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New York State Medicaid Update

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THE OFFICIAL NEWSLETTER OF THE NEW YORK STATE MEDICAID PROGRAM

Resource Verification Indicator (RVI) Added to Provisional Coverage (06) Eligibility Response and Targeted Managed Long Term Care Enrollment

Effective May 17, 2014, for consumers with 06 – Provisional Coverage, all eligibility verification methods will display or voice a message identifying the consumer as having verified resources.

The RVI value of 1, 2, 3, 4 or 9 defines the beneficiary's current resource eligibility status. RVI-1 indicates that resources have been verified for the 60-month look-back period; RVI- 2 indicates that resources have been verified only for the current month; RVI- 3 means the consumer has attested to the amount of his/her resources but the resource attestation has not been verified; RVI- 4 indicates that the consumer has made a prohibited transfer of resources; RVI- 9 indicates the consumer is exempted from the resource verification process. An RVI value of 3 precludes coverage of all long term care services, both community-based and institutional. RVI codes with a value of 1, 2 or 4 indicate eligibility for community-based long term care supports and services.

RVI information will be indicated for all consumers with 06 Provisional Coverage. The actual RVI codes are not returned on the response.

The Medicaid Eligibility Verification System (MEVS) Client Eligibility Program will be enhanced to provide RVI information for consumers with Medicaid Provisional coverage 06. The ePACES Eligibility Response Detail Report will display the new MEVS RVI information. The e-commerce Audio Response Unit MEVS Application supporting Eligibility Response voiced processing will be enhanced to voice the new RVI value information.

Following are the voiced or displayed RVI status responses for beneficiaries with 06 Provisional Coverage:

- ✓ For 06 coverage and RVI - 1 or RVI - 2, all eligibility verification methods will display or voice "No coverage – excess income, resources verified."
- ✓ For 06 coverage and RVI - 4, all eligibility verification methods will display or voice "No coverage – excess income, no NH services." (NH indicates "Nursing Home.")

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JUNE 2014 NEW YORK STATE MEDICAID UPDATE

POLICY AND BILLING GUIDANCE

PHARMACY UPDATE

ALL PROVIDERS

-CONTINUED FROM COVER-

Resource Verification Indicator (RVI) Added to Provisional Coverage (06) Eligibility Response and Targeted Managed Long Term Care Enrollment

Implications for Managed Long Term Care Plans

This enhanced resource eligibility information is important for Managed Long Term Care Plans (MLTCP) seeking to enroll consumers with Provisional Medicaid Coverage. Provisional Coverage indicates the consumer has surplus income and must incur or pay allowable medical expenses to meet the Medicaid income eligibility standard. Consumers with a surplus who wish to enroll into a MLTCP would meet the surplus requirement on the first day of the month as the surplus would be incurred or paid to the MLTCP. Collecting the surplus is the MLTCP's responsibility.

In some cases of Provisional Coverage, MLTCPs have denied beneficiary enrollments or refused to initiate the care assessment process due to limited eligibility information available to the provider. Incorporating the RVI message into the MEVS demonstrates the consumer's resource eligibility for community-based long term care services.

An eligibility response that identifies a beneficiary as having verified resources, along with Provisional Coverage, would direct a MLTCP to proceed with the assessment of consumer needs mandated by the contract with the Department of Health.

Medicaid Update for Bariatric Surgery Reimbursement

Effective May 1, 2014, New York State no longer requires that covered bariatric surgery procedures for Medicaid beneficiaries be performed in hospitals that meet the Center for Medicare and Medicaid Services' (CMS) minimum facility standards and are designated either by the American College of Surgeons and/or the American Society for Metabolic and Bariatric Surgery as a Medicare approved facility for bariatric surgery.

For covered bariatric surgeries performed on or after May 1, 2014, all hospitals will be reimbursed for bariatric surgical services for Medicaid fee-for-service (FFS) and managed care beneficiaries.

Elective Deliveries (C-sections or Inductions) Prior to 39 Weeks Gestation

Updated Billing Guidelines for Providers and Hospitals

As stated in the original policy, 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), Medicaid Managed Care, and Family Health Plus enrollees. All obstetric deliveries billed by hospitals currently require the use of a condition code to identify the gestational age of the fetus as of the date of delivery. Failure to provide a condition code on the inpatient delivery claim will result in the claim being denied.

Hospital Inpatient Claims

The following ICD-9 procedure codes require one of the condition codes below to be reported on the obstetrical claim: 73.01, 73.1, 73.4, 74.0, 74.1, 74.2, 74.4, and 74.99. Please note that condition code 81 has been added to the list of acceptable condition codes.

- ***Condition code 81*** *- C-sections or inductions performed at* ***less than 39 weeks gestation for medical necessity*****.**
  If this condition code is reported with an acceptable primary diagnosis code, the claim will be paid in full. If this condition code is reported with a primary diagnosis code that does not support medical necessity, the claim will be reduced by 10%. For condition code 81 **ONLY**, diagnosis code 650.0 (Normal Delivery) will be considered an acceptable primary diagnosis code, and the claim should be paid in full.

- ***Condition code 82*** *– C-sections or inductions performed at* ***less than 39 weeks gestation electively.***
  If this condition code is reported without an acceptable primary diagnosis code, the claim will be reduced by 10%.

- ***Condition code 83*** *– C-sections or inductions performed* ***at 39 weeks gestation or greater.***
  If this condition code is reported, the claim will pay in full.

The following ICD-9 primary diagnosis codes have been added to the original list of acceptable diagnosis codes published in the June 2013 Medicaid Update. (For use by both hospitals and practitioners billing for elective births by induction or C-section occurring at less than 39 weeks gestation).

For information published in the June 2013 Medicaid Update regarding Elective Delivery (C-Section and Induction of Labor) < 39 Weeks without Medical Indication, please visit:

http://www.health.ny.gov/health_care/medicaid/program/update/2013/2013-06.htm

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ICD 9 - 694.3 – Impetigo Herpetiformis.

ICD 9 - 651.71 – Multi-fetal gestation following (elective) fetal reduction, delivered, with or without mention of antepartum condition.

ICD 9 - 661.30 – Precipitate labor, unspecified as to episode of care or not applicable.

ICD 9 - 661.31 – Precipitate labor, delivered, with or without mention of antepartum condition.

ICD 9 - 661.33 – Precipitate labor, antepartum condition or complication.

ICD 9 - 656.01 – Fetal-maternal hemorrhage, delivered, with or without mention of antepartum condition.

ICD 9 - V27.1 – Delivery - singleton stillborn.

Practitioner Claims:

Reminder: Practitioner claims for obstetric deliveries must include one of the following modifiers. Failure to include one of the two modifiers below on a claim will result in denial of the claim.

- U8 - Delivery prior to 39 weeks of gestation.
- U9 - Delivery at 39 weeks of gestation or later.

Modifier UB

The UB modifier is a newly assigned modifier to be used for spontaneous obstetrical deliveries occurring between 37-39 weeks gestation. When billing for spontaneous obstetrical deliveries occurring between 37-39 weeks gestation, practitioners should report ICD-9 diagnosis code 650 as the PRIMARY diagnosis code with the U8 modifier AND the UB modifier.

Questions regarding MMC and FHPlus reimbursement and/or documentation requirements should be directed to the enrollee's MMC or FHPlus plan. Medicaid FFS Policy questions may be directed to OHIP Division of Program Development and Management at (518) 473-2160. Claiming questions should be directed to the eMedNY Call Center at (800) 343-9000.

Update on Drug Coverage for the Dual Eligible Population

Only drugs that are excluded by law from being covered by the Medicare Part D plans, such as select prescription vitamins and over-the-counter drugs are covered by NYS Medicaid for dual eligible patients Medicare/Medicaid:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_transition/docs/2014-01-01_medicare_exempt_drugs.pdf.

New York State Medicaid does not provide dual eligible patients with coverage of heparin, heparin flushes and sodium chloride flushes.

Effective July 1, 2014, Medicaid will enforce editing on prescriptions for heparin, heparin flushes and sodium chloride flushes for dual eligible patients. Patients and providers should consult the appropriate Medicare Part D prescription drug plan or Medicare Advantage Prescription Drug (MAPD) contracting plan for coverage of heparin prescriptions for medically accepted indications. Under Medicare Part B, payment for heparin and sodium chloride flushes are included in the main procedure/surgery/service that they are reported with. There is no separate payment for these products.

NYS Medicaid continues to cover heparin, heparin flushes and sodium chloride flushes for NYS Medicaid beneficiaries who are not Medicare eligible.

Medicaid Pharmacy Prior Authorization Programs Update

On April 24, 2014, the New York State Medicaid Drug Utilization Review Board (DURB) recommended changes to the Medicaid pharmacy prior authorization programs. The Acting 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 July 16, 2014, prior authorization (PA) requirements will change for some drugs in the following PDP classes:

- Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) – Prescription
- Antipsychotics – Second Generation
- Central Nervous System (CNS) Stimulants
- Multiple Sclerosis Agents
- Selective Serotonin Reuptake Inhibitors (SSRIs)
- Anti-infectives – Topical
- Growth Hormones
- Thiazolidinediones (TZDs)
- Sulfasalazine Derivatives
- Platelet Inhibitors
- Alpha-2 Adrenergic Agonists (for glaucoma) – Ophthalmic
- Phosphate Binders/Regulators
- Antihistamines – Second Generation
- Corticosteroids – Intranasal

For more detailed information on the above DURB recommendations, please see: http://www.health.ny.gov/health_care/medicaid/program/dur/meetings/2014/04/sum_0424_14_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 Prior Authorization Programs. This document contains a full listing of drugs subject to PDP, Clinical Drug Review Program, DUR Program, Brand Less than Generic program, Dose Optimization Program and the Mandatory Generic Drug Program: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf.

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

Medicaid enrolled prescribers with an active ePACES 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.

Update on Pharmacy Billing for Compounded Prescriptions

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

All ingredients of a compounded prescription **MUST** be submitted to Medicaid regardless of reimbursement.

Effective July 10, 2014, Medicaid Fee-for-Service will enforce editing to ensure a minimum of two ingredients (NDCs) in the Compound Segment, field 489-TE- (Compound Product ID) are submitted on a compound claim.

The information above provides more additional billing details to support the compound drug billing instructions listed in the February 2014 Medicaid Update:
http://www.health.ny.gov/health_care/medicaid/program/update/2014/feb14_mu.pdf

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

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

Rate Based Claims – Notification Change in the 835 for Retroactive Rate Adjustments

Currently, eMedNY utilizes the PER segment in Loop 2100 Claim Payment Information of the ASC X12N/005010X221A1 835 Remittance Advice to notify providers when a rate based claim has been reprocessed as a result of a retroactive adjustment. eMedNY will be removing this segment in order to be compliant with the appropriate usage of this segment.

On July 24, 2014, - Cycle number 1928, eMedNY will begin to return the following values in the 835 for retroactive rate adjustments:

- The literal **"RETRO RATE REVERSAL"** that is currently sent to let providers know of a Reversal in the PER segment of the 835-Remittance Advice shall be removed and a Remittance Advice Remark Code (RARC)-N689 (ALERT: REVERSAL DUE TO RETROACTIVE RATE CHANGE) shall be sent in the MIA05 of the Inpatient Adjudication Information segment or MOA03 – Outpatient Adjudication Information segment.

- The literal **"RETRO RATE CORRECTION"** that is currently sent to let providers know of a Correction of a previous payment in the PER segment of the 835-Remittance Advice will be removed and a Remittance Advice Remark Code (RARC)-N419 (RETROACTIVE RATE ADJUSTMENT) will be sent in the MIA05 of the Inpatient Adjudication Information segment or MOA03 – Outpatient Adjudication Information segment.

New York Medicaid Electronic Health Records (EHR) Incentive Program Update

The New York Medicaid EHR Incentive Program provides financial incentives to eligible providers and hospitals to promote the transition to EHRs. Providers who practice using EHRs are in the forefront of improving quality, reducing costs. Since December 2011 ***over $587.2 million*** in incentive funds have beer distributed ***within 14,092*** payments to New York State Medicaid providers.

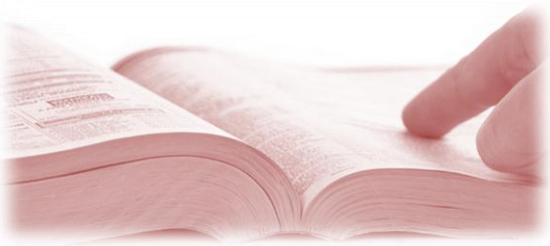
Taking a closer look: NYS Regional Extension Centers (RECs)

Are you looking for adoption and technical assistance when participating in the New York Medicaid EHR Incentive Program? NYS has two Regional Extension Centers (RECs) that provide partnership level support to assist providers in achieving Meaningful Use.

New York eHealth Collaborative (NYeC)
Serves: All of NY State except New York City and its five boroughs.
Link: www.nyehealth.org/
Tel: (646) 619-6400

New York City Regional Electronic Adoption Center for Health (NYC REACH)
Serves: Five boroughs of New York City
Link: www.nycreach.org/
Tel: (347) 396-4888

PROVIDER DIRECTORY



Office of the Medicaid Inspector General:
For general inquiries or provider self-disclosures, please call (518) 473-3782. For suspected fraud complaints/allegations, call 1-877-87FRAUD, (877) 873-7283, or visit www.omig.ny.gov.

Provider Manuals/Companion Guides, Enrollment Information/Forms/Training Schedules:
Please visit the eMedNY website at: www.emedny.org.

Providers wishing to listen to the current week's check/EFT amounts:
Please call (866) 307-5549 (available Thursday PM for one week for the current week's amount).

Do you have questions about billing and performing MEVS transactions?
Please call the eMedNY Call Center at (800) 343-9000.

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

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

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've experienced a change in ownership? Do you want to enroll another NPI? Did you receive a letter advising you to revalidate your enrollment?
Visit www.emedny.org/info/ProviderEnrollment/index.aspx and choose the link appropriate for you (e.g., physician, nursing home, dental group, etc.).

Medicaid Electronic Health Record Incentive Program questions?
Contact the New York Medicaid EHR Call Center at (877) 646-5410 for assistance.