NEW YORK STATE | Department of Health | Medicaid Program

Medicaid Update

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Gene Expression Profiling Test for Use in the Management of Breast Cancer Treatment

New York State Medicaid Coverage for the Oncotype DX® test for Breast Cancer

Effective 1/1/2015 for Medicaid fee-for-service (FFS), and 3/1/2015 for Medicaid Managed Care (MMC) Plans, the New York State Medicaid program will provide reimbursement for the Oncotype DX® test for Breast Cancer. This new coverage will assist practitioners in making determinations regarding effective and appropriate use of chemotherapy in female (ICD-9-CM code 174.0 – 174.9), or male (ICD-9-CM code 175.0 or 175.9) patients with recently diagnosed breast tumors, when all of the following criteria are met:

- Tumor is Stage 1 or Stage 2; AND
- Node-negative (non-metastatic), or micrometastatic disease (<2mm nodal involvement); AND
- Estrogen receptor positive (ER+), alone, or in combination with progesterone receptor positive (PR+); AND
- Human epidermal growth factor receptor 2 (HER2) negative; AND
- Tumor size is equal to or greater than 0.6 cm; AND
- The tumor is unilateral and non-fixed; AND
- Test is ordered within 6 months of diagnosis; AND
- When the test result will aid the patient and practitioner in making the decision regarding chemotherapy (i.e., when chemotherapy is a therapeutic option and is not precluded due to any other factor).

The Oncotype DX® test (represented by CPT code 81519) requires the use of formalin-fixed, paraffin-embedded tissue from the tumor (unstained slides are acceptable); the requesting provider must obtain specimen transportation kit boxes, requisition form and pathology guidelines for sample preparation from Genomic Health, Inc. (GHI). Specimens will be taken during an ambulatory surgery encounter or during an inpatient stay. Lab tests are carved out of the ambulatory surgery APG payment; as such, the Article 28 facility should not report the 81519 procedure code on their ambulatory surgery APG claim. GHI will bill Medicaid FFS and MMC Plans directly. GHI has negotiated a payment rate with Medicaid FFS. Please note that MMC Plans rates cannot exceed the negotiated Medicaid FFS rate. Specimens tested by Genomic Health, Inc. within two weeks of discharge from hospital inpatient status are included in the APR-DRG payment to the hospital facility.

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For patients with Medicaid FFS, ordering physicians will be required to complete two forms: the Genomic Health requisition form and the Oncotype DX® Criteria Verification form required by New York State; both forms are available on the Genomic Health website (physician login address is https://online.genomichealth.com/Login.aspx). The requisition form must be completed in its entirety, including Medicare-specific entries. The requisition form requires ordering physician information, patient information, hospital status (inpatient > 24 hours, hospital outpatient and non-hospital patient, for Medicare purposes), submitting diagnosis, information type, and the reason for ordering. The specimen number, date of surgery, comments for pathology, and "date block pulled from archive" (for Medicare purposes) are required, as well as attestation of medical necessity and patient consent. **A copy of the pathology report must accompany the requisition form.** Genomic Health, Inc. indicates that for the breast cancer assay, the specimen submitted for Oncotype testing must be ER+; if GHI determines that the submitted specimen is not ER+, a result will not be reported, and GHI will not report a test result and will not bill the payer or patient. **In addition, an Oncotype DX® Criteria Verification form should also be completed; this form will be available along with the requisition form on the website.** This form must be completed to verify medical necessity and serve as attestation that the inclusion criteria have been met, and that treatment options have been discussed with the patient.

It should be noted that, in accordance with 18 NYCRR 504.3(a) the ordering physician must maintain sufficient documentation regarding the required patient history to clearly support the medical necessity of the ordered test.

Retrospective reviews may be conducted periodically through a Medicaid-funded utilization management contractor or the Office of the Medicaid Inspector General. Medical records must be maintained by providers for a period of not less than six years from the date of payment.

Questions regarding Medicaid Managed Care (MMC) reimbursement and/or documentation requirements should be directed to the enrollee's MMC plan. The Managed Care Plans must adhere to the coverage criteria noted above, but may elect not to use the Oncotype DX® Criteria Verification form required for use by New York State FFS Medicaid providers. The Plans may also apply prior approval requirements for the test. Medicaid FFS policy questions may be directed to OHIP Division of Program Development and Management at (518) 473-2160. Questions on claim procedures should be directed to Computer Sciences Corporation at 1-800-343-9000.

ICD-9 to ICD-10 code conversion

ICD-9-CM		ICD-10-CM	
174.0	*Malignant neoplasm nipple & areola female breast*	*C50.011*	*Malignant neoplasm of nipple & areola, right female breast*
		C50.012	*Malignant neoplasm of nipple & areola, left female breast*
		C50.019	*Malignant neoplasm of nipple & areola, unsp female breast*
174.1	*Malignant neoplasm central portion female breast*	*C50.111*	*Malignant neoplasm of central portion of right female breast*
		C50.112	*Malignant neoplasm of central portion of left female breast*
		C50.119	*Malignant neoplasm of central portion of unsp female breast*
174.2	*Malignant neoplasm upper-inner quadrant female breast*	*C50.211*	*Malignant neoplm of upper-inner quadrant of right female breast*
		C50.212	*Malig neoplasm of upper-inner quadrant of left female breast*
		C50.219	*Malig neoplasm of upper-inner quadrant of unsp female breast*
174.3	*Malignant neoplasm lower-inner quadrant female breast*	*C50.311*	*Malig neoplm of lower-inner quadrant of right female breast*
		C50.312	*Malig neoplasm of lower-inner quadrant of left female breast*
		C50.319	*Malig neoplasm of lower-inner quadrant of unsp female breast*
174.4	*Malignant neoplasm upper-outer quadrant female breast*	*C50.411*	*Malig neoplm of upper-outer quadrant of right female breast*
		C50.412	*Malig neoplasm of upper-outer quadrant of left female breast*
		C50.419	*Malig neoplasm of upper-outer quadrant of unsp female breast*
174.5	*Malignant neoplasm lower-outer quadrant female breast*	*C50.511*	*Malig neoplm of lower-outer quadrant of right female breast*
		C50.512	*Malig neoplasm of lower-outer quadrant of left female breast*

		C50.519	*Malig neoplasm of lower-outer quadrant of unsp female breast*
174.6	*Malignant neoplasm axillary tail female breast*	*C50.611*	*Malignant neoplasm of axillary tail of right female breast*
		C50.612	*Malignant neoplasm of axillary tail of left female breast*
		C50.619	*Malignant neoplasm of axillary tail of unsp female breast*
174.8	*Malignant neoplasm other spec sites female breast*	*C50.811*	*Malignant neoplasm of ovrlp sites of right female breast*
		C50.812	*Malignant neoplasm of ovrlp sites of left female breast*
		C50.819	*Malignant neoplasm of ovrlp sites of unsp female breast*
174.9	*Malignant neoplasm of breast unspecified site*	*C50.911*	*Malignant neoplasm of unsp site of right female breast*
		C50.912	*Malignant neoplasm of unspecified site of left female breast*
		C50.919	*Malignant neoplasm of unsp site of unspecified female breast*
175.0	*Malignant neoplasm nipple & areola male breast*	*C50.021*	*Malignant neoplasm of nipple & areola, right male breast*
		C50.022	*Malignant neoplasm of nipple & areola, left male breast*
		C50.029	*Malignant neoplasm of nipple & areola, unsp male breast*
175.9	*Malignant neoplasm other & unspec sites male breast*	*C50.121*	*Malignant neoplasm of central portion of right male breast*
		C50.122	*Malignant neoplasm of central portion of left male breast*
		C50.129	*Malignant neoplasm of central portion of unsp male breast*
		C50.221	*Malig neoplasm of upper-inner quadrant of right male breast*
		C50.222	*Malig neoplasm of upper-inner quadrant of left male breast*
		C50.229	*Malig neoplasm of upper-inner quadrant of unsp male breast*
		C50.321	*Malig neoplasm of lower-inner quadrant of right male breast*
		C50.322	*Malig neoplasm of lower-inner quadrant of left male breast*

		C50.329	*Malig neoplasm of lower-inner quadrant of unsp male breast*
		C50.421	*Malig neoplasm of upper-outer quadrant of right male breast*
		C50.422	*Malig neoplasm of upper-outer quadrant of left male breast*
		C50.429	*Malig neoplasm of upper-outer quadrant of unsp male breast*
		C50.521	*Malig neoplasm of lower-outer quadrant of right male breast*
		C50.522	*Malig neoplasm of lower-outer quadrant of left male breast*
		C50.529	*Malig neoplasm of lower-outer quadrant of unsp male breast*
		C50.621	*Malignant neoplasm of axillary tail of right male breast*
		C50.622	*Malignant neoplasm of axillary tail of left male breast*
		C50.629	*Malignant neoplasm of axillary tail of unsp male breast*
		C50.821	*Malignant neoplasm of overlapping sites of right male breast*
		C50.822	*Malignant neoplasm of overlapping sites of left male breast*
		C50.829	*Malignant neoplasm of overlapping sites of unsp male breast*
		C50.921	*Malignant neoplasm of unspecified site of right male breast*
		C50.922	*Malignant neoplasm of unspecified site of left male breast*
		C50.929	*Malignant neoplasm of unsp site of unspecified male breast*
		New ICD-10-CM Codes	
		C79.81	*Secondary malignant neoplasm of breast*

From: American Medical Association (2014) ICD-10-CM Mappings: Linking ICD-9-CM to All Valid ICD-10-CM Alternatives. ©2013 OptumInsight, Inc.

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Revisions to the NYS Medicaid Fee-for-Service Laboratory Provider Manual

The following changes are effective January 1, 2015 and should serve as a replacement to Rules 5A and 5B currently outlined in the Laboratory Procedure Code Manual located at the following link: https://www.emedny.org/ProviderManuals/Laboratory/PDFS/Laboratory_Procedure_Codes.pdf

5A. Therapeutic drug monitoring is reimbursable when quantitative determination of blood concentration is clinically relevant as a part of a regimen designed to attain and sustain therapeutic effect by maintenance of blood level within a defined range. The intensity and probability of therapeutic or toxic effect must quantitatively correlate with blood concentration. In addition, one or more of the following criteria must be satisfied:

1) There is a narrow range between those concentrations giving the desired response and those producing toxicity;
2) readily assessed alternative endpoints (e.g., prothrombin time for oral anticoagulants) are lacking; or
3) there is large inter individual variability in the absorption and disposition of the drug.

Therapeutic monitoring is a covered service only when performed on specimens of blood. Use the drug specific codes 80150 through 80203. Code 80299 is to be used only for drugs, which meet the criteria for therapeutic monitoring, outlined above and are not listed by individual code. Codes 80299 is billable "By Report" and the drug(s) must be specified in the procedure description field on the Claim Form. Peak and trough (or predose and postdose) analyses, when clinically indicated (e.g., aminoglycosides), are reimbursable as two procedures.

5B. The fee for code 80300, 80301, 80303 or 80304 covers screening of one specimen for all drugs including but not limited to alcohol, amphetamines, barbiturates, benzodiazepines, cocaine and metabolites, methadone, methaqualones, opiates, phencyclidines, phenothiazine, propoxyphenes, quinine, tetrahydrocannaboinoids (marijuana) and tricyclic antidepressants. Screening by a broad-spectrum chromatographic procedure, which detects multiple drug classes, should be billed using code 80303 or 80304. Each step in the sequential development of a chromatograph is NOT considered a separate procedure. When an analytical condition, e.g., column temperature or flow rate, is changed such that additional controls must be run, subsequent analysis of the same specimen for additional drug(s) is considered a separate procedure for billing purposes. Screening for any number of drug classes by devices capable of being read by direct optical observations (e.g. dipsticks, cups, cards or cartridges, without or without instrument assistance) should be billed using 80300. Report 80300 once, irrespective of the number of direct observation drug class procedures or results on any date of service.

Screening for drugs using immunoassay or enzyme assay using multichannel chemistry analyzers should be billed using code 80301. Use 80301 once to report single or multiple procedures performed, irrespective of the number of procedures, classes or results on any date of service.

Policy and Billing Guidance

Use code 80301 for the following drugs/drug classes:

- Alcohol
- Amphetamines
- Barbiturates
- Benzodiazepines
- Buprenorphine
- Cocaine metabolites
- Heroin metabolites
- Methadone
- Methadone metabolites
- Methamphetamine
- Methaqualone
- Methylenedioxynethamphetamine
- Opiates
- Oxycodone
- Phencylicine
- Propoxyphene
- Tetrahydrocannabional (THC) metabolites (marijuana)
- Tricyclic Antidepressants

Codes 80320 through 80367 are only billable when a presumptive positive drug screen is found using codes 80300, 80301, 80303 or 80304. For confirmation testing, bill the appropriate definitive drug code related to the drug/drug class. Use of these codes for drug testing without a presumptive positive screen is not reimbursable. For therapeutic monitoring of drugs included in these codes, use 80299.

For a comprehensive list of 2015 Laboratory Procedure Code changes please visit the following link: https://www.emedny.org/ProviderManuals/Laboratory/PDFS/2015_Laboratory_Procedure_Code_Changes_-_1-8-15.pdf

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ICD-10 Reminder for Providers and Vendors

- The eMedNY Provider Testing Environment (PTE) is available for end-to-end testing of Medicaid claims with ICD-10 diagnosis codes (procedure codes for inpatient hospitals). The PTE mirrors the eMedNY production environment, in both content and functionality. Submitters and providers can be assured that successful testing through the PTE will minimize potential issues with submission of their production files come October 1, 2015. All Medicaid partners are urged to test at their earliest convenience.

- The https://www.emedny.org/icd/index.aspx website provides an extensive amount of eMedNY related ICD-10 information including FAQs and eMedNY end-to-end testing. The area should be visited regularly to ensure submitters have the most up to date ICD-10 information.

- Provider and vendors are encouraged to regularly access the federal CMS ICD-10 website www.cms.gov/Medicare/Coding/ICD10/index.html for the most comprehensive and detailed compilation of ICD-10 resources including Intro Guide to ICD-10, ICD-10 and Clinical Documentation, ICD-10 Official Coding Guidelines, General Equivalence Mappings (GEMs), and many other documents focusing on all aspects of ICD-10 implementation.

- Medicaid providers are reminded that they are ultimately responsible for ensuring that the data submitted to New York Medicaid by them, or a third party on their behalf, is correct and compliant with mandated standards and regulations. As such it is of utmost importance that providers take a proactive role and work diligently with their staff, clearinghouse, billing service or software vendor to ensure their practice will be able to successfully submit ICD-10 compliant transactions for services rendered on or after October 1, 2015.

- Effective October 1, 2015 New York Medicaid will only accept, recognize and process ICD-10 codes for services rendered on or after October 1, 2015. ICD-9 codes will only be accepted for services rendered prior to October 1, 2015. **Transactions which contain ICD-9 codes, with a date of service of October 1, 2015 or after will be denied.**

October 1, 2015 is less than nine months away. Transition to ICD-10 will take time and resources. If you are not yet preparing for transitioning to ICD-10 the time to start is now. Do not put your Medicaid payments at risk by delaying your compliance efforts.

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eMedNY Enhances ePACES Functionality for DVS Transactions and Dental Prior Approval Requests

Effective January 23, 2015 eMedNY will implement enhancements to the ePACES application to facilitate submission of Dispensing Validation System (DVS) transactions. The enhancements will allow durable medical equipment (DME) and dental providers to submit multiple Dispensing Validation System (DVS) transactions for the same client, for the same date of service without re-entering the patient and provider demographics and event information. DME and dental providers often need to submit multiple HCPCS for services being provided to the same client for a single date of service. The enhancements will streamline the DVS submission process, saving these providers time and resulting in better services for the patients.

Impact for DVS Requests

The new enhancements will allow providers to enter multiple DVS transactions for a client, for the same date of service, through a single DVS request.

A new **"Enter Another DVS for This Client"** button is being added in the DVS/PA TAB between the "Submit" and "Clear" buttons. When this button is selected the entered transaction will be submitted for processing by eMedNY and all fields on the "Prior Approval Items" tab including any data entered in the "More Details" section will be cleared. The "Client Information" (Client ID and Patient Account #) on the "General Information" tab will remain. This will allow another DVS transaction to be submitted for the same Client. Note: The "Submit" button will work as it has in the past.

Impacts for Dental – ePACES Electronic Prior Approval Requests (PA) and Required Attachments Upload

Beginning on or after January 23, 2015 dental providers who submit both PA requests and attachments electronically will be able to view in the PA Response/Comments Section if the Department of Health (DOH) inactivated or canceled their request, due to missing information etc. The DOH remarks will appear in the General Tab/Comment section of the PA response.

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

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Transition of Nursing Home Benefit and Population into Mainstream Medicaid Managed Care

Beginning February 1, 2015, managed care plans will cover the full range of Nursing Home services to current managed care enrollees new to Nursing Home care. Effective February 1, 2015, in New York City, all eligible beneficiaries age 21 and over in need of long term placement in a nursing facility will be required to join a Medicaid Managed Care Plan (MMCP) or a Managed Long Term Care Plan (MLTCP). On April 1, 2015, the counties of Nassau, Suffolk, and Westchester will be phased in, and the rest of the State is scheduled to transition beginning in July 2015 for both dual and non-dual eligible populations.

All current long term placed beneficiaries in a Medicaid certified skilled nursing facility (NH) prior to February 1, 2015 for Phase 1, April 1, 2015 for Phase 2, and July 1, 2015 for the upstate phase-in will remain in fee-for-service (FFS) Medicaid and will not be required to enroll in a Managed Care Organization (MCO). No individual will be required to change nursing homes resulting from this transition; however, new placements will be based upon the MCO's contractual arrangements and the needs of the individual. Effective October 1, 2015, voluntary enrollment into managed care becomes available to individuals residing in nursing homes who are in FFS Medicaid.

Phase-In Schedule

Phase 1- February 1, 2015	New York City – Bronx, Kings, New York, Queens, and Richmond Counties
Phase 2- April 1, 2015	Nassau, Suffolk and Westchester Counties
Phase 3- July 1, 2015	Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Rensselaer, Rockland, St. Lawrence, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Wayne, Washington, Wyoming, and Yates Counties
October 1, 2015	All counties - voluntary enrollment in Managed Long Term Care, Fully Integrated Duals Advantage and Mainstream Medicaid Managed Care becomes available to individuals residing in nursing homes who are in fee-for-service Medicaid

The steps toward this transition require that each party - MCOs, providers and the State - ensure that individuals in need of long term care services receive care in the most integrated and least restrictive setting. The ultimate goal is to foster a care delivery model that promotes transitional planning across the health care delivery system with the focus on providing services in the community whenever possible.

Details related to the nursing home transition, including eligibility and enrollment, access to care, transition planning, network and contracting, quality metrics and incentives, as well as finance and reimbursement, are outlined in the policy paper entitled "Transition of Nursing Home Benefit and Population into Managed Care." Additional information is included in a "Frequently Asked Questions" document. Both documents are located on the New York State Department of Health (DOH) web site at the following link: http://www.health.ny.gov/health_care/medicaid/redesign/mrt_1458.htm.

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New Medicaid FFS Pharmacy Early Fill Edit

Effective January 22, 2015, per the 2014-15 enacted budget, a new pharmacy early fill edit will be implemented that will tighten early fill parameters based on days' supply on hand in an effort to further reduce overutilization, stockpiling and/or diversion of drugs. This new enhanced edit will deny a claim if more than a 10 day supply of medication is remaining of the cumulative amount that has been dispensed over the previous 90 days, and will augment current editing where claims are denied when less than 75% of the previously dispensed amount has been used (the more stringent rule will apply). Beneficiaries will still have the ability to refill their prescription(s) early, allowing for ample supply of their medication(s) on hand.

The determination of an early fill will be applied to all claims for the same drug product and strength, regardless of prescribing provider, billing provider, or prescription number.

Like the current eMedNY claim denial messaging, eMedNY will indicate the reason for denial and specify the date that is the earliest the claim will be accepted for payment in the Response DUR/PPS Segment field 544-FY- (DUR Free Text Message). This can be found in the ProDUR/ECCA Provider manual and is shown below:

New edit 02242 (Early Fill Overuse)

NCPDP Reject Code- "88"- (DUR Error) and "ER"- (Overuse) will be returned in the rejected Response Status Segment field 511-FB- (Reject Code). The Response DUR/PPS Segment field 544-FY- FY REJECT- DRUG OVERUSE **(DYS)** XX/XX/XX

Existing edit 01642 (Early Fill Overuse)

NCPDP Reject Code- "88"- (DUR Error) and "ER"- (Overuse) will be returned in the rejected Response Status Segment field 511-FB- (Reject Code). The Response DUR/PPS Segment field 544-FY- FY REJECT- DRUG OVERUSE XX/XX/XX

Reminders:

LONG-TERM CARE PHARMACY PROVIDERS ONLY:

A newly admitted resident to a long-term care facility is eligible for an early fill on their medication. When medically necessary, a pharmacist can override edit 01642 "Early Fill Overuse" or edit 02242 "Early Fill Overuse" denial at the point of sale, by using a combination of the NCPDP Reason for Service Code (439-E4) 'NP', and a Submission Clarification Code (420-DK) of '02'. **Only** long term care providers are allowed to use the "02" Submission Clarification Code. Use of this override code will be monitored by the Department of Health.

PRESCRIBERS AND PHARMACIES FOR LOST/STOLEN REQUESTS:

Submission Clarification Code “04” (Lost/Stolen) in field 420-DK denies edit 01642 and edit 02242 when used for submission of a pharmacy claim. If a Medicaid beneficiary has experienced a loss or theft of medication, pharmacy providers should instruct beneficiaries to contact their prescriber. The decision to honor a beneficiary’s request should be based on the professional judgment of the prescriber.

In no event will approval be granted for lost or stolen controlled substances.

Prescribers or their authorized agents may initiate a prior authorization request for a loss or theft of medication by contacting the Bureau of Pharmacy Policy and Operations at (518) 486-3209 or emailing ppno@health.ny.gov for replacement. Approval will **ONLY** be granted for the balance of the medication reported lost or stolen.

Original article: http://www.health.ny.gov/health_care/medicaid/program/update/2011/april11mu.pdf

PRESCRIBERS AND PHARMACIES FOR VACATION REQUESTS:

Submission Clarification Code “03” (Vacation Supply) in field 420-DK, is **not** an acceptable override for both early fill edits and will deny. Beneficiaries should be instructed to make arrangements for the mailing of medications when a temporary absence prevents them from picking up their prescriptions.

Original article: http://www.health.ny.gov/health_care/medicaid/program/update/2010/july10mu.pdf

Questions regarding this new edit?

Please call the eMedNY Call Center at 800-343-9000

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Medicaid Pharmacy Prior Authorization Programs Update

Effective February 12, 2015, the fee-for-service pharmacy program will implement the following parameters. These changes are the result of recommendations made by the Drug Utilization Review Board (DURB) at the November 20, 2014 DURB meeting:

Metreleptin (Myalept)

- Confirmation of diagnosis for FDA-approved indications:
  - Leptin deficiency in patients with congenital generalized lipodystrophy (CGL) or acquired generalized lipodystrophy (AGL).
- Absence of covered diagnosis in patients claim history will require prescriber involvement.

Oral Pollen/Allergen Extracts (Grastek, Oralair, Ragwitek)

- Confirmation of diagnosis for FDA approved indication:
  - Pollen-induced allergic rhinitis confirmed by positive skin or in vitro testing for pollen-specific IgE antibodies.
- Absence of covered diagnosis in patient's claim history will require prescriber involvement.
- Step Therapy
  - Trial with a preferred intranasal corticosteroid. Override will require prescriber involvement.

Second Generation Antipsychotics (SGAs) utilized in the treatment of Major Depressive Disorder (MDD)

- Diagnosis requirement for all SGA prescriptions.
  - Absence of covered diagnosis in patient's claim history for beneficiaries not currently on therapy will require prescriber involvement.
- Step therapy for all SGAs prescribed for the treatment of MDD in the absence of other psychiatric comorbidities.
  - Trial with at least two (2) different antidepressants.

Ledipasvir/sofosbuvir (Harvoni)

- Activate coverage of Harvoni.
- Continue using clinical criteria* and/or point of service editing as approved at the September 2014 DURB meeting and implemented on October 16, 2014.
  - FDA labeling and compendia supported use
  - Prescriber experience and training
  - Patient readiness and adherence
  - Disease prognosis and severity

  *Clinical criteria was published in the October 2014 Medicaid Update (pages 9-11). Please refer to: http://www.health.ny.gov/health_care/medicaid/program/update/2014/oct14_mu.pdf

Central Nervous Stimulants and Non-Stimulants utilized in the treatment of Attention Deficit Hyperactivity Disorder (ADHD)

- Diagnosis requirement for an FDA-approved or Compendia supported indication for beneficiaries less than 18 years of age who are starting stimulant or non-stimulant therapy.
  - Absence of covered diagnosis in patient's claim history for beneficiaries not currently on therapy will require prescriber involvement.
- Prescriber involvement is required when initiating stimulant therapy in beneficiaries less than three (3) years of age.

- Prescriber involvement required when initiating non-stimulant therapy for beneficiaries less than six (6) years of age.

For more detailed information on the DURB, please refer:
http://www.health.ny.gov/health_care/medicaid/program/dur/index.htm

Below is a link to the most up-to-date information on the Medicaid FFS Pharmacy Prior Authorization (PA) Programs. This document contains a full listing of drugs subject to the Medicaid FFS Pharmacy Programs:
https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf

To obtain a PA, please contact the clinical call center at 1-877-309-9493. The clinical call center is available 24 hours per day, 7 days per week with pharmacy technicians and pharmacists who will work with you, or your agent, to quickly obtain a PA.

Medicaid enrolled prescribers with an active e-PACES account can initiate PA requests through the web-based application PAXpress ® at: https://paxpress.nypa.hidinc.com; 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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All Providers

NY Medicaid EHR Incentive Program Update

The NY Medicaid Electronic Health Record (EHR) Incentive Program provides financial incentives to eligible practitioners and hospitals to promote the transition to EHRs. Providers who practice using EHRs are in the forefront of improving quality, reducing costs and addressing health disparities. Since December 2011 ***over $633.7 million*** in incentive funds have been distributed *within* ***16,273*** payments to New York State Medicaid providers.

The NY Medicaid EHR Incentive Program Support Team takes great pride in offering providers free high quality program support and services. Don't take our word for it, call us at ***1-877-646-5410*** *to speak with a program analyst for one-on-one support or navigate to the NY Medicaid EHR Incentive Program Website to view our online services.*

Taking a closer look: NEW NY Medicaid EHR Incentive Program Updates

Meaningful Use (MU) Stage 2:

The New York Medicaid EHR Incentive Program is pleased to announce that Stage 2 attestations are now being accepted in MEIPASS. The Eligible Professional (EP) MU2 Walkthrough is available on the program website to help EPs navigate through the attestation. Additionally, the attestation deadline for Eligible Hospitals (EH) for Payment year 2014 has been extended to January 31, 2015.

Recorded EP Webinars:

In addition to regularly scheduled informational webinars, the NY Medicaid EHR Incentive program website now contains recorded webinars covering the same subjects. Webinar content available at the click of a button creates more flexibility for EPs interested in learning more about the program!

- February webinar dates on our Upcoming Event Calendar
- **NEW** Recorded Webinars available in the Document Repository
- **NEW** Public Health FAQs

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

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All Providers

Issuance of IRS Form 1099

Computer Sciences Corporation (CSC), eMedNY contractor for the Department of Health, issues Internal Revenue Service (IRS) Form 1099 to Medicaid providers at the beginning of each calendar year for the previous year's Medicaid payments. The 1099s are issued with the individual provider's social security number or for businesses, with the Federal Employer Identification Number (FEIN) registered with NY Medicaid.

IRS 1099s are issued to providers whose yearly Medicaid payments total $600.00 or more.

IRS 1099s for the year 2014 will be mailed no later than January 31, 2015.

As with previous years, please note that the IRS 1099 amount **is not** based on the date of the checks/EFTs; rather,
it is based on the date the checks/EFTs were released to providers.

Due to the two-week check lag between the date of the check/EFT and the date the check/EFT is issued, the IRS 1099 amount will not correspond to the sum of all checks/EFTs issued for your provider identification number during the calendar year. The IRS 1099 amount is based on check/EFT **release** date.

The IRS 1099 that will be issued for the tax year 2014 will include the following:

- Check dated 12/16/13 (Cycle 1895) released on 01/02/2014 through,
- Check dated 12/15/14 (Cycle 1947) released 12/31/14.

Group Practices: In order for group practice providers to direct Medicaid payments to a group NPI and corresponding IRS 1099 for the group, group practices must submit the group NPI in the appropriate field on the claim (paper or electronic). Claims that contain the individual provider NPI instead of the group practice NPI will cause payment to go to the *individual* provider and his/her IRS 1099. Regardless of who deposits the funds, the 1099 will be issued to the individual provider when the funds have been paid to the individual provider's NPI. CSC routinely receives calls from individual providers who may be employees or members of a group practice and who have been issued 1099s for funds the individual provider is unaware of.

Provider Address: It is imperative that providers keep their addresses current. An incorrect address will impact the provider's ability to receive his/her 1099 form in a timely manner.

The above information is provided to assist providers with reconciling the IRS 1099 amount.
Any questions should be directed to the eMedNY Call Center at: (800) 343-9000.

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Continued Medicaid Enrollment for Clinics and CSWs

Federal regulation 42 CFR, Part 455.414 requires New York State Medicaid to revalidate your enrollment every five years. Revalidation involves completion of the enrollment form for Clinics and Clinical Social Workers (CSW). Clinics include: Ambulatory Surgery Centers (ASC), Freestanding Clinics (DT& C), and Hemodialysis Centers (Freestanding).

You can save time and money by coordinating your New York State Medicaid revalidation with Medicare, another state's Medicaid program or CHIP Program. If you revalidate with New York within 12 months of your Medicare/state Medicaid/CHIP enrollment, the New York application fee will be waived.

The Revalidation process for Clinics and Clinical Social Workers will begin in January. Revalidation letters will be mailed to providers actively submitting claims to Medicaid. Find out more about Revalidation by clicking on the links below.

Click here for a PowerPoint presentation on Revalidation.

Click here for the Clinic Enrollment Form and Instructions.

Click here for the Clinical Social Worker Enrollment Form and Instructions.

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Continued Medicaid Enrollment for Home Health Agency Providers

Federal regulation 42 CFR, Part 455.414 requires New York State Medicaid to revalidate your enrollment every five years. Revalidation involves completion of the enrollment form, and since the risk level for Home Health Agency providers is either "moderate" or "high", a site visit is required.

You can save time and money by coordinating your New York State Medicaid revalidation with Medicare, another state's Medicaid program or CHIP Program. If you revalidate with New York within 12 months of your Medicare/state Medicaid/CHIP site visit, a New York site visit is not necessary and the New York application fee will be waived.

The Revalidation process for Home Health Agencies has begun. Revalidation letters have been mailed to Home Health providers actively submitting claims to Medicaid. Find out more about Revalidation by clicking on the links below.

Click here for a PowerPoint presentation on Revalidation.

Click here for the Home Health Agency Enrollment Form and Instructions

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All Providers

The Medicaid Update Moves to Electronic Distribution

***Reminder*:** In an effort to reduce costs and be more environmentally minded, beginning April 1, 2015 the Office of Health Insurance Programs will no longer produce a printed version of the Medicaid Update.

The Medicaid Update will ONLY be available electronically. This delivery system allows our providers to receive policy sensitive bulletins faster. The newsletter will be delivered monthly to your designated e-mail address in a Portable Document Format (PDF).

If you do not presently receive the Medicaid Update electronically, please send your request to the following e-mail: MedicaidUpdate@health.ny.gov.

Providers who are unsure about receiving an electronic-only version of the newsletter should bear in mind that the PDF newsletter can always be printed and read in hard copy. Additionally, the current and archived newsletters are posted on the DOH Website at the following address:
http://www.nyhealth.gov/health_care/medicaid/program/update/main.htm

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Provider Directory

Office of the Medicaid Inspector General:
For suspected fraud complaints/allegations, call 1-877-87FRAUD, (877) 873-7283, or visit www.omig.ny.gov.

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

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

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

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