NEW YORK STATE | Department of Health | Medicaid Program

Medicaid Update

The Official Newsletter of the New York State Medicaid Program

January 2016

Volume 32 | Number 1

Empowering Individuals through the Money Follows the Person (MFP) Demonstration Program

Transitions from Institutional Settings to Home and Community-Based Settings to be Sustained Through At Least 2020

Starting in 2007, the Centers for Medicare and Medicaid Services established the *Money Follows the Person (MFP) Demonstration* grant to support states' development of strategic infrastructure and policy changes designed to streamline the process for deinstitutionalization of vulnerable populations (e.g., seniors; individuals with physical, intellectual, and/or developmental disabilities; and individuals with traumatic brain injury). Many individuals often have a strong desire to return to community living. These transitions serve a dual purpose of respecting people's wishes and empowering them to lead more integrated lives while simultaneously lessening the economic impact that traditional care settings often place upon the long term care system.

Currently, New York, 44 other states and the District of Columbia participate in this nationwide transition initiative. Since inception, over 50,000 people with chronic conditions and/or disabilities have successfully made the transition nationally. New York's MFP Demonstration, which will receive over $108 million in federal funding (anticipated through 2020), maintains strategic partnerships with a number of Medicaid programs to ensure that vulnerable persons have access to home and community-based services. To date, over 1,600 New Yorkers have successfully transitioned via the State's MFP Demonstration.

One primary tool used by MFP to determine interest to transition is known as the Minimum Data Set (MDS) 3.0 Section Q referral process, which is commonly referred to as "Section Q." Every nursing home is required to periodically assess interest of all residents (and/or guardian) in returning to the community. All residents who answer affirmatively should be referred by the facility to a designated local contact agency within ten business days.

The New York Association on Independent Living (NYAIL) is now the designated contact agency statewide for all Section Q referrals. NYAIL accepts all referrals and works with local Independent Living Centers to provide the resident and/or their family with information on community-based care options and support. NYAIL's peer outreach and referral program assists seniors and individuals with physical, intellectual, and/or developmental disabilities or traumatic brain injury to receive the appropriate information about community-based living arrangements and, if they are interested in transitioning, to refer them to a Transition Center for further follow-up.

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The Medicaid Update is a monthly publication of the New York State Department of Health.

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NYAIL's Transition Centers provide transition planning and community readiness training to educate and support institutionalized individuals who may be subjected to a potential "disconnect" between facility discharge planners and the community-based service providers. The Transition Centers create a supportive link that bridges the transition process from pre-discharge to early establishment within their community of choice. As such, the Transition Centers are responsible for informing, supporting, and overseeing the transition of individuals from facility to community. To send NYAIL a Section Q referral, visit their website at http://www.ilny.org, or call (518) 465-4650 or toll free at (844) 545-7108.

In addition to the Transition Center and Peer Outreach initiatives, the MFP Demonstration also oversees a new demonstration project, the Lifespan of Greater Rochester's Community Care Connections (Lifespan) project, a three year project to effectively integrate a community-based aging services provider as an authentic member of the evolving health care delivery system to help older adults remain healthy in their own homes. This demonstration aims to prove that integrating traditional community-based aging services with medical systems of care will have a positive effect on the triple aims of cost, quality, and patient satisfaction. Lifespan will conduct a robust data collection and comprehensive evaluation during the demonstration which will drive the development of a model plan for successful replication throughout New York State.

The New York MFP Demonstration has also partnered with multiple New York State governmental entities, including the New York State Justice Center and the New York State Office for People with Developmental Disabilities (OPWDD). MFP has partnered with the New York State Justice Center to provide additional funding for the Technology-Related Assistance for Individuals with Disabilities (TRAID) project, which serves to increase well-timed access to and acquisition of assistive technologies, such as durable medical equipment, in support of individuals wishing to remain in or transition to a community setting. OPWDD, as part of its Transformation Agreement with CMS, is participating in the State's MFP Program within the larger context of de-institutionalization and is expected to support continued transitions of individuals who will be leaving the limited number of campus-based opportunities that OPWDD will continue to operate, skilled nursing facilities, or individuals who are aging out of specialized Children's Residential Programs. In the coming years, New York's MFP Demonstration looks forward to expanding its partnership base to promote healthy aging strategies and increase access to quality integrated mental health and physical health care for the Empire State's older adults and military veterans.

FOR MORE INFORMATION

- Nursing home facilities seeking further Section Q information should refer to the ***MDS 3.0 RAI Manual*** as published by the Centers for Medicare and Medicaid Services and available for download at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.

- Individuals or their guardians interested in learning more about the transition process or the location of the nearest Transition Center are encouraged to visit the New York Association on Independent Living on the web at http://www.ilny.org, by emailing info@ilny.org, or by calling (518) 465-4650.

- For further information regarding the New York MFP Demonstration, please visit us on the web at http://www.health.ny.gov/mfp. Questions may be directed to us by email at MFP@health.ny.gov or via phone at (518) 486-6562.

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All Providers

Flu Shot Clinics: Make Sure it's One Needle, One Syringe, Only One Time

In October 2015, a nurse in New Jersey was accused of re-using syringes for multiple patients while giving influenza vaccine injections at a company-sponsored influenza vaccination clinic. The New Jersey Department of Health and Senior Services investigated and determined that 67 employees who received the injections might have been exposed to bloodborne pathogens like hepatitis B virus (HBV), hepatitis C virus (HCV), or human immunodeficiency virus (HIV), due to unsafe injection practices.
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6449a3.htm?s_cid=mm6449a3_w

Events like these are of great concern to the Centers for Disease Control and Prevention (CDC), which says since 2001, more than 150,000 patients have been potentially exposed to bloodborne pathogens following unsafe injection practices in the U.S.

If you are in a position to conduct an influenza vaccination clinic in a healthcare setting or workplace, please make sure you follow these basics of infection prevention.

- Whenever possible, consider using pre-filled syringes for vaccinations. If this is not an option, make sure you use a new needle and new syringe each and every time you access a multi-dose vial. The CDC have documented cases of transmission of bloodborne pathogens when safe injection practices are not followed. Remember that even though multi-dose vials typically contain preservatives, they have no effect on viruses like HBV, HCV, and HIV.

- There is also some concern about "batching" or drawing up multiple doses of medication into syringes before dispensing medication. This practice is strongly discouraged by both the New York State Department of Health and the CDC. CDC recommends that vaccine be drawn up into a syringe at the time of administration. If vaccine must be pre-drawn, CDC offers the following cautions:

    - ✓ If more than one vaccine type is to be administered, separate administration stations should be set up for each vaccine type to prevent medication errors.

    - ✓ Vaccines should NOT be drawn up in advance of arriving at a clinic site. Drawing up doses of vaccine hours or even days before a clinic is NOT acceptable.

    - ✓ At the clinic site, no more than 1 multi-dose vial or 10 doses should be drawn up at one time by each vaccinator.

    - ✓ Patient flow should be monitored to avoid drawing up unnecessary doses.

    - ✓ At the end of the workday, any remaining vaccine in provider pre-drawn syringes should be discarded.

It should also be noted that the person drawing up the vaccine should be the person administering it. Finally, the manufacturer's instructions for storage of all medications, including vaccines, should always be followed.

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New York Medicaid Management Information System (NYMMIS) Training and Webinars

Registrations for in-person trainings are currently being accepted for the months of February and March of 2016. NYMMIS is also offering webinars, a convenient training alternative that allows providers to attend training using their own computers and telephones. Please visit the interim NYMMIS website at www.interimNYMMIS.com for more information.

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Register for the Voluntary New York State Hepatitis C Virus (HCV) Provider Directory

The New York State Department of Health AIDS Institute is pleased to announce the launch of the Hepatitis C Provider Directory. The Provider Directory will help people easily find hepatitis C providers when they need one.

Participation in this Directory is voluntary. The Directory will include physicians, nurse practitioners, physician assistants, and doctors of osteopathic medicine with experience in HCV care and treatment and who meet the NYSDOH definition of an experienced HCV provider.

To Register as a Provider:

Step 1: Log on to HCS at https://commerce.health.state.ny.us.

Step 2: Click 'My Content' ->'All Applications'.

Step 3: Click letter 'H' and select 'HIV/HCV Provider Directory'.

Step 4: Follow the instructions as provided on the screen.

Email hivproviderdirectory@health.ny.gov with any questions or concerns.

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All Providers

New York 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 $745 million*** in incentive funds have been distributed ***within 22,398*** payments to New York State Medicaid providers.

22,398 Payments	$745+ 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.

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.

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).

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ATTENTION: PROVIDERS OF NURSING FACILITY SERVICES, CERTAIN HOME AND COMMUNITY BASED WAIVER SERVICES AND SERVICES TO INDIVIDUALS ENROLLED IN A MANAGED LONG TERM CARE PLAN

2016 spousal impoverishment income and resource levels remain unchanged from 2015

Providers of nursing facility services, home and community based waiver services and services to individuals enrolled in a managed long term care plan, are required to PRINT and DISTRIBUTE the *"Information Notice to Couples with an Institutionalized Spouse"* (pages 8-11 of this newsletter) at the time they begin to provide services to their patients.

The 2015 federal maximum community spouse resource allowance of $**119,220** and the community spouse income allowance of **$2,980.50** remain unchanged**.** The maximum family member monthly allowance will remain **$664** for 2016.

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

INCOME AND RESOURCE AMOUNTS

January 1, 2016

Federal Maximum Community Spouse Resource Allowance: $119,220

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

January 1, 2016

Community Spouse Minimum Monthly Maintenance Needs Allowance:

The maximum MMMNA (i.e., if the community spouse has no income of his/her own) is **$2,980.50.**

NOTE: A higher amount may be established by court order or fair hearing due to exceptional circumstances that result in significant financial distress.

January 1, 2016

Family Member Monthly Allowance:

The maximum Family Member Allowance for each family member (i.e., if the community spouse has no income of his/her own) remains **$664.**

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

Information Notice to Couples with an Institutionalized Spouse:

Medicaid is an assistance program that may help pay for the costs of your or your spouse's institutional care, home and community based waiver services, or enrollment in a managed long term care plan. The institutionalized spouse is considered medically needy if his/her resources are at or below a certain level and the monthly income after certain deductions is less than the cost of care in the facility.

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

NOTE: Spousal impoverishment rules do not apply to an institutionalized spouse who is eligible under the Modified Adjusted Gross Income (MAGI) rules.

If you or your spouse are:
(1) In a medical institution or nursing facility and are likely to remain there for at least 30 consecutive days; or
(2) Receiving home and community based services provided pursuant to a waiver under section 1915(c) of the federal Social Security Act and are likely to receive such services for at least 30 consecutive days; or
(3) Receiving institutional or non-institutional services and are enrolled in a managed long term care plan; AND
(4) Married to a spouse who does <u>not</u> meet any of the criteria set forth under (1) through (3), these income and resource eligibility rules for an institutionalized spouse may apply to you or your spouse.

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

Information about resources:
The community spouse is allowed to keep resources in an amount equal to the greater of the following amounts:
(1) $74,820 (the State minimum spousal resource standard); or
(2) The amount of the spousal share up to the maximum amount permitted under federal law ($119,220 for 2016).

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

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

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

Information about income:
You may request an assessment/determination of:
(1) **The community spouse monthly income allowance (an amount of up to $2,980.50 a month for 2016); and**
(2) **A maximum family member allowance for each minor child, dependent child, dependent parent or dependent sibling of either spouse living with the community spouse (i.e., if the family member has no income of his/her own) remains $664.**

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

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

Additional Information

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

Undue Hardship Occurs When:
(1) **A community spouse fails or refuses to cooperate in providing necessary information about his/her resources;** ***(2)*** **The institutionalized spouse is otherwise eligible for Medicaid;** ***(3)*** **The institutionalized spouse is unable to obtain appropriate medical care without the provision of Medicaid; and**
(a)The community spouse's whereabouts are unknown; or
(b)The community spouse is incapable of providing the required information due to illness or mental incapacity; or
(c)The community spouse lived apart from the institutionalized spouse immediately prior to institutionalization; or
(d)Due to the action or inaction of the community spouse, other than the failure or refusal to cooperate in providing necessary information about his/her resources, the institutionalized spouse will be in need of protection from actual or threatened harm, neglect, or hazardous conditions if discharged from appropriate medical setting.

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

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

Contribution from Community Spouse

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

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

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NEW YORK STATE OF OPPORTUNITY. Department of Health

Date:

Request for Assessment Form

Institutionalized Spouse's Name:

Address:

Telephone Number:

Community Spouse's Name:

Current Address:

Telephone Number:

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

[ ] Couple's countable resources and the community spouse resource allowance

[ ] Community spouse monthly income allowance

[ ] Family member allowance(s)

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

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

_____

Signature of Requesting Individual

_____

_____

_____

Address and telephone # if different from above

Medicaid Eligibility Verification System (MEVS) Update for Qualified Medicare Beneficiary (QMB) Providers

Effective **January 21, 2016**, an enhancement to New York State's eMedNY system allows for payment of services provided to Qualified Medicare Beneficiary (QMB) eligibles if they are also eligible for either the Family Planning Benefit Program (FPBP) or the Excess Income Program.

MEMBER ELIGIBILITY	MEDICAID ELIGIBILITY VERIFICATION SYSTEM (MEVS) RESPONSE
FPBP ONLY	ELIGIBLE ONLY FAMILY PLANNING SERVICES
FPBP WITH QMB	FPBP AND MEDICARE COINSURANCE AND DED ONLY
EXCESS INCOME	NO COVERAGE: EXCESS INCOME
EXCESS INCOME WITH QMB	MEDICARE COINSURANCE AND DEDUCTIBLE ONLY

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Fully Integrated Duals Advantage (FIDA) Program Update

The Department's Division of Long Term Care, in partnership with the Center for Medicare and Medicaid Services (CMS), has announced changes to the Fully Integrated Duals Advantage (FIDA) program to provide greater flexibility to participants, plans and providers.

At the core, FIDA remains true to its original key components:

- Fully integrated delivery of Medicaid and Medicare services
- Person-centered care that promotes independence in the community
- Improved quality through care coordination
- High quality, cost-effective health care

Highlights of the FIDA reforms include:

- **The Participant´s right to choose the make-up of the Interdisciplinary Team (IDT).**
- Provider participation in an IDT is adjustable, depending on member availability, items being discussed in a given meeting, or the needs, wishes, and goals of the Participant.
- Primary Care Providers may review and sign off on a completed Person Centered Service Plan (PCSP) without attending IDT meetings.
- IDT members may meet at different times.
- The Care Manager may separately meet with different IDT members in developing the PCSP.
- Plans have authorization over any medically necessary services included in the PCSP that are outside of the scope of practice of IDT members.
- Providers are no longer required to complete training modules; rather, the training will be encouraged.
- In addition to these reforms, CMS has committed to reviewing its payment of health plans participating in the demonstration in addition to increasing rates for 2016 to offset the CMS-HCC risk adjustment model's under prediction of costs for full benefit dual eligible beneficiaries.

Benefits for Providers participating in FIDA:

- FIDA provides opportunities to work more closely with other providers your patients see, ensuring better overall care.
- FIDA may save providers time as the FIDA Plan will help coordinate care and support the participant to be compliant with their care plan.

- There is no need to bill multiple parties (e.g., New York State Medicaid, other health plans for cost sharing) as the FIDA Plan will pay providers in full.

- FIDA may decrease avoidable hospitalizations and urgent care visits due to better care coordination of Participants.

Enrollment eligibility rules have not changed. To be eligible for FIDA, an individual must*:

- Reside in any of the New York City boroughs or Nassau County;
- Be 21 years or older;
- Be entitled to Medicare Part A, enrolled in Medicare Part B, eligible to enroll in Part D, *and* receiving full Medicaid benefits; ***and***
- Be expected to need long-term care services for more than 120 days.

*Some exclusions apply.

FIDA offers an expanded package of covered items and services, which includes traditional Medicaid and Medicare benefits as well as behavioral health, home and community-based waiver services and community and facility long-term care services.

FIDA offers an integrated appeals process whereby the most consumer-favorable elements of the Medicare and Medicaid grievance and appeals systems are incorporated into a consolidated, integrated grievance and appeals system for FIDA Participants.

Participants have access to the services provided by the State Ombudsman known as the Independent Consumer Advocacy Network (ICAN). ICAN can be reached at 1-844-614-8800 or visit www.icannys.org.

For questions about benefits, provider networks and how to enroll contact New York Medicaid Choice at 1-855-600-3432 or visit www.nymedicaidchoice.com.

For more details about the FIDA program, including the revised IDT Policy, please see:

http://www.health.ny.gov/health_care/medicaid/redesign/mrt_101.htm

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Attention Ambulette and Taxi/Livery Providers

New Date for Enforcement of Updated Record Keeping Requirements

In the December 2015 Medicaid Update, the Department published its updated record keeping requirements for ambulette and taxi/livery providers. Specifically, the article indicated that effective January 1, 2016, the driver's attestation and signature are required components to the trip record used to substantiate a claim.

To allow sufficient time for providers using electronic trip records to comply with the new requirement, the State will begin enforcement of this updated requirement for claims submitted with service dates on or after March 1, 2016. Accordingly, compliance is expected on March 1, 2016 without exception.

If you have any questions, please call the Bureau of Transportation Administration at (518) 473-2160, or send an email to MedTrans@health.ny.gov.

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Frequency Limits on Dual Energy X-Ray Absorptiometry (DXA) Scans for Screening Purposes

<<<Clarification>>>

This article clarifies the policy set forth in the April 2015 Medicaid Update article titled, "Frequency Limits on Dual Energy X-Ray Absorptiometry (DXA) Scans for Screening Purposes." The April 2015 Medicaid Update article established a frequency limit of one DXA scan every two years for screening for osteoporosis.

When providing medically necessary screening for osteoporosis to women over the age of 65 and men over the age of 70, DXA scans will be reimbursed at a maximum of once every two years. When providing medically necessary DXA scans to women younger than 65 and men younger than 70 who present with significant risk factors for developing osteoporosis, these scans will be reimbursed at a maximum of once every two years. Medicaid does not cover the use of DXA scans to screen for vertebral fractures.

Certain individuals are at a higher risk for osteoporosis. For example, post-menopausal women have a greater risk of osteoporosis. Other risk factors include, but are not limited to: family history of osteoporosis; personal history of fractures after the age of 50; poor diet and physical inactivity; smoking; certain medications, including some steroids, Depo-Provera, and chemotherapy agents; certain medical conditions that predispose individuals to osteoporosis; and low body weight.

The following CPT codes are affected by this frequency limitation:

77080 dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)

77081 dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)

Questions regarding Medicaid Managed Care (MMC) implementation should be directed to the enrollee's MMC plan. Medicaid fee-for-service policy questions may be directed to OHIP Division of Program Development and Management at (518) 473-2160.

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New York State Medicaid Expansion of Coverage of Group A Streptococcus Testing for Practitioners

New York State Medicaid Fee-For-Service (FFS) and Medicaid Managed Care (MMC) will begin reimbursing practitioners for Group A Streptococcus rapid testing (CPT code 87651) when performed in the practitioner's office. This expansion in coverage is effective January 1, 2016 for FFS and April 1, 2016 for MMC.

Group A Streptococcal infection accounts for approximately one quarter of all cases of pharyngitis in school-aged children. Point of care testing for Group A Streptococcal infection often allows practitioners to determine an appropriate course of treatment during an initial visit. Rapid test results have been shown to reduce inappropriate antibiotic use, transmission of the disease to others, and the potential for medical complications.

Reminders:

- If signs and symptoms indicate an active infection but rapid test results are negative, additional testing should be considered.
- Practitioners performing point-of-care laboratory testing must hold the appropriate Clinical Laboratory Improvement Amendments (CLIA) certification for the complexity level of the testing being performed.
- Information for CLIA certification for New York State physician office laboratories can be found at the following website: http://www.wadsworth.org/labcert/polep/.

CPT CODE	Code Description
87651	Streptococcus, group A, amplified probe technique

Questions regarding Medicaid FFS policy should be directed to the 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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Billing New York State Medicaid for Family Planning Services

Family planning services are a covered benefit for New York State Medicaid members. In addition, New York State has two other programs that provide family planning services, the Family Planning Benefit Program (FPBP) and the Family Planning Extension Program (FPEP).

FPBP is a public health insurance program for New Yorkers who need family planning services, but may not be able to afford them. It is intended to increase access to **confidential** family planning services and to enable teens, women and men of childbearing age to prevent and/or reduce the incidence of unintentional pregnancies. FPEP is a public health insurance program available to women who were on Medicaid while they were pregnant, but subsequently were not eligible for comprehensive Medicaid coverage when the pregnancy ended.

Family planning services include:

- Most FDA approved birth control methods, devices, and supplies (e.g., birth control pills, injectables, patches, condoms, diaphragms, and IUDs);
- Emergency contraception services and follow-up care;
- Male and female sterilization;
- Preconception counseling and preventive screening and family planning options before pregnancy; and
- Transportation to and/or from covered visits for FPBP members. FPEP members are not eligible for transportation services.

Medicaid coverage is available for additional procedures and services performed during a family planning visit as well as follow-up procedures and treatment for "limited medical conditions" diagnosed during a family planning visit. Medicaid coverage is available for the treatment of specific sexually transmitted infections (STIs) when provided during a family planning visit.

<u>Claims submitted to New York State Medicaid for family planning and related services must contain</u>:

- The appropriate primary diagnosis code that reflects the primary reason for the visit:
  - a primary diagnosis code for contraceptive management services in the Z30 series – Table A - ICD-10 Diagnosis Codes for Contraceptive Management; **or**
  - a primary diagnosis code indicating an abnormal pap smear and a secondary diagnosis code in the Z30 series; **or**
  - a primary diagnosis code indicating an STI and a secondary diagnosis code in the Z30 series;
- When the primary diagnosis code is in the Z30 series, the family planning indicator should be sent as follows:
  - 150003 paper claim: Field 22H, place an "X" over the "Y" box

- 837 Institutional claim: Loop 2300, HI(01-12)-1, qualifier "BG"
- 837 Professional claim: Loop 2400, SV112, qualifier "Y"

➢ The appropriate CPT-4 code(s) for the evaluation and management service, medical procedure(s) and/or supply from Table B – Covered Services.

Important to note: Transportation to and/or from a family planning service is a Medicaid covered service available to both Medicaid and FPBP members. FPEP members are not eligible for transportation services. Providers should consult the Transportation manual to obtain information regarding transportation policy guidelines, procedures and the county contact list. The manual can be viewed at: http://www.emedny.org/ProviderManuals/Transportation/index.html. Please see Table C - FPBP Transportation Procedure Codes for billable codes.

Table A

ICD-10 Diagnosis Codes for Contraceptive Management

Z30.011	Z30.012	Z30.013	Z30.014	Z30.018	Z30.019	Z30.02	Z30.09	Z30.2	Z30.40
Z30.41	Z30.42	Z30.430	Z30.431	Z30.432	Z30.433	Z30.49	Z30.8	Z30.9	XXXXX

Table B

Covered Services

Procedure Code	Procedure Code Description
00851	ANESTHESIA FOR INTRAPERITONEAL PROCEDURES IN LOWER ABDOMEN INCLUDING LAPAROSCOPY; TUBAL LIGATION/TRANSECTION
00921	ANESTHESIA FOR PROCEDURES ON MALE GENITALIA (INCLUDING OPEN URETHRAL PROCEDURES); VASECTOMY, UNILATERAL OR BILATERAL
00952	ANESTHESIA FOR VAGINAL PROCEDURES (INCLUDING BIOPSY OF LABIA, VAGINA, CERVIX ORENDOMETRIUM); HYSTEROSCOPY AND/OR HYSTEROSALPINGOGRAPHY
10060	INCISION AND DRAINAGE OF ABSCESS (EG, CARBUNCLE, SUPPURATIVE HIDRADENITIS,
10140	INCISION AND DRAINAGE OF HEMATOMA, SEROMA OR FLUID COLLECTION
11420	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED ELSEWHERE), SCALP, NECK, HANDS, FEET, GENITALIA; EXCISED DIAMETER 0.5 CM OR LES
11421	EXCISION, BENIGN LESION INCLUDING MARGINS, EXCEPT SKIN TAG (UNLESS LISTED
11976	REMOVAL, IMPLANTABLE CONTRACEPTIVE CAPSULES
11981	INSERTION, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT
11982	REMOVAL, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT

Procedure Code	Procedure Code Description
11983	REMOVAL WITH REINSERTION, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT
17110	DESTRUCTION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY, SURGICAL CURETTEMENT), OF BENIGN LESIONS OTHER THAN SKIN TAGS OR CUTANEOUS VASCULAR PROLIFERATIVE LESIONS; UP TO 14 LESIONS
17111	DESTRUCTION (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY, SURGICAL CURETTEMENT), OF BENIGN LESIONS OTHER THAN SKIN TAGS OR CUTANEOUS VASCULAR PROLIFERATIVE LESIONS; 15 OR MORE LESIONS
46900	DESTRUCTION OF LESION(S), ANUS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), SIMPLE; CHEMICAL
46922	DESTRUCTION OF LESION(S), ANUS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM
46924	DESTRUCTION OF LESION(S), ANUS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), EXTENSIVE (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY)
54050	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), SIMPLE; CHEMICAL
54055	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), SIMPLE; ELECTRODESICCATION
54056	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), SIMPLE; CRYOSURGERY
54057	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), SIMPLE; LASER SURGERY
54060	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM
54065	DESTRUCTION OF LESION(S), PENIS (EG, CONDYLOMA, PAPILLOMA, MOLLUSCUM CONTAGIOSUM, HERPETIC VESICLE), EXTENSIVE (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY)
55250	VASECTOMY, UNILATERAL OR BILATERAL (SEPARATE PROCEDURE), INCLUDING
55450	LIGATION (PERCUTANEOUS) OF VAS DEFERENS, UNILATERAL OR BILATERAL (SEPARATE
56405	INCISION AND DRAINAGE OF VULVA OR PERINEAL ABSCESS
56420	INCISION AND DRAINAGE OF FEMALE GENITAL GLAND ABSCESS
56440	CREATION OF DRAINAGE TRACT FOR FEMALE GENITAL GLAND OR CYST
56501	DESTRUCTION OF LESION(S), VULVA; SIMPLE (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY)
56700	PARTIAL HYMENECTOMY OR REVISION OF HYMENAL RING
56820	COLPOSCOPY OF THE VULVA;
56821	COLPOSCOPY OF THE VULVA; WITH BIOPSY(S)
57061	DESTRUCTION OF VAGINAL LESION(S); SIMPLE (EG, LASER SURGERY, ELECTROSURGERY, CRYOSURGERY, CHEMOSURGERY)
57420	COLPOSCOPY OF THE ENTIRE VAGINA, WITH CERVIX IF PRESENT;
57421	COLPOSCOPY OF THE ENTIRE VAGINA, WITH CERVIX IF PRESENT; WITH BIOPSY(S) OF VAGINA/CERVIX

Procedure Code	Procedure Code Description
57452	COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT VAGINA;
57454	COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT VAGINA; WITH BIOPSY(S) OF THE CERVIX AND ENDOCERVICAL CURETTAGE
57455	COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT VAGINA; WITH BIOPSY(S) OF THE CERVIX
57456	COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT VAGINA; WITH ENDOCERVICAL
57460	COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT VAGINA; WITH LOOP ELECTRODE BIOPSY(S) OF THE CERVIX
57461	COLPOSCOPY OF THE CERVIX INCLUDING UPPER/ADJACENT VAGINA; WITH LOOP ELECTRODE CONIZATION OF THE CERVIX
57505	ENDOCERVICAL CURETTAGE (NOT DONE AS PART OF A DILATION AND CURETTAGE)
57510	CAUTERY OF CERVIX; ELECTRO OR THERMAL
57511	CAUTERY OF CERVIX; CRYOCAUTERY, INITIAL OR REPEAT
57520	CONIZATION OF CERVIX, WITH OR WITHOUT FULGURATION, WITH OR WITHOUT DILATION AND
57522	CONIZATION OF CERVIX, WITH OR WITHOUT FULGURATION, WITH OR WITHOUT DILATION AND
58100	ENDOMETRIAL SAMPLING (BIOPSY) WITH OR WITHOUT ENDOCERVICAL SAMPLING (BIOPSY),
58300	INSERTION OF INTRAUTERINE DEVICE (IUD)
58301	REMOVAL OF INTRAUTERINE DEVICE (IUD)
58340	CATHETERIZATION AND INTRODUCTION OF SALINE OR CONTRAST MATERIAL FOR SALINE INFUSION SONOHYSTEROGRAPHY (SIS) OR HYSTEROSALPINGOGRAPHY
58565	HYSTEROSCOPY, SURGICAL; WITH BILATERAL FALLOPIAN TUBE CANNULATION TO INDUCE OCCLUSION BY PLACEMENT OF PERMANENT IMPLANTS
58600	LIGATION OR TRANSECTION OF FALLOPIAN TUBE(S), ABDOMINAL OR VAGINAL APPROACH,
58615	OCCLUSION OF FALLOPIAN TUBE(S) BY DEVICE (EG, BAND, CLIP, FALOPE RING) VAGINAL
58670	LAPAROSCOPY, SURGICAL; WITH FULGURATION OF OVIDUCTS (WITH OR WITHOUT TRANSECTION)
58671	LAPAROSCOPY, SURGICAL; WITH OCCLUSION OF OVIDUCTS BY DEVICE (EG, BAND, CLIP, ORFALOPE RING)
71010	RADIOLOGIC EXAMINATION, CHEST; SINGLE VIEW, FRONTAL
71015	RADIOLOGIC EXAMINATION, CHEST; STEREO, FRONTAL
71020	RADIOLOGIC EXAMINATION, CHEST, 2 VIEWS, FRONTAL AND LATERAL;
74000	RADIOLOGIC EXAMINATION, ABDOMEN; SINGLE ANTEROPOSTERIOR VIEW
76830	ULTRASOUND, TRANSVAGINAL

Procedure Code	Procedure Code Description
76856	ULTRASOUND, PELVIC (NONOBSTETRIC), REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE
76857	ULTRASOUND, PELVIC (NONOBSTETRIC), REAL TIME WITH IMAGE DOCUMENTATION; LIMITED OR FOLLOW-UP (EG, FOR FOLLICLES)
77078	COMPUTED TOMOGRAPHY, BONE MINERAL DENSITY STUDY, 1 OR MORE SITES; AXIAL SKELETON (EG, HIPS, PELVIS, SPINE)
77080	DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR MORE SITES; AXIAL SKELETON (EG, HIPS, PELVIS, SPINE)
77081	DUAL-ENERGY X-RAY ABSORPTIOMETRY (DXA), BONE DENSITY STUDY, 1 OR MORE SITES; APPENDICULAR SKELETON (PERIPHERAL) (EG, RADIUS, WRIST, HEEL)
80048	BLOOD TEST, BASIC GROUP OF BLOOD CHEMICALS
80053	BLOOD TEST, COMPREHENSIVE GROUP OF BLOOD CHEMICALS
80061	BLOOD TEST, LIPIDS (CHOLESTEROL AND TRIGLYCERIDES)
80076	LIVER FUNCTION BLOOD TEST PANEL
81000	URINALYSIS, BY DIP STICK OR TABLET REAGENT FOR BILIRUBIN, GLUCOSE, HEMOGLOBIN, KETONES, LEUKOCYTES, NITRITE, PH, PROTEIN, SPECIFIC GRAVITY, UROBILINOGEN, ANYNUMBER OF THESE CONSTITUENTS; NON-AUTOMATED, WITH MICROSCOPY
81001	URINALYSIS, BY DIP STICK OR TABLET REAGENT FOR BILIRUBIN, GLUCOSE, HEMOGLOBIN, KETONES, LEUKOCYTES, NITRITE, PH, PROTEIN, SPECIFIC GRAVITY, UROBILINOGEN, ANYNUMBER OF THESE CONSTITUENTS; AUTOMATED, WITH MICROSCOPY
81002	URINALYSIS, BY DIP STICK OR TABLET REAGENT FOR BILIRUBIN, GLUCOSE, HEMOGLOBIN,
81003	URINALYSIS, BY DIP STICK OR TABLET REAGENT FOR BILIRUBIN, GLUCOSE, HEMOGLOBIN, KETONES, LEUKOCYTES, NITRITE, PH, PROTEIN, SPECIFIC GRAVITY, UROBILINOGEN, ANYNUMBER OF THESE CONSTITUENTS; AUTOMATED, WITHOUT MICROSCOPY
81007	URINALYSIS; BACTERIURIA SCREEN, EXCEPT BY CULTURE OR DIPSTICK
81015	URINALYSIS; MICROSCOPIC ONLY
81025	URINE PREGNANCY TEST, BY VISUAL COLOR COMPARISON METHODS
82040	ALBUMIN; SERUM, PLASMA OR WHOLE BLOOD
82043	ALBUMIN; URINE, MICROALBUMIN, QUANTITATIVE
82150	AMYLASE
82247	BILIRUBIN; TOTAL
82270	BLOOD, OCCULT, BY PEROXIDASE ACTIVITY (EG, GUAIAC), QUALITATIVE; FECES, CONSECUTIVE COLLECTED SPECIMENS WITH SINGLE DETERMINATION, FOR COLORECTAL NEOPLASM SCREENING (IE, PATIENT WAS PROVIDED 3 CARDS OR SINGLE TRIPLE CARD FORCONSECUTIVE COLLECTION)
82465	CHOLESTEROL, SERUM OR WHOLE BLOOD, TOTAL
82550	CREATINE KINASE (CK), (CPK); TOTAL

Procedure Code	Procedure Code Description
82553	CREATINE KINASE (CK), (CPK); MB FRACTION ONLY
82565	CREATININE; BLOOD
82570	CREATININE; OTHER SOURCE
82575	CREATININE; CLEARANCE
82670	ESTRADIOL
82677	ESTRIOL
82947	GLUCOSE; QUANTITATIVE, BLOOD (EXCEPT REAGENT STRIP)
82948	GLUCOSE; BLOOD, REAGENT STRIP
82950	GLUCOSE; POST GLUCOSE DOSE (INCLUDES GLUCOSE)
82951	GLUCOSE; TOLERANCE TEST (GTT), THREE SPECIMENS (INCLUDES GLUCOSE)
83001	GONADOTROPIN; FOLLICLE STIMULATING HORMONE (FSH)
83002	GONADOTROPIN; LUTEINIZING HORMONE (LH)
83690	LIPASE
84075	PHOSPHATASE, ALKALINE;
84144	PROGESTERONE
84146	PROLACTIN
84443	THYROID STIMULATING HORMONE (TSH)
84703	GONADOTROPIN, CHORIONIC (HCG); QUALITATIVE
85002	BLEEDING TIME
85004	BLOOD COUNT; AUTOMATED DIFFERENTIAL WBC COUNT
85007	BLOOD COUNT; BLOOD SMEAR, MICROSCOPIC EXAMINATION WITH MANUAL DIFFERENTIAL WBC
85013	BLOOD COUNT; SPUN MICROHEMATOCRIT
85014	BLOOD COUNT; HEMATOCRIT (HCT)
85018	BLOOD COUNT; HEMOGLOBIN (HGB)
85025	BLOOD COUNT; COMPLETE (CBC), AUTOMATED (HGB, HCT, RBC, WBC AND PLATELET COUNT)
85027	BLOOD COUNT; COMPLETE (CBC), AUTOMATED (HGB, HCT, RBC, WBC AND PLATELET COUNT)
85032	BLOOD COUNT; MANUAL CELL COUNT (ERYTHROCYTE, LEUKOCYTE, OR PLATELET) EACH
85045	BLOOD COUNT; RETICULOCYTE, AUTOMATED
85048	BLOOD COUNT; LEUKOCYTE (WBC), AUTOMATED
85049	BLOOD COUNT; PLATELET, AUTOMATED
85210	CLOTTING; FACTOR II, PROTHROMBIN, SPECIFIC
85300	CLOTTING INHIBITORS OR ANTICOAGULANTS; ANTITHROMBIN III, ACTIVITY

Procedure Code	Procedure Code Description
85378	FIBRIN DEGRADATION PRODUCTS, D-DIMER; QUALITATIVE OR SEMIQUANTITATIVE
85576	PLATELET, AGGREGATION (IN VITRO), EACH AGENT
85610	PROTHROMBIN TIME;
85651	SEDIMENTATION RATE, ERYTHROCYTE; NON-AUTOMATED
85652	SEDIMENTATION RATE, ERYTHROCYTE; AUTOMATED
85730	THROMBOPLASTIN TIME, PARTIAL (PTT); PLASMA OR WHOLE BLOOD
86580	SKIN TEST; TUBERCULOSIS, INTRADERMAL
86592	SYPHILIS TEST, NON-TREPONEMAL ANTIBODY; QUALITATIVE (EG, VDRL, RPR, ART)
86593	SYPHILIS TEST, NON-TREPONEMAL ANTIBODY; QUANTITATIVE
86631	ANTIBODY; CHLAMYDIA
86632	ANTIBODY; CHLAMYDIA, IGM
86687	ANTIBODY; HTLV-I
86689	ANTIBODY; HTLV OR HIV ANTIBODY, CONFIRMATORY TEST (EG, WESTERN BLOT)
86696	ANTIBODY; HERPES SIMPLEX, TYPE 2
86701	ANTIBODY; HIV-1
86702	ANTIBODY; HIV-2
86703	ANTIBODY; HIV-1 AND HIV-2, SINGLE RESULT
86762	ANTIBODY; RUBELLA
86780	ANTIBODY; TREPONEMA PALLIDUM
86900	BLOOD GROUP TYPING (ABO)
86901	BLOOD TYPING FOR RH (D) ANTIGEN
87015	CONCENTRATION (ANY TYPE), FOR INFECTIOUS AGENTS
87040	CULTURE, BACTERIAL; BLOOD, AEROBIC, WITH ISOLATION AND PRESUMPTIVE IDENTIFICATION OF ISOLATES (INCLUDES ANAEROBIC CULTURE, IF APPROPRIATE)
87070	CULTURE, BACTERIAL; ANY OTHER SOURCE EXCEPT URINE, BLOOD OR STOOL, AEROBIC, WITH ISOLATION AND PRESUMPTIVE IDENTIFICATION OF ISOLATES
87075	CULTURE, BACTERIAL; ANY SOURCE, EXCEPT BLOOD, ANAEROBIC WITH ISOLATION AND PRESUMPTIVE IDENTIFICATION OF ISOLATES
87077	CULTURE, BACTERIAL; AEROBIC ISOLATE, ADDITIONAL METHODS REQUIRED FOR DEFINITIVE
87081	CULTURE, PRESUMPTIVE, PATHOGENIC ORGANISMS, SCREENING ONLY;
87086	CULTURE, BACTERIAL; QUANTITATIVE COLONY COUNT, URINE
87088	CULTURE, BACTERIAL; WITH ISOLATION AND PRESUMPTIVE IDENTIFICATION OF EACH ISOLATE, URINE
87102	CULTURE, FUNGI (MOLD OR YEAST) ISOLATION, WITH PRESUMPTIVE IDENTIFICATION OF
87110	CULTURE, CHLAMYDIA, ANY SOURCE

Procedure Code	Procedure Code Description
87164	DARK FIELD EXAMINATION, ANY SOURCE (EG, PENILE, VAGINAL, ORAL, SKIN); INCLUDES
87166	DARK FIELD EXAMINATION, ANY SOURCE (EG, PENILE, VAGINAL, ORAL, SKIN); WITHOUT
87205	SMEAR, PRIMARY SOURCE WITH INTERPRETATION; GRAM OR GIEMSA STAIN FOR BACTERIA, FUNGI, OR CELL TYPES
87206	SMEAR, PRIMARY SOURCE WITH INTERPRETATION; FLUORESCENT AND/OR ACID FAST STAIN FOR BACTERIA, FUNGI, PARASITES, VIRUSES OR CELL TYPES
87207	SMEAR, PRIMARY SOURCE WITH INTERPRETATION; SPECIAL STAIN FOR INCLUSION BODIES OR PARASITES (EG, MALARIA, COCCIDIA, MICROSPORIDIA, TRYPANOSOMES, HERPES VIRUSES)
87210	SMEAR, PRIMARY SOURCE WITH INTERPRETATION; WET MOUNT FOR INFECTIOUS AGENTS (EG,SALINE, INDIA INK, KOH PREPS)
87252	VIRUS ISOLATION; TISSUE CULTURE INOCULATION, OBSERVATION, AND PRESUMPTIVE IDENTIFICATION BY CYTOPATHIC EFFECT
87254	VIRUS ISOLATION; CENTRIFUGE ENHANCED (SHELL VIAL) TECHNIQUE, INCLUDES IDENTIFICATION WITH IMMUNOFLUORESCENCE STAIN, EACH VIRUS
87255	VIRUS ISOLATION; INCLUDING IDENTIFICATION BY NON-IMMUNOLOGIC METHOD, OTHER THANBY CYTOPATHIC EFFECT (EG, VIRUS SPECIFIC ENZYMATIC ACTIVITY)
87270	INFECTIOUS AGENT ANTIGEN DETECTION BY IMMUNOFLUORESCENT TECHNIQUE; CHLAMYDIA TRACHOMATIS
87273	INFECTIOUS AGENT ANTIGEN DETECTION BY IMMUNOFLUORESCENT TECHNIQUE; HERPES SIMPLEX VIRUS TYPE 2
87274	INFECTIOUS AGENT ANTIGEN DETECTION BY IMMUNOFLUORESCENT TECHNIQUE; HERPES SIMPLEX VIRUS TYPE 1
87320	INFECTIOUS AGENT ANTIGEN DETECTION BY ENZYME IMMUNOASSAY TECHNIQUE, QUALITATIVEOR SEMIQUANTITATIVE, MULTIPLE-STEP METHOD; CHLAMYDIA TRACHOMATIS
87340	INFECTIOUS AGENT ANTIGEN DETECTION BY ENZYME IMMUNOASSAY TECHNIQUE, QUALITATIVEOR SEMIQUANTITATIVE, MULTIPLE-STEP METHOD; HEPATITIS B SURFACE ANTIGEN (HBSAG)
87389	INFECTIOUS AGENT ANTIGEN DETECTION BY ENZYME IMMUNOASSAY TECHNIQUE, QUALITATIVEOR SEMIQUANTITATIVE, MULTIPLE-STEP METHOD; HIV-1 ANTIGEN(S), WITH HIV-1 AND HIV-2 ANTIBODIES, SINGLE RESULT
87390	INFECTIOUS AGENT ANTIGEN DETECTION BY ENZYME IMMUNOASSAY TECHNIQUE, QUALITATIVEOR SEMIQUANTITATIVE, MULTIPLE-STEP METHOD; HIV-1
87486	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); CHLAMYDIA PNEUMONIAE, AMPLIFIED PROBE TECHNIQUE
87490	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); CHLAMYDIA TRACHOMATIS,DIRECT PROBE TECHNIQUE
87491	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); CHLAMYDIA TRACHOMATIS,AMPLIFIED PROBE TECHNIQUE

Procedure Code	Procedure Code Description
87495	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); CYTOMEGALOVIRUS, DIRECT PROBE TECHNIQUE
87510	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); GARDNERELLA VAGINALIS,DIRECT PROBE TECHNIQUE
87535	DETECTION TEST FOR HIV-1 VIRUS
87536	DETECTION TEST FOR HIV-1 VIRUS
87590	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); NEISSERIA GONORRHOEAE,DIRECT PROBE TECHNIQUE
87591	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); NEISSERIA GONORRHOEAE,AMPLIFIED PROBE TECHNIQUE
87620	DETECTION TEST FOR HUMAN PAPILLOMAVIRUS (HPV)
87621	DETECTION TEST FOR HUMAN PAPILLOMAVIRUS (HPV)
87623	DETECTION TEST FOR HUMAN PAPILLOMAVIRUS (HPV)
87624	DETECTION TEST FOR HUMAN PAPILLOMAVIRUS (HPV)
87625	DETECTION TEST FOR HUMAN PAPILLOMAVIRUS (HPV)
87797	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA), NOT OTHERWISE SPECIFIED; DIRECT PROBE TECHNIQUE, EACH ORGANISM
87798	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA), NOT OTHERWISE SPECIFIED; AMPLIFIED PROBE TECHNIQUE, EACH ORGANISM
87800	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA), MULTIPLE ORGANISMS; DIRECT PROBE(S) TECHNIQUE
87801	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA), MULTIPLE ORGANISMS; AMPLIFIED PROBE(S) TECHNIQUE
87808	INFECTIOUS AGENT ANTIGEN DETECTION BY IMMUNOASSAY WITH DIRECT OPTICAL OBSERVATION; TRICHOMONAS VAGINALIS
87899	INFECTIOUS AGENT DETECTION BY IMMUNOASSAY WITH DIRECT OPTICAL OBSERVATION; NOT OTHERWISE SPECIFIED
88141	CYTOPATHOLOGY, CERVICAL OR VAGINAL (ANY REPORTING SYSTEM), REQUIRING INTERPRETATION BY PHYSICIAN
88142	CYTOPATHOLOGY, CERVICAL OR VAGINAL (ANY REPORTING SYSTEM), COLLECTED IN PRESERVATIVE FLUID, AUTOMATED THIN LAYER PREPARATION; MANUAL SCREENING UNDER PHYSICIAN SUPERVISION
88143	CYTOPATHOLOGY, CERVICAL OR VAGINAL (ANY REPORTING SYSTEM), COLLECTED IN PRESERVATIVE FLUID, AUTOMATED THIN LAYER PREPARATION WITH MANUAL SCREENING AND RESCREENING UNDER PHYSICIAN SUPERVISION
88147	CYTOPATHOLOGY SMEARS, CERVICAL OR VAGINAL; SCREENING BY AUTOMATED SYSTEM UNDER PHYSICIAN SUPERVISION
88148	CYTOPATHOLOGY SMEARS, CERVICAL OR VAGINAL; SCREENING BY AUTOMATED SYSTEM WITH MANUAL RESCREENING UNDER PHYSICIAN SUPERVISION
88150	CYTOPATHOLOGY, SLIDES, CERVICAL OR VAGINAL; MANUAL SCREENING UNDER PHYSICIAN SUPERVISION

Procedure Code	Procedure Code Description
88152	CYTOPATHOLOGY, SLIDES, CERVICAL OR VAGINAL; WITH MANUAL SCREENING AND COMPUTER-ASSISTED RESCREENING UNDER PHYSICIAN SUPERVISION
88153	CYTOPATHOLOGY, SLIDES, CERVICAL OR VAGINAL; WITH MANUAL SCREENING AND RESCREENING UNDER PHYSICIAN SUPERVISION
88154	CYTOPATHOLOGY, SLIDES, CERVICAL OR VAGINAL; WITH MANUAL SCREENING AND COMPUTER-ASSISTED RESCREENING USING CELL SELECTION AND REVIEW UNDER PHYSICIAN SUPERVISION
88155	CYTOPATHOLOGY, SLIDES, CERVICAL OR VAGINAL, DEFINITIVE HORMONAL EVALUATION (EG,MATURATION INDEX, KARYOPYKNOTIC INDEX, ESTROGENIC INDEX) (LIST SEPARATELY IN ADDITION TO CODE S FOR OTHER TECHNICAL AND INTERPRETATION SERVICES)
88160	CYTOPATHOLOGY, SMEARS, ANY OTHER SOURCE; SCREENING AND INTERPRETATION
88161	CYTOPATHOLOGY, SMEARS, ANY OTHER SOURCE; PREPARATION, SCREENING AND INTERPRETATION
88162	CYTOPATHOLOGY, SMEARS, ANY OTHER SOURCE; EXTENDED STUDY INVOLVING OVER 5 SLIDESAND/OR MULTIPLE STAINS
88164	CYTOPATHOLOGY, SLIDES, CERVICAL OR VAGINAL (THE BETHESDA SYSTEM); MANUAL SCREENING UNDER PHYSICIAN SUPERVISION
88165	CYTOPATHOLOGY, SLIDES, CERVICAL OR VAGINAL (THE BETHESDA SYSTEM); WITH MANUAL SCREENING AND RESCREENING UNDER PHYSICIAN SUPERVISION
88173	CYTOPATHOLOGY, EVALUATION OF FINE NEEDLE ASPIRATE; INTERPRETATION AND REPORT
88174	CYTOPATHOLOGY, CERVICAL OR VAGINAL (ANY REPORTING SYSTEM), COLLECTED IN PRESERVATIVE FLUID, AUTOMATED THIN LAYER PREPARATION; SCREENING BY AUTOMATED SYSTEM, UNDER PHYSICIAN SUPERVISION
88175	CYTOPATHOLOGY, CERVICAL OR VAGINAL (ANY REPORTING SYSTEM), COLLECTED IN PRESERVATIVE FLUID, AUTOMATED THIN LAYER PREPARATION; WITH SCREENING BY AUTOMATED SYSTEM AND MANUAL RESCREENING OR REVIEW, UNDER PHYSICIAN SUPERVISION
88302	PATHOLOGY EXAMINATION OF TISSUE USING A MICROSCOPE
88305	PATHOLOGY EXAMINATION OF TISSUE USING A MICROSCOPE, INTERMEDIATE COMPLEXITY
88307	PATHOLOGY EXAMINATION OF TISSUE USING A MICROSCOPE, MODERATELY HIGH COMPLEXITY
89321	SEMEN ANALYSIS; SPERM PRESENCE AND MOTILITY OF SPERM, IF PERFORMED
93000	ELECTROCARDIOGRAM, ROUTINE ECG WITH AT LEAST 12 LEADS; WITH INTERPRETATION AND REPORT
93010	ELECTROCARDIOGRAM, ROUTINE ECG WITH AT LEAST 12 LEADS; INTERPRETATION AND REPORT ONLY
93040	RHYTHM ECG, ONE TO THREE LEADS; WITH INTERPRETATION AND REPORT

Procedure Code	Procedure Code Description
93307	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION (2D), INCLUDES M-MODE RECORDING, WHEN PERFORMED, COMPLETE, WITHOUT SPECTRAL OR COLORDOPPLER ECHOCARDIOGRAPHY
96372	THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG);SUBCUTANEOUS OR INTRAMUSCULAR
99050	SERVICES PROVIDED IN THE OFFICE AT TIMES OTHER THAN REGULARLY SCHEDULED OFFICE HOURS, OR DAYS WHEN THE OFFICE IS NORMALLY CLOSED (EG, HOLIDAYS, SATURDAY OR SUNDAY), IN ADDITION TO BASIC SERVICE
99051	SERVICE(S) PROVIDED IN THE OFFICE DURING REGULARLY SCHEDULED EVENING, WEEKEND, OR HOLIDAY OFFICE HOURS, IN ADDITION TO BASIC SERVICE
99070	SUPPLIES AND MATERIALS (EXCEPT SPECTACLES), PROVIDED BY THE PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL OVER AND ABOVE THOSE USUALLY INCLUDED WITH THE OFFICE VISIT OR OTHER SERVICES RENDERED (LIST DRUGS, TRAYS, SUPPLIES, OR MATERIALS PROVIDED)
99201	NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 10 MINUTES
99202	NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 20 MINUTES
99203	NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 30 MINUTES
99204	NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 45 MINUTES
99205	NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 60 MINUTES
99211	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT THAT MAY NOT REQUIRE THE PRESENCE OF A PHYSICIAN OR OTHERQUALIFIED HEALTH CARE PROFESSIONAL. USUALLY, THE PRESENTING PROBLEM(S) ARE MINIMAL. TYPICALLY, 5 MINUTES ARE SPENT PERFORMING OR SUPERVISING THESE
99212	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 10 MINUTES
99213	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 15 MINUTES
99214	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT, VISIT TYPICALLY 25 MINUTES
99215	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT, VISIT TYPICALLY 40 MINUTES
99241	PATIENT OFFICE CONSULTATION, TYPICALLY 15 MINUTES
99242	PATIENT OFFICE CONSULTATION, TYPICALLY 30 MINUTES
99243	PATIENT OFFICE CONSULTATION, TYPICALLY 40 MINUTES
99244	PATIENT OFFICE CONSULTATION, TYPICALLY 60 MINUTES
99245	PATIENT OFFICE CONSULTATION, TYPICALLY 80 MINUTES
99384	INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF LABORATORY/DIAGNOSTIC PROCEDURES, NEW PATIENT; ADOLESCENT (AGE 12 THROUGH 17 YEARS)

Procedure Code	Procedure Code Description
99385	INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF LABORATORY/DIAGNOSTIC PROCEDURES, NEW PATIENT; 18-39 YEARS
99386	INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF LABORATORY/DIAGNOSTIC PROCEDURES, NEW PATIENT; 40-64 YEARS
99394	ESTABLISHED PATIENT PERIODIC PREVENTIVE MEDICINE EXAMINATION, AGE 12 THROUGH 17 YEARS
99395	ESTABLISHED PATIENT PERIODIC PREVENTIVE MEDICINE EXAMINATION AGE 18-39 YEARS
99396	ESTABLISHED PATIENT PERIODIC PREVENTIVE MEDICINE EXAMINATION AGE 40-64 YEARS
A4264	PERMANENT IMPLANTABLE CONTRACEPTIVE INTRATUBAL OCCLUSION DEVICE(S) AND DELIVERYSYSTEM
A4266	DIAPHRAGM KIT
A4267	CONTRACEPTIVE SUPPLY, CONDOM, MALE, EACH
A4268	CONTRACEPTIVE SUPPLY, CONDOM, FEMALE, EACH
A4931	ORAL THERMOMETER, REUSABLE, ANY TYPE, EACH
J0696	INJECTION, CEFTRIAXONE SODIUM, PER 250 MG
J1050	INJECTION, MEDROXYPROGESTERONE ACETATE, 1 MG
J7297	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM, 52MG, 3 YEAR DURATION
J7298	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM, 52 MG, 5 YEAR DURATION
J7300	INTRAUTERINE COPPER CONTRACEPTIVE
J7301	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM, 13.5 MG
J7303	CONTRACEPTIVE SUPPLY, HORMONE CONTAINING VAGINAL RING, EACH
J7304	CONTRACEPTIVE SUPPLY, HORMONE CONTAINING PATCH, EACH
J7306	LEVONORGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANTS AND SUPPLIES
J7307	ETONOGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANT AND SUPPLIES
S4993	CONTRACEPTIVE PILLS FOR BIRTH CONTROL
T5999	SUPPLY,NOT OTHERWISE SPECIFIED

Table C

Transportation Procedure Codes

A0100	A0110	A0120	A0130	S0209	S0215

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

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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