NEW YORK STATE | Department of Health | Medicaid Program

Medicaid Update

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HIV Special Needs Plans Now Available on the New York State of Health Marketplace

Effective January 15, 2016, eligible consumers with Medicaid may now select and enroll in an HIV Special Needs Plan (SNP) through the New York State of Health (NYSoH) Marketplace. SNPs will appear as an enrollment option to Medicaid eligible consumers residing in New York City.

SNPs are comprehensive Medicaid Managed Care health plans designed to meet the health care needs of people living with HIV/AIDS. In addition to the full Medicaid benefit package, SNPs also cover enhanced HIV services and care coordination, plus Behavioral Health Home and Community Based Services for eligible enrollees.

Enrollment is limited to Medicaid eligible HIV positive adults and their children up to age 21, regardless of HIV status, residing in New York City. Effective March 2014, enrollment was expanded to include Medicaid eligible homeless adults regardless of HIV status. SNPs who accept enrollment are required to verify HIV or homeless status of all enrollees.

Consumers who have Medicaid coverage through the NYSoH may log into their account and enroll in a health care plan by navigating to the plan selection page, where SNPs will now appear as a choice to eligible consumers. NYSoH consumers may also contact the NYSoH Customer Service at 855-355-5777 to enroll in a SNP.

Questions can be directed to the AIDS Institute at 518-486-1383 or email to doh.sm.aims@health.ny.gov.

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All Providers

New York Medicaid Management Information System (NYMMIS) Current Courses and Computer-Based Trainings

Training is now available for all providers in both instructor-led and webinar formats. Current courses include; Introduction to NYMMIS: Features and Functionality and Introduction to Provider Enrollment. The NYMMIS Training Team is also producing several Computer-Based Trainings or CBT's which will be made available in upcoming months via the Learning Management System. Courses will be delivered electronically via the web directly to the learner's computer. Additional details will follow in the March Medicaid Update.

Please visit the interim NYMMIS website at www.interimNYMMIS.com for more information.

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All Providers

New York Medicaid EHR Incentive Program Update

The New York 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 $749 million*** in incentive funds have been distributed ***within 22,602*** payments to New York State Medicaid providers.

22,602 Payments	$749+ 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.

Visit www.emedny.org/meipass or contact 877-646-5410 Option 2 for more information.

For additional support, two regional extension centers are available:

- NYC Regional Electronic Adoption Center for Health (NYC REACH) supports providers located within the five boroughs of New York City.
- New York eHealth Collaborative (NYeC) supports providers located outside of New York City, including the upstate region and Long Island.

Pre-payment Scenarios Webinar

Attesting to the Incentive Program, only to receive outreach regarding a discrepancy with your encounter data? This course covers the different scenarios and how to effectively respond.
Sign up at www.emedny.org/meipass/info/Events.aspx.

2016 Public Health Reporting

For providers demonstrating meaningful use for the first time in 2016, the EHR reporting period is a continuous 90-day period within 2016. For providers who have previously demonstrated meaningful use, the EHR Reporting Period for 2016 is the full calendar year (January 1 to December 31).

Providers must formally register their intent to submit data for a given Public Health Reporting measure, before or within 60 days of the start of the EHR Reporting Period by using the Meaningful Use Registration for Public Health System (MURPH).

Please review the updated Eligible Professional MURPH Registration Guide and the Eligible Hospital MURPH Registration Guide for step-by-step instructions on how to complete your registration of intent.

Public Health Reporting measures include:

- Immunization Registry Reporting
- Syndromic Surveillance Reporting
- Specialized Registry Reporting
- Electronic Reportable Laboratory Result Reporting (Hospitals only)

For additional support with the public health reporting measures and registration, contact 877-646-5410 Option 3 or MUPublicHealthHELP@health.ny.gov.

Pre-Validation Services

Don't delay! Pre-validation services are available for EP's who have already determined their Medicaid patient volume for payment year 2015. Pre-validation prior to submitting the complete attestation may subsequently reduce the time of state review.

Contact hit@health.ny.gov to request a pre-validation file. Please make sure to include your NPI and patient volume method (individual or group aggregate).

Meaningful Use for Dentists

A new meaningful use webinar specifically for dentists has been added to the monthly schedule. The course includes suggestions for achieving each meaningful use measure and reporting clinical quality measures. Sign up at www.emedny.org/meipass/info/Events.aspx.

2015 Attestations

NY Medicaid is not yet accepting 2015 meaningful use attestations for Modified Stage 2. Announcements will be made on the program website and LISTSERV when providers may attest.

Attestations for Adopt, Implement, or Upgrade (AIU) are still being accepted. The attestation deadline for payment year 2015 is March 31, 2016.

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

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Clarification of Human Plasma-Derived Blood Factor and Recombinant Blood Factor Coverage Policy for the Treatment of Hemophilia

This article provides clarification of New York State Medicaid's coverage policy for human plasma-derived blood factors and recombinant blood factors when used to treat patients with hemophilia versus blood factors used for other FDA-approved indications.

Human plasma-derived blood factors and recombinant blood factors are covered by the New York State Medicaid program when prescribed for indications approved by the FDA. For indications related to the treatment of hemophilia for Medicaid Managed Care (MMC) enrollees, human plasma-derived blood factors and recombinant blood factors are not a covered service in the MMC benefit package and should be billed directly to Medicaid Fee-for-service (FFS).

This managed care carve-out policy applies to human plasma-derived blood factors and recombinant blood factors administered for the treatment of hemophilia in ***all non-inpatient*** settings, including in the home. Human plasma-derived blood factors and recombinant blood factors administered during an inpatient stay will continue to be covered by the enrollee's MMC plan as part of the APR-DRG or per diem rate.

When treating MMC enrollees with recombinant blood factors for FDA-approved indications other than the treatment of hemophilia, providers are directed to bill the enrollee's MMC plan, as the recombinant blood factor would be considered a "pharmaceutical" and is therefore covered under the enrollee's MMC benefit package.

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.

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New York State Medicaid Coverage for Removal of Impacted Cerumen

Effective April 1, 2016, for Medicaid Fee-for-Service (FFS) and June 1, 2016, for Medicaid Managed Care (MMC), the New York State Medicaid program will provide reimbursement to qualified medical practitioners (i.e., physicians, nurse practitioners and physician assistants) for the successful removal of impacted cerumen using instrumentation (represented by CPT code 69210).

CPT Code 69210 Criteria:

Medicaid reimbursement for the removal of impacted cerumen using CPT code 69210 will be provided when all of the following are met:

- One or more of the following four criteria for impacted cerumen is present:
  - Visual: cerumen impairs examination of clinically significant portions of the external auditory canal, tympanic membrane or middle ear condition.
  - Qualitative: extremely hard, dry, irritative cerumen causing symptoms such as pain, itching, hearing loss, etc.
  - Inflammatory: cerumen associated with foul odor, infection or dermatitis.
  - Quantitative: obstructive, copious cerumen that cannot be removed without magnification and multiple instrumentations requiring advanced practitioner skill.
- The removal is performed by a qualified practitioner using instrumentation such as wax loops, spoons, hooks, curettes, alligator forceps, Jobson Horne probes, suction, aural speculum, headlight, otoscope, and binocular microscopy.
- Documentation in the medical record includes: the patient's chief complaint, which criteria for impacted cerumen were met, what instrumentation was used, why instrumentation was necessary, who performed the removal, and the outcome of the procedure.

Medicaid reimbursement will NOT be provided for any of the following scenarios:

- Removal of cerumen that is not impacted, as defined above.
- Removal of impacted cerumen that is performed using irrigation, lavage or other simple techniques.
- A removal attempt of impacted cerumen that is unsuccessful.
- Removal by anyone other than a qualified medical practitioner, as defined above.

Billing Guidance for Medicaid FFS:

- If impacted cerumen is the patient's chief complaint (i.e., there is no other separate, identifiable evaluation service that is provided during the visit), qualified practitioners should bill CPT code 69210 for the removal. An evaluation and management (E&M) service is not separately payable (billable) in this situation.

- Payment may be made for both the impacted cerumen removal and an E&M visit on the same day if all of the following criteria are met:
  - There is a significant separate, identifiable E&M service provided during the same visit as the cerumen removal;

- The cerumen is discovered during the patient's visit, either when the patient brings the cerumen to the practitioner's attention or the practitioner discovers it;
- The criteria listed above for CPT code 69210 are met; AND
- Documentation in the medical record clearly reflects that the cerumen removal was separate from the reason for the E&M visit.

Note: In these cases, when 69210 is billed with an E&M service, a modifier 25 must be used to append the E&M code for proper adjudication.

Please note, however, that although the AMA CPT manual identifies CPT code 69210 as a unilateral procedure, NYS Medicaid considers CPT code 69210 as a bilateral procedure, consistent with Medicare guidelines, and will allow only one unit per date of service billed. CPT code 69210, therefore, should only be billed once on the same date of service, whether cerumen was removed from one or both ears. Also, additional payment will not be made for any coding reflecting the use of separate instrumentation, e.g., binocular microscopy-CPT code 92504.

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.

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Changes to the Nurse Practitioner Collaboration Agreement

eMedNY System Changes Completed

Modifications to the eMedNY Fee-for-Service (FFS) claiming system, reflecting the changes in the Nurse Practitioner (NP) collaboration requirements, have been completed for NPs enrolling/enrolled in New York State FFS Medicaid.

Pursuant to changes to New York State Education Law Section 6902(3) (see 8 NYCRR Sections 29.14 and 64.5), NPs practicing for more than 3,600 hours, in lieu of obtaining a written practice agreement with a physician, may document that they have collaborative relationships. These collaborative relationships may be with one or more licensed physician qualified to collaborate in the specialty involved or with a hospital, licensed under Article 28 of the Public Health Law, which provides services through licensed physicians qualified to collaborate in the specialty involved and having privileges at that institution. Documentation of collaborative relationships should be maintained in the NPs personal records and does not have to be submitted to Medicaid.

This change was part of the NP Modernization Act, which was enacted in 2014 as Chapter 56 of the Laws of 2014, Part D and became effective on January 1, 2015. The NP Modernization Act will expire on June 30, 2021, in order to provide opportunity to revisit and determine further expansions.

Collaboration Requirements for NPs with 3,600 hours or less:

The change in law does not change the rules for NPs practicing for 3,600 hours or less. They continue to be required to have a written practice agreement with a collaborating physician who is qualified to practice in the NP's specialty area of practice.

Newly certified NPs with 3,600 hours or less of qualifying experience must complete the following forms:

- New York State Education, Office of the Professions, NP form 4NP-Verification of Collaborative Agreement and Practice Protocol, available at the following link on the State Education website: http://www.op.nysed.gov/prof/nurse/np4np.pdf

AND

- New York State Department of Health, eMedNY - 410501 form, Notice of Collaborating Agreement NP and Physician, which can be found at the following link to Provider Enrollment under the NP: **https://www.emedny.org/info/ProviderEnrollment/index.aspx**

Physicians who have collaborating agreements or relationships with NPs must also be enrolled in the New York State Medicaid Program and must not have been excluded from participation in either the Medicaid or Medicare Program.

Questions about Provider Enrollment should be directed to Computer Sciences Corporation at 1-800-343-9000. Medicaid FFS policy questions may be directed to the Office of Health Insurance Programs' Division of Program Development and Management at (518) 473-2160.

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New York Medicaid Does Not Cover "Conversion Therapy"

This is to clarify that the Medicaid program does not cover "conversion therapy" under Fee-for-Service (FFS) Medicaid or Medicaid Managed Care (MMC).

"Conversion therapy" means any practice by a mental health professional that seeks to change an individual's sexual orientation or gender identity, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex.

This therapy is based on the premise that homosexuality is a mental disorder. However, the American Psychiatric Association stopped classifying homosexuality as a mental disorder in 1973, and today homosexuality is not considered a medical condition that requires treatment. Because Medicaid only covers care, services, and supplies necessary to prevent, diagnose, correct, or cure recognized medical conditions, it cannot cover "conversion therapy."

Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

Refer to the June 2015 Medicaid Update at https://www.health.ny.gov/health_care/medicaid/program/update/2015/jun15_mu.pdf for further information on Medicaid services available for persons diagnosed with gender dysphoria.

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 coverage should be directed to the enrollee's MMC plan.

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CPT Codes Now Requiring Prior Approval

Effective immediately, the following procedure codes now require prior approval. For information on obtaining prior approval, please see:
https://www.emedny.org/ProviderManuals/Physician/PDFS/Physician_PA_Guidelines.pdf

11950: Subcutaneous injection of filling material (eg, collagen); 1 cc or less
11951: 1.1 to 5 cc
11952: 5.1 to 10 cc
11954: over 10 cc
19316: Mastopexy (unilateral)
21120: Genioplasty; augmentation (autograft, allograft, prosthetic material)
21123: sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21193: Reconstruction of mandibular rami, horizontal, vertical, "C", or "L" osteotomy; without bone graft
21208: Osteoplasty, facial bones; augmentation (autograft, allograft or prosthetic implant)
21209: reduction
21270: Malar augmentation, prosthetic material
30400: Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410: complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420: including major septal repair
30430: Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435: intermediate revision (bony work with osteotomies)
30450: major revision (nasal tip work and osteotomies)
30462: tip, septum, osteotomies
30465: Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)
31588: Laryngoplasty, not otherwise specified (eg, for burns, reconstruction after partial laryngectomy)
40500: Vermilionectomy (lip shave), with mucosal advancement
67900: Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

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

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New York State Medicaid Reimbursement Policy for Attendance at Delivery (CPT Code 99464)

New York State Medicaid Fee-for-Service (FFS) and Medicaid Managed Care (MMC) will provide reimbursement to neonatologists and pediatricians who attend obstetrical deliveries in the hospital setting. Reimbursement for this service, represented by CPT code 99464 (Attendance at Delivery), will be effective April 1, 2016 for Medicaid FFS and May 1, 2016 for MMC.

Reimbursement Policy

In order to be reimbursed by Medicaid for CPT code 99464, a neonatologist or pediatrician must be present at the exact time of the delivery of the infant.

The services of the neonatologist or pediatrician:

- Must be considered medically necessary;
- Must be requested by the delivering provider;
- Must include medical record documentation of fetal distress or reasonable anticipation of newborn distress; and
- Must include documentation of the direct medical service(s) provided to the infant by the additional neonatologist or pediatrician in attendance.

Required Documentation in the Medical Record

The following documentation is required in the patient's medical record:

- The request of the delivering provider that a neonatologist or pediatrician be present at the delivery;
- Name of delivering provider who requested the presence of a neonatologist or pediatrician in the delivery room due to the high risk status of the delivery;
- Name and signature of attending neonatologist or pediatrician; and
- The infant's condition at birth and any sequela(e) requiring stabilization and treatment.

FFS Billing Guidance

- Reimbursement for CPT code 99464 will be limited to a neonatologist or pediatrician only. Reimbursement will not be made when services are provided by a nurse practitioner or physician assistant.
- If the neonatologist or pediatrician was called to the delivery room but was not present at the exact time of delivery, Medicaid cannot be billed.
- Reimbursement will not be made for services provided by a resident or fellow unless the supervising physician is present at the exact time the delivery occurs.
- Billing will be "by report." Documentation of patient-specific details must be provided.
- Code 99464 cannot be billed when attendance at delivery is performed only because it is mandated by hospital policy and not requested by the delivering provider.

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.

Prior Authorization

Important Information for Authorized Agents

Health care providers are required to complete the prior authorization (PA) process for various reasons including prescribing a drug for which there is an equally effective lower cost alternative, safety concerns and/or a potential for inappropriate use. In all cases prescribers will need to provide their clinical rationale for why the drug should be covered. Only the prescriber or the authorized agent can request a PA. PA requests need to be approved and validated through the Clinical Call Center, 1-877-309-9493.

Authorized Agent / Third Party Requests:

- An authorized agent is someone who is an employee of the prescribing practitioner and has access to the patient's medical records. For example, a nurse, medical assistant, etc.

- Third party phone or fax requests will not be accepted.

- Pharmacists cannot initiate PAs other than for a 72 hour emergency PA. If a prescriber grants a pharmacist the authority to handle his/her PA requests, the prescriber's actions would be considered "patient steering." This arrangement does not give the patient a choice as to where they go to get their drugs.

- Federal Law prohibits limiting a Medicaid beneficiary's freedom of choice except under certain circumstances including but not limited to recipient restriction. *Federal Social Security Act the State Plan for medical assistance Section. 1902 [42 U.S.C1396a] (a)(23).*

- Complaints from providers and enrollees involving steering should be sent to the Office of Medicaid Inspector General. Their website (http://www.omig.ny.gov/fraud/file-an-allegation) contains online forms for complaints.

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Pharmacy Update

REMINDER: Electronic Prescribing Mandate

The implementation date for mandatory electronic prescribing is March 27, 2016. Information regarding requirements can be found at https://www.health.ny.gov/professionals/narcotic/electronic_prescribing/. Electronic prescribing of both controlled and non-controlled substances is currently permissible in New York. Practitioners must ensure compliance with the requirement, including working with their software vendors to implement the additional security requirements needed for electronic prescribing of controlled substances, and registering their certified software applications with the Bureau of Narcotic Enforcement.

Below are highlights/key points that may be of particular interest to prescribers and pharmacists.

- A prescription generated on an electronic system that is printed out on the Official New York State Prescription form or faxed is **NOT** an electronic prescription.

- Amendments to Title 10 NYCRR Part 80 New York Codes, Rules and Regulations on Controlled Substances have been adopted and became effective as final regulations on March 27, 2013. The amendments authorize a practitioner to issue an electronic prescription for controlled substances in Schedules II through V and allow a pharmacist to accept, annotate, dispense and electronically archive such prescriptions.

- After March 27, 2016, a pharmacist is NOT required to verify that a practitioner properly falls under one of the exceptions from the requirement to electronically prescribe. Pharmacists may continue to dispense medications from valid written, oral, or fax prescriptions that are consistent with current laws, regulations, and Medicaid policies.

A comprehensive list of Frequently Asked Questions (FAQs) can be found at https://www.health.ny.gov/professionals/narcotic/electronic_prescribing/docs/epcs_faqs.pdf.

The FAQs provide an explanation of the laws and regulations, pharmacy registration forms, registration for official prescriptions and e-prescribing systems (ROPES), software and data requirements, waivers and exceptions, and resource information and contacts.

Questions? Please contact the Bureau of Narcotic Enforcement at
1-866-811-7957 or via e-mail to narcotic@health.ny.gov.

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Provider Directory

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

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

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

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

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

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

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

Need to change your address? Does your enrollment file need to be updated because you 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 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