



Medicaid Update

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New York Medicaid Leads the Nation Supporting People with Alzheimer's Disease and Other Dementias (AD/D) and their Caregivers

Implementing evidenced-based practices improves quality and reduces cost

It is estimated that over 5.3 million Americans are currently living with AD/D, which costs the nation about \$226 billion in 2015. Due to the major rise in prevalence with an aging population, this emerging issue is gaining national attention. The quality of life for people affected is not the only problem to consider; the lives of caregivers for the patients is significantly impacted as well, further contributing to costs. It is predicted that if something dramatic is not done, by 2050 there will be over 13.8 million Americans with AD/D, with approximately \$1.1 trillion in national spending.

Alzheimer's Disease in New York State

There are over 380,000 people living with AD/D in the state of New York. About 30% of this population, or 114,489 individuals, are recipients of Medicaid, which account for some of the largest per-person Medicaid expenses. In 2014 alone, New York Medicaid spent a combined \$1,619,136,370 in medical, home and community-based services, and nursing home costs for people with AD/D.

Alzheimer's disease is recognized as the most feared and costly of chronic diseases. One recent study estimated that per-person Medicaid spending is 19 times higher for people with AD/D than for those without. One reason for the high cost is that people with AD/D are 5.5 times more likely to have six or more chronic conditions than a similar person without AD/D. The presence of AD/D with another chronic disease increases the cost dramatically.

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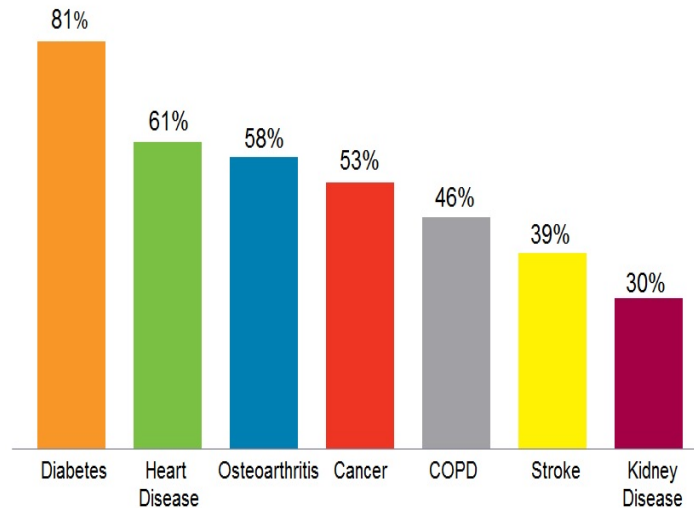
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Higher Cost Due to AD/D

Average increase in costs for person with AD/D vs. similar person with only the other condition.



Source: 2015 Alzheimer's Association Facts and Figures

New York State also has an estimated 1 million unpaid caregivers for this population of AD/D and other dementias patients. These caregivers provide 1.1 billion hours of unpaid care with an estimated value of \$14 billion. Twenty-five percent of this care is considered “constant,” where the caregivers are providing at least 40 hours of care each week. Providing care for individuals with AD/D has resulted in an estimated \$771 million in higher health care costs for the New York State caregivers.

New York State Alzheimer's Disease Support Initiative

Based on the extreme growth in prevalence of the disease, as well as the enormous cost burden, New York State's new support initiative is of utmost importance in this critical time. Starting earlier this year, the State began this evidenced-based initiative to provide a wide range of comprehensive and coordinated patient and caregiver services from early detection and management of co-occurring conditions to caregiver education and support services throughout the State. Goals for this initiative include reducing preventable emergency department visits and hospitalizations for individuals with AD/D, continuing community residence and reducing institutionalization of those diagnosed with AD/D, and also improving the health and well-being of caregivers and individuals with AD/D.

Through this first-in-the-nation initiative, New York State will be able to effectively support the vulnerable population through support strategies that alleviate the caregiver burden, enhance the quality of lives for both the caregiver and the individual with AD/D, reduce institutional placement for the patient and, therefore, lower healthcare costs. Recent studies have shown that this initiative is capable of achieving great success in improving the lives of the affected individuals and reducing the heavy cost burden.

Based on the Science

Through extensive research, Mary Mittelman and colleagues at New York University School of Medicine, among others, have found that greater access to early detection, counseling and support services, similar to those in the New York State Alzheimer’s Disease Caregiver Support Initiative, will result in benefits to people with Alzheimer’s disease and their caregivers.

Over the course of the 9.5 years of Mittelman’s randomized controlled trial study, spouse caregivers of Alzheimer’s disease patients received interventions consisting of individual and family counseling, support group participation, and telephone counseling. Results showed that when compared to the controls, people with dementia whose caregivers received the intervention experienced a reduced rate of 28.3% in nursing home placement. The reduced rate of nursing home placement equated to 557 days of additional time in the community for the people with dementia, all while maintaining a good quality of life. This strategy is positive for caregivers as well, providing improved social support and response to patient behavior, resulting in reduced symptoms of depression, lower stress levels and lower risk for developing chronic disease. Another paper published in August 2015 by the Alzheimer’s Association notes that one in four people with Alzheimer’s disease experience preventable hospitalization, and recommends strategies to address this issue that also resembles the New York approach.

The New York State Alzheimer’s Disease Support Initiative incorporates strategies that have been recognized as effective. Request for Applications have been conducted to fund caregiver support and training and Centers of Excellence; announcements of these resources are expected very soon and will be widely shared. Meanwhile, many of these services are available through the already implemented expansion of evidenced-based practices in the Alzheimer’s Disease Community Assistance Program and the Alzheimer’s Disease Assistance Centers (precursors to Centers of Excellence). Contact information for these and other resources are available at <http://www.health.ny.gov/diseases/conditions/dementia/>.

Office of Health Insurance Programs staff is working with experts at the University at Albany School of Public Health to implement a comprehensive evaluation of this project to identify ways to maximize the benefit to the people served. By making evidence-based services available throughout the State, expected results include a decrease in avoidable hospitalizations, delayed institutionalization, and improved caregiver outcomes.

Alzheimer’s Association. *2015 Alzheimer’s Disease Facts and Figures*. Retrieved from <http://www.alz.org/facts/overview.asp>; Accessed October 2, 2015.

Mittelman, M.S., Haley, W.E., Clay, O.J., & Roth, D.L. (2006). Improving Caregiver Well-Being Delays Nursing Home Placement of Patients with Alzheimer’s Disease. *Neurology*, 67(9), 1592-99.

Attention Prescribers

New York State Women, Infants, and Children (WIC) Program Soy Formula Change

Effective July 1, 2016, there will be a change to the standard soy-based infant formula offered by the New York State WIC Program.

For WIC participating infants under your care who are not being fully breastfed, please continue to prescribe Mead Johnson Enfamil Infant, which is the primary milk-based WIC formula. Enfamil Gentlease, Enfamil AR, and soy-based infant formula are also available upon the request of the parent or caregiver. On July 1, 2016, Gerber Good Start Soy will replace Enfamil ProSobee as the New York State WIC soy-based infant formula. Special formulas will continue to be available with appropriately documented medical and nutritional need.

For children over the age of one with special nutritional needs, standard and special formulas will continue to be available with appropriately documented medical and nutritional need.

Please refer to the New York State WIC Program's Formulary which can be found at: https://www.health.ny.gov/prevention/nutrition/wic/approved_formulas.htm.

If you have questions or need additional information, please contact the local WIC office in your area: https://www.health.ny.gov/prevention/nutrition/wic/local_agencies.htm

The following table summarizes the new soy formula changes:

Table with 2 columns: Removed from the WIC Formulary June 30, 2016 and Added to the WIC Formulary July 1, 2016. It lists the replacement of Enfamil ProSobee (Powder, Concentrate, and Ready-to-Use) with Gerber Good Start Soy (Powder, Concentrate, and Ready-to-Use).

New York Medicaid Management Information System (NYMMIS) Training Update

Training for NYMMIS is available now in instructor-led and webinar formats via the interim NYMMIS website. The courses currently offered are:

- Introduction to NYMMIS: Features and Functionality
- Introduction to Provider Enrollment

NYMMIS Computer-Based Trainings (CBTs) will be accessible in May 2016 via the new Learning Management System (LMS). The LMS is an online training repository for CBT videos and supporting materials that providers can access directly from their own computer with internet access. Registration for LMS will be available in May 2016; instructions will be available on the interim website at www.interimNYMMIS.com.

Visit the interim NYMMIS website at www.interimNYMMIS.com to register for a training session and to access the course schedule. Additional information and updates will also be included in future *Medicaid Updates*.

Essential Plan Coverage

Effective January 1, 2016, the Essential Plan (EP) became effective for consumers who are ineligible for Medicaid or Child Health Plus, and do not have access to affordable employer coverage. The Patient Protection and Affordable Care Act of 2010, provides states with the option to establish a Basic Health Program (BHP). The BHP offers health coverage for individuals with family incomes between 138-200% of the federal poverty level (FPL). In New York, the program has been named Essential Plan.

New York State also secured approval from the Centers for Medicare and Medicaid to include adult immigrants, aged 21-64 who are not pregnant, with family incomes from 0-138% of the FPL who are lawfully present in the United States, but do not qualify for Medicaid due to their immigration status. As a result of the Aliessa Court of Appeals decision, these immigrants are also entitled to additional services that are not available through the EP. Most services, including vision and dental benefits, will be provided through the EP benefit package. Aliessa immigrants will also be able to access non-emergent transportation and out-of-network family planning services on a fee-for-service (FFS) basis from providers who accept Medicaid, using a Common Benefit Identification Card (CBIC). Aliessa immigrants will have two cards, a CBIC and a plan identification card, which will indicate their EP enrollment.

When verifying eligibility, for the Aliessa population through their CBIC, the eligibility response will be **“EP-FAMILY PLANNING AND NON EMERG TRANS ONLY”**. This is because only these two services are accessed using the CBIC. Family planning and non-emergent transportation services should be submitted for reimbursement on a FFS basis. Additionally, appropriate hospital providers may also submit claims for Graduate Medical Education, for the Aliessa population, on a FFS basis. All other EP services will be accessed and verified through their EP.

All other EP enrollees who are between 138% FPL and 200% FPL, will receive benefits utilizing their EP plan identification card. All plans must include ten essential health benefits, as follows.

1. Ambulatory patient services (out-patient care);
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services (those that help patients acquire, maintain, or improve skills necessary for daily functioning) and devices;

8. Laboratory services;
9. Preventative and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

General EP questions, including health plan benefits and services, can be submitted to nyhxpm@health.ny.gov. For questions regarding the Aliessa population, please call 518-473-7541

All Providers

New York State of Health (NYSoH) Updated Provider Contacts

Providers servicing NYSoH Medicaid consumers in need of Recipient Restriction changes, Exception coding to allow Medicaid payment for case management services, Exclusion coding, or who experience certain life changing events can now utilize our updated points of contact.

NYSoH Medicaid recipients are identified in ePACES with H78 displayed in the Office field.

NYSoH Restrictions

Fee-For-Service (FFS) Individuals active in Recipient Restriction Program looking to change restricted providers. Individuals enrolled in managed care must contact the plan to request change.

hxrestrict@health.ny.gov ****(518) 560-4775 voice** ****(518) 474-4959 fax**

NYSoH Exceptions

Individuals in receipt of Comprehensive Medicaid Case Management Services including but not limited to Early Intervention. Submission of case management entry requests.

hxexcept@health.ny.gov ****(518) 560-4775 voice** ****(518) 474-4959 fax**

NYSoH Exclusions

Individuals participating in Residential Rehabilitation Services for Youth (RRSY). Submission of admission/discharge notices.

hxexclusions@health.ny.gov ****(518) 560-4775 voice** ****(518) 474-4959 fax**

NYSoH Level of Care Transitions

Individuals in need of certain services that are not available on NYSoH. Services include Managed Long Term Care, adults or children in need of Waiver Services, FFS Personal Care, FFS short term (up to 29 days) rehabilitation, all consumers (FFS or managed care) in need of long term (permanent placement) in nursing home, Intermediate Care Facility, Congregate Care Facility, Foster Care Home Managed Care disenrollments, Medicaid Buy-in Program for Working People with Disabilities and Medicare Savings Program requiring Medicare enrollment.

hxfacility@health.ny.gov (518) 473-6397 voice (518) 474-9062 fax

Questions may be referred to the Office of Health Insurance Programs, Bureau of Medicaid Eligibility and Marketplace Integration at (518) 473-6397.

**** indicates updated contact number**

All Providers

NY MEDICAID EHR INCENTIVE PROGRAM UPDATE

The NY Medicaid Electronic Health Record (EHR) Incentive Program provides financial incentives to eligible professionals 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 \$757 million** in incentive funds have been distributed **within 23,104** payments to New York State Medicaid providers.

23,104 Payments	\$757+ Million Paid	Are you eligible?
For more information, visit www.emedny.org/meipass		

Did you know?

2016 is the last year that eligible professionals (EPs) may begin participating in the Medicaid EHR Incentive Program. EPs may receive up to \$63,750 over the course of six years for the adoption and meaningful use of certified EHR technology.

2016 attestations for Adopt, Implement, or Upgrade (AIU) are available in [MEIPASS](#). For step-by-step guidance, please review the [AIU walkthrough](#) or contact the support team at 877-646-5410 Option 2.

Pre-Validation Services

Have you already determined your Medicaid patient volume? Eligible professionals may submit their data prior to attesting for preliminary review. Pre-validation prior to submitting the complete attestation may subsequently reduce the time of State review.

To process your request, please complete the appropriate pre-validation template and email it to hit@health.ny.gov.

- [Individual EP Pre-Validation](#)
- [Group EPs Pre-Validation](#)

Meaningful Use Attestations

NY Medicaid is not ready to accept 2015 or 2016 attestations for Modified Stage 2 Meaningful Use (MU). An extended deadline for 2015 MU attestations will be determined, and announcements will be made via [LISTSERV](#) and the [program website](#).

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

Medicaid Expands Coverage for Screening, Brief Intervention, and Referral to Treatment (SBIRT)

This Guidance Supersedes Guidance Published in June 2011

Medicaid currently covers SBIRT services for all Medicaid beneficiaries who are 12 years of age and older in hospital outpatient and emergency departments; free-standing diagnostic and treatment centers (D&TCs), including School-Based Health Centers (SBHCs) and services provided by office-based primary care practitioners. Reimbursement in other clinic settings, including clinics licensed or operated by the Office of Mental Health (OMH) or the Office of Alcoholism and Substance Abuse Services (OASAS) is also available.

What is SBIRT? SBIRT is an evidence-based practice model which has proven to be successful in modifying the consumption/use patterns of at-risk substance users, and in identifying individuals who need more extensive, specialized treatment. SBIRT is a comprehensive, integrated, public health approach that provides opportunities for early intervention before more severe consequences occur. Evidence-based tools that are demonstrated to be valid and reliable in identifying individuals with problem use or at risk for a Substance Use Disorder (SUD) must be used.

PRE-SCREENING: All patients who are 12 years of age or older should be asked prescreening questions to assess their level of alcohol and substance use. Patients whose alcohol use fall within moderate limits and drug tests screen negative should be encouraged and advised that their abstinence or low level of substance use will help them to maintain good health. Patients who screen positive on the pre-screen should be given the full screen.

SCREENING: The full screening tools identify substance use/abuse risk and the appropriate level of intervention for indicated individuals. Providers must explain the screening results to the patient face-to-face and, if the patient has screened positive, it is best practice if the provider can deliver or obtain on-site brief intervention services for the patient within the same visit.

OASAS has a list of evidence-based alcohol and substance use screening instruments available online at: <http://www.oasas.ny.gov/AdMed/sbirt/index.cfm>. Providers may propose to OASAS another evidence-based screening instrument that is not included on the list if 1) the instrument has been imperially validated in peer reviewed research article 2) it has clearly defined cutoffs between positive and negative screens and 3) the instrument is simple enough to be administered by a wide range of health care professionals. Requests for review of alternate screening instruments may be emailed to: SBIRTTY@oasas.ny.gov.

BRIEF INTERVENTION

Brief intervention services are appropriate for individuals who are identified through SBIRT screening as being at risk for a SUD. A brief intervention is a single or multiple session preventive health procedure conducted during the same visit as the screening and at follow-up visits, if necessary. It incorporates effective counseling and prevention strategies intended to motivate individuals to decrease or abstain from alcohol or drug use by increasing insight and awareness of substance use. New York does not endorse a specific approach, however, providers are required to use effective strategies for intervention and counseling services, e.g. Brief

Negotiated Interview (BNI); <http://www.bu.edu/bniart/sbirt-in-health-care/sbirt-educational-materials/sbirt-brief-intervention/> (Engagement/ build rapport, pros and cons of substance use, provide information/feedback on their substance use, assess readiness to change, and develop an action plan); FRAMES (give patient Feedback on their substance use, patient is Responsible for change, offer Advice about risks associated with substance use, provide a Menu of options for change, respond with Empathy, and increase patient's Self-efficacy).

Effective strategy examples are available online through the Substance Abuse and Mental Health Services Administration (SAMHSA) Web site at: <http://www.integration.samhsa.gov/clinical-practice/sbirt/brief-interventions> and the National Institutes of Health (NIH):

"Helping Patients Who Drink Too Much," A Clinician's Guide (Updated 2005) at: <http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&cad=rja&uact=8&ved=0CCQQFjABahUKEwioqZ7Cml7JAhWCHD4KHZsDB7g&url=http%3A%2F%2Fpubs.niaaa.nih.gov%2Fpublications%2FPractitioner%2FCliniciansGuide2005%2Fguide.pdf&usq=AFQjCNGznR0IXNj9oSs6iVPv7Z0RsTZMSA>

REFERRAL TO TREATMENT

SBIRT has been effective in identifying individuals who should be referred to specialized SUD treatment for further assessment and a level of care determination. Assessment of SUD and level of care determinations are comprehensive processes that are not part of SBIRT and should be done by those who have specialized training.

For individuals who screen at high risk for SUD, SBIRT can be appropriately used to motivate the individual to accept a referral to a treatment program. SBIRT also supports the health care practitioner by ensuring that a referral network is established for those patients who need more extensive, specialized treatment from an appropriate, OASAS-certified treatment program, or appropriate practitioners with specialty training in SUD. Any provider proposing to implement SBIRT must have at least one current referral agreement with an accessible OASAS-certified treatment provider to meet the needs of individuals who require such referrals.

PROVIDERS REIMBURSED UNDER MEDICAID

Licensed practitioners must complete an OASAS approved SBIRT training of at least four hours; however, if the licensed practitioner holds certification as indicated in Table 1 or 2, then the training is recommended, but not required. Licensed practitioners who do not hold certification as indicated in Table 1 must complete four hours of OASAS approved SBIRT training to bill for SBIRT services. Health educators and unlicensed practitioners must complete at least 12 hours of training facilitated by an OASAS approved SBIRT training provider *prior* to offering SBIRT services.

Providers listed in Table 1 may bill for SBIRT directly. Providers listed in Table 2 may not bill Medicaid independently for the services, however, they may bill Medicaid under the provider number of a licensed provider listed in Table 1.

Table 1: Provider types eligible to bill for office-based SBIRT services

Provider Type	Required OASAS Approved Training/Certification
Physicians (services may be performed by another provider type under the supervision of the physician)	4 hours, unless certified by the American Society of Addiction Medicine (ASAM); the American Board of Ambulatory Medicine (ABAM); the American Academy of Addiction Psychiatry (AAP) or the American Academy Osteopathic Association (AOA)
Nurse Practitioners	4 hours, unless qualified as a Certified Addictions Registered Nurse (CARN)
Nurse Midwives	4 hours
Psychologists	4 hours

Table 2: Provider types eligible to perform SBIRT and bill under a licensed provider (Includes provider types listed in Table 1).

Provider Type	Required Training/Certification
Physician Assistants	4 hours
Registered Nurses	4 hours, unless qualified as a CARN
Licensed Practical Nurses	4 hours
Licensed Master Social Worker (LMSW) or Licensed Clinical Social Worker (LCSW)	4 hours
Licensed Mental Health Counselors	4 hours
Licensed Marriage and Family Therapist	4 hours
Certified School Counselor	4 hours
Certified Rehabilitation Counselor	4 hours
OASAS-credentialed professionals including Credentialed Alcoholism and Substance Abuse Counselors (CASACs), Credentialed Prevention Professionals (CPPs) and Credentialed Problem Gambling Counselors	4 hours
Medical residents, Medical interns and licensed professionals who have graduated but who have not yet taken/passed their licensing exam.	4 hours
Health Educators and unlicensed individuals* (may only provide SBIRT services under the supervision of a licensed health care professional, following consistent protocols)	12 hours

* Health Educators and unlicensed individuals must have at least a high school diploma or GED and knowledge of alcohol and other drug use, which may be demonstrated through the recommended training, to be considered a qualified provider.

Additional information on OASAS approved SBIRT training providers is available on the OASAS Web site at: <http://www.oasas.ny.gov/training/providers.cfm>

DOCUMENTATION REQUIREMENTS

Patient records must include:

- Information on the service provided, i.e. screen or brief intervention;
- Name of screening instrument , and score on the screening instrument;
- Whether the screen was positive or negative;
- Start/stop time or face-to-face time spent with patient;
- Whether goals were developed;
- If a follow-up appointment was made; and
- If a referral to an SUD program was made.

Providers are required to retain documentation that personnel performing SBIRT meet the OASAS required training, education and supervision requirements.

SUPERVISION

Unlicensed providers must be supervised by a licensed health care professional listed in Table 1 and must follow established written or electronic protocols for evidence-based practice during the delivery of screening and intervention services. Protocols must be consistently followed and a licensed health care professional listed in Table 1 must ensure that quality assurance procedures are in place.

MEDICAID FEE-FOR-SERVICE (FFS) BILLING GUIDELINES

SBIRT may be billed to Medicaid using the following Healthcare Common Procedure Codes System (HCPCS) procedure codes. The claim will require a diagnosis code. Commonly used diagnosis codes are:

H0049 (alcohol and/or drug screening)	Z13.9 (Encounter for screening, unspecified)
H0050 (alcohol and/or drug service, brief intervention)	Z71.41 - Alcohol abuse counseling and surveillance of alcoholic
H0050 (alcohol and/or drug service, brief intervention)	Z71.51 - Drug abuse counseling and surveillance of drug abuse

Physicians and other health care practitioners listed in Table 1 may bill directly for SBIRT in authorized practice settings. SBIRT services do not require prior authorization or copayment under Medicaid FFS.

Medicaid patients who are seen in hospital outpatient and emergency departments, free-standing D&TCs including SBHCs and office-based primary care practitioners may receive SBIRT services from any of the practitioners listed in Table 1 or Table 2. Payment in these settings is calculated as part of the established ambulatory payment group (APG) methodology.

COVERAGE LIMITS

Medicaid FFS will reimburse for two screenings and six brief intervention sessions per year. The screenings may be provided by the same provider, or by different providers and at different locations. It is best practice that the first brief intervention session be provided during the same visit as the screening with follow up sessions scheduled as necessary. Medicaid Managed Care must also allow two screenings per calendar year in the allowable reimbursable settings without prior authorization. Plans may apply medical necessity criteria for SBIRT screenings beyond the two screening limit. Plans are responsible for up to six brief intervention sessions per calendar year, irrespective of provider, without prior approval. Plans may establish prior authorization requirements for additional brief interventions in order to assess whether further brief interventions or a referral for a formal chemical dependency assessment would be medically appropriate. Enrollees who receive a screening and initial intervention in an out-of-network emergency department may be required to receive subsequent interventions from an in-network provider.

Percutaneous Coronary Intervention (PCI) Update

The New York State Medicaid program’s policy seeking to recover reimbursement for “inappropriate”/“rarely appropriate” percutaneous coronary intervention (PCI) procedures performed on patients without acute coronary syndromes (ACS) or prior coronary artery bypass graft (CABG) surgery has been discontinued at this time. Please note that the New York State Department of Health (the Department) will continue to review data to identify and monitor PCI procedures that are potentially “inappropriate”/“rarely appropriate.”

In response to a recommendation from the Medicaid Redesign Team (MRT) Basic Benefit Workgroup, Medicaid fee-for-service (FFS) and Medicaid managed care (MMC) implemented an initiative in July 2013 that sought to reduce the rate of inappropriate PCI procedures. In conjunction with the Department’s Cardiac Services Program, the Department began reviewing data derived from compiled clinical information submitted by hospitals for Medicaid FFS and MMC members who underwent PCI procedures. Using the [Appropriate Use Criteria \(AUC\) for Coronary Revascularization](#) released in *The Journal of the American College of Cardiology* (Vol. 59, No. 9, February 28, 2012), Medicaid PCI procedures performed on patients without acute coronary syndromes or prior coronary artery bypass graft surgery (no ACS/no prior CABG) were stratified into one of the three levels of appropriateness. Providers performing PCIs that were determined to be “inappropriate”/“rarely appropriate” were subject to potential recoupment of reimbursement.

This initiative was based on PCI data from 2010 showing almost 16% of Medicaid PCIs performed on patients with no ACS/no prior CABG were inappropriate by AUC criteria. Ongoing data analysis has shown improvement. From 2010 to 2014, the percentage of inappropriate PCIs performed on patients with no ACS/no prior CABG dropped significantly from almost 16% to 6.8%. As a result of this improvement, while the Department will continue to monitor PCI data, recovery of reimbursement for PCI procedures performed on patients with no ACS/no prior CABG and confirmed as inappropriate has been suspended. No retroactive or prospective recoveries will be pursued at this time.

The Department reserves the right to reinstitute its policy to recover reimbursement for “inappropriate”/“rarely appropriate” PCIs at a later date.

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

eMedNY Corrections to Reimbursement Methodology for Physician Administered Drugs Provided to Medicare/Medicaid Dually Eligible Individuals

In accordance with changes to social services law, effective July 1, 2015 Medicaid began adjusting Medicare Part B coinsurance amounts to insure that the total Medicare/Medicaid payment to a provider did not exceed the amount that the provider would have received for a Medicaid-only patient. If the Medicare payment was greater than or equal to the Medicaid fee, no additional payment was made.

When the department implemented these reimbursement changes in January 2016, retroactive to July 1, 2015, there was an inadvertent error with the crossover logic in eMedNY. The error resulted in a higher reduction than originally intended for some physician administered drugs. System corrections are scheduled to be implemented late April 2016. Full payment for the Medicare Part B coinsurance amount for physician administered drugs will be retroactive to July 1, 2015. Claims processing will be automated; affected providers do not need to submit claim adjustments to receive the full Part B payment.

Questions on this matter may be directed to the Division of Program Development and Management at 518-473-2160.

Further Payment Reductions on Elective Delivery (C-Section and Induction of Labor) Less than 39 Weeks without Medical Indication

This is an update to the April 2015 *Medicaid Update* article “Payment Reductions on Elective Delivery (C-Section and Induction of Labor) less than 39 Weeks without Medical Indication.” This article notified providers that Medicaid Fee-For-Service (FFS) and Medicaid Managed Care (MMC) increased the reduction of payments for elective deliveries (both C-section and inductions of labor) under 39 weeks gestation, unless an acceptable medical indication was provided.

Effective April 1, 2016 and July 1, 2016, respectively, Medicaid FFS and MMC will further reduce payment for early elective deliveries without an acceptable medical indication. Claims for elective deliveries prior to 39 weeks, without medical indication, will be reduced by **50%**. The increased penalty reflects the Medicaid program’s commitment to providing high quality prenatal care by ensuring appropriate delivery for both mothers and babies.

The Department has become aware of claiming issues related to early elective deliveries resulting from the ICD-10 transition in October 2015. To address these issues, the Department will release updated guidance, including ICD-10 procedure codes and ICD-10 diagnosis codes, for billing deliveries. In the interim, providers should continue to follow the claiming guidance outlined in the [June 2013](#), [June 2014](#), and [April 2015 Medicaid Update](#) articles, and the [October 1, 2015](#) and [December 24, 2015](#) provider communications.

Medicaid FFS policy questions may be directed to the Office of Health Insurance Programs, Division of Program Development and Management at (518) 473-2160.

Medicaid FFS claiming questions may be directed to the eMedNY Call Center at (800) 343-9000.

MMC implementation questions may be directed to the enrollee’s MMC plan.

Use of an Electronic Prescribing Exception *Practitioner Reporting Requirement*

There are a number of exceptions to the electronic prescribing mandate which allow a practitioner to issue an Official New York State Prescription (ONYSRx) form, an oral prescription or a facsimile of a manually signed ONYSRx in lieu of an electronic prescription.

The Public Health Law requires that each time a practitioner uses one of the exceptions listed below, the practitioner must report the use of this exception to the Department of Health (DOH) within the required timeframe.

- Exceptions listed in Public Health Law §281(3)(b), (d) and (e) and their notification deadlines are as follows:
 - Temporary technological failure (notify as soon as practicable, but no more than 72 hours following the end of temporary failure);
 - Temporary electrical failure (notify as soon as practicable, but no more than 72 hours following the end of temporary failure);
 - To be dispensed by a pharmacy located outside the State or on federal property, including and not limited to the following examples; Veterans Administration, West Point, Fort Drum, and Indian Reservations (notify within 48 hours of the date of issue); and
 - The practitioner reasonably determines that it would be impractical for the patient to obtain substances prescribed by electronic prescription in a timely manner, and such delay would adversely impact the patient's medical condition (notify within 48 hours of the date of issue).

Note: A practitioner that has been granted a waiver from electronic prescribing or is covered under the exceptions listed in the blanket waiver is NOT required to notify DOH.

Practitioners should email the use of an exception for a controlled or non-controlled substance prescription to the following email address and provide the required information.

1. The email address is: erx@health.ny.gov
2. The practitioner's email notification to DOH should include the following and be sent within the required timeframe:
 - That it is a notification to DOH pursuant to Public Health Law §281 (4) or (5);
 - Practitioner's name;
 - Practitioner's license number;
 - Practitioner's telephone number;
 - Practitioner's preferred work email address;
 - Practitioner's work address;
 - Patient initials only (Do NOT send patient confidential information); and the reason(s) for the exception(s), including the citation(s) to PHL Section(s) 281 (3)(b), (d), and (e).

Note: This email may contain multiple practitioners and/or prescriptions with different reasons for the exception(s), if applicable. However, at no time can the email notification exceed the timeframe for the earliest reason for the exception listed in the email.

Pharmacy Update

Electronic Prescribing Exceptions *Dispensing Clarification for Pharmacists*

A pharmacist is **NOT** required to verify that a practitioner has a waiver from the requirement to electronically prescribe, or properly falls under one of the other exceptions from the requirement to electronically prescribe. Pharmacists may continue to dispense medications from otherwise valid written, oral or fax prescriptions that are consistent with current laws and regulations.

As a reminder, all faxed prescriptions must be on the Official New York State Prescription Form. Failover faxed prescriptions are not allowed in NY.

Select the following link for a reference chart for what a pharmacist can add or change on an Official New York State prescription or an electronic prescription for a controlled substance:

<http://www.health.ny.gov/publications/1086.pdf>

Practitioners are mandated to electronically prescribe both controlled and non-controlled substances effective March 27, 2016. However, there are number of exceptions in which a practitioner may issue an Official New York State prescription (ONYSRx) form, oral prescription or a fax of an ONYSRx. The exceptions are listed below:

- Exceptions listed in Public Health Law §281(3)(a-e):
 - Veterinarians
 - Temporary technological failure
 - Temporary electrical failure
 - An approved waiver
 - The practitioner reasonably determines that it would be impractical for the patient to obtain substances prescribed by electronic prescription in a timely manner, and such delay would adversely impact the patient's medical condition
 - To be dispensed by a pharmacy located outside the State

- Specific exceptional circumstances defined in the Commissioner of Health's blanket waiver letter signed on March 16, 2016
http://www.health.ny.gov/professionals/narcotic/electronic_prescribing/docs/2016-03-16_blanket_waiver_letter.pdf

In the Frequently Asked Questions (FAQs) on electronic prescribing, please see questions 9, 58, 59, and 129 for more information on dispensing from ONYSRx forms, oral prescriptions and a facsimile of an ONYSRx.

The FAQs can be found at

http://www.health.ny.gov/professionals/narcotic/electronic_prescribing/docs/epcs_faqs.pdf

Pharmacy Update

Medicaid Fee-For-Service (FFS) Reimbursement of Medicare Part B Pharmacy claims

As previously communicated in the [July 2015 Medicaid Update](#) , pursuant to changes to Social Services Law, the New York State Department of Health revised the Medicaid reimbursement methodology for pharmacy claims for Medicare/Medicaid dually eligible individuals. Medicaid no longer reimburses partial Medicare Part B coinsurance amounts when the Medicare payment exceeds the Medicaid fee or rate for that service.

This change to the reimbursement methodology has been effective for dates of service on and after July 1, 2015. **The Department has made recent system changes to enforce the new payment policy effective April 21, 2016.** As a result, previously paid claims that were not billed in accordance with the mandated changes will be adjusted automatically to reflect the new cost sharing limits. Providers will be notified prior to claim adjustments being made and how that rollout will occur as soon as the Department has finalized a reasonable approach.

The Centers for Medicare and Medicaid Services (CMS) gives examples of some of the most [frequently occurring scenarios for determining Part B and Part D coverages](#).

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

Provider Directory

Office of the Medicaid Inspector General:

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

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

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

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

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

Do you have questions about billing and performing MEVS transactions?

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

Provider Training:

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

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 have experienced a change in ownership? Do you want to enroll another NPI? Did you receive a letter advising you to revalidate your enrollment?

Visit <https://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.

Comments and Suggestions Regarding This Publication?

Please contact the editor, Amy Siegfried, at medicaidupdate@health.ny.gov