier and say no to extra calories. With calorie posting in chain restaurants, it is easier for busy families to make healthier, lower calorie meal selections. Changing eating habits can be difficult, but eating a little less when eating out is a powerful step that can help people maintain or lose weight and be healthier long-term. Providers are encouraged to highlight the iChoose600® campaign with patients and promote the use of the posted calories on menus. This can go a long way in helping patients achieve a healthier diet and lifestyle, and reduce their risk for obesity, diabetes, heart disease, and some cancers.

More information about menu labeling and simple ways to eat less when eating out can be found at [www.Health.NY.gov/iChoose600](http://www.Health.NY.gov/iChoose600) and [www.Facebook.com/iChoose600](http://www.Facebook.com/iChoose600).

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## Reminder: The Medicare Beneficiary Identifier is Confidential and Should be Protected as Personally Identifiable Information

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) required the Centers for Medicare & Medicaid Services (CMS) to remove Social Security Numbers (SSN) from all Medicare cards by April 2019. CMS has been working with state agencies across the country on the New Medicare Card replacement initiative to replace the existing SSN-based Health Insurance Claim Number (HICN) with an assigned Medicare Beneficiary Identifier (MBI). CMS is currently mailing new Medicare cards to people with Medicare on a flow basis, based on geographic location. New York State residents began receiving the new cards after June 2018.

The New York State Department of Health has chosen to implement this initiative in a phased approach. Therefore, plans and providers may see MBIs in some locations (Managed Care rosters and roster-related reports) while not yet in other locations (ePACES and Eligibility Inquiry). New York State is on target to complete the initiative and make MBIs available to plans and providers as appropriate by October 2018. While plans and providers begin receiving this information the MBI should not be shared with Medicare beneficiaries who have not received their new card. The MBI is confidential and should be protected as personally identifiable information.

If beneficiaries call before October 1, 2018 to ask for their MBIs because they haven’t received a new Medicare card yet, plans should let them know that the new Medicare cards are still being mailed. During this transition, beneficiaries can obtain their health plan services with their managed care plan IDs, and should not need their MBI. You can advise the beneficiary to call 1-800-MEDICARE as there might be a problem that needs to be corrected, like updating their mailing address with the Social Security Administration.

Additional guidance may be found at: <https://www.cms.gov/Medicare/New-Medicare-Card/Health-and-Drug-Plans/Health-and-drug-plans.html>.

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# Home Health Care Medicare Maximization Services: Audits Involving Medicare Demand Billing and Overpayments Involving Dual Eligible Recipients

The Office of the Medicaid Inspector General (OMIG) issued in the [February 2017 Medicaid Update](#) newsletter information for providers about new home health care services audits of Medicare demand billing and Medicaid overpayments involving dual eligible recipients. In April 2017, OMIG and its contractor, the University of Massachusetts Medical School (UMass), began auditing for dual eligible recipient Medicaid overpayments. Demand bill audits are scheduled to be issued in August 2018.

OMIG contracts with UMass to maximize Medicare reimbursement for dual eligible Medicare/Medicaid recipients who have received home health care services paid for by Medicaid. Medicaid is always the payor of last resort. Therefore, when a recipient is eligible for both Medicare and Medicaid, or has other third-party insurance benefits, the provider must bill Medicare or the other third-party insurance first for covered services prior to submitting a claim to Medicaid.

To ensure Medicaid is the payor of last resort, UMass identifies home health providers who have not billed Medicare for home health services previously paid by Medicaid, and directs the provider to “demand bill” Medicare for those services. If providers do not comply with this request, they are required to reimburse the Medicaid program for the amount Medicaid paid for these services as required under 18 New York Codes, Rules and Regulations (NYCRR) 540.6 (e).

UMass also pursues Medicare coverage for claims that were denied payment by Medicare at initial determination and paid by Medicaid. When a provider receives a Medicare payment as a result of a reversed Medicare denial, the provider has received a duplicate payment, which then makes the payment an overpayment. UMass sends notification letters to the provider who receives the overpayment to inform them that the provider is required to return the Medicare payment to the Medicaid program. If the amount of the Medicare payment is not reimbursed to the Medicaid program, OMIG will pursue recovery of the overpayment.

Providers who are noncompliant with requests to demand bill Medicare or who fail to return identified overpayments will be subject to an audit for recovery of all inappropriate payments. OMIG expects provider compliance with NYS Medicaid program regulations to ensure receipt of proper payments before the timeframes for submission of claims to Medicare are exhausted.

If you have any questions concerning the above information, you may contact the UMass Medicare Appeals Team at 1-866-626-7594.

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# Reminder: Breastfeeding Grand Rounds 2018: Increasing Skin-to-Skin Contact to Improve Perinatal Outcomes and Breastfeeding Success

Breastfeeding Grand Rounds (BFGR) 2018 will air on August 2, 2018 from 8:30 a.m. – 10:30 a.m. The 2018 BFGR live webcast will include an overview of skin-to-skin contact (Kangaroo Care) for newborn infants, including the strong evidence-base that skin-to-skin contact provides health benefits to infants and mothers and leads to breastfeeding success. Successful strategies, including prenatal education by Women, Infants, and Children (WIC) providers to increase early use and longer duration of skin-to-skin contact for all mothers will be discussed. Examples from New York, other states, and abroad will be highlighted.

This webcast is intended for local and state public healthcare professionals and paraprofessionals, clinicians (physicians, midwives, healthcare providers, nurses), and lactation specialists and will offer Continuing Medical Education (CME), Continuing Nursing Education (CNE), Lactation Continuing Education Recognition Points (LCERP), or general continuing education credits. For more information, and to view previous years' BFGR webcasts, please visit <http://www.albany.edu/sph/cphce/bfgr.shtml>.

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## NY Medicaid EHR Incentive Program Update

The [NY Medicaid Electronic Health Record \(EHR\) Incentive Program](#) promotes the transition to EHRs by providing financial incentives to eligible professionals and hospitals. Providers who demonstrate Meaningful Use of their EHR systems are leading the way towards Interoperability, which is the ability of healthcare providers to exchange and use patient health records electronically. The ultimate goal is to increase patient involvement, reduce costs and improve health outcomes. Since December 2011, over **\$923 million** in incentive funds have been distributed **through 35,264** payments to New York State Medicaid providers.

Since 2011, Eligible Professionals & Eligible Hospitals have received:	
Number of Payments	Distributed Funds
35,264	\$923,451,896

### MEIPASS is Open for 2017 Attestations

Beginning July 16, 2018, the NY Medicaid EHR Incentive Program began accepting 2017 Modified Stage 2 and Stage 3 Meaningful Use (MU) attestations via the [MEIPASS](#) system. Please log into MEIPASS to submit your attestation by the deadline of Monday, **October 15, 2018**, for Payment Year (PY) 2017.

- There are no more workbooks and you can now complete the full attestation in MEIPASS including Eligibility, Meaningful Use Objectives, and Clinical Quality Measures (CQM).
- MEIPASS has also been updated to accept electronic signatures, so you will not need to send in a hard copy for your PY 2017 Meaningful Use attestation.

For assistance submitting your MEIPASS attestation, please view the step-by-step online tutorials. You can view them through our website or by clicking the links below.

**Part 1: Beginning the Attestation Process Tutorial (YouTube)** - Completing the eligibility portion of a 2017 Meaningful Use attestation in the MEIPASS System. (<https://youtu.be/Wiqih2NY-lc>)

**Part 2A: Attesting to Modified Stage 2 Tutorial (YouTube)** - Attesting to 2017 Modified Stage 2 Meaningful Use in the MEIPASS System. (<https://youtu.be/MhF3QUwV0qM>)

**Part 2B: Attesting to Stage 3 Tutorial (YouTube)** - Attesting to 2017 Stage 3 Meaningful Use in the MEIPASS System. (<https://youtu.be/iDvdpZ- qu4>)

**Part 3: Clinical Quality Measure (CQM) Reporting Tutorial (YouTube)** - Reporting Clinical Quality Measures (CQMs) in the MEIPASS System. (<https://youtu.be/z-SfnNgBI24>)

**Part 4: eSignature and Attestation Submission Tutorial (YouTube)** - eSignature and attestation submission in the MEIPASS System. (<https://youtu.be/cNkb6ZybeiE>)

### Attesting to 2017 or 2018 Meaningful Use?

The NY Medicaid EHR Incentive Program hosts webinars and several sessions will be held over the next several months focused on preparing for payment year 2018. To sign up for the webinars and additional information, please visit our [webinar calendar](#).

### Updated Webinar Schedule – July 2018

We've added a new Webinar! **Modified Stage 2 for New Meaningful Users** is intended for Eligible Professionals who are attesting to Meaningful Use for the first time or who have attested before but prior to 2016.

Webinar	Date	Time
Meaningful Use Modified Stage 2	July 26, 2018	10:00am-11:00am
	August 2, 2018	3:00pm-4:00pm
	August 14, 2018	10:00am-11:00am
Meaningful Use Stage 3	August 8, 2018	11:00am-12:00pm
	August 14, 2018	1:00pm-2:00pm
<b>New! Modified Stage 2 for New Meaningful Users</b>	August 1, 2018	9:00am-10:00am
	August 20, 2018	3:00pm-4:00pm

### Listserv – Have program announcements sent right to your inbox!

The NY Medicaid EHR Incentive Program publishes listserv messages each month, and additional messages when there are important changes to the program that will impact eligible providers. In the listserv you will find:

- Updates regarding the NY Medicaid EHR Incentive Program Administration
- Attestation system (MEIPASS) announcements and updates
- Attestation dates and deadlines
- Current quarter webinar schedule
- Program requirements
- Links to training resources and tutorials
- CMS final rule releases and programmatic changes

### Register

- To register for the NY Medicaid EHR Incentive Program listserv:
  - Send an email to: [listserv@listserv.health.state.ny.us](mailto:listserv@listserv.health.state.ny.us)
  - In the body of the message enter: SUBSCRIBE EHR\_INCENTIVE-L Your Name
  - For example: SUBSCRIBE EHR\_INCENTIVE-L John Doe
- You can also register for the MU Public Health Reporting listserv for information on the Public Health Reporting Objective for the EHR Incentive Program:
  - Send an email to [listserv@listserv.health.state.ny.us](mailto:listserv@listserv.health.state.ny.us)
  - In the body of the message enter: SUBSCRIBE PUBLIC\_HEALTH-L your name
  - For example: SUBSCRIBE PUBLIC\_HEALTH-L Jane Doe

### Visit Our Website

Find the following information and much more:

- Payment Year 2017 and 2018 Requirements – [Modified Stage 2](#) and [Stage 3](#)
- [Eligible Hospital Requirements](#)
- [Public Health Reporting Objective Information](#)
- [Post-Payment Audit Guidance](#)

- [Frequently Asked Questions \(FAQs\)](#)
- Materials and Information – [Document Repository](#)

**One more Reminder - Prepare for your 2017 Attestation**

Update your registration for Public Health Reporting on the [Meaningful Use Registration for Public Health \(MURPH\)](#) application.

- Make sure that any changes to your personal information have been updated at:
  - CMS
  - eMedNY
  - MEIPASS
- Attend the [Modified Stage 2, Stage 3, or Modified Stage 2 for New Meaningful Users](#) webinars for more information on the above Objectives.



Questions? We have a dedicated support team ready to assist.

**Contact us at 877-646-5410, Option 2 or [hit@health.ny.gov](mailto:hit@health.ny.gov).**

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# Provider Directory

## Office of the Medicaid Inspector General:

For suspected fraud or abuse complaints/allegations, call 1-877-87FRAUD, (877) 873-7283, or visit [www.omig.ny.gov](http://www.omig.ny.gov).

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

Please visit the eMedNY website at <https://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 <https://www.emedny.org/training/index.aspx>. For individual training requests, call (800) 343-9000.

## Beneficiary Eligibility:

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

## Medicaid Prescriber Education Program:

For current information on best practices in pharmacotherapy, please visit the following websites:  
[http://www.health.ny.gov/health\\_care/medicaid/program/prescriber\\_education/presc-educationprog](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 (EHR) 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, Chelsea Cox, at [medicaidupdate@health.ny.gov](mailto:medicaidupdate@health.ny.gov)