



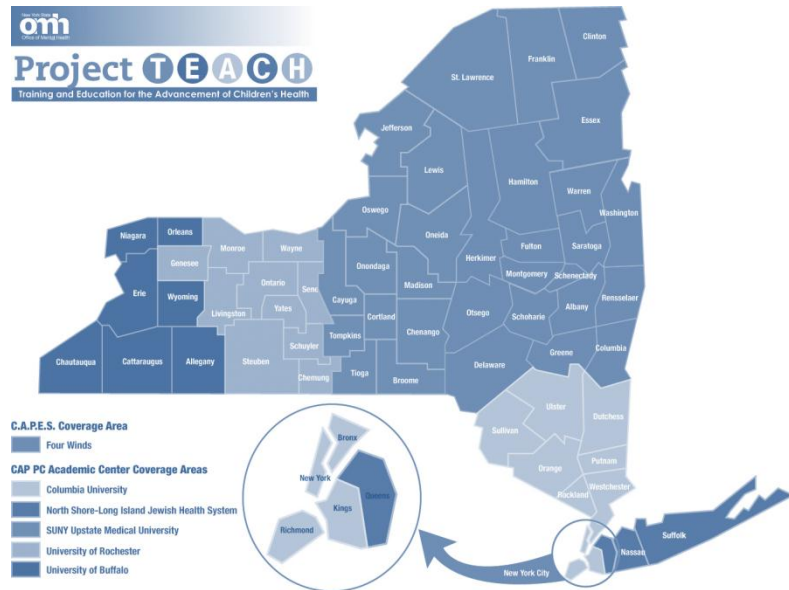
New York State Medicaid Update

THE OFFICIAL NEWSLETTER OF THE NEW YORK STATE MEDICAID PROGRAM

Project TEACH (Training and Education for the Advancement of Children's Health)

The Surgeon General estimates that 20 percent of children and adolescents in the United States suffer from mental illness severe enough to cause some level of impairment, yet less than 1 in 5 of these children receives treatment from a mental health provider.

To support the critical role that pediatricians and primary care physicians (PCPs) play in the early identification and treatment for emotional disturbances in children, the New York State Office of Mental Health (OMH), in collaboration with District II of the American Academy of Pediatrics (AAP), the New York State Chapter of the American Academy of Family Physicians (AAFP) and the conference of Local Mental Hygiene Directors (CLMHD) has funded Project TEACH (Training and Education for the Advancement of Children's Health). Project TEACH is committed to strengthening and supporting the ability of PCPs to provide mental health services to youth in their practices. Under Project TEACH, PCPs in NYS are eligible for a series of free services. Physicians participating in Project TEACH can:



- **Access rapid consultation** from child and adolescent psychiatrists. All PCPs are eligible to receive telephonic consultation about their patients' mental health needs.
- **Educational-based trainings** are held regularly on a variety of topics related to children's social and emotional development. CME credits are available to physicians for attending the training.
- **Access referral and linkage services** for their child and adolescent patients. PCPs can obtain direct consultation for their patients, either face to face with the psychiatrist or via videoconference. Referral and linkage services assist families and primary care providers to access community mental health and support services such as clinic treatment, case management, or family support.

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OMH has contracted with two providers for statewide coverage: C.A.P.E.S. and CAP PC.

- **The Child and Adolescent Psychiatry Education and Support (C.A.P.E.S.) Program for Primary Care Physicians** serves the northeastern part of the state. It is based out of Saratoga, under the auspices of the Four Winds Foundation. The C.A.P.E.S. Program has been active since 2005. It was created, and continues to be led, by Jeffrey M. Daly, M.D. For more information, please contact Michele Phillips at (518) 581-5015, ext. 3310, or visit www.capesprogram.org.
- **Child and Adolescent Psychiatry for Primary Care (CAP PC)** serves the remainder of the state. It is a consortium of five academic medical centers and their divisions of child and adolescent psychiatry. The child psychiatry divisions at these five university-based sites have partnered with the REACH Institute to provide primary care physicians with the education and support services that are offered. For more information please visit www.cappcnny.org or contact David Kaye M.D., Project Director, at (716) 859-5456.

Primary Care Rate Increase Attestation Now Available

Under the Affordable Care Act (ACA), Medicaid managed care and fee-for-service (FFS) primary care practitioners may qualify for increased reimbursement at the rate that would be paid for primary care services under Medicare. To determine if you qualify for the program, review the FAQ document. If you qualify, complete and return the attestation form by August 1, 2013, to be eligible for the increased reimbursement effective for dates of service on and after January 1, 2013. Payments will begin upon federal approval.

FAQs and Attestation Form links:

Physicians: <https://www.emedny.org/info/ProviderEnrollment/physician/Option1.aspx>

Nurse Practitioners: <https://www.emedny.org/info/ProviderEnrollment/nursePract/Option1.aspx>

Nurse Midwives: <https://www.emedny.org/info/ProviderEnrollment/midwife/Option1.aspx>

For specific questions, please review the FAQ document. Additional questions may be forwarded to: pcri@health.state.ny.us.

Providers can sign-up to receive ongoing updates on the PCRI program at:

PCRI-L@listserv.health.state.ny.us and through the eMedNY listerv at:
https://www.emedny.org/Listserv/eMedNY_Email_Alert_System.aspx

Long Term Home Health Care Program (LTHHCP) 1915(c) Medicaid Waiver Amendment Approved by the Centers for Medicare and Medicaid Services (CMS)

New York State (NYS) has received CMS approval to amend the 1915(c) Medicaid (MA) home and community-based services LTHHCP waiver. This waiver will align the LTHHCP waiver with the CMS approved 1115 Demonstrations and the planned expansion of mandatory Medicaid Managed Care (MMC) and the planned impact of the Managed Long Term Care (MLTC) enrollment plan.

Amendment to Article 29-AA of Public Health Law, legislation included in the NYS 2011-12 Enacted Budget, provided for mandatory enrollment of certain Medicaid (MA) recipients into MLTC plans—including LTHHCP waiver participants. Accordingly, all non-dual MA recipients will be required to enroll in a MMC plan and all dual eligible recipients, age 21 and over, in need of community-based long term care for more than 120 days will be required to enroll in a MLTC plan.

Beginning April 1, 2013, eligible MA recipients, who might otherwise be eligible to receive services through the LTHHCP, will enroll in a MMC or MLTC plan. As an alternative, and if eligible, enrollment into another Medicaid waiver program can exempt the LTHHCP participant from future mandatory managed care enrollment per current rules until such time that population is no longer exempt.

To promote continuity of care throughout the transition to managed care, the participant's current LTHHCP agency must provide the plan with the participant's current plan of care. Each enrollee who is receiving community-based long-term care services and supports will continue to receive services under the enrollee's pre-existing service plan for at least 90 days after enrollment, or until a care assessment has been completed by the Managed Care Organization (MCO), whichever is later. Service providers will remain unchanged throughout the transition period.

Mandated MLTC enrollment for dual-eligible LTHHCP participants began April 1, 2013 in New York City, Nassau, Suffolk, and Westchester counties.

As MLTC capacity is established statewide, new referrals and applications to LTHHCP will be closed in mandatory districts and enrollment of dual eligible community-based long term care service recipients will take place. The LTHHCP will remain operational for as long as required to meet the needs of participants for whom MLTC and MMC are not an option.

The contracted enrollment broker will notify LTHHCP participants via letter that they will soon receive their home care services through a different program. This notice will be sent initially to a small group of participants and continue. Current participants, noted above, will receive a second letter via mail, indicating that they have 60 days to choose a MLTC plan.

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POLICY & BILLING GUIDANCE

If the participant has not enrolled in a plan within the choice period, auto-assignment to a plan will occur. Upon enrollment, the plan will assume full responsibility for care management and the provision of services. The MLTC participant may request to change plans at any time by contacting NY Medicaid Choice at (888) 401-6582.

Mandated MMC enrollment for LTHHCP enrolled non-dual eligibles will occur on a statewide basis beginning April 1, 2013.

Referral of new non-dual applicants to the LTHHCP will cease May 15, 2013.

In Maximus counties, LTHHCP participants will receive a letter that they have 60 days to choose a plan. The enrollment broker will provide assistance in determining which plan contracts with the client's existing primary care physician and other service providers. Maximus is responsible for plan enrollment in those counties and will track the special 60 day choice period.

In non-Maximus counties, the local department of social services (LDSS) will be responsible for working with non-dual consumers to choose a health plan. The LDSS will also be responsible for working with the LTHHCP agency and the plan to coordinate the effective date of managed care enrollment. The LDSS case worker and the LTHHCP case manager will communicate with the participant, their family or other responsible person and work with the MMC to ensure a safe transition.

The MMC participant may request to change plans anytime during the first 90 days of enrollment by contacting NY Medicaid Choice at (800) 505-5678 or the LDSS in non-NY Medicaid Choice counties.

Therapeutic Injectables Provided to Medicare/Medicaid Dually Eligible Individuals

A number of Medicare/Medicaid crossover claims for drugs are being submitted without the corresponding National Drug Codes (NDCs). Effective July 1, 2013, claims will deny for drugs covered under Medicare Part B (primary) and Medicaid (secondary), if the NDC for each drug is not included on the claim. The lack of an NDC prevents Medicaid from claiming rebates from drug manufacturers, which is required by federal law. The NDC can be found on the drug invoice and/or packaging information.

Drugs obtained at 340B prices are excluded from this requirement. Institutional providers (e.g., hospital clinics, diagnostic and treatment centers) are NOT required to report. Drugs obtained at 340B prices must be identified by the “UD” modifier.

Questions:

- Medicaid billing questions? Please contact the eMedNY Call Center at (800) 343-9000.
- Fee-for-Service Policy questions? Please contact our Policy Division at (518) 473-2160.

Uniform Assessment System for New York (UAS-NY) Implementation Update

Beginning **July 1, 2013**, all home and community-based long term care Medicaid programs in the following counties will begin activities to **transition** to the Uniform Assessment System for New York (UAS-NY).

Albany	Franklin	Montgomery	Schenectady
Clinton	Fulton	Otsego	Schoharie
Columbia	Greene	Rensselaer	Washington
Essex	Hamilton	Saratoga	

All organizations that manage, conduct assessments, or provide services for any of following programs will be required to use UAS-NY.

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| <ul style="list-style-type: none">○ Adult Day Health Care○ Assisted Living Program○ Care at Home I/II Waiver○ Consumer Directed Personal Assistance Program | <ul style="list-style-type: none">○ Long Term Home Health Care Program○ Nursing Home Transition and Diversion Waiver○ Personal Care Services Program○ Traumatic Brain Injury Waiver |
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Once the transition activities are completed, organizations in these counties will use the UAS-NY to conduct assessments for these programs. Organizations in these counties will achieve full implementation of the UAS-NY no later than **December 1, 2013**. Organizations that are responsible for the client assessment must ensure that any contractors are identified and notified of this change.

UAS-NY Implementation Overview Webinar

The UAS-NY Project Team will conduct an overview of the UAS-NY, the transition activities, and timeline for organizations in these counties on **June 14, 2013**. The one-hour webinar will begin at **1:00 pm**. All organizations in these counties are strongly encouraged to participate as important information about the transition activities will be presented. To register for this event please click the following link: <https://uasny.webex.com/uasny/onstage/g.php?t=a&d=665243074>

Upon completion of your registration, you will receive an e-mail from messenger@webex.com with details to access the webinar. This e-mail is automatically generated and will include the link and password for the actual event.

Prior to the webinar, staff are encouraged to visit the Department's website for additional information concerning the UAS-NY. The website includes all previously recorded webinars and includes a summary of assessment instruments that will be replaced. Of particular importance is the January 29, 2013, UAS-NY Project Update Webinar. All materials are available online at: http://www.health.ny.gov/health_care/medicaid/redesign/uniform_assessment_system/index.htm

Questions concerning the transition and implementation of the UAS-NY may be e-mailed to: uasny@health.state.ny.us.

UAS-NY Timeline Revised for Managed Long Term Care Plans

The Office of Health Insurance Programs, Division of Long Term Care has revised the timeline for the implementation of the Uniform Assessment System for New York (UAS-NY) for Managed Long Term Care (MLTC) plans and their respective provider networks. MLTC plans and their networks will implement the UAS-NY effective October 1, 2013.

Note: This change does not alter the Pilot or Balance of State Programs statewide implementation plans. Refer to the “*Uniform Assessment System for New York (UAS-NY) Implementation Update*” article in this update.

The 90-day delay will enable MLTC plans to ensure that their staff and providers within their provider networks are operationally prepared to fully and successfully transition to using the UAS-NY. Specifically, MLTC plans and their provider networks will be afforded additional time to:

- ensure that all staff have Health Commerce System (HCS) accounts with Trust Level 3 assurance;
- enable staff to complete required and recommended online training; and
- integrate and align UAS-NY data with local data systems.

To ensure that MLTC plans and their respective networks are prepared to fully implement the UAS-NY, the Division of Long Term Care (DLTC) have established the following milestones:

- All HCS user accounts must be submitted to the Commerce Accounts Management Unit (CAMU) *no later than July 1, 2013*.
- Trust Level 3 assurance and UAS role assignments must be established by *no later than August 1, 2013*.
- All staff (assessors and support staff alike) must complete the required online training and begin using the UAS-NY in preparation for conducting assessments by **August 15, 2013**.
- Plans must use the UAS-NY for all new members who are scheduled to enroll effective **October 1, 2013**. This will require Plans to use the UAS-NY as early as **mid-August 2013**.
- The UAS-NY must be used for all reassessments beginning **October 1, 2013**.

UAS-NY project and DLTC staff will work closely with plans and their respective networks to support their transition to and implementation of the UAS-NY.

Questions concerning this e-mail and the UAS-NY should be directed to the UAS-NY Project Team at uasny@health.state.ny.us or (518) 408-1021.

Medicaid Billing for Alternate Level of Care

The purpose of this article is to reiterate guidance to Medicaid providers to ensure that the correct billing procedures are followed regarding Alternate Level of Care (ALC) days. NYCRR Title 10, Section 86 -1.15 (h) defines Alternate Level of Care services as “those services provided by a hospital to a patient for whom it has been determined that inpatient hospital services are not medically necessary, but that post-hospital extended care services are medically necessary, consistent with utilization review standards, and are being provided by the hospital and are not otherwise available.”



If the services provided do not meet these conditions, standard billing procedures are followed. However, when these types of services are provided, hospitals must properly report occurrence span code 75 with the date span the member was in Alternate Level of Care (ALC) on the acute care claim. eMedNY Inpatient Billing Guideline Section 2.3.3 requires that ALC claims be split-billed. Split-billing is the “submission of multiple date range claims that when compiled represent the period from Admit to Discharge.” Hospitals should not bill for acute levels of care for days when patients are in ALC setting.

Further information regarding ALC billing guidelines and regulations are available online at:

https://www.emedny.org/ProviderManuals/Inpatient/PDFS/Inpatient_Billing_Guidelines.pdf
http://www.health.ny.gov/regulations/nycrr/title_10/

Medicaid Billing Patient Status Codes



This article contains a review of guidance for Medicaid providers on patient status coding. It is crucial that hospitals correctly identify and code whether patients have been transferred or discharged as this will affect the Medicaid payment. According to NYCRR Title 10, Section 86-1.15, patients are considered to be discharged if they were admitted on or after December 1, 2009, and:

- the patient is released from the facility to a non-acute care setting; or
- the patient dies in the facility; or
- the patient is a neonate being released from a hospital providing neonatal specialty services back to the community hospital of birth for weight gain; or
- the patient is transferred to a facility or unit that is exempt from the case-based payment system, except when the patient is a newborn transferred to an exempt hospital for neonatal services.

A case shall be considered to be transferred if the patient is not discharged as above, is not transferred among two or more divisions of merged or consolidated facilities, is not assigned to a DRG specifically identified as a DRG for transferred patients only, and meets one of the following conditions:

- is transferred from an acute care facility reimbursed under the DRG case-based payment system to another acute care facility reimbursed under the same system; or
- is transferred to an out-of-state acute care facility; or
- is a neonate who is being transferred to an exempt hospital for neonatal services.

Hospitals must ensure the accuracy of the patient coding status in order to guarantee correct Medicaid payments. Further information regarding the coding of inpatient statuses are available online at:

http://www.health.ny.gov/regulations/nycrr/title_10/

Part 86-1.15

Part 86-1.21

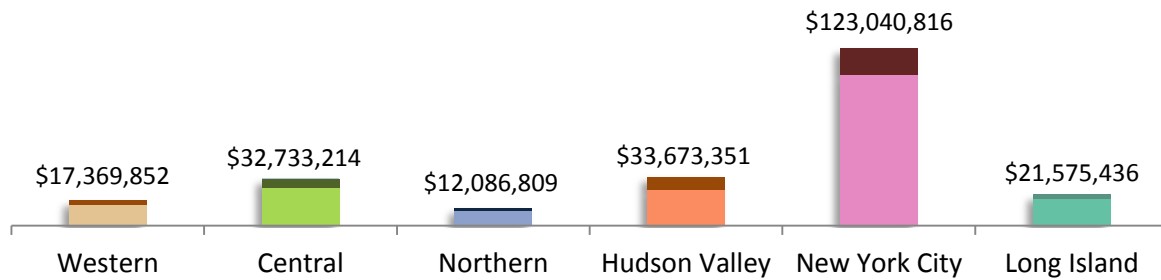
https://www.emedny.org/ProviderManuals/Inpatient/PDFS/Inpatient_Billing_Guidelines.pdf

New York Medicaid Electronic Health Records Incentive Program Update

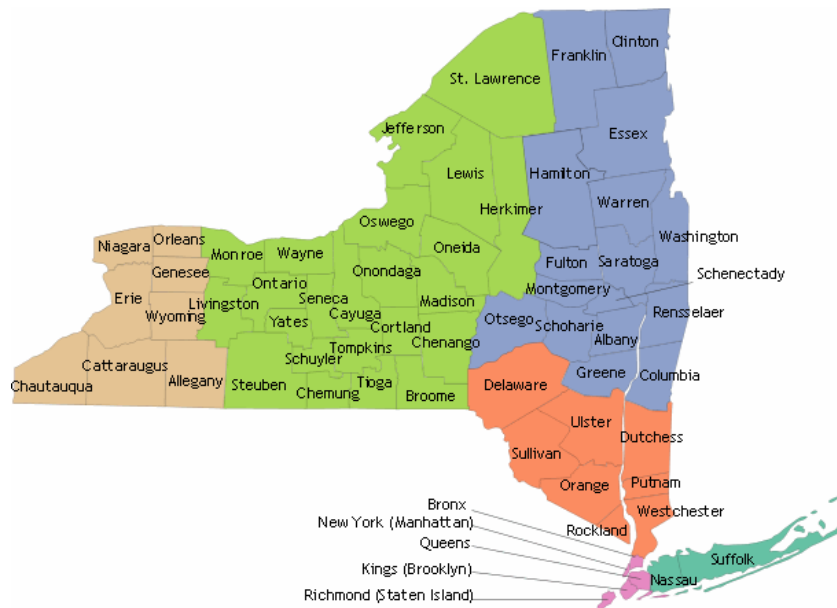
The New York Medicaid Electronic Health Records (EHR) Incentive program provides financial incentives to eligible practitioners and hospitals to promote the transition to EHR. Providers who practice using EHRs are in the forefront of improving quality of care, reducing costs, and addressing health disparities. Since December 2011, **over \$365.6 million** in incentive funds have been distributed to over **6,550** New York State Medicaid providers.

For more information about the EHR Incentive program, we encourage you to visit the program website at <https://www.emedny.org/meipass/> or attend one of the informational webinars hosted by the NYS Department of Health. To see the complete schedule of events and webinars, please view our **Upcoming Event Calendar** at <https://www.emedny.org/meipass/info/Events.aspx>.

Taking a Closer Look: Incentive Payments Paid to Hospitals by Region*



* Hospital Year 1 payments (light shade) and Year 2 payments (dark shade) as of April 22, 2013 by HEAL Grant Region.



Observation Services Legislation and Medicaid Payment

Effective April 1, 2013, New York State Medicaid, including Medicaid fee-for-service (FFS), Medicaid Managed Care and Family Health Plus (FHPlus) plans, will expand coverage of observation services. Existing guidelines can be found online at [May 2011 Medicaid Update](#) and [February 2012 Medicaid Update](#).

In response to legislation enacted October 3, 2012, (Laws of New York, 2012, Chapter 471), regulations governing observation services are being revised. However, in the interim, to obtain payment for observation services providers should bill in accordance with these guidelines.

Hospitals may provide observation services for those patients for whom a diagnosis and a determination concerning admission, discharge or transfer cannot be accomplished within eight hours after presenting in the Emergency Department (ED), but can reasonably be expected within 48 hours. In order to be reimbursed for observation services, a patient must be in observation status for a minimum of eight hours (with clinical justification). This is in addition to any time that the patient spent in the ED prior to receiving observation services.

Observation services may be provided in:

- approved units that have existing waivers;
- existing observation units (in compliance with current regulations at [10 NYCRR 405.19 \(g\)](#));
- new distinct observation units (in compliance with [10 NYCRR 405.19 \(g\)](#));
- inpatient beds; or
- the ED (only for hospitals designated as critical access hospitals or sole community hospitals).

A patient may remain in observation for up to 48 hours and then the hospital must determine if the patient is to be admitted, transferred to another hospital or discharged from the facility.

Billing Guidelines and Requirements

The following Medicaid payment policy and reimbursement criteria will apply concerning Medicaid payment for observation services. Required documentation for Medicaid payment for observation services include:

- a clinical justification for observation status;
- a working diagnosis;
- any tests or treatments administered while the patient is in observation status;
- progress notes by a responsible Physician, Physician Assistant, Midwife or Nurse Practitioner; and
- final disposition of the patient from staff assigned to observation.

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POLICY & BILLING GUIDANCE

Patients may be assigned to observation services through the ED (or hospital outpatient department if the facility does not have an ED). Medicaid covers observation services designated by HCPCS G0378 (hospital observation service, per hour) which groups to Ambulatory Patient Group (APG) 450, and is subject to consolidation and bundling logic. Observation services may be provided for up to 48 hours.

Medicaid pays for observation services on an hourly basis for up to 48 hours (excluding time in ED). The number of hours in observation status must be coded in the units of service field of the claim line on which G0378 is coded. The appropriate CPT/HCPCS codes for all ancillary services provided to the patient while in observation status should also be reported on the claim. Facilities will only be paid for observation if the length of stay in observation exceeds eight hours. If the length of stay in observation is less than 8 hours, the stay is not reimbursable by Medicaid. Nevertheless, providers should always comprehensively code all services provided during a visit/episode.

Observation services end when the patient is admitted as an inpatient, or is discharged from the hospital. If the patient is admitted to inpatient status, only the inpatient admission may be submitted for payment and the emergency room services and associated observation services should not be billed to Medicaid. If the patient must be transferred to another facility, the emergency room and observation services may be submitted for payment.

Note: Only those hours that the patient is actually in the observation unit may be billed with G0378. Significant procedures or high intensity ancillaries (MRI, PET scans, CT scans) will cause G0378 to package, meaning it will not be paid separately. Low level ancillaries (X-rays, laboratory tests) and drugs will not cause G0378 to package and Observation will be paid separately.

The UC modifier should be added to the observation claim line if the service is being provided in a discrete observation unit (established in compliance with [10 NYCRR 405.19 \(g\)](#)). Facilities will be reimbursed an enhanced hourly rate (i.e., 20 percent higher) for providing observation in designated units if they code the UC modifier. However, observation services provided in non-designated units (i.e., “scattered site beds”) should be coded using G0378 without the UC modifier.

Patients that are assigned to observation services must be advised of their status, verbally and in writing. This notification must clearly identify observation services as outpatient in nature, and indicate that the services will be subject to outpatient rules and co-payment requirements. The patient must also be advised that outpatient services do not satisfy Medicare inpatient requirements for skilled nursing facility services.

Note: Medicare’s payment policy for observation services is different than that utilized by Medicaid. Nevertheless, Medicaid will continue to reimburse the Medicare Part B coinsurance amounts (to the extent permitted by State statute) for dually-eligible recipients.

Please contact the Division of Certification and Surveillance at (518) 402-1003, if you have questions about the process for establishing an observation unit or operating standards. If you have questions about Medicaid reimbursement for observation services, please contact the Division of Program Development and Management at (518) 473-2160.

The New York State Medicaid Prescriber Education Program Drug Information Response Center Addresses Treatment of *H. pylori* and Statin Use

The New York State Medicaid Prescriber Education Program (NYSMPEP) is a collaboration between the New York State Department of Health (NYSDOH) and the State University of New York (SUNY). The NYSMPEP provides prescribers with an evidence-based, non-commercial source of the latest objective information about pharmaceuticals. In conjunction with the NYSMPEP, the Drug Information Response Center (DIRC) assists clinicians in the delivery of health care to their Medicaid patients by providing timely, evidence-based information on pharmacotherapy and serving as a resource for NYSMPEP academic educators in their outreach to prescribers. A recent response was prepared by the DIRC regarding the treatment of *H. pylori* and the use of hydroxymethylglutaryl-coenzyme A (HMG-CoA) reductase inhibitors (i.e., statins).

Helicobacter pylori (*H. pylori*) is a gram negative bacteria present in an estimated 30-40% of the US population.¹ Though the vast majority of infected individuals do not exhibit symptoms or develop complications, some may develop digestive problems, including stomach ulcers, peptic ulcer disease (PUD), gastritis, and possibly gastric malignancy. Patients who develop these conditions should be tested for the presence of *H. pylori*, as its eradication is associated with higher remission rates compared to patients with persistent infection.

The American College of Gastroenterology (ACG) recommends several oral regimens for eradication of *H. pylori*:¹

1. Standard dose PPI* + clarithromycin 500 mg + amoxicillin 1,000 mg, all twice daily
2. Standard dose PPI + clarithromycin 500 mg + metronidazole 500 mg, all twice daily
3. Bismuth subsalicylate 525 mg + metronidazole 250 mg + tetracycline 500 mg, all 4 times daily + ranitidine 150 mg twice daily or standard dose PPI daily to twice daily
4. Standard dose PPI + amoxicillin 1,000 mg both twice daily x 5 days followed by standard dose PPI + clarithromycin 500 mg + tinidazole 500 mg all twice daily x 5 days

*PPI = proton pump inhibitor; if esomeprazole is used, dose once daily

The first three regimens should be used for 10 to 14 days, as eradication rates may be lower with seven day regimens, though the international guidelines recommend durations of seven days or more.¹ The expected eradication rates for each regimen are 70% to 85% for the first two regimens, 75% to 90% for the third regimen, and >90% for the last regimen. The last regimen has been used internationally but still requires validation in the US.

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PHARMACY UPDATE

Statins may interact with the treatment regimens used to eradicate *H. pylori*. There is a lack of literature examining which regimen is preferred for treatment of *H. pylori* in patients currently taking statins.

The ACG does not make any recommendations regarding which regimen is preferred in patients receiving statins. Patients on regimens containing clarithromycin may be at an increased risk of adverse events, including myopathy and rhabdomyolysis, due to the interaction between clarithromycin and some statins.²

Clarithromycin is a potent inhibitor of cytochrome P450 (CYP) 3A4, and many of the statins are metabolized via this pathway. According to the prescribing information, clarithromycin is contraindicated with simvastatin and lovastatin. These drugs should be held for the duration of the course of therapy with clarithromycin. Atorvastatin should be limited to 20 mg daily and pravastatin to 40 mg daily when given with clarithromycin. Though there is no recommendation for pitavastatin use with clarithromycin, the manufacturer recommends limiting the dosage of pitavastatin to 1 mg daily in patients taking erythromycin.³ An *in vitro* study of pitavastatin suggests that there could be a clinically significant interaction with clarithromycin mediated by clarithromycin's inhibition of organic anion transporting polypeptide 1B1 (OATP1B1).⁴ OATP1B1 is responsible for the majority of the uptake of pitavastatin into hepatocytes. This would decrease pitavastatin's metabolism and increase the risk of myopathy and rhabdomyolysis. The use of a statin that is not metabolized via CYP3A4, such as fluvastatin or rosuvastatin, can be considered during clarithromycin therapy.^{2,5}

In summary, 3 of the 4 recommended regimens for *H. pylori* eradication contain clarithromycin, which interacts with some of the statins due to inhibition of CYP3A4. There is no recommendation from the ACG on the preferred drug regimen in patients currently receiving a statin, though individual agents may need to be discontinued or dose-adjusted. Until more evidence is available, providers should continue to pick 1 of the *H. pylori* regimens outlined above, as the regimens show similar effectiveness, and adjust statin therapy accordingly.

To contact an NYSMPEP academic educator in your area, please visit <http://nysep.nysdoh.suny.edu/contactus/contactus>

References:

1. Chey WD, Wong BCY. American College of Gastroenterology guideline on the management of Helicobacter pylori infection. *The American journal of gastroenterology*. 2007;102(8):1808-1825.
2. Clarithromycin (Biaxin) prescribing information. Abbott Laboratories, North Chicago, IL. 2012.
3. Pitavastatin (Livalo) prescribing information. Kowa Pharmaceuticals America, Inc. Montgomery, AL. 2012.
4. Hirano M, Maeda K, Shitara Y, Sugiyama Y. Drug-drug interaction between pitavastatin and various drugs via OATP1B1. *Drug metabolism and disposition*. 2006;34(7):1229-1236.
5. PL Detail-Document, Clinically Significant Statin Drug Interactions. Pharmacist's Letter/Prescriber's Letter. April 2012.

Medicaid Pharmacy Prior Authorization Programs Update

Effective June 6, 2013, the fee-for-service (FFS) pharmacy program will implement the following parameters, including step therapy and frequency/quantity/duration (F/Q/D) requirements. These changes are the result of recommendations made by the Drug Utilization Review Board (DURB) at the March 21, 2013, DURB meeting:

Long-Acting Beta-2 Agonists

- Quantity limits, as defined in the NYS Medicaid DURB summary, based on specified units per 30 days.
- Prospective DUR edit for all new long-acting beta agonist prescriptions for beneficiaries under FDA or compendia supported age, as defined in the NYS Medicaid DURB summary (electronic bypass for established therapy identified in the claims system). The Clinical Call Center must be contacted to override edit.

Second Generation Antipsychotics in Children

- Confirm diagnosis for the initial prescription for beneficiaries between minimum age, as defined in the NYS Medicaid DURB summary, and 18 years of age (electronic bypass for these beneficiaries for established therapy or any indication supported for second generation antipsychotics for pediatric use). The Clinical Call Center must be contacted to override edit.
- Prospective DUR edit for the initial prescription for beneficiaries younger than the drug-specific minimum age, as defined in the NYS Medicaid DURB summary (electronic bypass for these beneficiaries for established therapy). The Clinical Call Center must be contacted to override edit.

Dronabinol (Marinol)

- Confirm diagnosis for Medicaid covered uses as follows:
 - HIV/AIDS and eating disorder or cancer and eating disorders;
 - Cancer and nausea/vomiting.
- Step therapy for beneficiaries with HIV/AIDS, or cancer, AND eating disorders: trial with megestrol acetate suspension prior to dronabinol.
- Step therapy for beneficiaries with diagnosis of cancer and nausea/vomiting: trial with a NYS Medicaid-preferred 5-HT₃ receptor antagonist prior to dronabinol.
- Electronic bypass for covered diagnosis and prior utilization of a first line agent as identified in the claims system.

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PHARMACY UPDATE

Topiramate

- Confirm diagnosis to prevent reimbursement for Medicaid excluded uses (electronic bypass for covered diagnosis identified in the claims system).

For more detailed information on the above DURB recommendations, please refer to the meeting summary at:

http://www.health.ny.gov/health_care/medicaid/program/dur/meetings/2013/03/sum_0321_13_dur_b.pdf

Following is a link to the most up-to-date information on the Medicaid FFS Pharmacy Prior Authorization programs. This document contains a full listing of drugs subject to PDP, CDRP, the Drug Utilization Review program and the Mandatory Generic Drug Program (MGDP):

https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf

To obtain a prior authorization (PA), please call the prior authorization Clinical Call Center at (877) 309-9493. The Clinical Call Center is available 24 hours per day, 7 days per week with pharmacy technicians and pharmacists who will work with you, or your agent, to quickly obtain PA.

Medicaid enrolled prescribers with an active e-PACES account can initiate PA requests through the web-based application PAXpress®. The website for PAXpress is <https://paxpress.nypa.hidinc.com/>. The website may also be accessed through the eMedNY website at <http://www.eMedNY.org> as well as Magellan Medicaid Administration's website at <http://newyork.fhsc.com>.

Medicaid to Implement Changes for Hospitals and Nursing Home Claims Processing

As previously announced in the April 2013 Medicaid Update

Effective **June 21, 2013**, Medicaid will implement new claims editing to ensure patient responsibility amounts are deducted from the appropriate inpatient hospital or nursing home claim, and that claims for nursing home services (excluding leave of absence stays) are not reimbursed when the Medicaid beneficiary is in an inpatient hospital setting. Details are available online at:

http://www.health.ny.gov/health_care/medicaid/program/update/2013/2013-04.htm.

Medicaid to Implement Changes to Eligibility Inquiry/Response Transactions (ASC X12 270/271)

As previously announced in the April 2013 Medicaid Update

Effective July 2011, the Department of Health and Human Services (DHHS) published an Interim Final Rule to adopt the Operating Rules for Eligibility for Health Plan transactions. eMedNY plans to implement system enhancements related to the federal mandate to the Eligibility Transaction Inquiry/Response on **June 21, 2013**. The eligibility transaction changes will also affect users of ePACES. Updated ePACES Quick Reference Guides that reflect the changes for both eligibility inquiry and response will be available on the eMedNY website.

Providers will be seeing some new eligibility responses related to coverage codes, and copay amounts. In addition future date eligibility request for the current month will be allowed. Please see the details of the changes in the April Medicaid Update are available online at:

http://www.health.ny.gov/health_care/medicaid/program/update/2013/2013-04.htm.

New Training Schedule and Registration

Registration is now easier than ever!

- Do you have billing questions?
- Are you new to Medicaid billing?
- Would you like to learn more about ePACES?

If you answered YES to any of these questions, you should consider registering for a Medicaid training session. Computer Sciences Corporation (CSC) offers various types of educational opportunities to providers and their staff. Training sessions are available at no cost to providers and include information for claim submission, Medicaid Eligibility Verification, Electronic Funds Transfer, Electronic/PDF Remittance Advice Form Completion, and the eMedNY website.

Web Training Available

You may also register for a webinar. Training is conducted online and you can join the meeting from your computer and telephone. After registration is completed, just log in at the announced time. No travel involved.

Many of the sessions planned for the upcoming months offer detailed instruction about Medicaid's free web-based program-**ePACES which is** the electronic Provider Assisted Claim Entry System that allows enrolled providers to submit the following type of transactions:

- **Claims** (Dental, Professional, Institutional)
- **Eligibility Verifications**
- **Claim Status Requests**
- **Prior Approval/DVS Requests**

Physician, Nurse Practitioner, DME and Private Duty Nursing claims can even be submitted in "REAL-TIME" via ePACES. Real-time means that the claim is processed within seconds and professional providers can get the status of a real-time claim, including the paid amount without waiting for the remittance advice.

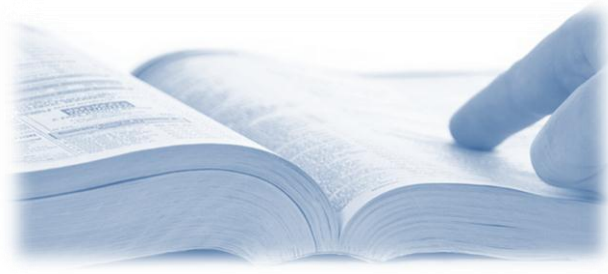
Fast and easy registration, locations, and dates are available on the eMedNY Website at: <http://www.emedny.org/training/index.aspx>.

CSC Regional Representatives look forward to having you join them at upcoming meetings!

If you are unable to access the Internet to register or have questions about registration, please contact the eMedNY Call Center at (800) 343-9000.

Note: We have recently updated the PROVIDER TRAINING pages of the website. Providers can view upcoming sessions in a calendar view, a table view or a print view.

PROVIDER DIRECTORY



Office of the Medicaid Inspector General:

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

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

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

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

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

Do you have questions about billing and performing MEVS transactions?

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

Provider Training:

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

Enrollee Eligibility:

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

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

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

Medicaid Electronic Health Record Incentive Program questions?

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

Do you have comments and/or suggestions regarding this publication?

Please contact Kelli Kudlack via e-mail at: medicaidupdate@health.state.ny.us.