



New York State Medicaid Update

THE OFFICIAL NEWSLETTER OF THE NEW YORK STATE MEDICAID PROGRAM

New York State Medicaid Prenatal Care Quality Improvement Project



Policy & Billing Guidance



The New York State Department of Health (Department), in a joint effort with the state's Medicaid managed care (MMC) plans, is implementing a statewide practice-based quality improvement initiative focusing on prenatal care providers. All practices participating in Medicaid will be required to provide information to the Department, for a limited number of randomly selected patients, related to the following key activities: tobacco cessation counseling, depression screening, care coordination, chronic disease management, recommended immunizations, assessment and treatment for preterm birth. Practices will submit the data via a web-based tool and these data will augment other quality measurement and improvement activities currently in place for MMC plans and hospitals.

Improving maternal and infant health outcomes is a public health priority identified in the Department's *Prevention Agenda 2013-2017: New York State's Health Improvement Plan*.ⁱ Key indicators, including low birth weight and preterm birth, have not improved over the last decade, and economic and other disparities persist. Women enrolled in Medicaid experience a disproportionate number of adverse birth outcomes in New York State. For example, between 2008 and 2010, preterm births comprised 12.6% of New York Medicaid births as compared to 11.5% of non-Medicaid births.ⁱⁱ The *Prevention Agenda* identifies a reduction in this disparity by 10% and an overall reduction in preterm births by 12%, to reach a preterm rate of 10.2%, as goals to be achieved by December 31, 2017.

Updated NYS Medicaid Prenatal Care Standards (Standards) issued in 2009, consistent with American Congress of Obstetricians and Gynecologists (ACOG) standards, address access to care, obstetrical risk assessment and referral, management of pre-existing conditions, psychosocial risk assessment, nutritional screening/counseling/referral, health education, prenatal and postpartum care services and coordination of care. **Provisions in the Standards, incorporated in statute, require providers to participate in quality improvement initiatives, including special reports and data submissions, as requested by the NYS DOH Commissioner of Health.** The Standards can be accessed at: http://www.health.ny.gov/health_care/medicaid/standards/prenatal_care/

A Medicaid prenatal care study, conducted by IPRO on behalf of the Department, Office of Quality and Patient Safety, evaluated the care received by New York Medicaid-enrolled women who gave birth in 2009ⁱⁱⁱ. The study revealed overall improvement and strength in the delivery of recommended services



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POLICY AND BILLING GUIDANCE

New York State Medicaid Prenatal Care Quality Improvement Project	cover
Expanded Coverage for Fragile X Syndrome- Prenatal Carrier Testing	4
Patient Centered Medical Home (PCMH) Application Discount Code	6
Article 28 Hospital Outpatient Departments (HOPDs) New Billing Requirements	7
Mandatory Compliance Program Certification Requirement under 18 NYCRR §521.3(b)	8
Certification of Compliance with Section 6032 of the Deficit Reduction Act of 2005	11

PHARMACY UPDATE

Transmission of the Official Prescription Serialized Number requirement	12
Information Regarding Prescriptions for Controlled Substances.....	14
New York State Medicaid Fee-for-Service Guidelines for Palivizumab (Synagis®)	15
Ordering, Prescribing, Referring, Attending (OPRA) Prescription Requirements/Unlicensed Providers....	16
Medicaid Fee-for- Service (FFS) Emergency Services Coverage	18
Attention Prescribers: Final e-Prescriber Payments to be Issued by eMedNY	19

ALL PROVIDERS

NY Medicaid EHR Incentive Program Update	20
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Policy & Billing Guidance

to pregnant women, but also some gaps in care relative to the Standards. Recommendations included on-going monitoring of compliance with ACOG-recommended best practices and, most notably, of key performance indicators.

In June 2014, the Department began collecting data resulting from the prenatal care provided to a random sample of Medicaid patients in New York State. For each practice, this will take place no more frequently than on an annual basis. The Department and IPRO designed and tested, in consultation with clinical advisers, a web-based data collection and reporting application to promote practice-based measurement and improvement. The tool includes standardized measures of prenatal care, which will allow providers to benchmark performance to statewide averages and performance goals. These data will serve to inform internal quality improvement initiatives and provide a valuable component of quality oversight in addition to other approaches currently used by the Department, including MMC plan measurement through the Quality Assurance Reporting Requirements (QARR) and requirements in the MMC model contract.

The study recommendations also included opportunities for improvement and evidence for efficacy of interventions. Many of these focused areas are identified in the *Prevention Agenda* as risk factors that can impact birth outcomes, such as smoking, domestic violence and obesity and are associated with statewide initiatives.

To further assist in the coordination of care between health plans and providers, the Department has also compiled a list of the NYS MMC plans' High Risk OB Care Management Programs, including the name and contact information of the primary contact at each plan's program. This list can be accessed at:

http://www.health.ny.gov/community/pregnancy/health_care/prenatal/mmc_high_risk_ob_care_management_contacts.htm

For additional information about this initiative, please contact the Office of Quality and Patient Safety at (518) 486-9012 or via email at: qi@health.ny.gov.

References:

ⁱ New York State Department of Health. Prevention Agenda 2013-2017: New York State's Health Improvement Plan. Available at http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/index.htm.

ⁱⁱ New York State Department of Health. Ratio of Medicaid births to non-Medicaid births for percentage of preterm birth. Source: 2008-2010 vital statistics data as of February 2012. Available at http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/p44.htm.

ⁱⁱⁱ New York State Department of Health Office of Quality and Patient Safety. *Medicaid Perinatal Care Study*, March 2013. Available at http://www.health.ny.gov/health_care/medicaid/standards/prenatal_care/docs/perinatal_care_study.pdf



Policy & Billing Guidance

Expanded Coverage for Fragile X Syndrome - Prenatal Carrier Testing

Prenatal Testing:

Effective September 1, 2014 Medicaid fee-for-service (FFS), and November 1, 2014 Medicaid Managed Care (MMC) and Family Health Plus (FHPlus) will begin covering prenatal carrier testing for fragile X syndrome when one or more of the following criteria is met:

- There is a personal or family history of fragile X tremor/ataxia syndrome, autism spectrum disorder or unexplained mental retardation in a 1st, 2nd or 3rd degree* relative of either parent;
- The mother has elevated Follicle Stimulating Hormone (FSH) levels before age 40 or premature ovarian failure with no known cause; or
- The mother or a 1st or 2nd degree* female relative of either parent is a confirmed carrier.

**1st degree relatives: Parents, children, siblings*

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

3rd degree relatives: First cousins

General Background:

Fragile X syndrome is the most common known genetic cause of autism and intellectual disability, and occurs when there is a loss of fragile X mental retardation protein (FMRP). The mutated gene (FMR1) does not produce sufficient protein for proper brain cell development. FMR1 is located on the X chromosome and can be passed from one generation to another without showing any obvious signs of fragile X syndrome.

Fragile X syndrome is a genetic condition that causes a range of problems, including developmental disabilities, psychological, physical and cognitive impairment. Fragile X is found in all ethnic groups and affects both males and females, and is more prevalent in males. Males are often more severely



Policy & Billing Guidance

affected; intelligence quotient (IQ) measures frequently indicate mild to severe mental retardation (20-70) with approximately one-third of affected males also having an autism spectrum disorder diagnosis. Females and less affected males have milder mental retardation and/or learning disabilities. Additionally, there are physical, sensory, social and emotional symptoms associated with fragile X syndrome.

Fragile X syndrome is estimated to affect approximately 1 in 2500-4000 males and 1 in 7000-8000 females. For carriers of fragile X, the prevalence in females is estimated to be 1 in 130-250 population, and 1 in 250-800 for males.ⁱ

Molecular genetic testing is used to measure the number of cytosine-guanine-guanine (CGG) repeats within the promoter region of the FMR1 gene. The normal range is approximately 30 repeats of the CGG sequence. Between 50 and 200 repeats is considered a premutation, and any number over 200 repeats represents a full mutation of the gene.

Reminders:

- Diagnostic testing of children for fragile X syndrome continues to be covered if medically necessary.
- DNA-based molecular analysis is the standard method used to determine a diagnosis of fragile X syndrome in children with suspected developmental delays.
- Follow-up genetic counseling should be provided to those who test positive for a fragile X premutation or full mutation.
- Prenatal testing of a fetus by amniocentesis or chorionic villus sampling should be offered following a positive fragile X carrier test in either parent.
- Consistent with existing policy, NYS Regulation 505.7 requires 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 please visit the following link:
<http://w3.health.state.ny.us/dbspace/NYCRR18.nsf/b2d7d4e6cbd45bd285256546004b78bd/6665022caf89cd9f85256722007690d8?OpenDocument>



Policy & Billing Guidance

Codes:

81243	FMR1 (fragile X mental retardation 1) (e.g., fragile X mental retardation) gene analysis; evaluation to detect abnormal (e.g., expanded) alleles
81244	FMR1 (fragile X mental retardation 1) (e.g., fragile X mental retardation) gene analysis; characterization of alleles (e.g., expanded size and methylation status)

Questions regarding Medicaid FFS policy should be directed to the Division of Program Development and Management at (518) 473-2160. Questions regarding MMC and FHPlus reimbursement and/or documentation requirements should be directed to the enrollee's MMC or FHPlus plan.

References:

¹ <http://emedicine.medscape.com/article/943776-overview>

Patient Centered Medical Home (PCMH) Application Discount Code

The New York State Department of Health (NYSDOH), in partnership with the National Committee for Quality Assurance (NCQA), is permitted to offer a sponsorship code (a 20% discount) to clinicians who participate with Medicaid in New York and are applying to NCQA for new or renewed Patient Centered Medical Home (PCMH) recognition. The discount code may be applied to pre-clinician submission fees for the 2011 or 2014 PCMH recognition programs. Because NCQA offers multi-site practices of three or more independent sites a 50% discount per clinician application fees, such practices are not eligible for an additional discount through this sponsorship.

The NYSDOH-sponsored discount code is available only to clinicians who currently participate with the New York State Medicaid program. To obtain the code, the applicant must send a written request for the code to the NYSDOH at pcmh@health.ny.gov. The request must include the name and National



Policy & Billing Guidance

Provider Identifier (NPI) of each clinician requesting use of the code. Please allow up to two weeks for the NYSDOH to review your request once submitted.

Once obtained, the code can be entered into the 'discount code' field of the NCQA PCMH online application any time prior to submission in order to apply a 20% discount. Questions specific to NYSDOH's PCMH discount code can be sent to pcmh@health.ny.gov.

General questions about NCQA's PCMH recognition, sponsorship program, or online application should be sent to NCQA via their online portal: <http://ncqa.force.com/pcs/login>.

Article 28 Hospital Outpatient Departments (HOPDs) New Billing Requirements for Ordered Ambulatory Services provided to Medicare/Medicaid Dually Eligible Beneficiaries

Beginning September 1, 2014, HOPDs will be able to take advantage of the automatic crossover of claims from Medicare to Medicaid.

Medicare Part B crossover claims on the 837i must contain valid New York State Medicaid rate codes because claims crossed over to Medicaid without a valid rate code are denied with edit 02176 (rate code invalid on direct crossover). However, providers had been instructed not to include an APG rate code on claims for ordered ambulatory services. As a result, Article 28 Hospital Outpatient Departments (HOPDs) were also instructed to submit claims directly to Medicaid for ordered ambulatory services (carved out of APGs). To permit claims for ordered ambulatory services to cross-over from Medicare a new rate code has been established.

The new rate code that HOPDs will have to include on institutional claims (837i) submitted to Medicare for ordered ambulatory services provided to dually eligible beneficiaries is:

1200 HOPD ORDERED AM (INSTITUTIONAL CLAIM XOVER)



Policy & Billing Guidance

Claims with rate code '1200' will automatically cross over from Medicare to Medicaid. Rate code '1200' will allow eMedNY to identify the claim as an ordered ambulatory professional claim and process it as such.

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

Medicaid rate code '1200' should appear on the claim to Medicare as '12.00'.

The ordered ambulatory services that can be billed with rate code '1200' can be found in the New York State Medicaid Program Ordered Ambulatory Procedure Codes manual online at:

https://www.emedny.org/ProviderManuals/OrderedAmbulatory/PDFS/OrderedAmbulatory_Procedure_Codes.pdf

Additional information about ordered ambulatory services provided in hospital outpatient departments can be found online in *The Policy and Billing Guidance Ambulatory Patient Groups (APGs) Provider Manual* at: http://www.health.ny.gov/health_care/medicaid/rates/manual/

Claim questions? Please call **Computer Science Corporation (CSC)** at (800) 343-9000.

Policy questions? Please call the **Bureau of Policy Development and Coverage** at (518) 473-2160.

Mandatory Compliance Program Certification Requirement under 18 NYCRR §521.3(b) - *Reminder*

THIS IS A REMINDER FROM THE NEW YORK STATE OFFICE OF THE MEDICAID INSPECTOR GENERAL (OMIG) FOR ALL REQUIRED PROVIDERS WHO ARE SUBJECT TO THE NYS SOCIAL SERVICES LAW SECTION 363-d MANDATORY COMPLIANCE PROGRAM REQUIREMENT.

On December 1, 2014, OMIG will make available on OMIG's Web site, the NYS Social Services Law Compliance Program Certification Form (Certification Form) for 2014. The Certification Form for 2013 will remain active on OMIG's Web site until December 1, 2014 for newly enrolling Medicaid providers.



Policy & Billing Guidance

OMIG will host a webinar in November, 2014 that will explain the new 2014 certification form. Please check OMIG's listserv, Facebook page or Twitter feeds for registration information.

The following required providers must have compliance programs. If you are required to have a compliance program, you are also required to certify on OMIG's Web site (www.omig.ny.gov) that your compliance program meets the requirements of the applicable law and regulations. The certification must occur in December of each year.

OMIG has actively enforced Social Services Law § 363-d and Part 521, of Title 18 of the New York State Codes, Rules and Regulations since 2009. The regulation mandates all required providers under the Medicaid program who fall under the following categories to **certify in December of each year** that they have adopted, implemented and maintain an effective compliance program:

- *persons subject to the provisions of articles 28 or 36 of the New York State Public Health Law;*
- *persons subject to the provisions of articles 16 or 31 of the New York State Mental Hygiene Law;*
- *other persons, providers or affiliates who provide care, services or supplies under the Medicaid program, or persons who submit claims for care, services or supplies for or on behalf of another person or provider for which the Medicaid program is or should be reasonably expected by a provider to be a substantial portion of their business operations.*

(emphasis added)

Under 18 NYCRR § 521.2 (b), "substantial portion" of business operations means any of the following:

(1) when a person, provider or affiliate claims or orders, or has claimed or has ordered, or should be reasonably expected to claim or order at least \$500,000 in any consecutive 12-month period from the Medical Assistance Program;

(2) when a person, provider or affiliate receives or has received, or should be reasonably expected to receive at least \$500,000 in any consecutive 12-month period directly or indirectly from the Medical Assistance Program; or

(3) when a person, provider or affiliate who submits or has submitted claims for care, services, or supplies to the Medical Assistance Program on behalf of another person or persons in the aggregate of at least \$500,000 in any consecutive 12-month period.



Policy & Billing Guidance

Each compliance program must contain the eight elements required under SSL § 363-d and 18 NYCRR § 521.3 (c). **Upon applying for enrollment in the medical assistance program, and during the month of December each year thereafter**, 18 NYCRR 521.3 (b) requires those subject to the mandatory compliance program obligation to certify to the Department of Health and OMIG that a compliance program meeting the requirements of the regulation is in place.

Please note that the New York State Department of Health is revalidating Medicaid providers' enrollment in the medical assistance program. As part of the Department of Health's revalidation process, required providers will be asked to submit evidence that they met the December certification obligation. Certifying in December and retaining a copy of the Certification Confirmation and/or confirmation emails will help Medicaid required providers complete the revalidation process.

The regulation and Frequently Asked Questions (FAQs) are available on the OMIG Web site, on the Compliance landing page at <http://www.omig.ny.gov/compliance>. The 2014 form will available at that same location starting on December 1, 2014.

It is the responsibility of required providers to determine if:

- a. it has a compliance plan that meets the requirements of SSL § 363-d and 18 NYCRR § 521.3 (c); and
- b. its compliance program is effective.

Required providers must assess their compliance programs to determine whether the required provider can certify that its compliance program is effective or is not effective.

Additionally, OMIG recommends a regular visit to its Web site to review the information and resources that are published under the Compliance tab on OMIG's home page. The Compliance Library under the Compliance tab provides copies of current forms, publications and other resources that could prove helpful in conducting a self-assessment and completing the certification form in December.

OMIG also recommends that required providers sign up for e-mail notices from OMIG by subscribing to OMIG's listserv. Anyone can become a subscriber at no cost by signing up on OMIG's home page. The listserv is a great way to keep informed of the introduction of new compliance tools and information on compliance. As additional compliance-related resources are posted by OMIG, those on OMIG's listserv will receive notices of their publication. Providers may also wish to follow OMIG on Twitter at @NYSOMIG or follow OMIG on Facebook.

If you have any questions, please contact the OMIG's Bureau of Compliance at (518) 408-0401 or by using the Bureau of Compliance's dedicated e-mail address compliance@omig.ny.gov.



Policy & Billing Guidance

Certification of Compliance with Section 6032 of the Deficit Reduction Act of 2005, Section 1902 of the Social Security Act, and Title 42 of the United States Code Section 1396a(a)(68) - *Reminder*

THIS IS A REMINDER FROM THE NEW YORK STATE OFFICE OF THE MEDICAID INSPECTOR GENERAL (OMIG) FOR ALL PROVIDERS WHO ARE SUBJECT TO THE REQUIREMENTS UNDER TITLE 42 OF THE UNITED STATES CODE SECTION 1396a(a)(68), [42 USC §1396a(a)(68)].

On December 1, 2014, OMIG will make available on OMIG's Web site, the Federal Deficit Reduction Act (DRA) of 2005 DRA Certification Form (Certification Form) for 2014.

OMIG will host a webinar in November, 2014 to explain the new 2014 certification form. Please check OMIG's listserv, Facebook page or Twitter feeds for when registration for this session will be available.

42 USC §1396a provides in relevant part that:

(a) A State plan for medical assistance must—

(68) provide that any entity that receives or makes annual payments under the State plan of at least \$5,000,000, as a condition of receiving such payments, shall—

(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1320a-7b(f) of the title;



Policy & Billing Guidance

(B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; ...

The Office of the Medicaid Inspector General addresses this mandate by monitoring a provider's certification of compliance status and conducting compliance program reviews of required providers.

The certification form and frequently asked questions (FAQs) are available on the OMIG Web site, on the Compliance landing page at <http://www.omig.ny.gov/compliance>.

If you have any questions, please contact the OMIG's Bureau of Compliance at (518) 408-0401 or by using the Bureau of Compliance's dedicated e-mail address compliance@omig.ny.gov.

Transmission of the Official Prescription Serialized Number is required for All NYS Fee-for-Service Medicaid Claims - *Reminder*

When submitting claims for prescriptions written in New York State on an Official New York State Prescription form, the serialized number from the Official Prescription **MUST** be used.

In specific situations, valid prescriptions for prescription drugs and/or supplies may still be dispensed when not written on Official New York State Prescription Forms. The table below lists some of the specific situations when this is allowed and indicates the appropriate code to be entered in **NCPDP field 454-EK** in lieu of the Prescription Serial Number:



Pharmacy Update

Code	Value
99999999	◆ Oral prescriptions
EEEEEEEE	◆ Prescriptions submitted electronically (computer to computer)*
NNNNNNNN	◆ Prescriptions for carve-out drugs for nursing home patients (excluding controlled substances)
SSSSSSSS	◆ Fiscal orders for supplies
ZZZZZZZZ	◆ Prescriptions written by out-of-state prescribers or by prescribers within the US Department of Veterans Affairs

*Prescriptions submitted electronically, that do not transmit properly or default to a facsimile, must conform to the requirements of the NYS Education Law at: <http://www.op.nysed.gov/prof/pharm/pharmelectrans.htm>. Prescriptions received by the pharmacy as a facsimile must be an original hard copy on the Official New York State Prescription Form that is manually signed by the prescriber, and that serial number must be used. Prescriptions for controlled substances that are submitted electronically but fail transmission MAY NOT default to facsimile.



Pharmacy Update

Information Regarding Prescriptions for Controlled Substances - *Reminder*

Oral Prescriptions for Schedule II and Benzodiazepines

Per 10 NYCRR Section 80.68:

In an emergency, a practitioner may orally prescribe up to a 5-day supply of a Schedule II controlled substance or benzodiazepine.

Oral Prescriptions for Schedule III, IV (excluding benzodiazepines) and V

Per 10 NYCRR Section 80.70:

A practitioner may orally prescribe up to a 5-day supply of a Schedule III or Schedule V controlled substance. A practitioner may also orally prescribe a Schedule IV (excluding benzodiazepines) controlled substance in a quantity up to a 30-day supply or 100 dosage units, whichever is less.

Faxed Prescriptions for Controlled Substances

Per 10 NYCRR Section 80.67 and 80.69:

Practitioners may fax to a pharmacy official prescriptions for controlled substances for patients enrolled in a hospice program or residing in a Residential Healthcare Facility (RHCF). **Note:** The dispensing pharmacy must have a written agreement with the hospice program or RHCF and the practitioner must indicate on the faxed prescription that the patient is a “hospice patient” or “RHCF patient”.

Practitioners may also fax to a pharmacy official prescriptions for controlled substances to be compounded for direct parenteral administration to patients.

All other faxed prescriptions for controlled substances must comply with requirements for oral prescriptions for controlled substances.

Note: A facsimile is not considered an electronic prescription. An original hard copy prescription must be manually signed by the prescriber and if issued in New York must be on an Official New York State (NYS) Prescription form. This original prescription may be transmitted by facsimile from the prescriber to the pharmacy.

Electronic Prescriptions for Controlled Substances

A practitioner may transmit an electronic prescription for controlled substances in Schedules II through V per amendments made to 10 NYCRR Part 80 Rules and Regulations on Controlled Substances, effective March 27, 2013. The practitioner and pharmacy must use a certified software application that is consistent with all federal security requirements to process electronic prescriptions for controlled



Pharmacy Update

substances. New York State regulations also require each pharmacy and practitioner to register their certified software application with the Department of Health, Bureau of Narcotic Enforcement (BNE). Please visit BNE's webpage at: http://www.health.ny.gov/professionals/narcotic/electronic_prescribing/ and http://www.health.ny.gov/professionals/narcotic/electronic_data_transmission/ for additional information.

When transmitting dispensed prescription information to the Department of Health for oral prescriptions for controlled substances, pharmacists should enter the number '9' eight times in the NCPDP field 454-EK for the prescription serial number. For faxed prescriptions, the serial number on the official prescription should be transmitted in that field. For more information on prescription serial number please view the Medicaid Update August 2014 article titled **“Transmission of the Official Prescription Serialized Number is required for All NYS Fee-for-Service Medicaid Claims”**.

Practitioners orally prescribing or faxing official prescriptions for controlled substances are required to send the original Official NYS Prescription form to the dispensing pharmacy within 72 hours.

Please refer to the current versions of the laws and regulations governing controlled substances and the official prescription forms in New York State at:
https://www.health.ny.gov/professionals/narcotic/laws_and_regulations/

New York State Medicaid Fee-for-Service Guidelines for Palivizumab (Synagis®) - Effective 10/16/14

Palivizumab is an intramuscular injection used as prophylaxis for respiratory syncytial virus (RSV). It is used in certain high-risk infants and children with histories of prematurity (35 weeks or less), chronic lung disease (CLD), or congenital heart disease. RSV is a leading cause of bronchiolitis and pneumonia in infants. Palivizumab is usually administered in five monthly doses throughout the RSV season, typically beginning in November or December. Palivizumab should not be used for the treatment of established RSV disease.



Pharmacy Update

The American Academy of Pediatrics (AAP) recently updated their guidelines to identify infants and children who should be considered for RSV prophylaxis. One major change was that Palivizumab prophylaxis is not recommended in the second year of life except for children who require at least 28 days of supplemental oxygen after birth and who continue to require medical intervention (supplemental oxygen, chronic corticosteroid or diuretic therapy).

Consistent with the Drug Utilization Review (DUR) Board's recommendation in December, 2010 to follow AAP guidelines regarding RSV prophylaxis, the Department will be changing the age maximum for prescriptions that will not require prior authorization from children less than two (2) years to children less than one (1) year of age at the onset of RSV season. Criteria for approval will include an exception for those infants in the second year of life requiring at least 28 days of supplemental oxygen after birth and who continue to require medical intervention (supplemental oxygen, chronic corticosteroid or diuretic therapy).

A full review of the guidelines will be conducted at a future DUR Board meeting.

Ordering, Prescribing, Referring, Attending (OPRA) Prescription Requirements for Unlicensed Providers

In December 2013, New York State (NYS) Medicaid issued a Special Edition (Vol.29, No.13) of the Medicaid Update to provide enrollment requirements and guidance for all OPRA servicing/billing providers: http://www.health.ny.gov/health_care/medicaid/program/update/2013/dec13_muspec.pdf

The purpose of this article is to provide an update regarding OPRA prescription requirements for unlicensed residents, interns and foreign physicians in training.

- NYS Medicaid recognizes prescriptions written by providers legally authorized to prescribe per NYS Education Law Article 131 Section 6526 and 10 NYCRR 80.75(e). This includes unlicensed residents, interns and foreign physicians in training programs, under the supervision of a NYS Medicaid enrolled physician.



Pharmacy Update

- In accordance with NYS Education Law, NYS Medicaid does NOT require the name and signature of the supervising physician to be included on the prescription. However, in order to enable billing by the dispensing pharmacy, prescriptions written by unlicensed residents must include the NPI of the supervising/attending physician who is enrolled in Medicaid (see last bullet point below regarding billing requirements).
- NYS Medicaid only enrolls licensed providers. As a result, unlicensed residents, interns or foreign physicians in training programs are not eligible for enrollment as NYS Medicaid providers.
- Effective January 2014, NYS Fee-For-Service (FFS) Medicaid implemented claims editing that enforced the OPRA requirement for healthcare professionals, practice managers, facility administrators, and servicing/billing providers. Therefore, pharmacy claims for services ordered by unlicensed residents, interns and foreign physicians in training programs reject when initially submitted for payment.

The following options are available to pharmacies, to enable payment:

- Resubmit the claim, using the National Provider Identifier (NPI) of the enrolled NYS Medicaid provider (the intern or resident's supervising physician).
- In the event the NPI number of the supervising physician cannot be obtained, or the pharmacy's billing system is limited to submitting only one prescriber NPI number, then use the "Urgent/Emergency Override Option" (outlined below).

Directions for the urgent/emergency override option:

- If you have a prescription written by an unlicensed resident, intern or foreign physician in a training program you will receive a reject code of "56" via NCPDP transaction stating the provider has a non-matched Prescriber ID listed in NCPDP field number 511 -FB. For claims prescribed by unlicensed residents interns or foreign physicians in training programs, pharmacies are allowed to provide the medication and receive reimbursement by resubmitting the claim using the following emergency override procedure:
- In the Reason for Service Code Field (439-E4) also known as the Drug Utilization Conflict Field – enter "PN" (Prescriber Consultation)
- In the Result of Service Code Field (441 -E6) – enter one of the following applicable values (**1 A, 1 B, 1 C, 1 D, 1 E, 1 F, 1 G, 1 H, 1 J, 1K, 2A, 2B, 3A, 3B, 3C, 3D, 3E, 3F, 3G, 3H, 3J, 3K, 3M, 3N, or 4A**)
- In the Submission Clarification Code Field (420-DK) also known as the Drug Prescription Override Field – enter "02" (Other Override)

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



Pharmacy Update

Medicaid Fee-for-Service (FFS) Emergency Services Coverage

Coverage will **not** be extended for medications when the federal definition of an "emergency medical condition" is not met. Drugs **not** included in "emergency services coverage" **will not change based on the type of facility at which a patient receives their prescription.**

Medicaid FFS does **not** reimburse all covered drugs for patients whose coverage is deemed as "emergency services only".

Medicaid coverage may be available for care and services that were necessary for the treatment of an "emergency medical condition". Per federal regulation the term emergency medical condition is defined as; after sudden onset, a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- (a) placing the patient's health in serious jeopardy;
- (b) serious impairment to bodily functions; or
- (c) serious dysfunction of any bodily organ or part.

Patients whose drug coverage is limited may receive a pharmacy reason response of "Patient is Not Covered", for drugs that do not meet the definition of "emergency medical condition". Providers can then verify if a patient has coverage for "emergency services only", based on the reason response, by performing an eligibility request on ePACES; found under the eMedNY Tools Center at: <https://www.emedny.org/index.aspx>. The Eligibility Response for these patients will return, "emergency services only".

Provided below is a link to the Department of Health's MRT webpage where you can access background information and communication about this initiative and a list of emergency services covered drugs (scroll to the bottom of the page).
http://www.health.ny.gov/health_care/medicaid/redesign/supplemental_info_mrt_proposals.htm



Pharmacy Update

Please note-

- Short acting narcotics should only be written for **an emergency 5 day supply**.
- HIV prophylaxis therapy following occupational exposure & non occupational exposure (sexual assault) can be obtained via an exception process by following the procedure below.

Override Requests: Exception/override requests require a letter of medical necessity written by the patient's physician, providing rationale as to why this request meets the federal definition of an emergency medical condition as described above for the following medication(s). Please title request "emergency services only," and send to the ppno@health.ny.gov mailbox or fax in to 518-473-5508, for review by a Medical Director.

If an exception is made both the physician and the pharmacy will be contacted. Both parties will also receive written documentation for their records notating the approved drug and timeframe.

Pharmacies should not attempt to override this edit unless they have been contacted by the Department & have received an approval letter. Office of Medicaid Inspector General (OMIG) will be reviewing claims information for compliance to the initiative.

For questions on this policy providers may e-mail the pharmacy mailbox at: ppno@health.ny.gov, or call (518) 486-3209. For questions on performing eligibility request on ePACES, providers may contact Computer Sciences Corporation at (800)-343-9000.

Attention Prescribers: Final e-Prescriber Payments to be Issued by eMedNY

The New York State 2014-15 Budget (Section 6 of Part C of Chapter 60 of the Laws of 2014), repealed the authorization of incentive payments to eligible pharmacies and medical practitioners for approved ambulatory Medicaid e-prescriptions effective April 1, 2014.

Incentive payments covering e-prescriptions through the fourth quarter of calendar year 2013 have been sent to providers.

In Cycle 1932 (check dated 09/01/2014, release/mail date of 09/17/2014), the **final** e-Prescriber incentive payments covering the first quarter of calendar year 2014 will be issued by eMedNY. Payments will appear as a financial transaction (lump-sum payment) on the provider's Medicaid remittance statement. Paper remittances will have an additional identifier of "LSE" to indicate an e- Prescribing payment.

Questions can be directed to the eMedNY Call Center at 800-343-9000.



All Providers

NY Medicaid Electronic Health Records (EHR) Incentive Program Update

The NY Medicaid EHR Incentive Program provides financial incentives to eligible practitioners and hospitals to promote the transition to EHRs. Providers who practice using EHRs are in the forefront of improving quality, reducing costs, and addressing health disparities. Since December 2011 **over \$600.2 Million** in incentive funds have been distributed **within 14,804** payments to New York State Medicaid providers.

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Taking a closer look: Program introduces NY Medicaid Enrollment Education!

Healthcare Practitioners wanting to participate in the NY Medicaid EHR Incentive Program must meet all eligibility requirements and program prerequisites. One of the program prerequisites is to be enrolled as a Fee-For-Service (FFS) provider in NY Medicaid.

Additionally, groups, clinics and institutions that are receiving incentive payments from eligible professionals (EP) participating in the NY Medicaid EHR Incentive Payment Program must be enrolled as NY Medicaid FFS providers.

GROUP PROVIDER ENROLLMENT

<https://www.emedny.org/meipass/ep/enrollment/group.aspx#g1=g1-a>

NY Medicaid EHR Incentive Program

INDIVIDUAL PROVIDER ENROLLMENT

<https://www.emedny.org/meipass/ep/enrollment/individual.aspx#g1=g1-a>

Emedny.org/meipass

The NY Medicaid EHR Incentive Program website now offers step-by-step enrollment work aids for both individuals and organizations. Above are some helpful links to assist providers looking to enroll in NY Medicaid, check them out!

For one-on-one support contact Program Support Team at 1-877-646-5410 Option #1.



Provider Directory

Office of the Medicaid Inspector General:

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

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

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

Providers wishing to listen to the current week's check/EFT amounts:

Please call (866) 307-5549 (available Thursday PM for one week for the current week's amount).

Do you have questions about billing and performing MEVS transactions?

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

Provider Training:

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

Enrollee Eligibility:

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

Medicaid Prescriber Education Program:

For current information on best practices in pharmacotherapy, please visit the following websites:
http://www.health.ny.gov/health_care/medicaid/program/prescriber_education/presc-educationprog
<http://nypep.nysdoh.suny.edu/home>

Need to change your address? Does your enrollment file need to be updated because you've experienced a change in ownership? Do you want to enroll another NPI? Did you receive a letter advising you to revalidate your enrollment?

Visit www.emedny.org/info/ProviderEnrollment/index.aspx and choose the link appropriate for you (e.g., physician, nursing home, dental group, etc.).

Medicaid Electronic Health Record Incentive Program questions?

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