



Medicaid Update

THE OFFICIAL NEWSLETTER OF THE NEW YORK STATE MEDICAID PROGRAM

Attention: Providers of Nursing Facility Services, Certain Home and Community-Based Waiver Services and Services under A PACE Program

2012 Spousal Impoverishment Income and Resource Levels Increase

Providers of nursing facility services, certain home and community-based waiver services and services under a PACE program, are required to PRINT and DISTRIBUTE the "Information Notice to Couples with an Institutionalized Spouse" (pages 3-6 of this newsletter) at the time they begin to provide services to their patients.

Effective January 1, 2012, the federal maximum community spouse resource allowance increases to **\$113,640** while the community spouse income allowance increases to **\$2,841**. The maximum family member monthly allowance remains **\$613** until the Federal Poverty Levels for 2012 are published in the Federal Register.

This information should be provided to any institutionalized spouse, community spouse, or representative acting on their behalf so as to avoid unnecessary depletion of the amount of assets a couple can retain under the spousal impoverishment eligibility provisions.

INCOME AND RESOURCE AMOUNTS

January 1, 2012

Federal Maximum Community Spouse Resource Allowance: \$113,640

NOTE: A higher amount may be established by court order or fair hearing to generate income to raise the community spouse's monthly income up to the maximum allowance. **NOTE:** The State Minimum Community Spouse Resource Allowance is \$74,820.

January 1, 2012

Community Spouse Minimum Monthly Maintenance Needs Allowance is an amount up to: \$2,841

(if the community spouse has no income of his/her own) **NOTE:** A higher amount may be established by court order or fair hearing due to exceptional circumstances that result in significant financial distress.

January 1, 2012

Family Member Monthly Allowance for each family member is an amount up to: \$613

The maximum Family Member Monthly Allowance of \$613 (if the family member has no income of his/her own) is subject to change when the Federal Poverty Levels for 2012 are published in the Federal Register.

NOTE: If the institutionalized spouse is receiving Medicaid, any change in income of the institutionalized spouse, the community spouse, and/or the family member may affect the community spouse income allowance and/or the family member allowance. Therefore, the local social services district should be promptly notified of any income variations.



DECEMBER 2011 NEW YORK STATE MEDICAID UPDATE

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

PLEASE CALL: 1-877-87FRAUD

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





POLICY AND BILLING GUIDANCE

Information Notice to Couples with an Institutionalized Spouse

Medicaid is an assistance program that may help pay for the costs of your or your spouse’s institutional care, home and community based waiver services, or Program of All-inclusive Care for the Elderly (PACE) program. The institutionalized spouse is considered medically needy if his/her resources are at or below a certain level and the monthly income after certain deductions is less than the cost of care in the facility.

Federal and State laws require that spousal impoverishment rules be used to determine an institutionalized spouse’s eligibility for Medicaid. These rules protect some of the income and resources of the couple for the community spouse.

If you or your spouse are:

- (1) In a medical institution or nursing facility and is likely to remain there for at least 30 consecutive days; or
- (2) Receiving home and community-based services provided pursuant to a waiver under section 1915(c) of the federal Social Security Act and are likely to receive such services for at least 30 consecutive days; or
- (3) Receiving institutional or non-institutional services under a PACE program as defined in sections 1934 and 1894 of the federal Social Security Act; AND
- (4) Married to a spouse who does not meet any of the criteria set forth under (1) through (3), these income and resource eligibility rules for an institutionalized spouse may apply to you or your spouse.

If you wish to discuss these eligibility provisions, please contact your local department of social services. Even if you have no intention of pursuing a Medicaid application, you are urged to contact your local department of social services to request an assessment of the total value of your and your spouse’s combined countable resources. It is to the advantage of the community spouse to request such an assessment to make certain that allowable resources are not depleted by you or your spouse’s cost of care. To request such an assessment, please contact your local department of social services or mail the attached completed “Request for Assessment Form.” New York City residents, calling from within New York City, should contact the Human Resources Administration (HRA) Infoline toll-free at (877) 472-8411. If calling from outside the five boroughs, the HRA Infoline number is (718) 557-1399.

Information about resources:

Effective January 1, 1996, the community spouse is allowed to keep resources in an amount equal to the greater of the following amounts:

- (1) \$74,820 (the State minimum spousal resource standard); or
- (2) The amount of the spousal share up to the maximum amount permitted under federal law (\$113,640 for 2012).

For purposes of this calculation, “spousal share” is the amount equal to one-half of the total value of the countable resources of you and your spouse at the beginning of the most recent continuous period of institutionalization of the institutionalized spouse. The most recent continuous period of institutionalization is defined as the most recent period you or your spouse met the criteria listed in items 1 through 4 (under “If you or your spouse are:”). In determining the total value of the countable resources, we will not count the value of your home, household items, personal property, your car, or certain funds established for burial expenses.

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POLICY AND BILLING GUIDANCE

The community spouse may be able to obtain additional amounts of resources to generate income when the otherwise available income of the community spouse, together with the income allowance from the institutionalized spouse, is less than the maximum community spouse monthly income allowance, by requesting a fair hearing or commencing a family court proceeding against the institutionalized spouse. Your attorney or local Office for the Aging can provide you with more information.

Either spouse or a representative acting on their behalf may request an assessment of the couple's countable resources, at the beginning, or any time after the beginning of a continuous period of institutionalization. Upon receipt of such request and all relevant documentation, the local district will assess and document the total value of the couple's countable resources and provide each spouse with a copy of the assessment and the documentation upon which it is based. If the request is not filed with a Medicaid application, the local department of social services may charge up to \$25.00 for the cost of preparing and copying the assessment and documentation.

Information about income:

You may request an assessment/determination of:

- (1) The community spouse monthly income allowance (an amount of up to \$2,841 a month for 2012); and
- (2) A maximum family member allowance for each minor child, dependent child, dependent parent or dependent sibling of either spouse living with the community spouse remains \$613 (if the family member has no income of his/her own) until the 2012 federal poverty levels are published in the federal register.

The community spouse may be able to obtain additional amounts of the institutionalized spouse's income, due to exceptional circumstances resulting in significant financial distress, than would otherwise be allowed under the Medicaid program, by requesting a fair hearing or commencing a family court proceeding against the institutionalized spouse. Significant financial distress means exceptional expenses which the community spouse cannot be expected to meet from the monthly maintenance needs allowance or from amounts held in resources. These expenses may include, but are not limited to: recurring or extraordinary non-covered medical expenses (of the community spouse or dependent family members who live with the community spouse); amounts to preserve, maintain, or make major repairs to the home; and amounts necessary to preserve an income-producing asset. Social Services Law 366-c.2(g) and 366-c.4(b) require that the amount of such support orders be deducted from the institutionalized spouse's income for eligibility purposes. Such court orders are only effective back to the filing date of the petition. Please contact your attorney or local Office for the Aging for additional information.

If you wish to request an assessment of the total value of your and your spouse's countable resources, a determination of the community spouse resource allowance, community spouse monthly income allowance, or family member allowance(s) and the method of computing such allowances, please contact your local department of social services. New York City residents, calling from within New York City, should call the Human Resources Administration (HRA) Infoline toll-free at (877) 472-8411. If calling from outside the five boroughs, the HRA Infoline number is (718) 557-1399.

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POLICY AND BILLING GUIDANCE

Additional Information

For purposes of determining Medicaid eligibility for the institutionalized spouse, a community spouse must cooperate by providing necessary information about his/her resources. Refusal to provide the necessary information shall be reason for denying Medicaid for the institutionalized spouse because Medicaid eligibility cannot be determined. If denial of Medicaid would result in undue hardship for the institutionalized spouse and an assignment of support is executed or the institutionalized spouse is unable to execute such assignment due to physical or mental impairment, Medicaid shall be authorized. However, if the community spouse refuses to make such resource information available, then the Department, at its option, may refer the matter to court.

Undue hardship occurs when:

- (1) A community spouse fails or refuses to cooperate in providing necessary information about his/her resources;
- (2) The institutionalized spouse is otherwise eligible for Medicaid;
- (3) The institutionalized spouse is unable to obtain appropriate medical care without the provision of Medicaid; and

(a) The community spouse's whereabouts are unknown; or

(b) The community spouse is incapable of providing the required information due to illness or mental incapacity; or

(c) The community spouse lived apart from the institutionalized spouse immediately prior to institutionalization; or

(d) Due to the action or inaction of the community spouse, other than the failure or refusal to cooperate in providing necessary information about his/her resources, the institutionalized spouse will be in need of protection from actual or threatened harm, neglect, or hazardous conditions if discharged from appropriate medical setting.

An institutionalized spouse will not be determined ineligible for Medicaid because the community spouse refuses to make his or her resources in excess of the community spouse resource allowance available to the institutionalized spouse if:

- (1) The institutionalized spouse executes an assignment of support from the community spouse in favor of the social services district; or
- (2) The institutionalized spouse is unable to execute such assignment due to physical or mental impairment.

Contribution from Community Spouse

The amount of money that we will request as a contribution from the community spouse will be based on his/her income and the number of certain individuals in the community depending on that income. We will request a contribution from a community spouse of 25% of the amount his/her otherwise available income that exceeds the minimum monthly maintenance needs allowance plus any family member allowance(s). If the community spouse feels that he/she cannot contribute the amount requested, he/she has the right to schedule a conference with the local department of social services to try to reach an agreement about the amount he/she is able to pay.

Pursuant to Section 366(3)(a) of the Social Services Law, Medicaid MUST be provided to the institutionalized spouse, if the community spouse fails or refuses to contribute his/her income towards the institutionalized spouse's cost of care. However, if the community spouse fails or refuses to make his/her income available as requested, then the Department, at its option, may refer the matter to court for a review of the spouse's actual ability to pay.

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POLICY AND BILLING GUIDANCE

Request for Assessment Form

Date:

Institutionalized Spouse's Name:

Address:

Telephone Number:

Community Spouse's Name:

Current Address:

Telephone Number:

I/we request an assessment of the items checked below:

- Couple's countable resources and the community spouse resource allowance
- Community spouse monthly income allowance
- Family member allowance(s)

Check if you are a representative acting on behalf of either spouse. Please call your local department of social services if we do not contact you within 10 days of this request.

NOTE: If an assessment is requested without a Medicaid application, the local department of social services may charge up to \$25 for the cost of preparing and copying the assessment and documentation.

Signature of Requesting Individual

Address and telephone # if different from above



All Medicare Part B Providers:

Payment of Medicare Part B Coinsurance Will Change

In this article:

- **Understanding Medicaid Redesign Team (MRT) Proposal #164**
- **Providers of Institutional Claims May no Longer “Opt-Out” of the Crossover Process**
- **Inclusion of Valid Rate Codes on ALL Crossover Claims is Required**

Understanding MRT Proposal #164

Limitation on Medicare Part B Coinsurance

Pursuant to Medicaid Redesign Team Proposal #164 (MRT #164), changes to New York State Social Service Law direct the Medicaid program to limit Medicaid payment for Medicare Part B services. The limitation of Part B coinsurances applies to practitioners, hospital outpatient departments and diagnostic and treatment centers (Article 28 Facilities).

Practitioners

The August 2011 Medicaid Update notified practitioners that implementation of MRT #164 would be effective October 1, 2011. Medicaid would no longer reimburse any portion of the Medicare Part B coinsurance amount if the service (i.e., CPT procedure code) was not covered by Medicaid.

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

Implementation of MRT #164 for Article 28 facilities will be **January 1, 2012**. The [August 2011 Medicaid Update](#) notified hospital outpatient departments and diagnostic and treatment centers (Article 28 facilities) that MRT #164 requires the Medicaid program to limit Medicaid payment for Medicare Part B services provided to Medicare/Medicaid dually eligible recipients. This change limits payment of Medicare Part B coinsurance amounts so that the total Medicare/Medicaid payment to the provider does not exceed the amount that the provider would have received for a Medicaid-only patient.

Note: Article 28 facilities were initially notified that payment changes were expected to be implemented on October 1, 2011. However, the eMedNY systems changes required to implement this new payment policy required an implementation delay, moving the implementation date to **January 1, 2012**.

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POLICY AND BILLING GUIDANCE

Clinic Billing Requirements

- **Providers of Institutional Claims May No Longer “Opt-Out” of the Crossover Process**
 - Effective for dates of service on or after January 1, 2012, all claims submitted to Medicare on the institutional claim form (837i) will be processed through the eMedNY system. This means that the choice to “opt out” of the crossover process is no longer available for institutional claims submitted on the 837i. (Clinic claims submitted to Medicare on the 837p will continue to be paid through the “opt-out” crossover process as appropriate.)

- **Valid Rate Codes Must be Reported on ALL Crossover Claims**
 - Effective January 1, 2012, Medicare Part B crossover claims must contain valid New York State Medicaid rate codes. All claims must have a **valid** rate code when submitted to Medicare as a Medicare/Medicaid crossover. If the claim crosses over to Medicaid without a valid rate code, that claim will deny with edit 02176, RATE CODE INVALID ON DIRECT CROSSOVER.

Claims containing valid Medicaid rate codes submitted to Medicare should appear in the following format:

Example – Rate code ‘1400’ should appear on the claim to Medicare as ‘14.00’. The reason for this is Medicare has an edit that will reject a claim if the sum of the Value Code Amount is greater than the Claim Charge Amount.

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

For claiming questions, please contact Computer Sciences Corporation (CSC) at (800) 343-9000.

For Medicaid policy questions, please contact the Office of Health Insurance Programs at (518) 473-2160.

For Medicaid managed care or Family Health Plus enrollees, please call the enrollee’s health plan.



POLICY AND BILLING GUIDANCE

Policy Clarification:

Transporting a Medicaid Enrollee Who Needs To Be Lifted Onto an Examination Table

Medicaid will reimburse for the most appropriate mode of transportation required to transport an eligible enrollee to a Medicaid covered service. Due to the increasing number of wheelchair users with excessive weight issues and other disabilities that are unable to transfer out of a wheelchair, the enrollees are faced with the prospect of requiring a lift out of the wheelchair onto an examination table.

When a wheelchair user is unable to move from the wheelchair and needs to be lifted (i.e., transferred) from the wheelchair onto an examination table, this transfer is the responsibility of a personal aide of the enrollee and/or medical practitioner. Lifting of the enrollee is not the responsibility of the transportation driver.

It is not appropriate to request the stretcher mode of transportation for an enrollee in order for the enrollee to be transferred easily onto the examination table by the stretcher personnel. Stretcher mode is inappropriate for transportation purposes because the enrollee can be safely transported in a wheelchair.

For wheelchair users who need assistance in getting out of their chair, orderers of transportation need to coordinate the enrollee's medical care among those practitioners who are able to accommodate the lifting of the enrollee onto the examination table.

Transportation vendors should not be required to:

- o accompany the enrollee throughout their appointment for the purposes of relaying treatment information to the nursing home staff or caregiver;
- o enter an examination room for the purposes of transferring the enrollee on or off of an examination table; nor,
- o leave provider-owned equipment (i.e., a stretcher) at the treating facility in order for the medical practitioner to render necessary treatment.

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



POLICY AND BILLING GUIDANCE

Podiatrists, Dentists, Optometrists, and Pharmacies

The Office of the Medicaid Inspector General (OMIG) in consultation with the State Education Department, the Department of Health (DOH), and the Office of Health Insurance Programs (OHIP), is implementing new Medicaid edit logic for edit 1498 (Profession Code Indicated Not Qualified To Prescribe). This updated edit logic will be implemented effective January 28, 2012 and will deny Medicaid fee-for-service claims when the prescriber is a Podiatrist, Optometrist or Dentist and the medication prescribed is within therapeutic class 32485 (HIV specific Antiviral).

For additional information please contact the eMedNY Call Center at (800) 343-9000.



POLICY AND BILLING GUIDANCE

All Rehabilitation Providers – Effective February 23, 2012

Rehabilitation Visits Will Require Prior Authorization

October 1, 2011:

Medicaid began to limit physical therapy, occupational therapy and speech therapy to 20 visits each per twelve-month benefit period.

February 23, 2012

Prior authorizations will be required for physical therapy, occupational therapy and speech therapy provided to fee-for-service Medicaid enrollees.

The Social Service Laws of 2011 changed the rehabilitation benefit (Medicaid Redesign Team Proposal #34). The [August 2011 Medicaid Update](#) notified providers that effective **October 1, 2011**, physical therapy, occupational therapy, and speech therapy are limited to 20 visits each per twelve-month benefit year. On October 1, 2011, Medicaid fee-for-service (FFS) enrollees who have received 20 or more visits of physical, occupational, or speech therapy between April 1, 2011 and September 30, 2011, will not be entitled to have Medicaid reimburse additional visits for that therapy type until April 1, 2012.

For Medicaid fee-for-service (FFS) enrollees, the twelve-month benefit year is a state fiscal year and begins April 1 of each year and runs through March 31 of the following year.

Medicaid managed care (MMC) enrollees are limited to 20 visits each of physical therapy, occupational therapy and speech therapy between October 1 and December 31, 2011, regardless of how many visits the enrollee received prior to October 1. Family Health Plus (FHPlus) enrollees are limited to 20 speech therapy visits between October 1 and December 31, 2011 (the FHPlus benefit package already limits enrollees to 20 visits each of physical therapy and occupational therapy per calendar year). For MMC and FHPlus enrollees, the benefit year begins January 1 of each subsequent year and ends December 31. Therefore, beginning January 1, 2012, MMC and FHPlus enrollees are eligible to receive up to 20 visits for each therapy type during the calendar year.

This benefit limit applies to rehabilitation visits in private practitioners' offices, certified hospital out-patient departments, and diagnostic and treatment centers (free-standing clinics). The rehabilitation limit applies to Medicaid fee-for-service (FFS), Medicaid managed care (MMC), and Family Health Plus (FHPlus) enrollees. Refer to the August 2011 Medicaid Update for enrollees, settings, and circumstances exempt from the 20-visit limitation.

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POLICY AND BILLING GUIDANCE

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

Therapy Types and Modifiers

All providers submitting claims or prior authorizations for Medicaid FFS enrollees for physical, occupational, and speech therapy must now use a modifier. The modifier identifies the therapy type and provides a mechanism for counting and matching. Without a modifier, the claim will be denied.

Table 1. Therapy Types, Modifiers, and Definitions

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

Effective February 23, 2012

Prior Authorizations

Medicaid managed care (MMC) and Family Health Plus (FHPlus) health plans continue to track therapy visits provided to their enrollees. Prior authorization for therapy visits continues to be done through the enrollee's health plan.

For Medicaid fee-for-service (FFS) enrollees, the requirement to get a prior authorization (PA) for physical therapy, occupational therapy, and speech therapy visits begins **February 23, 2012**.

NOTE: FFS providers do not need to obtain a prior authorization for FFS enrollees who are exempt from the service limit (e.g., R/E 95 and R/E 81 enrollees) or for rehabilitation therapy provided in exempt settings (e.g., hospital inpatient, skilled nursing facilities' residents), or for rehabilitation services provided through a certified home health agency (CHHA).

Requesting a Prior Authorization for a Fee-For-Service Patient

Prior authorizations are generated through the "Dispensing Validation System" (DVS). DVS requests through eMedNY will afford providers:

- Dispensing Validation Numbers for prior authorizations, and
- The ability to cancel a previously obtained authorization.

A prior authorization (PA) may **not** be requested retroactively. DVS operates on "real time" and will give an immediate response to a request for a PA. The DVS system can be accessed using one of the following methods:

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POLICY AND BILLING GUIDANCE

ePACES

This is a web-based application that allows providers to request and receive HIPAA-compliant Claim, Prior Approval, Eligibility, Claim Inquiry, and Dispensing Validation System (DVS) transactions.

The ePACES method requires a computer with Internet connection and registration with ePACES at www.emedny.org/epaces. This method is recommended for providers with a small to medium sized practice. Here, information is entered into the ePACES online system for verification. While the service is free, a computer with Internet access is required.

To take advantage of ePACES, providers need to complete an enrollment process. Enrollment information is available in the Self Help section of the eMedNY website at www.emedny.org/epaces. The enrollment process can generally be completed within one business day. **NOTE: ePACES** allows multiple requests for DVS prior authorization on any given day. However, each date of service must be entered individually.

PC-to-Host Link

This method requires a PC, a dial-up modem, and a software application (not supplied by eMedNY) to generate a specific message format. Verification responses are returned within seconds. The PC-to-Host method is suggested for low volume and medium volume providers. The necessary software application may be developed in-house by the trading partner seeking to access eMedNY or procured from a third party. Contact the eMedNY Call Center to obtain communication specifications, if interested in developing this application yourself. **NOTE: PC-to-Host Link** allows multiple requests for DVS prior authorization on any given day. However, each date of service must be entered individually.

VeriFone POS (Point of Service) Device

The VeriFone method requires a VeriFone Omni 3750/Vx570, power outlet, and analog telephone line. Once initially set up, all that is needed is to swipe the member's benefit card or to key in their Medicaid Client Identification Number (CIN), and to enter some information on the touch pad. This is the easiest and fastest verification method. The VeriFone Terminal costs \$817 (includes shipping and handling) plus tax. Please contact the eMedNY Call Center at 800-343-9000 for additional information. **NOTE:** The **POS** device allows a prior authorization request on the current date of service only.

Procedure Codes and Modifiers

DVS requires procedure codes, in coordination with modifiers, to distinguish therapy types. The procedure code used in requesting a prior authorization may or may not be one that will be submitted on the claim. All requests for a prior authorization require the use of a modifier and one of the procedure codes included in Table 2. This includes rate-based billing providers, such as article 28 facilities.

When prompted by the DVS, the following therapy-appropriate codes should be entered:

Table 2. Modifiers and Procedure Codes

Therapy Type	Procedure Code	Modifier
Physical Therapy	97530 or 97542	GP
Occupational Therapy	97530 or 97542	GO
Speech Therapy	92506 or 92507	GN

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POLICY AND BILLING GUIDANCE

For more information on accessing and using the DVS, refer to the MEVS/DVS Manual. The [eMedNY Medicaid Eligibility Verifications System \(MEVS\) and Dispensing Validation System \(DVS\) Provider Manual](#) will be updated to include rehabilitation prior authorization information in time for the prior authorization effective date of February 23, 2012.

A DVS authorization (prior authorization) does not guarantee payment. The same conditions apply when a claim is submitted for payment regardless of prior authorization. The client must be eligible on the date that the service is provided. However, without a prior authorization, the claim will be denied.

Cancellations

All unused prior authorizations must be cancelled by the provider who requested them within ninety (90) days. The cancellation must include the PA number and the date of service that corresponds to the authorization that is being cancelled.

The cancellation must be done within ninety (90) days of original request. This is important because the system will only issue twenty (20) prior authorizations per therapy type for each benefit year. If the unused authorization is not cancelled, it will impact the enrollee's ability to access rehabilitation services.

Billing and Claiming Guidance

All claims for physical therapy, occupational therapy, and speech therapy, regardless of whether a prior authorization is required, **must** contain a modifier (**see Table 1**). The modifier follows the procedure code on the claim and identifies therapy type. Without the modifier, the claim will be denied.

Private Practitioner Claims

The prior authorization (PA) number and modifier must be on the claim. A PA number, as well as the appropriate procedure code(s) and modifier(s), is required for each date of service. For the same date of service, the same PA number must be used on each line of the claim. Multiple procedures, of the same therapy type, on one date of service will use the same prior authorization number, go on the same claim, and count as one visit.

Clinic Claims

For claims with one therapy type – A prior authorization (PA) must be obtained for each date of service. The PA number will be at the header level on the claim.

For claims with multiple therapy types – A prior authorization (PA) must be obtained for each date of service for each therapy type. However, only one PA number will be at the header level on the claim. The PA number on the header may be any of the PAs for services being claimed. During processing, eMedNY will identify procedure codes requiring a PA number and will locate the appropriate PAs (including those not listed on the claim). If even one PA number was not previously obtained, the entire claim will be denied.

Watch for additional information in upcoming Medicaid Updates.

For claiming questions, DVS technical assistance, enrollment, and POS purchase information, please contact Computer Sciences Corporation (CSC) at (800) 343-9000.

For Medicaid policy questions, please contact the Office of Health Insurance Programs at (518) 473-2160.

For Medicaid managed care or Family Health Plus enrollees, please call the enrollee's health plan.



Personal Emergency Response System (PERS)

Effective January 1, 2012, Personal Emergency Response System (PERS) vendors providing services to individuals enrolled in Mainstream Medicaid Managed Care Plans (MMCPs) will no longer seek authorization for services from the Local Department of Social Services (LDSS). **MMCPs will authorize and reimburse claims for all PERS services provided to MMCP enrollees on or after January 1, 2012.** Claims for services authorized by the LDSS and provided prior to January 1, 2012, but submitted after January 1, 2012, will be paid under the fee for service system.

The MMCPs can identify members currently in receipt of PERS by the presence of rate codes 2513 and 2514 on the fee-for-service (FFS) claims data provided by the state through the Health Commerce System (HCS). For members identified as receiving PERS, MMCPs should contact the LDSS personal care services program for the following information: the vendor currently providing the service, the authorization period and a copy of the PERS checklist.

Most MMCPs have assessed enrollees' needs for PERS during the transition of the personal care benefit, which began August 1, 2011, and will have arranged for PERS vendors to receive authorization from the MMCP to continue services after January 1, 2012. Any vendor currently providing PERS services to a mainstream Medicaid managed care enrollee under an LDSS authorization that has not made such arrangements, should contact the individual's MMCP for direction about continuation of services after December 31, 2011. PERS services should be continued by the existing vendor and paid by the MMCP for 60 days or until a new assessment is completed, unless other arrangements have been confirmed with the MMCP.

For questions relating to the PERS transition to mainstream Medicaid managed care, please e-mail OMCmail@health.state.ny.us or call the Division of Health Plan Contracting & Oversight, at (518) 474-5515.



Fee-for-Service Pharmacy Reform Prior Authorization for Atypical Antipsychotics

The enacted 2011-2012 New York State (NYS) Executive Budget included several significant changes to the Medicaid fee-for-service (FFS) pharmacy benefit. One of those changes was to eliminate the exemption from prior authorization requirements for drugs in the following therapeutic classes: atypical anti-psychotics, anti-depressants, anti-rejection drugs used for the treatment of organ and tissue transplants and anti-retroviral drugs used in the treatment of HIV/AIDS.

As previously announced, the Department delayed implementation of this initiative until systems were in place to support the grandfathering of patients stabilized on non-preferred atypical anti-psychotics. Those systems will be in place in late December 2011.

Effective December 29, 2011, prior authorization will be required for atypical anti-psychotics identified as non-preferred on the Medicaid Preferred Drug List.

System editing will be performed at the point-of-service that will allow claims to reimburse without prior authorization when clinical criteria are met such as when a beneficiary has been stabilized on a non-preferred product. When clinical criteria are not met, pharmacy providers will receive an edit message instructing them to notify the prescriber to change the prescription to a preferred drug, if appropriate, or to obtain prior authorization through the clinical call center at **(877) 309-9493** for the non-preferred drug.



Upcoming Changes to the Fee-for-Service Pharmacy Prior Authorization Process

On December 29, 2011, the Department will begin phasing in changes to the Medicaid pharmacy fee-for-service (FFS) prior authorization process. System editing will be performed at the point-of-sale to allow claims to pay without prior authorization when clinical criteria are met, such as when a beneficiary has been stabilized on an atypical anti-psychotic or when a claim meets clinical rules established by the Medicaid Drug Utilization Review Board or Pharmacy & Therapeutics Committee.

Effective December 29, 2011:

- All FFS pharmacy claims will be subject to clinical rules at the point-of-sale.
- An automated approval will be issued if all rules associated with the requested product are satisfied; which will result in a paid claim.
- A failed clinical rule will result in a failed claim. A rejection message will be provided at the point-of-sale instructing pharmacy providers to notify the prescriber to change the prescription if appropriate or to obtain prior authorization through the clinical call center at **(877) 309-9493**.
- Prescribers must obtain prior authorization through the clinical call center for claims that do not meet clinical criteria.

What does this mean for me?

- Pharmacy providers will no longer have to validate prior authorizations.
- Prescribers will only have to obtain prior authorization when clinical criteria are not met.
- Prior authorization numbers will be generated systematically and will no longer need to be written on a prescription or submitted on a claim.

Coming in February, 2012

- Prescribers will be able to enter prior authorization requests through PAXpress®, a web-based pharmacy information system.
- PAXpress® will also allow prescribers to search the Medicaid formulary for the clinical rules attached to specific drugs.
- Prior authorization will continue to be available through the clinical call center at **(877) 309-9493**.
- To access PAXpress®, prescribers must have an active e-PACES account.

More detailed information on the PAXpress® system will be provided in upcoming Medicaid Update newsletters. To enroll in e-PACES, please visit <https://www.emedny.org/selfhelp/index.aspx>.



Medicaid Redesign Team Fee-for-Service Pharmacy Reform Limit Opioids to a Four Prescription Fill Limit Every 30 Days

As of December 1, 2011, prescriptions for opioid analgesics for fee-for-service (FFS) Medicaid beneficiaries will be limited to four fills every thirty days.

Effective December 29, 2011, claims submitted in excess of this limit will be denied. Pharmacy point-of-service system enhancements will be implemented to review claims history for certain clinical criteria in order to automatically bypass the four prescription limit, when clinically appropriate.

In extenuating circumstances when it has been determined that an additional opioid analgesic prescription is medically necessary, prior authorization may be obtained by calling the Medicaid prior authorization clinical call center at **(877) 309-9493**. Prescribers may be asked to provide documentation to support the need to exceed the limits.



The New York State Medicaid Prescriber Education Program Hypertension White Paper and Key Messages

The New York State Medicaid Prescriber Education Program (NYSMPEP) is a partnership between the New York State Department of Health (NYSDOH) and the State University of New York (SUNY), as approved by state legislation. This program was designed to provide prescribers with an evidence-based, non-commercial source of the latest objective information about pharmaceuticals.

NYSMPEP developed a white paper entitled "*Hypertension in Diverse Populations – A New York State Medicaid Clinical Guidance Document.*" The white paper is novel because it is the first guidance document on hypertension that focuses on socioeconomic and psychosocial disparities and their potential impact on cardiovascular disease (CVD) risk. The white paper was published in the Journal of the American Society of Hypertension July 2011 issue and can be obtained as open-access references at the journal's website ([http://www.ashjournal.com/article/S1933-1711\(11\)00153-7/fulltext](http://www.ashjournal.com/article/S1933-1711(11)00153-7/fulltext)) or the NYSMPEP website (<http://nysep.nysdoh.suny.edu/hypertension/title>).

The key messages of the white paper and the NYSMPEP hypertension module are summarized below:

- Socioeconomic and psychosocial factors are more important than genetic or ethnic differences in determining blood pressure levels and CVD risk profiles.
- In order to lower CVD risk, controlling blood pressure, cholesterol, and blood sugar are of high importance.
- The blood pressure goal in patients with hypertension is <140/90 mmHg. There is conflicting evidence whether lower blood pressure goals are of benefit in patients with hypertension and diabetes mellitus or chronic kidney disease. There is scant evidence to suggest lower blood pressure goals for African American patients developed by the International Society on Hypertension in African Americans are warranted.
- Most patients will require more than one medication to control blood pressure. Preferred two-drug combinations include an angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker with either a thiazide-type diuretic or dihydropyridine calcium channel blocker. Using combinations instead of monotherapy will lower blood pressure to a greater degree because complementary drugs can work on compensatory blood pressure-raising mechanisms.
- Effective communication, trust, and partnership between prescriber and patient are essential to achieve lasting blood pressure control. Suggestions for improving the patient-prescriber relationship are contained within the white paper.



Fee-For-Service Providers

New York State Medicaid Program – Dispense Brand Name Drugs When Less Expensive Revision

On April 26, 2010, New York Medicaid implemented a new cost containment initiative which promotes the use of certain multi-source brand name drugs when the cost of the brand name drug is less expensive than the generic equivalent.

Current list of brand name drugs included in this program (Date Revised 12/30/2011):*

- Adderall XR
- Arixtra
- Astelin
- Carbatrol
- Concerta
- Diastat
- Duragesic
- Effexor XR
- Kadian
- Lipitor
- Lovenox
- Nasacort AQ
- Uroxatral
- Valtrex
- Zyprexa tablet

*List is subject to change

Please be aware that brand name drugs included in this program:

- will not require 'Dispense as Written' (DAW) or 'Brand Medically Necessary' on the prescription; **and do not need to be billed using the NCPDP (408-D8) Dispense As Written/Product Selection Code of '1'**.
- have a generic copayment; and are therefore in conformance with State Education Law which intends that patients receive the lower cost alternative;
- will be paid at the Brand Name Drug reimbursement rate or usual and customary price, whichever is lower (neither the SMAC nor FUL will be applied);
- will not require prior authorization.



Medicaid Redesign Team (MRT) Proposal #15C: Evaluate the Use of Average Acquisition Cost (AAC) as a Medicaid Fee-for-Service Pharmacy Reimbursement Benchmark

In accordance with legislation passed in April 2011, the Department of Health is undertaking a comprehensive survey of Medicaid enrolled pharmacies to identify drug acquisition costs and associated costs of dispensing. The overall goal of this initiative is to create a pharmacy reimbursement benchmark that is valid, transparent, timely and sustainable.

In the coming months, Medicaid enrolled pharmacies will be surveyed to identify drug acquisition costs, defined as “the invoice price to the pharmacy of a prescription drug dispensed to a Medicaid recipient, minus the amount of all discounts and other cost reductions attributable to such dispensed drug.” A separate survey will be conducted to determine the average cost of dispensing (“COD”).

All data necessary to calculate average costs will be collected through a secure process and in a manner that ensures provider confidentiality. The Department will be assisted in the development and implementation of AAC by Ernst & Young, LLP and First Data Bank, Inc., the State’s current supplier of electronic drug data. Ernst & Young, LLP will develop the survey instrument, the statistical sampling methodology and the calculation required to determine AAC and COD. The State will electronically collect the required information from providers and transmit de-identified raw data to FDB; and FDB will apply the defined algorithms to the raw data to arrive at AACs and publish them to the State.

The Department will conduct focus groups, which will include stakeholders selected to ensure an appropriate representation of different classes of pharmacy trade, business scale and location. The focus group process is tentatively scheduled for mid-January through mid-February. This phase will result in the creation of draft survey instruments for both AAC and COD, which will subsequently be prototyped and amended as necessary to create final forms that are both easy to implement and accurate.

As with all MRT initiatives, the Department is committed to an open and fully engaged dialogue with stakeholders in this effort to create a transparent, fair and enduring methodology for Medicaid fee-for-service drug reimbursement and a reasonable dispensing fee.

Additional information will be provided in future Medicaid Updates and at regularly scheduled stakeholder meetings. Information can also be found on the Medicaid Redesign Team website at: http://www.health.ny.gov/health_care/medicaid/redesign/.



ALL PROVIDERS

Reminder:

5010 Remittances Begin January 1, 2012

As previously communicated, in support of the January 1, 2012, Version 5010 compliance date, effective with cycle 1794 eMedNY will begin sending **only** 5010 remittances 835/820 to providers receiving electronic remittances. Cycle 1794 covers activity adjudicated by eMedNY from December 29, 2011 through January 4, 2012, and will have a check date of January 9, 2012.

Providers are urged to work aggressively toward their 5010 remittance conversion to ensure they will be ready to accept the 5010 format by the January 1, 2012 compliance date. Providers who believe they will not be ready to accept the 5010 remittance and would face undue hardship may request an exception by completing the Electronic Remittance Request Form found at:

https://www.emedny.org/info/ProviderEnrollment/Provider%20Maintenance%20Forms/5010_Electronic_Remittance_Request_Form.pdf

Check the 4010 box for Production Remit Format, complete the remainder of the form, and FAX, email or send it to CSC as directed on the form. Providers will need to complete a separate form for each provider/ETIN combination that is set up for electronic remittances.

Providers who receive paper or PDF remittances are not impacted and should NOT complete this form.

For questions, please contact the eMedNY Call Center at (800) 343-9000.

PROVIDER DIRECTORY

Office of the Medicaid Inspector General:

For general inquiries or provider self-disclosures, please call (518) 473-3782.

For suspected fraud complaints/allegations, call 1-877-87FRAUD (1-877-873-7283), or visit www.omig.ny.gov.

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

Please visit the eMedNY website at: www.emedny.org.

Do you have questions about billing and performing MEVS transactions?

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

Provider Training:

To sign up for a provider seminar in your area, please enroll online at: <http://www.emedny.org/training/index.aspx>. For individual training requests,

call (800) 343-9000 or e-mail: emednyproviderrelations@csc.com.

Enrollee Eligibility:

Call the Touchtone Telephone Verification System at any of the following numbers: (800) 997-1111, (800) 225-3040, or (800) 394-1234.

Address Change?

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

Fee-for-Service Providers: A change of address form is available at: <http://www.emedny.org/info/ProviderEnrollment/allforms.html>.

Rate-Based/Institutional Providers: A change of address form is available at: <http://www.emedny.org/info/ProviderEnrollment/allforms.html>.

Does your enrollment file need to be updated because you've experienced a change in ownership?

Fee-for-service providers please call (518) 402-7032.

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

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

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