



Medicaid Update

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Statewide Formulary for Opioid Dependence Agents and Opioid Antagonists

10/1/2021 New Information highlighted below

Effective October 1, 2021, per the enacted New York State (NYS) Budget for State Fiscal Year (SFY) 2020-2021, in accordance with §367-a (7)(e) of Social Services Law, the NYS Department of Health (DOH) is implementing a single statewide formulary for Opioid Antagonists and Opioid Dependence Agents for NYS Medicaid fee-for-service (FFS) as well as Medicaid Managed Care (MMC). Under this statewide formulary, NYS Medicaid FFS and MMC will:

- follow a single formulary when:
 - coverage parameters are consistent across the Medicaid Program,
 - preferred products are available without prior authorization (PA) when prescribed consistent with Food and Drug Administration (FDA) package labeling, and
 - non-preferred products require PA; as well as
- use standard clinical criteria for approval of a non-preferred drug in accordance with §273 (3)(a) of Public Health Law.

Single Statewide Formulary – Effective October 1, 2021

Opioid Antagonists*

Preferred	Non-Preferred	Coverage Parameters
naloxone (syringe, vial)	None	Not Applicable
naltrexone	None	Not Applicable
NARCAN® (nasal spray)	None	Not Applicable

Opioid Dependence Agents - Injectable*

Preferred	Non-Preferred	Coverage Parameters
SUBLOCADE®	None	Not Applicable
VIVITROL®	None	Not Applicable

*All agents are subject to FDA-approved quantity/frequency/duration limits.

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All Providers

Opioid Dependence Agents - Oral/Transmucosal*

Preferred	Non-Preferred	Coverage Parameters
buprenorphine	Bunavail™	Clinical Criteria (CC): PA required for initiation of opioid therapy for patients on established opioid dependence therapy. Quantity Limit (QL): <ul style="list-style-type: none"> buprenorphine sublingual (SL): Six tablets dispensed as a two-day supply; not to exceed 24 mg per day buprenorphine/ naloxone tablet and film (Bunavail™, SUBOXONE®, ZUBSOLV® up to 5.7 mg/1.4 mg strength): Three sublingual tablets or films per day; maximum of 90 tablets or films dispensed as a 30-day supply; not to exceed 24 mg-6 mg of SUBOXONE®, or its equivalent per day buprenorphine/naloxone tablet (ZUBSOLV® 8.6 mg/2.1 mg strength): Maximum of 60 tablets dispensed as a 30-day supply buprenorphine/naloxone tablet (ZUBSOLV® 11.4 mg/2.9 mg strength): Maximum of 30 tablets dispensed as a 30-day supply
SUBOXONE® **	Buprenorphine/ Naloxone film	
buprenorphine/ naloxone tablet	ZUBSOLV®	

*All agents are subject to FDA-approved quantity/frequency/duration limits.

**A new prescription is not required when a member is switching from the generic product to the brand product, consistent with the Medicaid FFS Brand Less Than Generic (BLTG) program, which can be found on the Magellan Health Inc. "BLTG program" web page at: https://newyork.fhsc.com/providers/BLTGP_about.asp. The prescription will have a generic copayment and does not require "Dispense as Written (DAW)" or "Brand Medically Necessary" on the prescription. This applies to SUBOXONE®, only.

MMC Billing

- MMC enrollees will continue to access these medications by presenting their plan card to the pharmacy.
- PA is required for all non-preferred agents. Providers should contact the MMC plan to obtain authorization when necessary. Contact and billing information can be found on the NYS "MMC Pharmacy Benefit Information Center" web page at: <https://mmcdruginformation.nysdoh.suny.edu/>.
- MMC Plans will notify pharmacy providers about using the brand product SUBOXONE® instead of the generic alternative, consistent with Medicaid FFS:
 - MMC Plans will provide guidance on DAW Code requirements.
 - MMC Plans will reimburse claims consistent with brand drug reimbursement for SUBOXONE®.
 - If a pharmacy is out of stock of brand name SUBOXONE® and the member needs the medication, the pharmacist should contact the MMC Plan for a one-time override to allow for the generic equivalent to be dispensed until the brand is restocked.

Medicaid FFS Billing

- Medicaid FFS members will continue to access these medications by presenting their Medicaid benefit card to the pharmacy.
- PA is required for all non-preferred agents. Providers should contact Magellan plan to obtain authorization when necessary. Contact and billing information can be found on the Magellan Health Inc. “NYS Medicaid Pharmacy Programs” home page at: <https://newyork.fhsc.com/>.
- Pursuant to the Medicaid FFS BLTG program for prescription claims submitted, Medicaid FFS:
 - messages pharmacy providers about utilizing the brand product SUBOXONE® instead of the generic alternative; and
 - reimburses claims consistent with Medicaid FFS-approved drug reimbursement for brand name drugs.

Pharmacies will receive the following National Council for Prescription Drug Programs (NCPDP) Implementation messages for the Product/Service ID, field 407-D7, when a generic National Drug Code (NDC) is submitted:

Code Type	Code	Message	Field	Resources
NCPDP Reject Code	“78”*	Cost Exceeds Maximum	FIELD 511-FB REJECT CODE	NCPDP Companion Guide: https://www.emedny.org/HIPAA/5010/transactions/NCPDP_D.0_Companion_Guide.pdf
NCPDP Response Code/Message	“421”**	Dispense Brand Drug Instead of Generic Equivalent	FIELD 526-FQ ADDITIONAL MESSAGE INFORMATION: Insert MEVS Response Code	eMedNY ProDUR/ECCA Provider Manual (D.0): https://www.emedny.org/ProviderManuals/Pharmacy/ProDUR-D.0-ECCA_Provider_Manual/ProDUR_ECCA_Provider_Manual(D.0).pdf

*NYS DOH is exploring the use of the updated NCPDP Reject Code “606”: ‘Brand drug/specific labeler code required’. NYS DOH will provide updated billing guidance if/when use of that NCPDP Reject Code becomes available in FFS.

**For the Medicaid Eligibility Verification System (MEVS) Response Code, providers can visit the NYS DOH *eMedNY Prospective Drug Utilization Review/Electronic Claims Capture and Adjudication ProDUR/ECCA Provider Manual (D.0)* at: [https://www.emedny.org/ProviderManuals/Pharmacy/ProDUR-D.0-ECCA_Provider_Manual/ProDUR_ECCA_Provider_Manual\(D.0\).pdf](https://www.emedny.org/ProviderManuals/Pharmacy/ProDUR-D.0-ECCA_Provider_Manual/ProDUR_ECCA_Provider_Manual(D.0).pdf).

Pharmacies are not required to submit Dispense as Written (DAW)/Product Selection Code of “1”, but are required to submit DAW Code of “9” in field 408-D8:

Code Type	Code	Code Description	Field
DAW Code	“9”	Substitution allowed by Prescriber – Plan Request Brand	408-D8

Pharmacies will receive the following NCPDP message when the appropriate DAW code is **not submitted** in field 408-D8:

Code Type	Code	Message	Field
NCPDP Reject Code	“22”	M/I Dispense as Written Code	408-D8

Questions and Additional Information:

- The Single Statewide Medication Assisted Treatment (MAT) Formulary web site can be found at: <https://newyork.fhsc.com/providers/mat.asp>.
- The *All Stakeholder: Implementation Update Statewide Formulary for Opioid Dependence Agents and Opioid Antagonists* webinar regarding Single Statewide MAT can be found at: https://health.ny.gov/health_care/medicaid/redesign/mrt2/meetings/docs/2021-08-31_mtg1.pdf.
- MMC billing and/or PA requirement questions should be referred to the NYS “MMC Pharmacy Benefit Information Center” web page at: <https://mmcdruginformation.nysdoh.suny.edu/>.
- Medicaid FFS billing/claims questions should be directed to General Dynamics Information Technology Company (GDIT) at (800) 343-9000.
- Medicaid FFS PA requirement questions should be directed to Magellan Health Inc. at (877) 309-9493.
- Medicaid FFS policy questions should be directed to the Medicaid Pharmacy Policy Unit at ppno@health.ny.gov.
- Medicaid FFS BLTG program information can be found on the Magellan Health Inc. “BLTG program” web page at: https://newyork.fhsc.com/providers/BLTGP_about.asp.

Clarification on Previous Guidance: National Drug Code Usage for Physician Administered Drugs with Ambulatory Patient Groups

Previous guidance regarding the Ambulatory Patient Group (APG) fee schedule and APG Group, states that an accurate National Drug Code (NDC) must be reported for all physician-administered drugs billed to Medicaid fee-for-service (FFS) on an institutional claim that uses APGs. This *Medicaid Update* article clarifies utilizing multiple NDCs for the same drug on the same date of service and does not affect previous guidance. The previous April 2019 *Medicaid Update* guidance titled, *Reporting of the National Drug Code is Required for all Fee-for-Service Physician Administered Drugs*, found at: https://www.health.ny.gov/health_care/medicaid/program/update/2019/apr19_mu.pdf, required providers to report accurate NDCs for all FFS, physician-administered drugs.

Billing Drugs from the APG Group

Providers should not bill multiple claim lines with the same physician administered drugs (commonly referred to as J-code drugs) on the same date of service, even if the drugs administered have different NDCs. If a provider bills in this manner and the drug is assigned to a single APG group, the provider will be overpaid; both claim lines will pay in full. To avoid this overpayment, providers should combine all units of the J-code drug administered and bill it on one claim line with the NDC reported for the claim that has the highest number of units administered. If the same number of units were administered for each NDC/J code, providers should choose one NDC to use for submitted claims. *If claims have been submitted with multiple lines for a single J-code drug that paid through the APG Group, these claims were overpaid. Providers are required to adjust their claims and bill the drugs administered on one claim line (retroactive to July 1, 2019).*

Example 1:

The following is an example of what **not** to do for a drug claim from an APG Group:

Line	Proc Code	Procedure Code Description	Mod 1	Mod 2	Units of Service	NDC	Expected APG	APG Description	Payment Action	Allowed Weight	Add-on Payment	Full APG Payment	Total Payment
1	99212	Office/outpatient visit est	None	None	--	None	871	SIGNS, SYMPTOMS AND OTHER FACTORS INFLUENCING HEALTH STATUS	Full Payment	0.6968	\$ --	\$127.88	\$127.88
2	J0180	agalsidase beta inj	UD	None	35	58468-0040-01	464	CLASS XII COMBINED CHEMOTHERAPY AND PHARMACOTHERAPY	Full Payment	50.0061	\$25.42	\$6,000.73	\$6,026.15
3	J0180	agalsidase beta inj	UD	None	29	58469-0041-01	464	CLASS XII COMBINED CHEMOTHERAPY AND PHARMACOTHERAPY	Full Payment	50.0061	\$ --	\$6,000.73	\$6,000.73
4	J0180	agalsidase beta inj	UD	JW	1	58468-0041-01	464	CLASS XII COMBINED CHEMOTHERAPY AND PHARMACOTHERAPY	No Payment	0.0000	\$ --	\$ --	\$ --

Example 2:

The following is an example of how to properly bill the above claim for a drug from an APG Group:

Line	Proc Code	Procedure Code Description	Mod 1	Mod 2	Units of Service	NDC	Expected APG	APG Description	Payment Action	Allowed Weight	Add-on Payment	Full APG Payment	Total Payment
1	99212	Office/outpatient visit est	None	None	--	None	871	SIGNS, SYMPTOMS AND OTHER FACTORS INFLUENCING HEALTH STATUS	Full Payment	0.6968	\$ --	\$127.88	\$127.88
2	J0180	agalsidase beta inj	UD	None	64	58468-0040-01	464	CLASS XII COMBINED CHEMOTHERAPY AND PHARMACOTHERAPY	Full Payment	50.0061	\$25.42	\$6,000.73	\$6,026.15
3	J0180	agalsidase beta inj	UD	JW	1	58469-0041-01	464	CLASS XII COMBINED CHEMOTHERAPY AND PHARMACOTHERAPY	No Payment	0.0000	\$ --	\$ --	\$ --
Total Paid												\$6,154.03	

Abbreviations: "est" - established patient; "inj" - Injection; "Mod" - Modifier; "Proc" - Procedure

Modifier Codes: "JW" - used to report the drug amount discarded, or not administered, by the patient. This modifier should only be appended to drugs or biologicals that are single-dose vials or packages; "UD" - required to identify a 340B purchased drug in addition to the corresponding HCPCS system and NDC

In Example 2, the third from Example 1 is removed and all units provided to the patient are added to Line 2. The first NDC was chosen as it reflects the drug with the most units provided while the drug waste logic did not change. For guidance on drug waste logic, providers can refer to the *Clarification of Policy for Practitioner, Ordered Ambulatory, and APG Reimbursement - and - New Billing Instructions for Wasted Drugs Using Modifier JW* article within the August 2015 issue of the *Medicaid Update* at: https://www.health.ny.gov/health_care/medicaid/program/update/2015/august15_mu.pdf.

Billing Drugs from the APG Fee Schedule

Providers may continue to code multiple lines to denote different NDCs when billing **only** for physician-administered drugs through the APG Fee Schedule. Providers can refer to the NYSDOH “APG and Px-Based Weights History and APG Fee Schedules” web page at: https://www.health.ny.gov/health_care/medicaid/rates/methodology/history_and_fee_schedule.htm.

Questions:

- All Medicaid FFS coverage and policy questions should be directed to the Office of Health Insurance Programs (OHIP) Division of Program Development and Management (DPDM) by phone at (518) 473-2160 or by email at FFSMedicaidPolicy@health.ny.gov.
- All FFS billing/claims questions should be directed to the eMedNY Call Center at (800) 343-9000.

Medicaid Consumer Fact Sheets Now Available

Following a recommendation from the Medicaid Redesign Team (MRT) II, the New York State (NYS) Department of Health (DOH) Office of Health Insurance Programs (OHIP) created Medicaid consumer fact sheets focused on chronic health conditions. Each fact sheet provides information regarding how a condition can be prevented or managed, as well as relevant Medicaid benefits that can be used to help members stay healthy. Topics include sickle cell disease, diabetes, high blood pressure, asthma control, HIV-PrEP (Human Immunodeficiency Virus - Pre-Exposure Prophylaxis), and smoking cessation. Fact sheets can be found on the MRT II Policies and Guidance web page, at: https://health.ny.gov/health_care/medicaid/redesign/mrt2/policy/index.htm, and are available in English, Spanish, Traditional Chinese, Russian, Haitian Creole, Bengali, and Korean. The most recently added Sickle Cell Disease fact sheet is also available in Simplified Chinese, Polish, Yiddish, Arabic, and Italian.

NY State of Health: Higher Income New Yorkers May Now Qualify for Financial Assistance to Lower the Cost of Health Coverage

New federal financial assistance is now available through NY State of Health to qualifying, higher-income individuals. This financial assistance is being implemented as part of the American Rescue Plan Act (ARPA) signed into law on March 11, 2021, which can be found at: <https://www.congress.gov/bill/117th-congress/house-bill/1319/text>.

Nearly 120,000 enrollees with income below 400 percent federal poverty level (FPL) are already receiving enhanced tax credits and nearly 18,000 higher-income enrollees are eligible for these federal tax credits for the first time. Higher-income individuals enrolled outside of NY State of Health and uninsured individuals may also be eligible for enhanced tax credits available through NY State of Health. Before the ARPA, tax credits were not available to higher-income individuals and their families (i.e., those earning more than \$51,040 and families of four earning more than \$104,800). Through the ARPA, these federal tax credits are available to these individuals and their families when enrolling in a health plan through NY State of Health.

Individuals with low and moderate incomes (i.e., those earning up to \$51,040 and families of four earning up to \$104,800) who were previously eligible for tax credits are now eligible for higher tax credits. NY State of Health automatically applied higher tax credits without enrollees needing to take any action. Enrollees can make changes to their account by logging into their NY State of Health account, contacting an Enrollment Assistor, and/or calling NY State of Health at (855) 355-5777.

To allow as many individuals as possible to access these enhanced tax credits, the 2021 Open Enrollment Period has been extended through December 31, 2021. Individuals and families can apply for coverage through the NY State of Health website at: <http://www.nystateofhealth.ny.gov>, by phone at (855) 355-5777, or by connecting with a free enrollment assistor via the NY State of Health Find a Broker/Navigator" search tool at: https://nystateofhealth.ny.gov/agent/hx_brokerSearch?fromPage=INDIVIDUAL&lang=en.

Additional Information

To read more about how NY State of Health enrollees' benefit from the ARPA, providers can visit the *How NY State of Health Enrollees Benefit from the American Rescue Plan* web page, found at: <https://info.nystateofhealth.ny.gov/americanrescueplan>.

New York State Medicaid Fee-for-Service Program: Pharmacists as Immunizers Fact Sheet

In accordance with New York State (NYS) Education Law, pharmacists are authorized to administer the following vaccines to patients 18 years of age and older: zoster, pneumococcal, meningococcal, tetanus, diphtheria, and pertussis vaccines. For patients two years of age and older, pharmacies may administer influenza vaccines. Additional information can be found on the NYS Education Department “Administration of Immunizations” web page at: <http://www.op.nysed.gov/prof/pharm/pharmimmunizations.htm>.

Only Medicaid enrolled pharmacies will receive reimbursement for immunization services and products. Services must be provided and documented in accordance with NYS Education laws and regulations, including the reporting of all immunizations administered to members less than 19 years of age to either the NYS Department of Health (DOH), using the NY State Immunization Information System (NYSIIS), or to the New York City Department of Health and Mental Hygiene (NYC DOHMH) using the New York Citywide Immunization Registry (CIR).

Pharmacies will only be able to bill for **Medicaid non-dual eligible members**. Dual eligible members will continue to access immunization services through Medicare. Medicaid Managed Care (MMC) enrollees will continue to access immunization services through their health plans. For Medicaid Managed Care Organization (MCO) billing guidance, providers must contact the individual plan. Providers can access individual plan information via the NYS MMC Pharmacy Benefit Information Center web page at: <https://mmcdruginformation.nysdoh.suny.edu/>, then select the individual plan and choose “**Pharmacy Vaccine Billing Guidance**”.

Reimbursement for these vaccines may be based on a patient specific, or non-patient specific, order. These orders must be kept on file at the pharmacy. The ordering prescriber must be actively enrolled as a NYS Medicaid provider, unless otherwise exempt, and the prescribers National Provider Identifier (NPI) is required on the claim for the claim to be paid.

Vaccines for administration to individuals **under the age of 19** are recommended by the Advisory Committee on Immunization Practices (ACIP) and are provided to Medicaid FFS members and MMC enrollees free of charge by the Vaccines for Children (VFC) program.

- Pharmacies wishing to administer VFC-available vaccines to Medicaid members under 19 years of age may enroll in the VFC program. **Please note: The VFC program is currently enrolling pharmacies to receive the influenza vaccine only.**
- Pharmacies enrolled in the VFC program may submit claims to FFS and MMC for the administration fee for VFC-eligible vaccinations administered at the pharmacy.
- Pharmacies that are not enrolled in the VFC program may choose to provide vaccines for members under 19 years of age at no charge to the member/enrollee or Medicaid program, and be reimbursed an immunization fee of \$17.85 by NYS Medicaid.
- Pharmacies immunizing Medicaid members 18 years of age with pneumococcal, meningococcal, tetanus, diphtheria, and pertussis vaccines **may not** bill Medicaid for the costs of these vaccines, as these members are VFC-eligible such that they may receive these vaccines through a VFC healthcare practice or clinic.
- NYS Medicaid should **never** be billed for the **cost** of any vaccine for persons under 19 years of age when it is available through the VFC Program. This applies to both FFS and MMC. Pharmacies that bill Medicaid for the cost of vaccines when it is available through the VFC Program are subject to recovery of payment.

Additional information on the VFC Program, based on location, can be found at the following web pages:

- **New York City (NYC):** NYC Health “VFC Provider Requirements - Enrollment and Re-Certification” web page (<https://www1.nyc.gov/site/doh/providers/nyc-med-cir/vaccines-for-children-requirements.page>)
- **Outside of NYC:** NYS DOH “New York State Vaccines for Children (VFC) Program” web page (https://www.health.ny.gov/prevention/immunization/vaccines_for_children/)

Billing Instructions for Medicaid FFS

Consistent with Medicaid immunization policy, pharmacies may bill the vaccine administration fee and, when applicable, acquisition cost of the vaccine using the appropriate procedure codes. To view a list of procedure codes, providers can refer to the *NYS Medicaid Pharmacy Services Fee Schedule* at: https://www.emedny.org/ProviderManuals/Pharmacy/PDFS/Pharmacy_Fee_Schedule.xls.

Please note: National Drug Codes (NDCs) are not to be used for billing the vaccine product through Medicaid FFS. Reimbursement for the cost of the vaccine for members 19 years of age and older will be made at no more than the **actual** acquisition cost to the pharmacy. No dispensing fee or member co-payment applies. Pharmacies will bill with a quantity of “1” and a daily supply of “1”.

Table A: Vaccine claims submitted via the National Council for Prescription Drug Programs (NCPDP) D.0 format

NCPDP D.0. Claim Segment Field	Value
436-E1 (Product/Service ID Qualifier)	Enter value of “09” which qualifies the code submitted in field 407-D7 (Product/Service ID) as a procedure code.
407-D7 (Product/Service ID)	Enter an applicable procedure code listed in Table B and/or C. Up to four claim lines can be submitted with one transaction.
442-E7 (Quantity Dispensed)	Enter the value of “1” for the procedure administration code in Table B.
405-D5 (Day Supply)	Enter the value of “1”.
411-DB (Prescriber ID)	Enter Prescriber National Provider Number (NPI) number.
454-EK (Scheduled Prescription ID Number)	Enter serial number “99999999” when applicable for non-patient specific orders.*
419-DJ (Prescription Origin Code)	Enter origin code “5”.*

*For further guidance on origin code and serial number values that must be submitted on the claim, refer to the Matching Origin Codes to Correct Prescription Serial Number Within Medicaid Fee-For-Service (FFS) article in the July 2016 issue of the *Medicaid Update* at: https://www.health.ny.gov/health_care/medicaid/program/update/2016/jul16_mu.pdf. For the origin code, “5” and the corresponding serial number of “99999999” for “Pharmacy dispensing” is to be used for applicable non-patient specific orders. The NCPDP D.0 Companion Guide can be found on the eMedNY “5010/D.0 Transaction Instructions” web page at: <https://www.emedny.org/HIPAA/5010/transactions/index.aspx>.

Billing for Immunizations of Members 19 Years of Age and Older

For billing of administration of multiple vaccines on the same date to members 19 years of age and older, procedure code “90471” should be used for the first vaccine and “90472” for any other vaccines administered on that day. One line should be billed for “90472” indicating the additional number of vaccines administered (insert quantity of one or two).

Billing for Immunizations of Members 19 Years of Age and Younger

For VFC-eligible vaccines, regardless of enrollment in the VFC Program, the pharmacy would submit procedure code “90460” (administration of free vaccine) for administration of first or subsequent dose and then submit the appropriate vaccine procedure code(s) with a cost of \$0.00. A system edit will ensure that when there is an incoming claim for the administrative fee (procedure code “90460”) there is also a claim in history for a VFC- eligible vaccine procedure code reimbursed at \$0.00. If no history claim is found, the claim will be denied for edit “02291”. For NCPDP claim transactions that are denied for edit “02291”, the corresponding Medicaid Eligibility Verification System (MEVS) Denial Reason Code “738” *History Not Found for Administrative Vaccine Claim* will be returned as well as the NCPDP Reject code “85”, *Claim Not Processed*.

Table B: The following procedure codes below should be billed for select influenza vaccines for ages two years of age and over; pneumococcal and meningococcal vaccines for 18 years of age and over, and zoster for 50 years of age and over.

Procedure Code	Procedure Description
“90620”	Meningococcal recombinant protein and outer membrane vesicle vaccine, Serogroup B, 2 dose schedule, for intramuscular use
“90621”	Meningococcal recombinant lipoprotein vaccine, Serogroup B, 2 or 3 dose schedule, for intramuscular use
“90653”	Influenza virus vaccine (IIV), preservative free, for use in individuals 65 years of age and above, for intramuscular use
“90662”	Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
“90670”	Pneumococcal conjugate vaccine, 13-valent, for intramuscular use
“90672”	Influenza virus vaccine, quadrivalent, live, for intranasal use in individuals two years of age through 49
“90674”	Influenza virus vaccine; quadrivalent, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use
“90682”	Influenza virus vaccine, quadrivalent, quadrivalent recombinant influenza vaccine (RIV4), derived from recombinant deoxyribonucleic acid (DNA), preservative and antibiotic free for intramuscular use
“90686”	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals three years of age and older, for intramuscular use
“90688”	Influenza virus vaccine, quadrivalent, split virus, when administered to individuals three years of age and older, with preservative, for intramuscular use
“90694”	Influenza virus vaccine, quadrivalent (allV4), inactivated, adjuvanted, for individuals 65 years of age and above, preservative free, for intramuscular use
“90714”	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, for use in individuals seven years or older, for intramuscular use
“90715”	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), for use in individuals seven years or older, for intramuscular use
“90732”	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals two years of age or older, for subcutaneous or intramuscular use
“90733”	Meningococcal polysaccharide vaccine [any group(s)], for subcutaneous use, age two years of age and older
“90734”	Meningococcal conjugate vaccine, Serogroups A, C, Y and W-135 (trivalent), for intramuscular use, age 11 through 55
“90750”	Zoster (shingles) Vaccine, age 50 and older for intramuscular use
“90756”	Influenza virus vaccine, quadrivalent, antibiotic free, for intramuscular use

Table C: The following procedure codes below should be used for the actual administration of the vaccines listed above by a pharmacist.

Procedure Code	Procedure Description
"90473"	Immunization administration of seasonal influenza intranasal vaccine for ages 19 and above \$8.57
"90471"	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid) \$13.23
"90472"	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure) \$13.23
"90460"	Immunization administration of free vaccine through VFC Program for ages under 19 years \$17.85

For additional information on the procedure codes for vaccines found in the tables above, refer to the *OTC and Supply Fee Schedule* document on the eMedNY "Pharmacy Manual" web page at: <https://www.emedny.org/ProviderManuals/Pharmacy/index.aspx>.

Questions and Additional Information:

- Medicaid FFS billing/claims questions should be directed to the eMedNY Call Center by phone at (800) 343-9000.
- MMC enrollment, reimbursement, billing, and/or documentation requirement questions should be directed to the MMC enrollee's specific MMC Plan. Providers can access individual plan information via the NYS "MMC Pharmacy Benefit Information Center" web page at: <https://mmcdruginformation.nysdoh.suny.edu/>, **then select the individual plan and choose "Pharmacy Vaccine Billing Guidance"**.
- Additional information on influenza can be found on the NYS DOH "What You Should Know About the Flu" web site at: <http://www.health.ny.gov/diseases/communicable/influenza/>.
- Additional vaccine and immunization information can be found on the CDC "Vaccine and Immunizations" web page at: <http://www.cdc.gov/vaccines/>.
- Additional information on the pharmacy administration of immunizations can be found on the NYS Education Department "Administration of Immunizations" web page at: <http://www.op.nysed.gov/prof/pharm/pharmimmunizations.htm>.
- NYS Medicaid coverage policy and billing guidance for COVID-19 vaccine administration can be found within the *NYS Medicaid Coverage Policy and Billing Guidance for the Administration of COVID-19 Vaccines Authorized for Emergency Use* at: https://health.ny.gov/health_care/medicaid/covid19/guidance/docs/billing_guidance.pdf.

Clarification and Reminder: Pharmacy Providers Servicing Medicaid Fee-for-Service Members and Medicaid Managed Care Enrollees

New York State (NYS) Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC) require member/enrollee consent prior to requesting a renewal or new prescription from a prescriber and before submitting a claim for a refill. The article titled *Attention Pharmacy Providers: New Prescriptions*, published in the May 2021 issue of the *Medicaid Update*, located at: https://www.health.ny.gov/health_care/medicaid/program/update/2021/docs/mu_no06_may21_pr.pdf, directed pharmacies to document consent for renewals and refills. This guidance is to clarify that most software systems and methods of outreach or intake (i.e., electronic) can capture the details of request and consent.

Pharmacies should not directly outreach to prescribers for renewals, or refill a prescription, without a member/enrollee or member/enrollee designee's request *first*. Additionally, pharmacies may not enroll their Medicaid FFS members or MMC enrollees in automatic refill programs.

Renewals/New Prescriptions

A NYS FFS member or MMC enrollee, who has exhausted prescription refills, may obtain a renewal in one of the following three ways:

1. The Medicaid member/enrollee may contact their prescriber for a renewal.
2. The Medicaid member/enrollee may contact their pharmacy for a renewal and give the pharmacy consent to contact the prescriber on their behalf.
3. The pharmacy may contact the Medicaid member/enrollee to inquire if a renewal is necessary, obtain consent if necessary, and then contact the prescriber on their behalf.

Reminders regarding original prescriptions:

- A prescription/fiscal order must originate from the office of the prescriber.
- A fax-back may not be used to bill a prescription/fiscal order to Medicaid.
- A fax received as a failed electronic prescription order may not be used to bill a prescription/fiscal order to Medicaid.
- A fax received at the pharmacy, that is not on an Official NYS Prescription (ONYSRX) form with its unique serial number, is not an original prescription.

Refills

A NYS FFS member or MMC enrollee may obtain a refill in one of the following two ways:

1. The Medicaid member/enrollee may contact their pharmacy requesting a refill.
2. The pharmacy may contact the Medicaid member/enrollee to inquire if a refill is necessary, obtain consent if necessary, and then submit a claim for dispensing on their behalf.

Early Fill-Vacation

NYS Medicaid ensures an ample supply of medication(s) to accommodate for most temporary absences and allows a 90-day supply for most maintenance medications. As explained in the article titled *New Medicaid FFS Pharmacy Early Fill Edit* in the January 2015 issue of the *Medicaid Update*, located at: https://www.health.ny.gov/health_care/medicaid/program/update/2015/jan15_mu.pdf, members/enrollees are allowed to fill before the total amount of previous supply was used. A claim will pay if more than a 75 percent of the previously dispensed amount has been used, or up to a 10-day supply of medication is remaining of the cumulative amount that has been dispensed over the previous 90 days (the more stringent rule will apply). Member/enrollees can still refill their prescription(s) early, allowing for an ample supply of their medication(s) on hand.

Members/enrollees must prepare well in advance of travel and have the following options to ensure they have the supply needed for a temporary absence:

- A member/enrollee may arrange with a pharmacy for:
 - a possible 90-day supply for certain maintenance medications (members/enrollees may ask their prescriber to increase the day supply dispensed when the member/enrollee has been stabilized on the medication and has been taking their medication on a consistent basis though it may require a new prescription) and/or
 - a possible early fill up to allow amounts outlined above.
- A member/enrollee can make alternative arrangements, such as relying on a trusted friend or family member, to have necessary medication mailed in a secure method that will guarantee delivery.

Please note: Early filling of more than the allowed amount for vacation or a temporary absence, as stated above and in the above linked article, for either Medicaid FFS members or MMC enrollees, is not permissible.

For additional information regarding original prescriptions being required for renewals, refills, and early fill, providers may refer to the eMedNY “Pharmacy Manual” web page at: <https://www.emedny.org/ProviderManuals/Pharmacy/index.aspx>.

Questions:

- Questions regarding this policy should be directed to the Medicaid Pharmacy Policy Unit by phone at (518) 486-3209 or by email at PPNO@health.ny.gov.
- Questions regarding early fill cumulative amounts for MMC enrollees should be directed to the MMC Plan.

Policy and Billing

New Billing Requirement for Home Health Agencies: Demand Billing, No-Pay RAP

On January 1, 2021, the Centers for Medicare and Medicaid Services (CMS) implemented a new Medicare billing requirement for Home Health Agencies (HHAs) requiring a No-Pay Request for Anticipated Payment (RAP) for all dual-eligible Medicare/Medicaid recipients prior to billing each final claim. The No-Pay RAP must be submitted within five calendar days after the start of care date for the first 30-day period of care in a 60-day certification period and within five calendar days after the “from date” for the second 30-day period of care in the 60-day certification period. This CMS billing requirement must be satisfied for all dual-eligible Medicare/Medicaid recipients even if the final claim is not intended to be billed to Medicare. **Effective immediately**, all HHAs must submit No-Pay RAPs to Medicare for all services rendered to dual-eligible Medicare/Medicaid recipients.

The Office of the Medicaid Inspector General (OMIG) has contracted with the University of Massachusetts Medical School (UMass) to perform Home Health Medicare Maximization Services. This contract seeks to maximize Medicare reimbursement for dual-eligible Medicare/Medicaid recipients who have received home health care services paid by Medicaid. Under this OMIG project, HHAs may be directed to demand bill claims to Medicare to ensure Medicaid remains the payor of last resort.

Demand Bill Directives will be issued in September 2021 to inform HHAs which claims require a Medicare demand bill submission. The dates of service included in the upcoming review period overlap with the start of the new CMS No-Pay RAP billing requirements. HHAs should have initiated a No-Pay RAP prior to receipt of the Demand Bill Notice. If the No-Pay RAP was not submitted in compliance with the new Medicare billing requirement for any period of care on the Demand Bill Directive, the HHA should take the following three steps:

1. **submit** a No-Pay RAP to CMS for all identified dates of service,
2. **file** a Demand Bill final claim with a KX modifier and indicate within the Remarks section of the claim “late RAP due to Medicaid TPL demand billing request”, and
3. **follow** all outlined instructions within the Demand Bill Directive pertaining to timely and complete submission of information and documentation to UMass.

CMS is allowing the above steps as a temporary fix for the submission of demand bills for which No-Pay RAPs were not previously submitted.

Questions

All questions regarding this article should be directed to UMass at (866) 626-7594.

New York State Medicaid Drug Testing Policy

The drug testing policy guidance in this article is **effective September 1, 2021** for Medicaid fee-for-service (FFS) and **effective October 1, 2021** for Medicaid Managed Care (MMC) Plans [including mainstream MMC Plans, HIV (Human Immunodeficiency Virus) Special Needs Plans (SNPs), as well as Health and Recovery Plans (HARPs)]. This article updates the New York State (NYS) Medicaid drug testing policy published in the April 2017 issue of the *Medicaid Update*.

NYS Medicaid drug testing policy follows a two-step testing process/structure that consists of the use of screening (presumptive) tests then confirmatory (quantitative) tests. Presumptive drug class screening tests using Common Procedural Terminology (CPT) codes “80305”, “80306” or “80307” are the first step in the process. Only substances that return positive results or are inconclusive on screening tests (presumptive) or results on screening tests that are inconsistent with clinical presentations are reimbursable for confirmation (quantitative) testing using CPT codes “80321” through “80377” listed on the fee schedule. **Definitive** or direct confirmation tests using CPT code “G0480” are only reimbursable when no screening methods for the substances are available.

Test(s) for a drug(s) or drug classes must be ordered by the provider and should be considered for inclusion based on the patient’s medical history and/or current clinical presentation. Broad panel tests, reflex tests initiated by the lab, and routine standing orders are not reimbursable. Medical records must support the need for each drug or drug class being tested and must be kept on file, in accordance with regulations, for audit purposes.

Table: Presumptive Drug Class Screening

CPT Code	Description
“80305”	Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (e.g., immunoassay) capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.
“80306”	Drug test(s), presumptive, any number of drug classes, qualitative, any number of devices or procedures, (e.g., immunoassay) read by instrument assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.
“80307”	Drug test(s), presumptive, any number of drug classes, qualitative, any number of devices or procedures by: <ul style="list-style-type: none"> • instrument chemistry analyzers (e.g., utilizing immunoassay [e.g., EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), • chromatography (e.g., GC, HPLC), and • mass spectrometry either with or without chromatography, (e.g., DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) Including sample validation when performed, per date of service.

Note: Test abbreviations are defined in order of citation in table as follows: EIA/ELISA – enzyme-linked immunosorbent assay; EMIT – enzyme multiplied immunoassay technology; FPIA – fluorescence polarization immunoassay; IA – immunosorbent assay; KIMS – Kinetic Interaction of Microparticles in Solution; RIA – radioimmunoassay; GC – gas chromatography, HPLC – high performance liquid chromatography; DART – direct analysis in real time; DESI – desorption electrospray ionization; GC-MS – gas chromatography mass spectrometry; GS-MS/MS – gas chromatography (tandem) mass spectrometry; LC-MS – liquid chromatography mass spectrometry; LC-MS/MS – liquid chromatography (tandem) mass spectrometry; LDTD – laser diode thermal desorption; MALDI – matrix-assisted laser desorption/ionization; MALDI-TOF – time of flight.

Testing of the following drug/drug classes are included in screening by NYS Medicaid:

- Alcohol
- Amphetamines
- Barbiturates
- Benzodiazepines
- Buprenorphine
- Clonazepam
- Cocaine
- Fentanyl
- Kratom (Mitragyna speciosa; Mitragynine; 7-hydroxymitragynine)
- Lorazepam
- Methadone
- Methadone metabolites
- Opiates
- Oxycodone
- Phencyclidine
- 6-monacetylmorphine (6-MAM)
- Synthetic cannabinoids [5-fluoro-MDMB-PICA (methyl dimethylbutanoate – one pot procedure indole <gives> carbolic acid)] (K1 and K2: Group 1 and Group 2)
- Tetrahydrocannabinol (THC) metabolites (marijuana)
- Tramadol

The reimbursement for codes “80305”, “80306” and “80307” in the Table cover the screening tests of one specimen **for all drugs** listed above. The codes should only be billed once irrespective of the number of drug class procedures or results on any date of service. Screening by broad-spectrum chromatographic procedure, which detects multiple drug classes, should be billed using code “80307”. Each step in the sequential development of a chromatograph is **not** considered a separate procedure. Only when an analytical condition (e.g., column temperature or flow rate) is changed, such that additional controls must be run, is subsequent analysis of the same specimen for additional drug(s) considered a separate procedure for billing purposes. Screening for drugs using immunoassay or enzyme assay using multichannel chemistry analyzers should be billed using code “80307”. Use “80307” once to report single or multiple procedures performed, irrespective of the number of procedures, classes, or results on any date of service.

Confirmatory Drug Testing

Billing for confirmatory testing using CPT Codes “80320” through “80377” is allowable when the codes are listed on the fee schedule and one or more of the following conditions are met:

- a presumptive positive drug screen is found using codes “80305”, “80306”, “80307” and/or
- a screen result is inconclusive or inconsistent with clinical presentation

For confirmatory testing, providers should bill the appropriate code related to the drug/drug class. If there is no screening method available for a drug class, providers can refer to “Definitive Drug Testing” below.

Definitive Drug Testing

Definitive Testing (“G0480”) may be billed for testing of drugs or drug classes when there is no screening method available. NYS Medicaid covers definitive drug testing using this code for up to seven drug classes. CPT code “G0480” is reimbursable once per date of service, up to a maximum of six times within 365 days. CPT code “G0480” cannot be billed in conjunction with CPT codes “80305”, “80306”, or “80307” for drugs/drug classes included in the screening codes (Table: Presumptive Drug Class Screening).

CPT Code	Description
“G0480”	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase); qualitative or quantitative, all sources, includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed.

Questions and Additional Information:

- Medicaid FFS coverage and policy questions should be directed to the Office of Health Insurance Programs (OHIP) Division of Program Development and Management (DPDM) by phone at (518) 473-2160 or by email at FFSMedicaidPolicy@health.ny.gov.
- MMC general coverage questions should be directed to the OHIP Division of Health Plan Contracting and Oversight (DHPCO) at covques@health.ny.gov or (518) 473-1134.
- MMC reimbursement and/or billing requirements questions should be directed to the enrollee’s MMC Plan. For an MMC directory by plan., providers can refer to the NYS Medicaid Program *Information for All Providers: Managed Care Information* document, located at: [https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information for All Providers Managed Care Information.pdf](https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information%20for%20All%20Providers%20Managed%20Care%20Information.pdf).
- FFS claim questions should be directed to the eMedNY Call Center at (800) 343-9000.

New York State Medicaid Expansion of Non-Invasive Prenatal Trisomy Screening Policy

Effective September 1, 2021 for New York State (NYS) Medicaid fee-for-service (FFS) and **effective November 1, 2021** for Medicaid Managed Care (MMC) Plans [including mainstream MMC Plans, HIV (Human Immunodeficiency Virus) Special Needs Plans (SNPs), as well as Health and Recovery Plans (HARPs)], coverage of non-invasive prenatal trisomy screening using cell-free fetal DNA (deoxyribonucleic acid) will be expanded to include pregnant members age 30 and older. Additionally, this coverage now includes twin pregnancies, but not higher multi-gestational pregnancies. Consistent with current policy, non-invasive prenatal trisomy screening will continue to be covered when at least one of the following criteria is met:

- either parent has a family history of aneuploidy in a 1st* or 2nd** degree relative;
- standard serum screening or fetal ultrasonographic findings indicate an increased risk of aneuploidy;
- parent(s) have a history of a previous pregnancy with a trisomy; and/or
- either parent is known to have a Robertsonian translocation.

*1st degree relatives: Parents, children, siblings

**2nd degree relatives: Grandparents, aunts and uncles, nieces and nephews, and grandchildren

Note: This is an update to the October 2014 *Medicaid Update* article titled *NYS Medicaid Now Covers Non-invasive Prenatal Testing for Trisomy 21, 18 and 13* which can be found at: https://www.health.ny.gov/health_care/medicaid/program/update/2014/oct14_mu.pdf.

Reminders:

- **Genetic counseling** should be provided to women prior to non-invasive prenatal testing and to those who test positive for a fetal chromosomal abnormality.
- **Prenatal testing** of a fetus by amniocentesis or chorionic villus sampling will continue to be covered:
 - subsequent to a positive or high-risk score in a non-invasive prenatal trisomy screening test; or
 - subsequent to an inconclusive result in a high-risk pregnancy.
- **Diagnostic testing** (e.g., cytogenetic analysis or molecular genetic testing) for suspected aneuploidies continues to be covered if medically necessary.
- **Cell-free fetal DNA testing** should not be offered to women who are pregnant with three or more fetuses because it has not been sufficiently evaluated in these groups.
- **Micro-deletion testing**, in conjunction with non-invasive trisomy testing, is not reimbursable.
- Consistent with existing policy, Title 18 of New York Consolidated Rules and Regulations (NYCRR) §505.7(g)(4) require that providers order tests individually. No payment will be made for tests ordered as groupings or combinations of tests. For more information on this and additional regulations pertaining to laboratory services, refer to the “§505.7 - Laboratory Services” web page, located at: <https://regs.health.ny.gov/content/section-5057-laboratory-services>.

Questions and Additional Information:

- Medicaid FFS coverage and policy questions should be directed to the Office of Health Insurance Programs (OHIP) Division of Program Development and Management (DPDM) by phone at (518) 473-2160 or by email at FFSMedicaidPolicy@health.ny.gov.
- MMC enrollment, reimbursement, billing and/or documentation requirement questions should be directed to the enrollee’s specific MMC Plan. Providers can refer to the NYS Medicaid Program *Information for All Providers: Managed Care Information* document at: https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers_Managed_Care_Information.pdf, for an contact information per MMC Plan.
- Medicaid FFS billing/claim questions should be directed to the eMedNY Call Center at (800) 343-9000.

Mosquito Repellent Coverage Discontinued

Effective September 1, 2021 for New York State (NYS) Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC) will cease coverage for mosquito repellent when prescribed to members/enrollees to prevent Zika virus infections. A previous article titled *Mosquito Repellent Coverage*, found in the September 2016 issue of the *Medicaid Update* at: https://www.health.ny.gov/health_care/medicaid/program/update/2016/sep16_mu.pdf, indicated the coverage of mosquito repellent would continue until the risk of infection, as reported by the Centers for Disease Control and Prevention (CDC), reduced. The CDC reports there are no current Zika outbreaks worldwide and specifically, “There is no current local transmission of the Zika virus in the continental United States (US)...”; therefore, NYS Medicaid will cease coverage of mosquito repellent and will revisit this policy if the situation warrants. Exception requests will be handled on a case-by-case basis.

Questions and Additional Information:

- Questions regarding MMC enrollee exception requests and coverage should be directed to the individual plan. Specific plan information can be found at the NYS MMC Pharmacy Benefit Information Center web site at: <https://mmcdruginformation.nysdoh.suny.edu/>.
- Additional information reported by the CDC can be found by visiting the following CDC web pages:
 - “Zika Travel Information” web page at: <https://wwwnc.cdc.gov/travel/page/zika-information>
 - “Zika in the US” web page at: <https://www.cdc.gov/zika/geo/index.html>

Provider Directory

Office of the Medicaid Inspector General:

For suspected fraud, waste or abuse complaints/allegations, call 1-877-87FRAUD, (877) 873-7283, or visit Office of Medicaid Inspector General (OMIG) web site at: 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).

For questions about billing and performing MEVS transactions:

Please call the eMedNY Call Center at (800) 343-9000.

Provider Training:

Please enroll online for a provider seminar at: <https://www.emedny.org/training/index.aspx>. For individual training requests, call (800) 343-9000.

Beneficiary Eligibility:

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

Medicaid Prescriber Education Program:

For current information on best practices in pharmacotherapy, please visit the following web sites:

- DOH Prescriber Education Program page: https://www.health.ny.gov/health_care/medicaid/program/prescriber_education/presc-educationprog.
- Prescriber Education Program in partnership with SUNY: <http://nypep.nysdoh.suny.edu/>.

eMedNY

For a number of services, including: change of address, updating an enrollment file due to an ownership change, enrolling another NPI, or revalidating an existing enrollment, please visit the eMedNY Provider Enrollment page at: <https://www.emedny.org/info/ProviderEnrollment/index.aspx>, and choose the appropriate link based on provider type.

NY Medicaid Electronic Health Record (EHR) Incentive Program

Contact the New York Medicaid EHR Call Center at (877) 646-5410 for assistance.

Comments and Suggestions Regarding This Publication

Please contact the editor, Angela Lince, at medicaidupdate@health.ny.gov.