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New York State

Medicaid Update

MAY 2014

VOLUME 30 ■ NUMBER 5

THE OFFICIAL NEWSLETTER OF THE NEW YORK STATE MEDICAID PROGRAM

Expansion of Smoking Cessation Counseling (SCC) by Dental Practitioners

Effective April 1, 2014, for Medicaid fee-for-service (FFS) and July 1, 2014, for the Medicaid managed care benefit package, dental practitioners will be able to provide and receive Medicaid reimbursement for smoking cessation counseling (SCC) services as defined in their scope of practice. This coverage does not supersede or alter any regulations issued by the NYS Department of Education governing scope of practice for dentists.

A dental practitioner will be allowed to provide two smoking cessation counseling sessions to a Medicaid beneficiary within any 12 continuous months.

Smoking cessation counseling services provided by dental practitioners are reimbursable in the following settings:

- Office-based dental practitioners;
- Article 28 hospital outpatient departments (OPD), free-standing diagnostic and treatment centers (D&TCs) and school based health centers (SBHCs) that employ dentists. Note: APG payment is available to the Article 28 facility only and not to the dentist; dental professional services are included in the APG payment to the facility;
- Federally qualified health centers (FQHCs), including FQHC school based health centers (SBHCs) that employ dentists and bill using Ambulatory Patient Groups (APGs). Note: APG payment is available to the FQHC only; dental professional services are included in the APG payment to the facility; and
- Federally Qualified Health Centers (FQHCs), including FQHC school-based health centers (SBHCs) that bill under the Prospective Payment System (PPS) receive an all-inclusive clinic threshold rate for all services provided to the patient. The PPS payment may include provision of smoking cessation counseling when provided during a dental visit. Pursuant to the information below, smoking cessation counseling should take place during a dental visit as an adjunct service and is not reimbursable as a stand-alone service.

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Andrew M. Cuomo
GOVERNOR
State of New York

Howard A. Zucker, M.D., J.D.
ACTING COMMISSIONER OF HEALTH
New York State DOH

Jason A. Helgerson
MEDICAID DIRECTOR
Office of Health Insurance Programs

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

MAY 2014 NEW YORK STATE MEDICAID UPDATE

POLICY AND BILLING GUIDANCE

PHARMAC Y UPDATE

ALL PROVIDERS

Reimbursement for smoking cessation counseling (SCC) must meet the following criteria:

- SCC must be provided face-to-face by either a dentist or by a dental hygienist that is supervised by the dentist.
- SCC must be billed by either an office-based dental practitioner or by an Article 28 clinic that employs a dentist.
- Dental practitioners can only provide individual SCC services, which must be greater than three minutes in duration, NO group sessions are allowed.
- Dental claims for SCC must include the CDT procedure code D1320 (tobacco counseling for the control and prevention of oral disease).
- Article 28 clinics that bill with APGs must include the ICD-9 CM Diagnosis code 305.1 (tobacco use disorder).
- In a dental office or an Article 28 clinic, SCC should only take place during a dental visit as an adjunct when providing a dental service and NOT billed as a stand-alone service.
- A dental practitioner will be allowed to provide two smoking cessation counseling sessions to a Medicaid beneficiary within any 12 continuous months.
- Smoking Cessation Counseling complements existing Medicaid covered benefits for prescription and non-prescription smoking cessation products including nasal sprays, inhalers, Zyban (bupropion), Chantix (varenicline), over-the-counter nicotine patches and gum.
- To receive reimbursement for SCC services the following information must be documented in the patient's dental record:
  - **At least 4 of the 5 A's: smoking status and if yes, willingness to quit;**
  - **If willing to quit, offer medication as needed, target date for quitting, and follow-up date (with documentation in the record that the follow-up occurred);**
  - **If unwilling to quit, the patient's expressed roadblocks;**
  - **Referrals to the New York State Smoker's Quitline and/or community services to address roadblocks and for additional cessation resources and counselling, if needed.**

CDT Procedure Code	Office-Based Dental Practitioners	Article 28 Clinics that bill with APGs
D1320 Tobacco counseling for the control and prevention of oral disease. Billable only as an individual session, >3 minutes.	$10.00 per visit	**OPD-** $20.00 per visit **D&TC-** $17.00 per visit (procedure based weight; approximate statewide average)

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Smoking cessation services are included in the prospective payment system (PPS) rate for those FQHCs that do not participate in APG reimbursement.

Dentists should be aware of the following guideline for smoking cessation counseling:

The Clinical Practice Guideline, *"Treating Tobacco Use and Dependence: 2008 Update"* demonstrated that efficacious treatments for tobacco users exist and should become a part of standard care giving.

This guideline recommends that a practitioner should follow the **"5 A's"** of treating tobacco dependence, which include:

Ask	Ask the patient about tobacco use at every visit, and document the response.
Advise	Advise the patient to quit in a clear and personalized manner.
Assess	Assess the patient's willingness to make a quit attempt at this time.
Assist	Assist the patient to set a quit date and make a quit plan; offer medication as needed.
Arrange	Arrange to follow-up with the patient within the first week, either in person or by phone, and take appropriate action to assist them.

For patients not ready to make a quit attempt, clinicians should use a brief intervention designed to promote the motivation to quit. Content areas that should be addressed can be captured by the **"5 R's"**:

Relevance	Encourage the patient to state why quitting is relevant to them, being as specific as possible.
Risks	Ask the patient to identify potential negative consequences of their tobacco use, including acute, environmental, and long-term risks.
Rewards	Ask the patient to identify potential benefits, such as improved health, saving money, setting a good example for children, and better physical performance.
Roadblocks	Ask the patient to identify barriers (e.g., fear of withdrawal, weight gain, etc.), and provide treatment and resources to address them.
Repetition	The motivational intervention should be repeated every time the patient is seen.

Research suggests that the "5 R's" enhance future quit attempts. Additional information is available in Chapter 3 of the guideline, titled Clinical Interventions for Tobacco Use and Dependence.

Further information regarding evidence based clinical approaches to SCC and pharmacotherapy is available from these sources:

American Dental Association: "Tobacco Guidelines Get Update" - Dr. K. Vendrell Rankin, professor, Department of Public Health Sciences at Baylor College of Dentistry, served as one of 70 external reviewers for the guideline and represented the ADA in the process. http://www.ada.org/news/2110.aspx

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American Dental Association: "Oral Health Topics- Smoking and Tobacco Cessation: Dentist Version - A compilation of resources to assist dentists in conducting smoking and tobacco cessation counseling. http://www.ada.org/2615.aspx

AHRQ's Treating Tobacco Use and Dependence Pathfinder: Resources for Clinicians and Consumers - This site provides the DHHS Public Health Service Clinical Practice Guideline for *Treating Tobacco Use and Dependence: 2008 Update* and includes evidence-based treatment, provider and patient educational materials. http://www.ahrq.gov/path/tobacco.htm

Quick Reference Guide for Clinicians – This site provides an abbreviated version of the *Treating Tobacco Use and Dependence: 2008 Update.* This guide includes counseling and pharmacotherapy methods. http://www.ahrq.gov/legacy/clinic/tobacco/tobaqrg.htm

Refer Your Patients to their Medical Provider who can reinforce the smoking cessation message and recommend or prescribe appropriate medications. As an adjunct to provider treatment, **refer to the NYS Smokers' Quitline** for free counseling and a two week starter kit of nicotine replacement therapy; the Quitline also has patient and provider education materials and fact sheets. http://www.nysmokefree.com

Health Systems for a Tobacco Free New York - New York State's 10 regional Health Systems contractors offer health care provider organizations assistance with adopting system-level changes that foster comprehensive tobacco dependence treatment for all tobacco users.

Smokefree.gov website sponsored by NCI, CDC, and the American Cancer Society - Provides tobacco users with online cessation support and links to other resources. http://www.smokefree.gov/

For more information regarding Medicaid coverage of SCC, please visit the Department's Medicaid Update website at http://www.health.ny.gov/health_care/medicaid/program/update/medup-index.htm. Click on 'smoking' in the Medicaid Update Index and you can view past Medicaid Update articles that have been published.

Policy questions? Please call the Division of Program Development and Management at (518) 473-2160. Billing questions? Please contact the eMedNY Call Center at (800) 343-9000. Questions regarding MMC and FHPlus reimbursement and/or documentation requirements should be directed to the enrollee's MMC or FHPlus plan.

Expansion of Medicaid Managed Care Covered Benefits to Include HIV Resistance Testing Effective April 1, 2014 - Updated

Publication Notice: The March 2014 Medicaid Update article explained that effective April 1, 2014, as a part of MRT proposal #1458, Medicaid Managed Care Plans (MMCP) began coverage of the following HIV resistance laboratory tests as prescribed by a physician:

- Genotypic testing;
- Phenotypic testing;
- HIV tropism assay.

These laboratory tests may be used in any combination to identify specific HIV strains and drug resistance in order to determine the most effective treatment.

The original Medicaid Update Article inadvertently omitted CPT code 87906; this code should be recognized as a covered laboratory test. The following table is an updated list of CPT codes associated with covered HIV resistance laboratory testing:

CPT	Description
87900	Infectious agent drug susceptibility phenotype prediction using regularly updated genotypic bioinformatics
87901	Infectious agent genotype analysis by nucleic acid (DNA or RNA); HIV-1, reverse transcriptase and protease regions
87903	Infectious agent phenotype analysis by nucleic acid (DNA or RNA); HIV 1, through 10 drugs tested
87904	Additional phenotype analysis - each additional drug tested (List separately in addition to primary procedure)
87906	Infectious agent genotype analysis by nucleic acid (DNA or RNA); HIV-1, other region (EG, Integrase, Fusion)
87999	Miscellaneous Reimbursement (Trofile co-receptor tropism assay)

MMCPs may require prior authorization for these services. For additional information, providers should direct questions to the enrollee's MMCP.

Medicaid Pharmacy Prior Authorization Programs Update

Effective June 12, 2014, the fee-for-service (FFS) pharmacy program will implement the following parameters. These changes are the result of recommendations made by the Drug Utilization Review Board (DURB) at the March 6, 2014, DURB meeting:

Central Nervous System (CNS) Stimulant and Second Generation Antipsychotics (SGA) Concurrent Utilization

- For beneficiaries below the age of 18 years of age on concurrent CNS stimulant and SGA therapy:
  - Confirm diagnoses that support the concurrent utilization of the CNS stimulant and SGA medication
  - Absence of covered diagnosis in patient's claim history will require prescriber involvement

Nuedexta® (dextromethorphan/quinidine)

- Confirm diagnosis for FDA-approved indications, pseudobulbar affect (PBA), secondary to multiple sclerosis or amyotrophic lateral sclerosis in patients ≥ 18 years of age
  - Absence of covered diagnosis in patient's claim history will require prescriber involvement
- Quantity Limit (based on FDA-approved prescribing information):
  - Two (2) capsules per day (60 units per 30 days)
- Duration Limit:
  - Ninety (90) days of therapy (promote evaluation of therapy after 90 days as PBA symptoms may improve spontaneously)

Fulyzaq® (crofelemer)

- Confirmation of HIV/AIDS or anti-retroviral therapy (ART) in claim history
  - Absence of evidence of covered diagnosis or ART in patient's claim history will require prescriber involvement
- Step Therapy: Trial with alternative anti-diarrheal agent
  - Override will require prescriber involvement

Juxtapid® (lomitapide) and Kynamro® (mipomersen)

- Confirm diagnosis of homozygous familial hypercholesterolemia
  - Absence of covered diagnosis in patient's claim history will require prescriber involvement
- Step Therapy: Trial with high intensity statin therapy
  - Override will require prescriber involvement

For more detailed information on the DURB, please refer:
http://www.health.ny.gov/health_care/medicaid/program/dur/index.htm

Below is a link to the most up-to-date information on the Medicaid FFS Pharmacy Prior Authorization (PA) Programs. This document contains a full listing of drugs subject to the Medicaid FFS Pharmacy Programs:
https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf

To obtain a PA, please contact the clinical call center at 1-877-309-9493. 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 authorized agent, to quickly obtain a PA. Medicaid enrolled prescribers can also initiate PA requests using a web-based application. PAXpress® is a web based pharmacy PA request/response application accessible through a new button "PAXpress" located on eMedNY.org under the MEIPASS button.

Additional PA program information is available at the following websites:
http://www.nyhealth.gov or http://newyork.fhsc.com or http://www.eMedNY.org

Update on Medicaid Fee-for-Service (FFS) Pharmacy Billing Instructions for Coordination of Benefits (COB) Submission

Effective May 22, 2014, the Department will be implementing system enhancements to improve the submission of Medicaid FFS pharmacy claims when the patient has other third party coverage. These changes were made to ensure that all values in specified fields are recognized and function appropriately, other patient responsibility amounts are accepted and other third party insurance billing is validated when the claim is not covered.

Coordinating benefits ensures the correct party pays first. Medicaid is the payer of last resort. This means when a patient has other insurance or Medicare; federal regulations require that all available resources be used before Medicaid considers payment. If there is a responsible third party who should be paying for the patients' health benefits, for example a health insurance provider, that responsible third party should be paying first.

Medicaid pays the lesser of Patient Responsibility (PR) or the Medicaid fee regardless of the Patient Responsibility Amount. For pharmacy this rule applies to all PR, which includes deductible, co-insurance, copay and other patient responsibility.

The following list of values have been updated and are recognized when reported via NCPDP D.0 in the COB segment, field 351-NP (Other Payer Patient Responsibility Amount Qualifier). These values are considered as acceptable for payment when qualifying PR amounts are reported in field 352-NQ (Other Payer Patient Responsibility Amount) for claims involving third party liability (TPL) other insurance. All payments paid by any/all third parties, including Medicare, should be included on the claim.

Qualifier values Accepted- Field 351-NP:

- Blank = Not Specified
- 01= Deductible
- 02= Product/Selection/Brand Drug Amount
- 04=Amount reported from previous payer as Exceeding Periodic Benefit Maximum
- 05= Copay Amount
- 07= Coinsurance Amount
- 08= Product Selection/Non-Preferred Formulary Selection Amount
- 09= Health Plan Assistance Amount
- 10=Provider Network Selection Amount
- 11= Product/Selection/Brand Non-Preferred Formulary Selection Amount
- 12= Coverage Gap Amount

The following list of values reported in field 351-NP (Other Payer Patient Responsibility Amount Qualifier) will be considered as **NOT** acceptable for payment**.** If any of the following values are submitted, the claim will fail a new Pre-adjudication edit NCPDP Reject code 536 (Other Payer – Patient Responsibility Amount Qualifier Value Not Supported).

Qualifier values Not Accepted – Field 351-NP:

- 03= Sales Tax Amount
- 06= Patient Pay Amount
- 13=Processor Fee Amount

The following list of values reported in field 308-C8 (Other Coverage Code) are considered acceptable. This field is used by the pharmacy to indicate whether or not the patient has other insurance coverage or is enrolled in a Medicare Managed Care Organization (MCO). Valid entries for field 308-C8 are:

- 0 = Not Specified
- 1 = No Other Coverage Identified
- 2 = Other Coverage Exists, Payment Collected
- 3 = Other Coverage Exists, This Claim Not Covered.
- 4 = Other Coverage Exists, Payment Not Collected

The following updates will be made to the specified values submitted in field 308-C8:

- **Submission of Other Coverage Code "3"- (Other Coverage Exists, This Claim Not Covered).** A new Pre-adjudication edit NCPDP Reject code 6E (M/I Other Payer Reject Code) will be failed when a value of "3" (Other Coverage Exists, This Claim Not Covered) is sent in Other Coverage Code field 308-C8, and in the COB Segment, field 472-6E (Other Payer Reject Code) does not contain the Reject code from the prior payer. This field may be repeated 5 times to allow reporting of up to 5 reject codes as qualified by field 471-5E (Other Payer Reject Count). The NCPDP Reject code "13" (M/I Other Coverage Code) will also be returned on the rejected response.

- **Submission of Other Coverage Code "4" (Other Coverage Exists, Payment Not Collected).** The value code of "4" may be submitted in field 308-C8 for situations where the prior payer did not make a payment, however PR- (Patient Responsibility Amount) is due.

- **Submission of Other Coverage Code "8"- (Billing for Co-pay). This is not a valid value.** A new claims edit 02227 (Claims Other Insurance Payment Collection Code is Equal to "8") will be failed when the value of "8" is sent in field 308-C8. The NCPDP Reject code "13" (M/I Other Coverage Code) will be returned on the rejected response.

Contact the eMedNY Call Center at (800) 343-9000 for questions regarding COB billing or any billing issue.

Reminder: Requirements for Faxed Prescription Drug Orders

Prescribers may fax prescriptions and fiscal orders for drugs directly to a pharmacy unless otherwise prohibited by state or federal law or regulations.

The pharmacist is responsible to make a good faith effort to verify the validity of the prescription and the prescriber's identity if the prescriber is unknown to the pharmacist.

- All orders received by the pharmacy as a fax must be on the Official New York State Prescription Form. Faxed refill authorization requests are **not** allowed under the Medicaid Program.
- A faxed order must originate from a secure and unblocked fax number. The source fax number must be clearly visible on the fax that is received.
- A faxed order must include the physician imprint/stamp and signature.
- Each faxed prescription or fiscal order may include only one drug. Lists of drugs are not acceptable as faxed orders. Drugs ordered from a nursing home are exempt from this requirement.

Questions? Please call the Medicaid Policy Unit at (518) 486-3209 or via e-mail to: PPNO@heatlh.state.ny.us.

Electronic Prescribing Incentive Payments Discontinued Effective April 1, 2014

The NYS 2014-15 Budget has repealed the authorization for payment of an incentive to eligible pharmacies and medical practitioners for approved ambulatory Medicaid e-prescriptions (Section 6 of Part C of Chapter 60 of the Laws of 2014).

As a result, effective April 1, 2014, payment of an incentive to eligible pharmacies and medical practitioners for each approved ambulatory Medicaid e-prescription, plus a maximum of five refills per prescription, is discontinued.

eMedNY Enhancement Allows Providers to Submit Certain Requests and Transactions Online

eMedNY has implemented a Provider Portal available to enrolled providers at www.emedny.org. After clicking on the Provider Portal button users may choose to create a web portal account. Only a few pieces of information are required to establish a portal "Administrator" account. Administrators can create accounts for other users in his/her organization. A step-by-step guide for creating an account is available online at: https://www.emedny.org/selfhelp/ProviderPortal/Enrolling_in_Web_Portal.pdf.

Portal users have the advantage of being able to submit Electronic Funds Transfer (EFT) requests and Electronic Remittance Request forms online via the portal.

CORE WEB SERVICES

In addition to the enhancements listed above, users can also register for CORE Web Services via the Provider Portal. The CORE Web Service is designed to facilitate the exchange of X12 270/271 Health Care Eligibility Benefit Inquiry and Response information, and 276/277 Health Care Claim Status Request and Response information, for interactive (real-time) transactions and batch files according to CORE standards. CORE standards require the use of Hypertext Transfer Protocol Secure (HTTPS) over the public Internet. The X12 payload is required to be enclosed within a message envelope that meets the CORE standards for the following two protocols:

- HTTP MIME Multipart
- SOAP + WSDL

The general CORE Standards can be found at the following website:
http://www.caqh.org/pdf/CLEAN5010/270-v5010.pdf.

Detailed information about eMedNY's CORE Web Services can be found here:
https://www.emedny.org/selfhelp/CORE_Web_Services_User_Guide.pdf.

All questions regarding connectivity and billing will go through the eMedNY Call Center at (800) 343-9000. If necessary, a ticket will be escalated to a call back unit.

Important Note: It is solely the responsibility of the submitter or user to develop or create their CORE Web Services compliant application. eMedNY will in no way support the end user application, therefore it is strongly recommended that the Trading Partner take appropriate action to have available technical support.

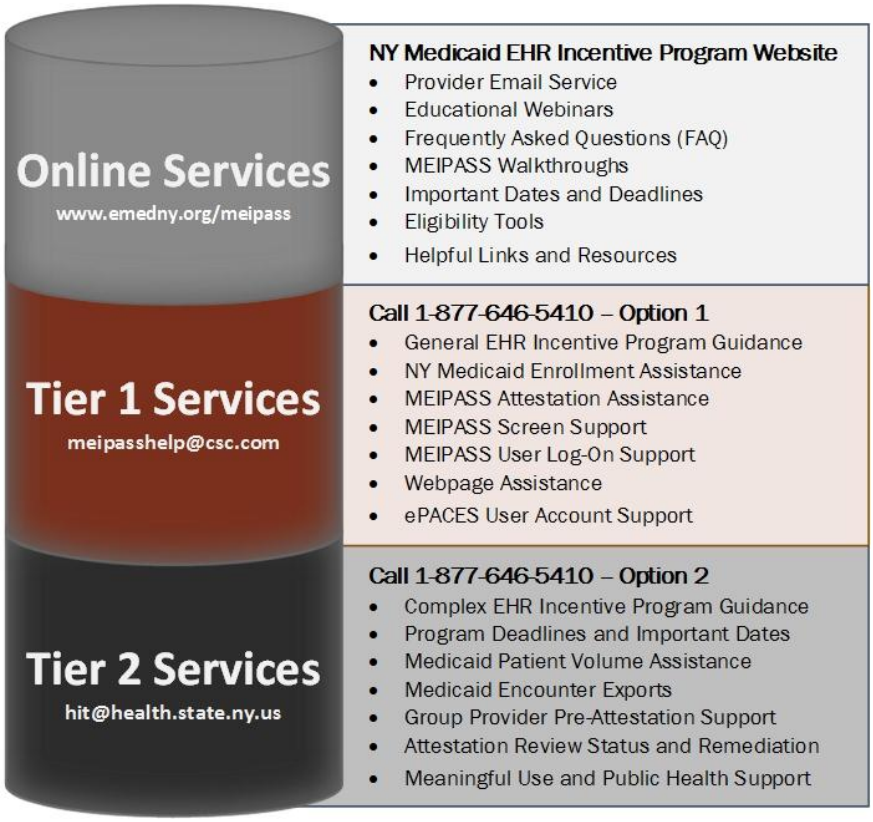
New York Medicaid EHR Incentive Program Update

The New York Medicaid EHR Incentive Program provides financial incentives to eligible practitioners 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 $571.8 million*** in incentive funds have been distributed *within* ***13,150*** payments to New York State Medicaid providers.

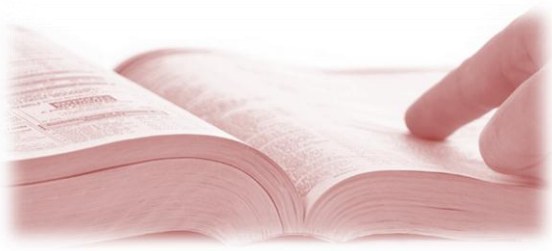
The New York Medicaid EHR Incentive Program Support Team takes great pride in offering providers free high quality program support and services. Don't take our word for it, call us at **1-888-646-5410 and** speak with a program analyst for one-on-one support or navigate to the NY Medicaid EHR Incentive Program website to view our online services.

Please review our **Service Portfolio** for a complete listing of services to assist providers in participating in the New York Medicaid EHR Incentive Program.

Taking a closer look: NY Medicaid EHR Incentive Program Service Portfolio



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.

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'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.