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New York State Medicaid Update

THE OFFICIAL NEWSLETTER OF THE NEW YORK MEDICAID PROGRAM

■ This is a reminder to all hospitals, free-standing clinics and individual practitioners about the requirements of the Medicaid program related to requesting compensation from Medicaid beneficiaries, including Medicaid beneficiaries who are enrolled in a Medicaid managed care or Family Health Plus (FHPlus) plan, or who have been found to be presumptively eligible for Medicaid.

Medicaid Beneficiaries Cannot Be Billed

By enrolling in the Medicaid program, a provider agrees to accept payment under the Medicaid program as payment in full for services rendered. A provider may not make a private pay agreement with a beneficiary to accept a Medicaid fee for a particular covered service and then provide a different upgraded service (usually a service that is beyond the scope of the Medicaid program) and agree to charge the beneficiary only the difference in fee between two services, in addition to billing Medicaid for the covered service. It is an unacceptable practice to knowingly demand or collect any reimbursement in addition to claims made under the Medicaid program, except where permitted by law.

ACCEPTANCE AND AGREEMENT

- *When a provider accepts a Medicaid beneficiary as a patient, the provider agrees to bill Medicaid for services provided or, in the case of a Medicaid managed care or Family Health Plus (FHPlus) enrollee, the beneficiary's managed care plan for services covered by the contract.*
- *The provider is prohibited from requesting any monetary compensation from the beneficiary, or their responsible relative, except for any applicable Medicaid co-payments.*
- *The provider is prohibited from requesting any monetary compensation from pregnant women or children who have been found to be presumptively eligible for Medicaid.*
- *A provider may charge a Medicaid beneficiary, including a Medicaid or FHPlus beneficiary enrolled in a managed care plan, only when both parties have agreed prior to the rendering of the service that the beneficiary is being seen as a private pay patient.*
- *This agreement must be mutual and voluntary.*
- *If, for example, a provider sees a beneficiary, and advises them that their Medicaid card is valid, eligibility exists for the date of service and treats the individual, the provider may not change their mind and bill the beneficiary for that service **or any part of that service.***



It is suggested that providers keep the beneficiary's signed consent on file so that they may be treated as a private pay patient. A provider who participates in Medicaid fee-for-service **may not bill Medicaid fee-for-service** for any services included in a beneficiary's managed care plan, with the exception of family planning services, when the provider does not provide such services under a contract with the recipient's health plan. **-continued on page 3-**



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POLICY & BILLING GUIDANCE

Medicaid Beneficiaries Cannot Be Billed -continued from cover page-

A provider who does not participate in Medicaid fee-for-service, but who has a contract with one or more managed care plans to serve Medicaid managed care or FHPlus members, **may not bill Medicaid fee-for-service** for any services. Nor may any provider bill a beneficiary for services that are covered by the beneficiary's Medicaid managed care or FHPlus contract, unless there is prior agreement with the beneficiary that they are being seen as a private pay patient as described above. The provider must inform the beneficiary that the services may be obtained at no cost from a provider that participates in the beneficiary's managed care plan.

Note: Due to the requirement that PRIOR agreement be made for reimbursement, Medicaid beneficiaries may never be charged for services rendered in an Emergency Room (except applicable Medicaid co-payments).

CLAIM SUBMISSION

The prohibition on charging a Medicaid or FHPlus recipient applies:

- *When a participating Medicaid provider or a Medicaid managed care or FHPlus participating provider fails to submit a claim to Computer Sciences Corporation (CSC) or the recipient's managed care plan within the required timeframe; or*
- *When a claim is submitted to CSC or the recipient's managed care plan, and the claim is denied for reasons other than that the patient was not eligible for Medicaid or FHPlus on the date of service.*

COLLECTIONS

A Medicaid beneficiary, including a Medicaid managed care or FHPlus enrollee, must not be referred to a collection agency for collection of unpaid medical bills or otherwise billed, *except for applicable Medicaid co-payments*, when the provider has accepted the enrollee as a Medicaid or FHPlus patient. Providers may, however, use any legal means to collect applicable unpaid Medicaid co-payments.

EMERGENCY MEDICAL CARE

A hospital that accepts a Medicaid beneficiary as a patient, including a Medicaid or FHPlus recipient enrolled in a managed care plan, accepts the responsibility for making sure that the patient receives all medically necessary care and services. *Other than for legally established co-payments*, a Medicaid or FHPlus recipient should never be required to bear any out-of-pocket expenses for:

- *Medically necessary inpatient services; or,*
- *Medically necessary services provided in a hospital-based emergency room (ER).*

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POLICY & BILLING GUIDANCE

Medicaid Beneficiaries Cannot Be Billed –continued–

This policy applies regardless of whether the individual practitioner treating the beneficiary in the facility is enrolled in the Medicaid program. When reimbursing for ER services provided to Medicaid managed care or FHPlus enrollees, health plans must apply the:

- *Prudent Layperson Standard;*
- *Provisions of the Medicaid Managed Care/FHPlus Model Contract; and,*
- *Department Directives.*

CLAIMING PROBLEMS

If there is a problem with a claim submission, the provider must first contact CSC. If the claim is for a service included in the Medicaid managed care or FHPlus benefit package, the enrollee's managed care plan must be contacted.

Questions? Please call the Office of Health Insurance Programs at (518) 473-2160.



Update on Federal Medical Assistance Percentage (FMAP) Contingency Reduction - Provider Restoration Payments

The State implemented a 1.1% across the board reduction to Medicaid payments that were processed on or after September 16, 2010. Subsequent concerns expressed by the Center for Medicare and Medicaid Services have led to a change in implementation to claims with dates of service beginning on or after September 16, 2010. Therefore, a reconciliation has been prepared to refund monies collected on claims with a date of service prior to September 16 but paid after that date, and for exempt providers who had been inadvertently reduced. The State began distribution of restoration payments in billing cycle 1746 (checks dated 2/7/2011, released 2/23/2011). The paper remittance includes a single line containing the lump sum payment identified by Financial Reason Code 'LSF'. Electronic remittances reflect the lump sum payment in the PLB segment with the qualifier 'LS'.

Any questions may be directed to: b1191@health.state.ny.us. Please include your provider name and Medicaid number in the email so that questions can be reviewed and responded to in an orderly manner.

The modified reduction will remain in effect for claims with dates of service on or after September 16, 2010, which are paid by March 31, 2011.



Medical Direction of CRNAs Clarification of Payment Rules

■ The following information provides clarification of Medicaid’s policy regarding the billing and payment to anesthesiologists for “medically directing” services provided by certified registered nurse anesthetists (CRNAs).

Effective January 1, 2011, Medicaid’s anesthesia teaching policy was revised to allow teaching anesthesiologists to bill for “medical direction” of up to four concurrent procedures/cases involving qualified individuals, all of whom could be resident physicians, CRNAs, or a combination of these individuals (see November 2010 Medicaid Update article, “Anesthesia Supervision Billing and Payment Update”).

The “QK” modifier (medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals) is to be used for cases in which the teaching/supervising anesthesiologist is medically directing CRNAs who are self-employed or employed by the facility. (The “QK” modifier is also applicable to cases in which the anesthesiologist is medically directing resident physicians). In such cases, the anesthesiologist will receive 50% of the fee that would apply if the anesthesiologist performed the case alone.

When a CRNA, employed by an anesthesiologist or an anesthesiology group, provides services under the medical direction of an employing anesthesiologist, the “QK” modifier should not be used. The anesthesia administration procedure code should be billed, without a modifier, under the national provider identification number (NPI #) of the anesthesiologist or the anesthesiology group. The anesthesiologist or the group will receive 100% of the fee that would apply if the anesthesiologist performed the case alone.

For policy questions, please call (518) 473-2160. For billing questions, please call (800) 343-9000.



Radiology Management Program for New York Medicaid Fee-for-Service

Effective April 4, 2011, New York State Medicaid fee-for-service will implement a radiology management program to ensure that beneficiaries receive the most clinically appropriate imaging studies. The program will be applied to non-emergency outpatient CT, CTA, MRI, MRA, cardiac nuclear and PET procedures, for fee-for-service beneficiaries. Beneficiaries who are eligible for both Medicaid and Medicare (dual eligible) or beneficiaries who are enrolled in a managed care plan are not included.

RadConsult™, administered by HealthHelp, is a consultative, educational program that improves quality and reduces the cost of care by providing expert peer consultation and the latest evidence-based medical criteria for diagnostic imaging. It provides access to consultations with subspecialists affiliated with academic radiology departments.

Ordering practitioners will be required to obtain prior approval. Requests will be reviewed against guidelines, and an approval number will be issued. Approvals will be required for claims payment.

If you are interested in attending an upcoming educational webinar, please email kurczj@healthhelp.com with the following information:

- Facility or practice name and NPI;
- Address of practice;
- Number of providers in the practice;
- First and last name of the main point of contact; and
- Contact phone, fax and email.

To learn more about this new program, please visit: www.eMedNY.org.



Billing Instructions for Skilled Nursing Facility Stays for Medicaid Advantage and Medicaid Advantage Plus Enrollees

Medicaid Advantage

Individuals who are dually eligible for both Medicare and Medicaid may enroll in a Medicaid Advantage plan and receive health benefits under both programs within one managed care plan. When a Medicaid Advantage enrollee enters a nursing home for a **non-permanent** stay, the health plan covers the stay for a limited time period, up to a maximum of 100 days. If skilled nursing care is still medically necessary after this period, and the stay is still considered non-permanent, the nursing home may bill the additional days to eMedNY in the usual manner using the appropriate rate code for the client. The Coordination of Benefits segments should reflect denial of coverage by the Medicaid Advantage plan through the use of the “OFILL” entry. **Facilities should only bill eMedNY for stays not covered within the managed care benefit package.** Compliance with the appropriate billing through eMedNY will be accomplished through post payment review and audit.

Medicaid Advantage enrollees whose stay in a nursing home is deemed **permanent** will be disenrolled from the Medicaid Advantage plan effective the first day of the month of entry (if the stay is deemed permanent upon entry) or the first day of the month of classification of the stay as permanent, subsequent to entry. Nursing homes should contact the local social services district in the enrollee’s county of residence to coordinate disenrollment. Nursing home stays that are deemed permanent should be billed to eMedNY.

Medicaid Advantage Plus

Medicaid Advantage Plus (MAP) is a managed care product for individuals who are dually eligible for both Medicare and Medicaid and are eligible for nursing home placement but live in the community upon enrollment. When a MAP enrollee is admitted to a nursing home, the plan’s benefit package covers both **non-permanent and permanent stays**. As long as the individual is enrolled in MAP, the nursing home should bill the MAP plan for authorized placements, regardless of the length of stay.

Providers can identify Medicaid Advantage and MAP enrollees during eligibility checks via the plan codes. A list of these plan codes can be accessed through eMedNY at:

http://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers-Managed_Care_Information_%202011-1.pdf.

Questions? Please contact the Office of Health Insurance Programs at (518) 473-0122.



Billing for Family Planning Services for Managed Care Enrollees

All Medicaid managed care enrollees, and those Family Health Plus enrollees in Fidelis Care (New York State Catholic Health Plan), may choose to obtain family planning services from any qualified Medicaid enrolled provider. Medicaid fee-for-service providers who do not participate with an enrollee's managed care plan may bill eMedNY for family planning services. Providers who participate in the enrollee's health plan (except for Fidelis) must bill the enrollee's health plan.

The following criteria determine if a claim is considered a family planning service and is payable by eMedNY:

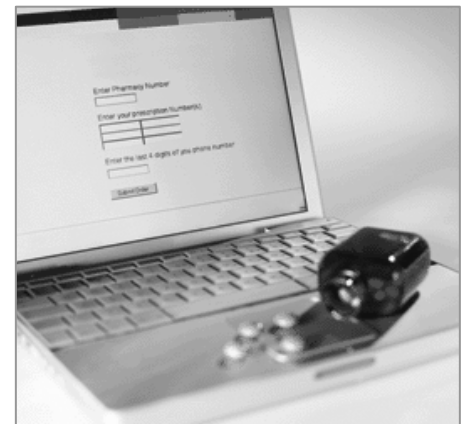
- ***The Claim Family Planning Indicator is marked "yes", OR***
- ***The Specialty Code assigned to the claim indicates a Family Planning Clinic Specialty Code "906", OR***
- ***The drug, diagnosis or secondary diagnosis is related to family planning, OR***
- ***A clinic claim indicates sterilization or abortion codes "A" through "K", OR***
- ***A non-inpatient claim indicates sterilization or abortion codes "A" thru "F", OR***
- ***An inpatient claim indicates sterilization codes "F" through "K", OR***
- ***An inpatient claim indicates abortion codes "A" through "E" or "G" through "K".***

Note: Medicaid pays for medically necessary abortions only. The costs of elective abortions for New York City residents are paid entirely by the City.

Questions about billing for family planning services should be directed to the eMedNY Call Center at (800) 343-9000.

Department Unveils Controlled Substance Information (CSI) on Dispensed Prescriptions Program

Prescription drug (Rx) abuse is a fast-growing health problem in the United States. According to the Substance Abuse and Mental Health Services Administration's 2009 National Survey on Drug Use and Health, non-medical use of prescription drugs for people 12 and older has increased 20 percent since 2002. Additionally, non-medical users of prescription drugs outnumber new users in any other class of drugs. Of the 2.6 million new users in 2009, 2.2 million were non-medical users of prescription pain relievers.



In an effort to curtail this rising trend, the New York State Department of Health, Bureau of Narcotic Enforcement has implemented the Controlled Substance Information (CSI) on Dispensed Prescriptions Program. The CSI provides direct, secure access to practitioners to view their patients' recent controlled substance prescription history. The CSI is available 24 hours a day/7 days a week.

Practitioners can view controlled substance prescription information through their existing Health Commerce System (HCS) account at: <https://commerce.health.state.ny.us/hcsportal/appmanager/hcs/home> if a patient has received controlled substance prescriptions from two or more practitioners and filled them at two or more pharmacies during the previous calendar month. This information will allow practitioners to better evaluate patients' treatment with controlled substances and determine whether there may be abuse or non-legitimate use.

Practitioners that do not currently have an HCS account can register online at: <https://hcsteamwork1.health.state.ny.us/pub/top.html>.

Questions? Please contact the Bureau of Narcotic Enforcement at (866) 811-7957 (Option #4).



New York State Medicaid Preferred Diabetic Supply Program Reminder

Effective March 1, 2011, Abbott, Bayer and LifeScan are the preferred manufacturers for the New York State Medicaid Preferred Diabetic Supply Program (PDSP).

Preferred blood glucose monitors and corresponding test strips from the preferred manufacturers will be available without prior approval. Beneficiaries currently using non-preferred products will require a new fiscal order to obtain preferred monitors and strips. If preferred products do not meet a beneficiary's medical needs, a non-preferred product will require prior approval. Prior approval is based on documentation of medical necessity. If approved, non-preferred products are billed using HCPCS codes on the DME claim form.

The current Preferred Supply List (PSL) is available online at:

<https://newyork.fhsc.com/providers/diabeticsupplies.asp>.

Providers are encouraged to frequently visit the PDSP website for updates to the program. Additional information is available at the following websites:

www.nyhealth.gov or <http://newyork.fhsc.com> or www.eMedNY.org.

Questions? PDSP Policy: (518) 486-3209, Prior Approval: (800) 342-3005, Billing: (800) 343-9000.



Did You Know?

Medicaid Covers Smoking Cessation Pharmacotherapies

Smoking cessation therapy consists of prescription and non-prescription agents. Covered agents include nasal sprays, inhalers, Zyban (bupropion), Chantix (varenicline), over-the-counter nicotine patches and gum.

Two courses of smoking cessation therapy per recipient, per year are allowed. A course of therapy is defined as no more than a 90-day supply (an original order and two refills, even if less than a 30-day supply is dispensed in any fill). If a course of smoking cessation therapy is interrupted, it will be considered one complete course of therapy. Any subsequent prescriptions would then be considered the second course of therapy.

Some smoking cessation therapies may be used together. Professional judgment should be exercised when dispensing multiple smoking cessation products. Duplicative use of any one agent is not allowed (i.e., same drug and same dosage form and same strength).

For all smoking cessation products, the recipient must have an order. A prescription is the terminology for an order of a prescription product. A fiscal order refers to an order, which looks just like a prescription—written on a prescription blank, for an over-the-counter product.

Prescription nicotine patches will no longer be reimbursed. New York State Medicaid will only reimburse for over-the counter nicotine patches. For more information on the New York State Medicaid Smoking Cessation policy, please call (518) 486-3209.

Help your patients' kick this deadly habit!

**NYS SMOKERS' QUITLINE:
(866) NY-QUITS (866-697-8487)**

1099 Form Important Information

Computer Sciences Corporation (CSC), the eMedNY contractor for the NYS Department of Health (NYSDOH), annually issues the Internal Revenue Service (IRS) Form 1099 to providers for the previous year's Medicaid payments. 1099 forms are issued with the individual provider's Social Security Number, or if a business, with the Federal Employer Identification Number (FEIN) registered with New York State Medicaid. As with previous years, the IRS 1099 amount is not based on the date of the checks/EFTs; rather, it is based on the date the checks/EFTs were released to providers.

Since there is a two-week payment lag between the date of the checks/EFTs and the date the check/EFT is issued, the IRS 1099 amount will not correspond to the sum of all checks/EFTs issued for your provider identification number during the calendar year.

The IRS 1099 issued for 2010 will include the following:

- > *Check/EFT dated 12/21/09 (Cycle 1687) released on 01/06/2010 through,*
- > *Check/EFT dated 12/13/10 (Cycle 1738) released 12/29/10.*

Each year, CSC receives calls from individual providers who are issued 1099s for funds the practitioner is unaware of. This generally occurs because in order for group practice providers to direct Medicaid payments to a group NPI and corresponding IRS 1099 for the group, group practices must submit the group NPI in the appropriate field on the claim (paper or electronic). When claims are submitted without the group NPI, it causes the payment to go to the *individual* provider and his/her IRS 1099. Regardless of who deposits the funds, the 1099 will be issued to the individual provider when the funds had been paid to the individual provider's NPI.

NOTE: 1099s are not issued to providers whose yearly payments are less than \$600.00. **IRS 1099s for the year 2010 will be mailed no later than January 31, 2011.**

Questions? Please contact the eMedNY Call Center at (800) 343-9000.

PROVIDER DIRECTORY

Office of the Medicaid Inspector General:

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

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

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

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 email: emednyproviderrelations@csc.com.

Enrollee Eligibility:

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

Address Change?

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

Fee-for-Service Providers: A change of address form is available at:

<http://www.emedny.org/info/ProviderEnrollment/allforms.html>.

Rate-Based/Institutional Providers: A change of address form is available at:

<http://www.emedny.org/info/ProviderEnrollment/allforms.html>.

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

ownership? Fee-for-Service Providers please call (518) 402-7032.

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

Comments and Suggestions Regarding This Publication?

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

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

PLEASE CALL: 1-877-87FRAUD

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

