



Medicaid Update

THE OFFICIAL NEWSLETTER OF THE NEW YORK STATE MEDICAID PROGRAM

Medicaid Electronic Health Records Incentive Program

Healthcare providers who adopt, implement or upgrade certified electronic health records (EHR) technology may be eligible for a share of up to \$27 billion in financial incentives under the Medicare and Medicaid EHR Incentive Program, one of the many fiscal stimulus programs created by the American Recovery and Reinvestment Act of 2009 (ARRA). This incentive program is intended to speed the transition of medical practice from paper-based processes to interoperable electronic systems, providing clinical benefits as well as reducing the overall cost of health care.



Practitioner Incentive

Under the terms of the Medicaid EHR Incentive Program, incentives may be paid to the following practitioner types:

- Physicians
- Dentists
- Certified nurse-midwives
- Nurse practitioners
- Physician assistants, if they are practicing in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is led by a physician assistant.

Eligible professionals (EPs) who adopt certified EHR technology and demonstrate meaningful use of the EHR system can receive up to \$63,750 over six years of participation in the program, with the largest single payment (up to \$21,250) in the first year.

Annual incentive payments are issued directly to EPs in a lump sum payment, although the incentive payment may be voluntarily assigned to the EP's employer or practice. Practitioners may also be eligible to receive up to \$44,000 in incentive payments from a similar program offered through Medicare, but they may only participate in one of the EHR incentive programs – not both.

To be eligible for the Medicaid EHR Incentive Program, practitioners must:

- Be actively enrolled providers in New York State Medicaid, not sanctioned or excluded from receiving Medicaid payments;
- Furnish a substantial portion of their covered services outside the hospital inpatient and emergency department settings; and
- Demonstrate sufficient Medicaid or needy patient volume.

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AUGUST 2011 MEDICAID UPDATE

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ATTENTION PROVIDERS & PHARMACISTS: See following page for important information for Medicaid Managed Care and Family Health Plus beneficiaries.

ATTENTION: PROVIDERS AND PHARMACIES

Please assist us in notifying beneficiaries of this upcoming program change!
Please tear out this poster and display in your practice. Feel free to copy and distribute.

EFFECTIVE OCTOBER 1, 2011

MEDICAID MANAGED CARE AND FAMILY HEALTH PLUS BENEFICIARIES

*THIS NOTICE PROVIDES INFORMATION ABOUT UPCOMING
CHANGES TO YOUR MANAGED CARE BENEFIT.*



- ▶ You must use your health plan card to receive your prescriptions, not your Medicaid benefit card, starting October 1, 2011.
- ▶ At the end of August, your health plan will send information about your pharmacy benefit and what drugs are included on your health plan. When you receive this information, if you have questions, you should contact your health plan.
- ▶ Health plans each have their own list of drugs. If a drug is not on your health plan's list, you or your pharmacist may need to talk to your doctor about changing to a drug on your health plan's list, or your doctor can ask the plan to let you continue taking the same drug. More information regarding what drugs are on your health plan's list will be sent to you by your health plan at the end of August.
- ▶ If you are taking a drug that is not on your plan's list and you are unable to contact your doctor to change to a covered drug, your health plan will allow a one-time only fill of your medication.
- ▶ You must use a pharmacy that takes your health plan. If your pharmacy does not take your health plan, you may need to obtain new prescriptions from your doctor to bring to a plan pharmacy. More information regarding your plan's participating pharmacies will be sent to you at the end of August.
- ▶ Your co-payments for drugs will not change.

**Effective October 1, 2011, your pharmacy benefits will be provided by your health plan.
Contact your health care plan if you have any questions about this change.**



POLICY & BILLING GUIDANCE

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Medicaid Patient Volume Eligibility Criteria

The patient volume eligibility criteria vary depending on provider type and care setting. Most practitioners will need to demonstrate that at least 30 percent of their patient encounters are paid all or in part by Medicaid (including Medicaid managed care but excluding Child Health Plus).

There are alternate opportunities to qualify in some situations:

- Pediatricians may qualify by demonstrating a 20–30 percent Medicaid patient volume, but in this case their incentive payments will be reduced by 1/3.
- Providers who practice predominately in an FQHC or RHC (as well as certain tribal clinics owned and operated by American Indian and Alaska Native tribes and tribal organizations) may qualify by demonstrating that at least 30 percent of their patient encounters were for needy individuals (which includes Medicaid beneficiaries as well as Child/Family Health Plus recipients and anyone who receives care at reduced or no cost based on their ability to pay).

Hospital Incentive

The program also makes incentives available to acute care hospitals that serve a minimum of 10 percent Medicaid patient volume, as well as children’s hospitals (which have no minimum Medicaid patient volume requirement). Eligible hospitals (EHs) in New York State may receive Medicaid EHR incentive payments estimated to range from \$25,000 to \$11.5 million according to a formula that accounts for overall hospital size and the proportion of acute care services that are provided to Medicaid beneficiaries. EHs may simultaneously receive incentive payments from the Medicare program using a similar formula based on Medicare patient volume.

Adopt/Implement/Upgrade and Meaningful Use

To be eligible for the EHR incentive in the first year of program participation, providers (EPs and EHs) must adopt, implement or upgrade EHR technology that has been certified to comply with a set of standards established by the Office of the National Coordinator for Health Information Technology (ONC). In subsequent participation years, providers must additionally demonstrate that they “meaningfully used” the certified EHR technology by meeting a series of objectives which become progressively more advanced as time goes on.

How Do I Participate?

Registration for the Medicaid EHR Incentive program is expected to begin in the fourth quarter of 2011. Providers must register at the national level to participate in the incentive program, and must use a state-level system to attest to the specific eligibility criteria for the Medicaid incentive. Details on how to prepare for the program will be published in future editions of the Medicaid Update.

Where Can I Get More Information?

Details on how to prepare for the program will be published in future editions of the Medicaid Update. In the meantime, more information on the Medicare and Medicaid EHR Incentive programs can be found on the Centers for Medicare and Medicaid Services Web site at <http://www.cms.gov/ehrincentiveprograms/>. Specific questions may be e-mailed to the New York Medicaid EHR Incentive program support team at hit@health.state.ny.us.



POLICY & BILLING GUIDANCE

Coverage and Billing Guidelines for 17 Alpha-Hydroxyprogesterone Caproate (17P)

The following information clarifies the New York State Medicaid policy regarding the acquisition and billing for 17 alpha-hydroxyprogesterone caproate (17P). 17P is an injectable long-acting synthetic derivative of progesterone. It is available as both a compounded sterile product and commercially as a product under the brand name Makena™. Both forms, the compounded 17P and Makena™, are used for the prevention of preterm delivery in patients with a documented history of spontaneous preterm birth. Both the compounded 17P and Makena™, are covered under the Medicaid program and will be reimbursed based on the provider's acquisition cost. Medicaid Managed Care (MMC) and Family Health Plus (FHPlus) plans are responsible for these drugs for their members.

DRUG ACQUISITION

- As with all practitioner-administered drugs, the practitioner is responsible for obtaining the drug, administering it to the patient and billing Medicaid or the beneficiary's MMC or FHPlus plan, as appropriate.
- Compounded 17P and Makena™ are medical benefits, not pharmacy benefits. The patient should not be given a prescription to obtain these drugs from a pharmacy. Doing so will result in a pharmacy claim denial and may cause an unnecessary delay in treatment.
- Compounded 17P is available from pharmacies that compound sterile products.
Note: Pharmacies should not bill Medicaid directly for this product, but rather they should bill the practitioner ordering/purchasing the product.
- Makena™ is available in the commercial marketplace for purchase by providers.
- Compounded 17P is significantly less expensive than the commercially available product, Makena™. Providers are strongly encouraged to consider providing 17P in the most cost-effective form available. (**Note:** MMC and FHPlus plans may require preauthorization of these drugs based on medical necessity and cost effectiveness.) *

***Reminder:** If a plan renders an adverse determination and the provider was not consulted during the authorization process, the provider may ask for a reconsideration of the adverse determination by contacting the plan's clinical peer reviewer. Plan adverse determinations may be appealed by the enrollee or their designee on an expedited basis if the enrollee's health would be jeopardized by a delay. If the plan appeal is upheld, the enrollee may have a right to an independent external appeal. Enrollees also have a right to a fair hearing. See the health plan's provider manual for additional information on appeals.

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POLICY & BILLING GUIDANCE

BILLING GUIDELINES

➤ **For dates of service on or after July 1, 2011:**

- Physicians, nurse practitioners, licensed midwives and Article 28 clinics should use the newly established procedure code, **Q2042**, when billing for compounded 17P and Makena™.
- Medicaid fee-for-service claims for compounded 17P, billed with the new procedure code Q2042, may be submitted electronically. Claims for Makena™, using the new procedure code, must be submitted on paper with the invoice showing the acquisition cost of the drug.
- MMC and FHPlus providers should also use the new procedure code, Q2042, when billing for compounded 17P and Makena™. Claims submission should be in accordance with the health plan's claiming requirements.
- Article 28 clinics should bill compounded 17P and Makena™ as ordered ambulatory services (Category of Service 0282 or 0163) using procedure code Q2042. As noted above, claims for compounded 17P, billed with the new procedure code Q2042, can be submitted electronically. Claims for Makena™ must be submitted on paper with the invoice showing the acquisition cost of the drug. (**Note:** Q2042 should not be billed as a line item on an APG claim).

➤ **For dates of service before July 1, 2011:**

- Claims for compounded 17P or Makena™ should be submitted with procedure code **J3490** (Unclassified Drugs).
- Medicaid fee-for-service reimbursement for J3490 is "By Report." The billing provider must submit a paper claim with documentation of medical necessity and a copy of the invoice showing the acquisition cost of the drug. Providers must include the NDCs used in compounding for 17P or, if the commercially available product is used, the NDC for Makena™.
- Claims to MMC and FHPlus plans should be in accordance with the plan's claiming requirements.
- J3490 is carved-out of Article 28 clinic APGs and will not pay if billed as a line item. Claims for compounded 17P and Makena™ should be billed to Medicaid as ordered ambulatory services using COS 0282 or 0163.

Questions regarding MMC/FHPlus reimbursement and/or documentation requirements should be directed to the enrollee's MMC or FHPlus plan.

Questions regarding Medicaid fee-for-service policy and claiming should be directed to the Bureau of Policy Development and Coverage at (518) 473-2160.



POLICY & BILLING GUIDANCE

Effective October 1, 2011

Limitation on Rehabilitation Visits Medicaid Redesign Team Proposal #34 (MRT #34)

Effective October 1, 2011, physical therapy, occupational therapy, and speech therapy will be limited to 20 visits **each** per twelve-month benefit year as defined below. This benefit limit applies to rehabilitation visits in private practitioners' offices, certified hospital out-patient departments, and diagnostic and treatment centers (free-standing clinics). The rehabilitation limit applies to Medicaid fee-for-service (FFS), Medicaid managed care (MMC), and Family Health Plus (FHPlus) enrollees.

Exemptions

Enrollees, settings, and/or circumstances that are **not** subject to the 20-visit limitation are considered **Exempt**. Enrollees, settings, and/or circumstances that **are** subject to the 20-visit limitation are considered **Not Exempt**. Review the Enrollees, Settings, and Circumstances chart for details.

| ENROLLEES, SETTINGS, AND CIRCUMSTANCES EXEMPT AND NOT EXEMPT | | | |
|---|--------|--------|------------|
| ENROLLEES | FFS | MMC | FHPlus |
| Children (0 - 18 years of age) | Exempt | Exempt | N/A* |
| Children (19 & 20 year olds) | Exempt | Exempt | Not Exempt |
| Recipients with a developmental disability (R/E code 95) | Exempt | Exempt | Not Exempt |
| Medicare/Medicaid dually eligible recipients when Medicare pays for the rehabilitation service | Exempt | Exempt | Not Exempt |
| Recipients with a traumatic brain injury (TBI) (R/E code 81 <u>or</u> a primary diagnosis ICD-9 code in the 850 – 854 series) | Exempt | Exempt | Not Exempt |
| SETTINGS AND CIRCUMSTANCES | FFS | MMC | FHPlus |
| Residents receiving rehabilitation services in a nursing home in which they reside | Exempt | Exempt | N/A** |
| Rehabilitation services provided by a certified home health agency (CHHA) | Exempt | Exempt | Exempt |
| Rehabilitation services received as a hospital inpatient | Exempt | Exempt | Exempt |
| * Children 0-18 years of age are not enrolled in FHPlus. | | | |
| ** This is not a FHPlus-covered benefit. | | | |

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POLICY & BILLING GUIDANCE

Effective October 1, 2011

Medicaid FFS Enrollees: For Medicaid FFS enrollees, the twelve-month benefit year begins on April 1st of each year and runs through March 31st of the following year. On October 1, 2011, Medicaid FFS enrollees who have received 20 or more visits of physical therapy, occupational therapy, or speech therapy between April 1, 2011 and September 30, 2011, will not be entitled to have Medicaid reimburse additional visits for that therapy type until April 1, 2012.

Medicaid Managed Care and Family Health Plus Enrollees: For Medicaid managed care and Family Health Plus (FHPlus) enrollees, the twelve-month benefit year is a calendar year, beginning January 1st of each year and running through December 31st of the same year. For calendar year 2011, Medicaid managed care and FHPlus plans may choose to count therapy visits between April 1 and September 30 toward the 20 visit limit, or they may choose to begin counting visits as of October 1, 2011. In either case, plans may not begin limiting visits until October 1, 2011.

Example: An enrollee received 26 physical therapy visits and 9 speech therapy visits between April 1, 2011 and September 30, 2011.

Medicaid FFS Enrollees: The Medicaid FFS enrollee has exceeded the 20-visit limitation on physical therapy visits for the current benefit year. Therefore, Medicaid will not reimburse for any more physical therapy visits until April 1, 2012. However, the enrollee has 11 more Medicaid-reimbursable speech therapy visits and 20 occupational therapy visits available through March 31, 2012. A new benefit year begins April 1, 2012.

Medicaid Managed Care and Family Health Plus Enrollees: Medicaid managed care and FHPlus providers should contact the enrollee's health plan to obtain approval/authorization for rehabilitation visits. A new benefit year begins January 1, 2012.

Claims will **not** be denied retroactively for Medicaid FFS, Medicaid managed care or Family Health Plus enrollees who have received more than 20 visits between April 1, 2011 and September 30, 2011.

Billing and Claiming Guidance

Visits in Excess of the 20-visit Limitation: The 20-visit limitation on physical therapy, occupational therapy, and speech therapy is a benefit limit. There is no means or opportunity to request an approval or an authorization that will allow for additional visits to be reimbursed by Medicaid or a health plan.

Prior to treatment, it is the provider's responsibility to determine if the recipient has previously used any or all of their allotted visits while under the care of another provider of the same therapy type. In calculating the 20-visit limitation, all providers for each therapy type are combined. If the recipient has Medicaid fee-for-service, providers should ask the recipient about any previous visits of the same therapy type. If the recipient is enrolled in a managed care or Family Health Plus health plan, providers should contact the health plan for approval as is currently done.

If more than 20 visits in a benefit year are required, the recipient may elect to pay privately. Providers should discuss payment arrangements with recipients, and may ask them to sign a written agreement. It is important this be discussed prior to the 21st visit, and it is suggested that the provider maintain the patient's signed payment arrangement in the patient record.

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POLICY & BILLING GUIDANCE

Modifiers: Modifiers apply to clinics and private practitioners billing FFS. Because some Current Procedure Terminology (CPT) codes used when claiming for rehabilitation services can be used by more than one discipline, modifiers must be included on the claims. Each therapy type has a unique modifier. Modifiers will facilitate correct counting for each therapy type. Physical therapy, occupational therapy, and speech therapy claims submitted by clinics and private practitioners that do not contain a modifier will be denied.

Modifiers for each therapy type are:

| Therapy Type | Modifier | Definition |
|----------------------|----------|--|
| Physical Therapy | GP | Services delivered under an outpatient physical therapy plan of care. |
| Occupational Therapy | GO | Services delivered under an outpatient occupational therapy plan of care. |
| Speech Therapy | GN | Services delivered under an outpatient speech-language pathology plan of care. |

Coming in Early 2012

In early 2012, system changes will enable Medicaid FFS providers to confirm that a beneficiary has remaining rehabilitation visits.

Claiming Questions

For Medicaid FFS enrollees, please contact Computer Sciences Corporation (CSC) at (800) 343-9000. For Medicaid managed care or Family Health Plus enrollees, please contact the health plan.

Policy Questions

For Medicaid FFS enrollees, please call the Office of Health Insurance Programs at (518) 473-2160. For Medicaid managed care or Family Health Plus enrollees, please call the Office of Health Insurance Programs, Division of Managed Care at (518) 473-0122.



POLICY & BILLING GUIDANCE

ARTICLE CLARIFICATION:

Medicaid Coverage of Mental Health Counseling by LCSWs and LMSWs Approved for Article 28 Outpatient Hospital Clinics and Free-Standing D&TCs

This is a clarification to the Medicaid Update **June 2011 Volume 27**, Number 8 article as titled above. Please note under the section on "Ordering/Documentation Requirements," only one of the three options stated is enough. This section has been revised to read as follows:

"Ordering/Documentation Requirements"

Mental health counseling by a LCSW/LMSW must be supported by a written referral from:

- The beneficiary's personal physician, other licensed medical practitioner, or a medical resource, such as a clinic, acting as the beneficiary's physician; or
- An appropriate school official; or
- An official or voluntary health or social agency.





MEDICAID REDESIGN TEAM PROPOSAL #164

Limitations on Medicare Part B Coinsurance

Pursuant to Medicaid Redesign Team Proposal #164, recent changes to New York State Social Service Law direct the Medicaid program to limit payments made to practitioners for Medicare/Medicaid dually eligible recipients.

Medicaid presently pays practitioners the full Medicare Part B annual deductible and partial Medicare Part B coinsurance amounts (20 percent of the Part B coinsurance) for Medicaid covered services provided to Medicare/Medicaid dually eligible recipients. However, the full Medicare Part B coinsurance amount is reimbursed for procedures if the service is not covered by Medicaid. This payment policy is changing. **Effective October 1, 2011, Medicaid will no longer reimburse practitioners any portion of the Medicare Part B coinsurance amount if the service is not covered by Medicaid.**

Please note that the Medicare and Medicaid payment (if any) must be accepted as full payment by the provider. The Medicaid recipient cannot be billed for any portion of the claim that Medicaid does not pay.

Hospital Outpatient Department and Diagnostic and Treatment Center Claims (Article 28 facilities)

Medicaid Redesign Team Proposal #164 also requires the Medicaid program to limit Medicaid payment for Medicare Part B services provided by hospital outpatient departments and diagnostic and treatment centers to Medicare/Medicaid dually eligible recipients. The changes require the Medicaid program to limit payment for Medicare Part B coinsurance amounts so that the total Medicare/Medicaid payment to the provider does not exceed the amount that the provider would have received for a Medicaid-only patient. These payment changes were initially expected to be implemented on October 1, 2011. However, the eMedNY systems changes required to implement this new payment policy have required us to delay implementation until January 1, 2012. Additional information will be available in a future Medicaid Update.

Questions? Please contact the Bureau of Policy Development and Coverage at (518) 473-2160.



POLICY & BILLING GUIDANCE

AMBULETTE PROVIDERS

Personal Assistance is Required When Billing for Ambulette Service

Personal assistance means the “provision of physical assistance by [a] provider of ambulette services or the provider’s employee to [an enrollee] for the purpose of assuring safe access to and from the [enrollee’s] place of residence, ambulette vehicle and Medicaid covered health service provider’s place of business.” An ambulette provider billing for ambulette service is required to provide personal assistance to Medicaid enrollees at no additional or enhanced fee.

Personal assistance consists of rendering of physical assistance to both ambulatory and non-ambulatory (e.g., wheelchair-bound) Medicaid enrollees in:

- Walking, climbing or descending stairs, ramps, curbs or other obstacles;
- Opening and closing doors;
- Accessing the ambulette vehicle; and
- The moving of obstacles, as necessary, to ensure the safe movement of the Medicaid enrollee.

The Office of the Medicaid Inspector General (OMIG) has conducted preliminary on-site field reviews of various ambulette services, and found that many service providers did not provide personal assistance as required.

If, upon audit, the OMIG finds personal assistance was not provided by the ambulette service provider, the provider who billed for ambulette service may be subject to financial or other provider-specific sanctions, as designated by the OMIG.

Questions? Please contact the Medicaid Transportation Policy Unit at (518) 473-2160 or via e-mail to MedTrans@health.state.ny.us.



PHARMACY UPDATE

Medicaid Benefits to Change for Medicare/Medicaid Dual Eligibles

Effective October 1, 2011, the Medicaid program will no longer cover drugs in the following drug classes when billed for full benefit Medicare/Medicaid dual eligibles:

- Atypical antipsychotics;
- Antidepressants;
- Antiretrovirals used in the treatment of HIV/AIDS; and
- Antirejection drugs used for tissue and organ transplants.

Drugs in these classes must be billed directly to the Medicare/Medicaid enrollee's Part D plan, or when applicable, to Medicare Part B. Prior authorization or exception requests may be required by the Part D plan.

The New York State Medicaid Program will continue to cover certain drugs which are excluded from the Medicare Part D benefit, such as barbiturates, benzodiazepines, some prescription vitamins and some non-prescription drugs. These drugs may continue to be billed directly to Medicaid.

We strongly encourage prescribers and pharmacists to work with Medicare Part D plans prior to October 1, 2011, to obtain coverage of these drugs and avoid interruption in their patients' drug therapy.

Please contact Medicare at 1-800-MEDICARE for information regarding Medicare drug benefits. Questions pertaining to Medicaid drug coverage may be directed to (518) 486-3209.



Coverage of Clotting Factor and Injectable Antipsychotic Drugs for Managed Care Enrollees

Effective October 1, 2011, Medicaid managed care and Family Health Plus (FHPlus) enrollees will obtain their pharmacy benefit through their managed care plan. Infusion and injectable drugs will continue to be covered as a medical (not pharmacy) benefit by managed care plans. The following pharmaceuticals are exceptions to the coverage rules.

HEMOPHILIA CLOTTING FACTOR PRODUCTS

Clotting factor products will be “carved-out” of the managed care pharmacy benefit and should be billed to Medicaid on a fee-for-service basis for both Medicaid managed care and FHPlus enrollees. This carve-out applies to clotting factors administered in *all non-inpatient settings*, including in the home. Clotting factors administered during an inpatient stay will continue to be covered by the managed care plan as part of the APR-DRG or per diem rate.

The state intends to bundle these products into the managed care pharmacy benefit in the future. Practitioners will be notified in advance of policy changes.

Beginning October 1, 2011, pharmacies billing for these products should bill as a Medicaid pharmacy fee-for-service claim using the enrollee’s alpha-numeric Client Identification Number (CIN) on the health plan card, and the National Drug Code (NDC) for the clotting factor product being dispensed.

INJECTABLE ANTI-PSYCHOTIC DRUGS

Effective October 1, 2011, risperidone microspheres (Risperdal® Consta®), paliperidone palmitate (Invega® Sustenna®) and olanzapine (Zyprexa® Relprevv™) will be carved-out of the managed care benefit and billable on a fee-for-service basis *only when administered to SSI and SSI-related enrollees in mainstream Medicaid managed care plans*. Managed care plans will be responsible for these drugs when administered to non-SSI and non-SSI-related Medicaid managed care enrollees and to any HIV SNP and FHPlus enrollee.

These drugs are billed as medical claims using the following codes:

- **Risperidone microspheres – J2794**
- **Paliperidone palmitate – J2426**
- **Olanzapine – J2358**

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



PHARMACY UPDATE



New York State Medicaid
Prescriber Education Program



The New York State Medicaid Prescriber Education Program, featuring a Drug Information Response Center

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

This information is provided by the two complementary arms of the NYSMPEP, directly to prescribers in their offices via SUNY clinical pharmacy faculty (academic educators) and via the Web site at: <http://nysep.nysdoh.suny.edu>.

The DIRC supports prescribers by enhancing the partnership with their assigned regional academic educators. This is achieved by providing in-depth research into questions that arise from this contact. In addition, as responses to questions are vetted and determined to be generalized to the broad primary care audience, selected questions and responses are posted directly on the NYSMPEP Web site.

Requests pertaining to pharmacotherapy of any medical condition are entertained and responses prepared within 48 business hours. Responses to recent drug information requests may be found at: <http://nysep.nysdoh.suny.edu>. The DIRC serves to disseminate the latest objective information about pharmaceuticals to Medicaid prescribers, focusing on topics of interest to both prescribers and the general public.

The DIRC is staffed by clinical pharmacy faculty members from the SUNY campus at Buffalo, as part of their duties for the NYSMPEP. Prescribers who are interested in this service should contact the NYSMPEP via e-mail at: PEP@nysdoh.suny.edu.

Regional contact information is available on the NYSMPEP Web site. Prescribers can expect personal consultation with an NYSMPEP educator to meet their individual academic and clinical needs. Please visit: <http://nysep.nysdoh.suny.edu/contactus>.



New York State Medicaid Program Pharmacists as Immunizers Fact Sheet

Effective October 14, 2010, the administration of select vaccines by qualified pharmacists employed by, or under contract with, Medicaid enrolled pharmacies is reimbursable under NYS Medicaid. Administration of vaccines is conducted pursuant to NYS Education Law and regulations (8NYCRR63.9) which permits licensed pharmacists who obtain additional certification to administer influenza and pneumococcal vaccinations to adults 18 years of age and older.

The following conditions will apply:

- Only Medicaid enrolled pharmacies that employ or contract with NYS certified pharmacists to administer vaccines will receive reimbursement for immunization services and products. Each pharmacist certified to administer immunizations will receive a new registration certificate that will contain the prefix "I". Pharmacy interns cannot administer immunizations in New York State.
- Services must be provided and documented in accordance with NYS Department of Education laws and regulations. Please visit <http://www.op.nysed.gov/prof/pharm/part63.htm#immunization> for additional information.
- This information only applies to Medicaid fee-for-service enrollees. Medicaid Managed Care and Family Health Plus beneficiaries continue to access immunization services through their health plans. Pharmacists should check with the beneficiary's health plan before immunizing to determine the health plan's coverage policy regarding immunizations provided by pharmacists.
- Reimbursement is based on a patient specific or non-patient specific order. These orders must be kept on file at the pharmacy. The ordering prescriber's NPI is required on the claim for the claim to be paid.
- Consistent with Medicaid immunization policy for practitioners, pharmacies bill the administration and cost of the vaccine using the following procedure codes. Please note that NDCs are not to be used for billing the vaccine product. Reimbursement for the product will be made at no more than the actual acquisition cost to the pharmacy. No dispensing fee or enrollee co-payment applies. Pharmacies will bill with a quantity of "1" and a day supply of "1".

| <i>Procedure Code</i> | <i>Procedure Description</i> |
|-----------------------|--|
| 90656 | Seasonal Influenza virus vaccine, preservative free, for intramuscular use |
| 90658 | Seasonal Influenza virus vaccine, for intramuscular use |
| 90660 | Seasonal Influenza, live, for intranasal use |
| 90732 | Pneumococcal vaccine, for intramuscular use |
| G0008 | Administration of seasonal influenza virus vaccine, intramuscular use |
| 90473 | Administration of seasonal influenza intranasal vaccine |
| G0009 | Administration of pneumococcal vaccine |

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PHARMACY UPDATE

- The Seasonal Flu vaccine for individuals under the age of 19 is being provided free of charge by the Vaccines for Children (VFC) program. Therefore, Medicaid will not reimburse providers for the Seasonal Flu vaccine for individuals under the age of 19. For VFC enrollment information, please visit: http://www.health.ny.gov/prevention/immunization/vaccines_for_children.htm.

The following chart describes the codes and fees that are reimbursable to pharmacies.

| Immunization Type | Vaccine Code | Administration Code | Medicaid Reimbursement for Vaccine | Medicaid Reimbursement for Administration (Amount varies based on billing provider) | Vaccine for Children Program (VFC) |
|-------------------|--------------|---|---|---|---|
| Seasonal Flu | 90656 | G0008 for intramuscular administration | Age 19 and older Actual Acquisition Cost+ | \$13.23 | Up to Age 19 \$13.23 Bill vaccine administration code only (do not bill vaccine procedure code) |
| | 90658 | | | | |
| | 90660 | 90473 for intranasal or oral administration | | \$8.57 | |
| Pneumococcal | 90732 | G0009 for intramuscular administration | Same as above | \$13.23 | \$13.23 Bill vaccine administration code only (do not bill vaccine procedure code) |

The maximum fees for these drugs are adjusted periodically by the state to reflect the estimated acquisition cost. Insert acquisition cost per dose in amount charged field on claim form.

Questions regarding Medicaid reimbursement of immunizations may be directed to the Medicaid Pharmacy Program at (518) 486-3209 or via e-mail to: PPNO@health.state.ny.us.

Additional information on influenza is available on the NYS Department of Health Web site at: <http://www.health.ny.gov/diseases/communicable/influenza/>.



Fee for Service Pharmacy Reimbursement Changes



The Center for Medicaid and Medicare (CMS) has granted the Department approval to move forward with the following fee-for-service pharmacy reimbursement changes that were enacted in the 2011-2012 NYS Executive Budget:

- Change reimbursement rates for brand name drugs from AWP less 16.25% to AWP less 17%.
- Reduce dispensing fees paid for generic drugs from \$4.50 to \$3.50.
- Discontinue the specialized HIV pharmacy reimbursement rate.

All changes are retroactive to April 1, 2011.

Reimbursement and dispensing fee changes will be updated in the claims processing system effective 8/25/2011. Retroactive adjustments for dates of service from April 1, 2011 through August 24, 2011 will be spread out over remittance cycles through March 31, 2012, using the following process:

- Data will be pulled for enrolled pharmacies with claims for service dates 4/1/2011-8/24/2011.
- Claims for brand drugs that were paid at AWP-16.25% will be recalculated at AWP-17%.
- Dispensing fees paid for generic prescriptions will be recalculated to \$3.50.
- The total amount to be recovered from future remittances will be identified for each pharmacy.
- The amount identified will be divided by the remaining number of remittances and deducted evenly through the end of the State fiscal year.

The Department will notify providers of the beginning date for implementation of retroactive adjustments as soon as the date is established.



Attention: Family Planning and Reproductive Health Service Providers

After the pharmacy benefit is bundled into the Medicaid managed care and Family Health Plus (FHPlus) benefit effective October 1, 2011, members enrolled in Fidelis Care New York will continue to obtain these family planning and reproductive health services, including family planning drugs, from qualified Medicaid providers and pharmacies. **This applies only to Medicaid managed care and FHPlus enrollees of Fidelis Care New York (Fidelis) which operates in counties throughout the state.**

How can a provider identify enrollees affected by this change?

Medicaid managed care recipients who are enrolled in Fidelis will continue to receive family planning services as a Medicaid fee-for-service benefit. Health care providers and pharmacies billing for these services, should continue to bill Medicaid using the recipients alpha-numeric Client Identification (CIN) as shown on their health plan identification card. You may also use the patient's CIN to verify coverage and plan enrollment through eMedNY.

Family Health Plus recipients will not have a Medicaid card issued to them. For Medicaid providers not familiar with the cards provided by the health plan, the card **cannot be swiped**. *The client identification number (CIN) will have to be entered manually into the system.*

What family planning services and items will remain billable to Medicaid fee-for-service for Fidelis Medicaid managed care and Fidelis FHPlus enrollees?

Items billable to Medicaid fee-for-service are: birth control pills; IUDs; other kinds of birth control (such as patches, shots, etc.); tubal ligation; vasectomy; medically necessary abortions; and, emergency contraception.

Family Health Plus covers over-the-counter (OTC) emergency contraception but does not cover OTC birth control such as condoms, foam, etc.

How will the provider be reimbursed for these services?

The provider must participate in Medicaid and be qualified to provide family planning and reproductive health services, or related laboratory services. Providers will bill eMedNY directly by submitting an electronic claim indicating family planning or reproductive health services. Reimbursement will be made at the Medicaid rates and fees.

For details on the codes and fields identifying these services, please refer to the online provider manuals at: <http://www.emedny.org/ProviderManuals/index.html> and HIPAA 837 Companion Guides at: http://www.emedny.org/hipaa/emedny_transactions/transactions.html.

To register with Medicaid as a provider, visit: <http://www.emedny.org/info/ProviderEnrollment/index.html>.

Pharmacists can access the list of Medicaid reimbursable drugs at: <http://www.eMedNY.org/info/formfile.html>.

For billing questions or problems submitting claims, please contact the eMedNY Call Center at (800) 343-9000.



ALL PROVIDERS

New ePACES Training Schedule and Registration

With the implementation of changes for HIPAA-compliant electronic submissions, including **ePACES**, CSC Regional Representatives have scheduled educational sessions to demonstrate the new **ePACES** screens and functionality. These sessions are scheduled statewide and will be held through the summer.

ePACES is the electronic Provider Assisted Claim Entry System which allows enrolled providers to submit the following type of transactions:

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



Physician, Nurse Practitioner, DME and Private Duty Nursing claims can even be submitted in "REAL-TIME" via

ePACES. Real-time means that the claim is processed within seconds and professional providers can get the status of a real-time claim, including the paid amount without waiting for the remittance advice.

Fast and easy seminar registration, locations, and dates will soon be available on the eMedNY Web site at: <http://www.emedny.org/training/index.aspx>.

CSC Regional Representatives look forward to meeting with you at upcoming seminars!

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.

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 (1-877-873-7283), or visit www.omig.ny.gov.

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

Please visit the eMedNY Web site at: www.emedny.org.

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 any of the following numbers: (800) 997-1111, (800) 225-3040, or (800) 394-1234.

Address Change?

Address changes should be directed to the eMedNY Call Center at (800) 343-9000.

Fee-for-Service Providers: A change of address form is available at:

<http://www.emedny.org/info/ProviderEnrollment/allforms.html>.

Rate-Based/Institutional Providers: A change of address form is available at:

<http://www.emedny.org/info/ProviderEnrollment/allforms.html>.

Does your enrollment file need to be updated because you've experienced a change in ownership? Fee-for-service providers please call (518) 402-7032.

Rate-Based/Institutional providers please call (518) 474-3575.

Do you have comments and/or suggestions regarding this publication?

Please contact Kelli Kudlack at: medicaidupdate@health.state.ny.us.

Do you suspect that a Medicaid provider or beneficiary has engaged in fraudulent activities?

PLEASE CALL: 1-877-87FRAUD

Your call will remain confidential. You may also complete a complaint form online at: www.omig.ny.gov.

