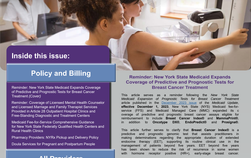
Department of Health
# Medicaid Update
March 2011
Volume 48 | Number 3



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## Policy and Billing

### Reminder: Coverage of Licensed Mental Health Counselor and Licensed Marriage and Family Therapist Services Provided in Article 28 Outpatient Hospital Clinics and Free-Standing Diagnostic and Treatment Centers

**This article is intended to notify providers that State Medicaid coverage of Licensed Mental Health Counselor and Licensed Marriage and Family Therapist services provided in Article 28 Outpatient Hospital Clinics and Free-Standing Diagnostic and Treatment Centers for services provided by Licensed Mental Health Counselors (LMHC) and Licensed Marriage and Family Therapists (LMFT), effective December 1, 2010, has been approved by the Centers for Medicare and Medicaid Services (CMS).**

In a reminder, see the *Coverage of Licensed Mental Health Counselor and Licensed Marriage and Family Therapist Services Provided in Article 28 Outpatient Hospital Clinics and Free-Standing Diagnostic and Treatment Centers* article in the December 2010 issue of the Medicaid Update. Services provided by LMHC and LMFT are covered when provided in Article 28 Outpatient Hospital Clinics and Free-Standing Diagnostic and Treatment Centers when the provider is reimbursed from Medicaid fee-for-service rates. Services provided by LMHC and LMFT are limited below to respect reimbursement from MVC Medicaid for mental health counseling when provided by LMHCs and LMFTs.

Article 28 Clinics
Hospital CPTs and Revenue Codes that accept LMHC and LMFT services:

| | | |
|---|---|---|
| 90791 | Psychiatric diagnostic evaluation | |
| 90792 | Psychiatric diagnostic evaluation with medical services | |
| 90832 | Psychotherapy, 30 minutes with patient and/or family member | |
| 90834 | Psychotherapy, 45 minutes with patient and/or family member | |
| 90837 | Psychotherapy, 60 minutes with patient and/or family member | |

HCPCS:
MHCs should use Medicaid Rate Code 0 (zero):

| | |
|---|---|
| H0004 | LMHC individual (LMFT) Services, 15 to 30 minutes with patient |
| H0004 | LMHC individual (LMFT) Services, 45 to 50 minutes with patient |
| H0004 | LMHC individual (LMFT) Services, 60 minutes with patient |
| H2021 | Family Services (LMFT/LMHC) with or without patient present |

FQHC/RHCs:
Providers that have opted out of Ambulatory Payment Groups (APGs) should bill the Prospective Payment System (PPS) rate.

For additional information regarding mental health counseling provided in Article 28 outpatient hospital clinics, as well as reimbursement for services provided by Licensed Mental Health Counselors and Licensed Marriage and Family Therapists, see the *Mental Health Services* section of the Medicaid Update.

**Questions and Additional Information:**
- Questions regarding the Medicaid Program should be directed to the Office of Health Insurance Program (OHIP) Division of Program Development and Management (DPM) by telephone at (518) 474-2160 or by email at OHIPdevelopment@health.state.ny.us
- FFS Management Care questions should be directed to the appropriate Managed Care Plan.
- MMC reimbursement rates questions should be directed to the appropriate Medicaid Managed Care Plan for details. MMC Plan of the enrollee.
- MMC Plan contact information can be found in the eMedNY *New York State Medicaid Program Information for All Providers - Medicaid Update* newsletter.
- Additional information is available on the eMedNY *New York State Medicaid Program Fee-for-Service Latest Updates - Provider Updates and Coverage Guidelines Manual*.

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### Medicaid Fee-for-Service Complementary Coverage for New York State Federally Qualified Health Centers and Rural Health Clinics

The following article provides information on Medicaid coverage of services provided by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).

Prospective Payment System
FQHCs and RHCs are reimbursed for New York State (NYS) Medicaid covered services under an all-inclusive Prospective Payment System (PPS) rate. Medicaid covered services are those services for which there is a Medicaid fee-for-service rate. Services provided by practitioners who are not employed by the services rendered to the NYS Medicaid beneficiary under billing the Medicaid rate, do eligible Medicaid beneficiaries and is billable each time a NYS Medicaid member crosses the threshold of the FQHC or RHC and receives a covered service from a practitioner who is employed by the FQHC or RHC. Services provided by practitioners who are not employed by the FQHC or RHC are not reimbursable under the PPS rate.

FQHC/RHCs should submit a single PPS claim for an eligible Medicaid visit utilizing the assigned rate code for each date of service the NYS Medicaid member is seen by a FQHC or RHC practitioner. Medicaid covered services provided by practitioners who are employed by the FQHC or RHC are included in the PPS rate. Services provided by practitioners who are employed by the FQHC or RHC are not billable separately including any evaluation and management/preventative medicine codes, significant procedures, and any associated procedure performed. Multiple claims for Medicaid covered services provided by practitioners who are employed by the FQHC or RHC are not billable to NYS Medicaid.

Eligible Timeframe
A Medicaid visit is defined as a face-to-face encounter between a beneficiary and a provider, or telehealth, medical or behavioral health, dental, or nutritional assessment. Medicaid covered services provided by practitioners who are employed by the FQHC or RHC are included in the PPS rate.

Does Not Qualify as an Eligible Threshold Visit
Services provided by a practitioner other than a qualified practitioner do not qualify as an eligible/billable threshold visit. To view a *Section 1905(l)(1) and qualifies as an eligible threshold visit* procedure should refer to the HCPCS table.

Other HCPCS, CPT, or Revenue Codes procedure should refer to the HCPCS table.

To view *physician rate setting methodology information*, providers should refer to this month's issue.

To view *Medicaid covered services provided by practitioners who are employed by the FQHC or RHC*, providers should refer to this month's issue.

**Questions and Additional Information:**
- Questions regarding the Medicaid Program should be directed to OHIP Division of Program Development and Management (DPM) by telephone at (518) 474-2160 or by email at OHIPdevelopment@health.state.ny.us
- Questions regarding the Medicaid Fee-for-Service Program Guidelines should be directed to the MMC Plan of the enrollee. MMC Plan contact information can be found in the eMedNY *New York State Medicaid Program Information for All Providers - Medicaid Update* newsletter.
- FQHC/RHC is responsible for ensuring that the applicable laws and regulations relative to the MMC contracts are adhered to. Additional questions and questions about contract interpretation should be directed to the MMC Plan.
- FFS claim questions should be directed to the eMedNY. Call Carrier at (800) 343-9600.
- EFS provider enrollment questions should be directed to the eMedNY Call Center at (800) 343-9600.

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### Pharmacy Providers: NYRx Policy and Delivery Policy

Prescription and over the counter (OTC) drugs are covered for Medicaid fee-for-service (FFS) fee-for-service (FFS) Medicaid beneficiaries. Medicaid Managed Care (MMC) Plans are responsible for providing prescription drugs and other pharmacy services to their members. Prior to processing a drug claim, the pharmacy provider must determine the payer for the drug claim, FFS or MMC.

Pharmacy Providers:
All dispensing and/or delivery claims shall be submitted to the appropriate payer for payment. However, the pharmacy provider may be required to submit a claim to FFS for a MMC member in order to receive payment. Prior to processing a drug claim, the pharmacy provider must determine the payer for the drug claim, FFS or MMC.

**Questions and Additional Information:**
- Pharmacy Providers are directed to the eMedNY Call Center at (800) 343-9600.
- NYRx coverage and policy questions should be directed to the NYS Medicaid Pharmacy Policy Unit by telephone at (518) 486-5208 or by email at NYRxQuestions@dsk.state.ny.us

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### Doula Services for Pregnant and Postpartum Women

**Effective March 1, 2011**, New York State (NYS) Medicaid will reimburse for doula services for all pregnant and postpartum NYS Medicaid beneficiaries. Doula services will be covered in the Medicaid Managed Care (MMC) Plans and in Medicaid fee-for-service (FFS). Doula services are defined as non-medical services provided to a pregnant woman or a woman in the postpartum period. Doula services include doula services provided in NYS enrolled doula firms and **Effective October 1, 2011**, doula services will be covered in NYS Medicaid Independent Practitioner Doula Services. Doula services provided by Independent Practitioner Doulas will be limited to NYS Medicaid Independent Practitioner Doulas who are enrolled in the NYS Medicaid Program.

NYS Medicaid members, including NYS Medicaid members enrolled in MMC, are eligible for doula services during pregnancy and up to 12 months after the birth of a child. Medicaid members who are pregnant and who are enrolled in a Medicaid Managed Care Plan (MMC Plan) are required to receive their eligibility for doula services and care with the new pregnancy, any unused postnatal doula services from the prior pregnancy will not carry over.

Doula services are a preventative health service, and as such, must be recommended by a physician or other licensed practitioner of the healing art prior to the date of service. The recommendation must be in the form of a written prescription or be documented in the member's medical record. The recommendation must be made based on the medical or psychosocial needs of the member. The recommendation must be made prior to the member's first doula visit and must be renewed at least every 12 months.

A doula is a public health paraprofessional and is not required to be a licensed or certified NYS Medicaid provider type. Doula providers must be enrolled in the NYS Medicaid Program. Doula services are not a substitute for, or a duplicate of, services that are the responsibility of the MMC Plan and will be NYS Medicaid directly for doula services. The NYS Medicaid-enrolled doula firms must ensure sufficient staffing and supervision of their Independent Practitioner Doulas to ensure that services are provided in accordance with the plan of care, and that services are provided in a manner that ensures the health and safety of the Medicaid beneficiary. Doula services must be provided in accordance with a recommendation for doula services.

Doula services are provided in the member's home, community or community-based resources related to childbirth and parenting:
- development of a birth plan and birth preparedness education;
- ongoing emotional support, including during the birth process;
- facilitation of communication between the NYS Medicaid member and medical providers; and
- assistance with breastfeeding initiation and maintenance, including providing breastfeeding health promotion during prenatal and labor and delivery and after pregnancy and the birth of the child.

To view information regarding *doula Medicaid FFS during the MMC carve out*, providers should refer to the Doula Services for Pregnant and Postpartum Women article in this month's issue.

To view *Medicaid FFS information*, providers should refer to the Doula Services for Pregnant and Postpartum Women article in this month's issue.

To view information regarding *doula Medicaid FFS during the MMC carve out*, providers should refer to the Doula Services for Pregnant and Postpartum Women article in this month's issue.

**Questions and Additional Information:**
- Questions regarding the Medicaid Program should be directed to the eMedNY Call Center at (800) 343-9600.
- NYRx coverage and policy questions should be directed to the NYS Medicaid Pharmacy Policy Unit by telephone at (518) 486-5208 or by email at NYRxQuestions@dsk.state.ny.us

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## All Providers

### New York State Department of Health Telehealth Provider Survey Results Now Available

The "eMedNY Provider Telehealth Survey" results are now available on the New York State Medicaid Program Website.

Background
In order to better understand the health care needs and preferences of New Yorkers, the Department of Health and other the Commission Directive (DYD Commission) to conduct a Telehealth Survey. The survey was conducted between August 2010 to October 2010. All providers who participated in the survey were asked to indicate their current use of telehealth, their plans for future use of telehealth, and their opinions on the use of telehealth. The survey results will be used to inform telehealth quality development in NYS.

**Questions**
Any questions regarding the Telehealth Provider Survey results integration should be directed to NYS OHIP at Telehealth-Policy@health.state.ny.us.

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### Essential Plan Coverage for Pregnant Enrollees and their Newborns

In an effort to continue to provide health coverage to pregnant women who are ineligible for Medicaid, the Department of Health is expanding the Essential Plan (EP) to cover pregnant women who are ineligible for Medicaid. The Essential Plan is a State-funded program that is part of the Affordable Care Act (ACA) Expansion Waiver, pregnant individuals who were enrolled in EP prior to reporting their pregnancy will stay enrolled in EP after reporting their pregnancy. Pregnant women who are ineligible for Medicaid may now apply for coverage under the Essential Plan. Pregnant women who were ineligible for Medicaid when they applied for EP and who were found to be eligible for Medicaid after they reported their pregnancy, will be transferred to Medicaid. Pregnant women who were ineligible for Medicaid when they applied for EP and who were found to be eligible for Medicaid after they reported their pregnancy, will be transferred to Medicaid. Pregnant women who were ineligible for Medicaid when they applied for EP and who were found to be eligible for Medicaid after they reported their pregnancy, will be transferred to Medicaid. Pregnant women who were ineligible for Medicaid when they applied for EP and who were found to be eligible for Medicaid after they reported their pregnancy, will be transferred to Medicaid.

Allowing the pregnant individual to stay enrolled in EP ensures that the individual will keep her maternity coverage and continue to receive prenatal care without interruption. Pregnant women who are found to be eligible for Medicaid, they will be transferred to Medicaid. Pregnant women who are found to be eligible for Medicaid, they will be transferred to Medicaid.

**Questions and Additional Information:**
- Questions regarding the Medicaid Program should be directed to the eMedNY Call Center at (800) 343-9600.
- Newborn eligibility and policy questions should be directed to

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### Medicaid Breast Cancer Surgery Updates

Research shows that breast cancer, which is the most common cancer among women, can be prevented and treated with proper medical care. Therefore, it is the policy of the New York State (NYS) Department of Health (DOH) that NYS Medicaid reimburse medical services, diagnostic and therapeutic procedures, and medical supplies for the treatment of breast cancer. The following information provides information on Medicaid coverage of breast cancer surgery.

Each year NYS DOH reviews the list of non-invasive medical services and supplies covered for **effective April 1, 2011**. NYS DOH has conducted its review for the coverage of breast cancer surgery. The following information provides information on Medicaid coverage of breast cancer surgery. Medicaid coverage of breast cancer surgery is limited to the following procedures, when medically necessary, and when the member is eligible for Medicaid:

Effective Date: Medicaid coverage of breast cancer surgery is limited to the following procedures, when medically necessary, and when the member is eligible for Medicaid:

**Questions**
Questions should be directed to

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### Practitioner Administered Drug Search Tool Now Available on the eMedNY Website

The 2005 Federal Deficit Reduction Act (DRA) requires providers to report the National Drug Code (NDC) when billing for practitioner administered drugs. The NDC is a 10 digit, 3 segment number. The NDC identifies the labeler, product, and trade package of a drug. The NDC is required on all drug claims. The NDC is required on all drug claims. The NDC is required on all drug claims