NEW YORK STATE | Department of Health | Medicaid Program

Medicaid Update

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Nassau and Suffolk Counties to be included in Transportation Carve-out for Managed Care Enrollees Effective December 1, 2015

To implement the Medicaid Redesign Team's (MRT) Transportation Reform Initiative #29, the Department is phasing in a Medicaid fee-for-service non-emergency medical transportation (NEMT) management program under which transportation services are carved out of the Medicaid managed care benefit package. The first NEMT program for managed care enrollees was implemented in the Hudson Valley Region in January 2012, with additional Hudson Valley counties moving to the NEMT manager in March and September of 2012. Implementation in New York City began in January 2013. An additional 24 counties in the Finger Lakes and Northern New York moved to the NEMT manager on January 2014, and 7 Western New York counties were transitioned to the NEMT manager on January 1, 2015.

In the final phase of this MRT initiative, effective December 1, 2015, emergency and non-emergency transportation services will be carved-out of the Medicaid managed care benefit package for all Medicaid managed care enrollees in Nassau and Suffolk Counties. LogistiCare Solutions, LLC was selected as the NEMT management contractor for Nassau and Suffolk Counties.

Effective December 1, 2015, medical providers are advised to contact LogistiCare Solutions, LLC at the number below to arrange for NEMT of managed care enrollees in Nassau and Suffolk Counties:

Contact Information for Providers

Nassau and Suffolk Counties	844-678-1106

Managed care enrollees in Nassau and Suffolk Counties may use the number below to make their own NEMT arrangements through Logisticare.

Contact Information for Enrollees

Nassau and Suffolk Counties	844-678-1103

-continued on page 3-

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In This Issue…..

-continued from cover-

A recap of previous phases of this MRT initiative and related contact information is included below.

The upstate carve-out schedule for NEMT of managed care enrollees is provided below:

January 1, 2012 – Albany, Columbia, Fulton, Greene, Montgomery, Orange, Putnam, Rockland, Sullivan, Ulster, Warren, Washington, Westchester

March 1, 2012 – Broome, Cayuga, Dutchess, Oneida, Onondaga, Rensselaer, Schenectady, Schoharie

September 1, 2012 – Delaware, Essex, Saratoga

January 1, 2014 – Chemung, Chenango, Clinton, Cortland, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Ontario, Orleans, Oswego, Otsego, St. Lawrence, Schuyler, Seneca, Steuben, Tioga, Tompkins, Wayne, Yates

January 1, 2015 – Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Wyoming

Enrollees and medical providers in all counties except Nassau, Suffolk and the five boroughs of New York City should contact Medical Answering Services, LLC (MAS), at the county-specific numbers provided in the following listing, to arrange for non-emergency medical transportation:

Albany	855-360-3549		Oneida	855-852-3288
Allegany	866-271-0564		Onondaga	855-852-3287
Broome	855-852-3294		Ontario	866-733-9402
Cattaraugus	866-371-4751		Orange	855-360-3543
Cayuga	866-932-7743		Orleans	866-260-2305
Chautauqua	855-733-9405		Oswego	855-733-9395
Chemung	855-733-9399		Otsego	866-333-1030
Chenango	855-733-9396		Putnam	855-360-3547
Clinton	866-753-4435		Rensselaer	855-852-3293
Columbia	855-360-3546		Rockland	855-360-3542
Cortland	855-733-9397		Saratoga	855-852-3292
Delaware	866-753-4434		Schenectady	855-852-3291
Dutchess	866-244-8995		Schoharie	855-852-3290
Erie	800-651-7040		Schuyler	866-753-4480
Essex	866-753-4442		Seneca	866-753-4437
Franklin	888-262-3975		St. Lawrence	866-722-4135
Fulton	855-360-3550		Steuben	855-733-9401
Genesee	855-733-9404		Sullivan	866-573-2148
Greene	855-360-3545		Tioga	855-733-9398

Hamilton	866-753-4618		Tompkins	866-753-4543
Herkimer	866-753-4524		Ulster	866-287-0983
Jefferson	866-558-0757		Warren	855-360-3541
Lewis	800-430-6681		Washington	855-360-3544
Livingston	888-226-2219		Wayne	855-852-3295
Madison	855-852-3286		Westchester	866-883-7865
Monroe	866-932-7740		Wyoming	855-733-9403
Montgomery	855-360-3548		Yates	866-753-4467
Niagara	866-753-4430			

Implementation of the transportation carve out in New York City was effective January 1, 2013. Medical providers in New York City should contact LogistiCare, the New York City NEMT manager, at the numbers below to arrange for NEMT of managed care enrollees:

Contact Information for Providers

NYC Facility Services Dept. (For facility transportation arrangements)	877-564-5925
Brooklyn facility (fax)	877-585-8758
Queens facility (fax)	877-585-8759
Manhattan facility (fax)	877-585-8760
Bronx facility (fax)	877-585-8779
Staten Island facility (fax)	877-585-8780
Hospital Discharge	877-564-5926

Managed care enrollees in New York City may use the numbers below to make their own NEMT arrangements through LogistiCare or to register a complaint:

Contact Information for Enrollees

NYC Reservations (For enrollee reservations)	877-564-5922
NYC Ride Assist (For transportation complaints)	877-564-5923

Questions regarding the Medicaid fee-for-service transportation benefit should be directed to MedTrans@health.ny.gov.

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Record Keeping Requirements

A Reminder for All Transportation Vendors

In accordance with Title 18 NYCRR §504.3(a), transportation vendors will be reimbursed only when complete, acceptable, verifiable records are available to auditors upon request. The documentation below is required for **every leg** of a trip, and must be maintained for a period of six years following the date of payment. If any of the required information is incomplete, or deemed unacceptable or false, any relevant paid reimbursement will be recouped.

Ambulance Service Vendors

Ambulance service providers are responsible for maintaining the Pre-Hospital Care Report, a complete record of the ambulance trip that satisfies Medicaid's trip documentation requirements.

Ambulette, Taxi, and Livery Vendors

For each leg of the trip, verification must be completed at the time of the trip and include, at a minimum:

- The Medicaid enrollee's name and Medicaid identification number;
- The date of the transport;
- Both the origination of the trip and time of pickup;
- Both the destination of the trip and time of drop off;
- The vehicle license plate number; and
- The full printed name of the driver providing the transport.

Electronic Records

The use of electronic record-keeping methodology is becoming more prevalent. Transportation vendors using electronic methods to prepare and maintain contemporaneous documentation to support Medicaid claims must produce documentation with an accurate system-generated, unmodifiable date and time stamp for each leg of a billable trip.

Driver Signature

Although the driver's signature is not required at this time, it is advised that vendors include an attestation in the trip documentation that states, *"I provided the indicated transportation services,"* and request the driver's signature. Additionally, the weekly eMedNY-generated prior authorization roster listing all authorized trips should be preserved.

Supplemental Documentation

The following items presented as the only evidence of a trip are not considered acceptable documentation. However, these documents may be considered ***supplemental*** to additional required documentation and can be presented to supplement required documentation:

- A driver/vehicle manifest or dispatch sheet;
- Issuance of a prior authorization by an approved official with subsequent checkmarks;
- A prior authorization roster; or
- An attendance log from a day program.

Questions? Please contact the Medicaid Transportation Policy Unit at (518) 473-2160.

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Ordered Ambulatory Payment Policy for PET Scan Procedures and Tracers

REVISED - Effective September 1, 2015

The Medicaid Program is revising the reimbursement methodology for positron emission tomography (PET) scans. Presently, the Ordered Ambulatory Fee schedule pays a global fee for the PET scan. The global fee includes the cost of the radioactive tracer administered to the patient.

Effective September 1, 2015, Medicaid is carving out the cost of the tracer from the global fee. The facility will receive payment for the professional/technical component for the PET scan and will bill the radioactive tracer on a separate claim line (in addition to the professional/technical PET scan component). The facility must report actual acquisition cost for the tracer and/or tracer components along with the invoice(s) net of any rebates, discounts or other cost considerations. Please note that Medicaid payment for the professional/ technical component of the PET scan has been reduced to reflect that the tracer cost has been carved out of the global fee. This change in policy is aligned with Medicare's policy, which pays for the procedures and tracers separately. The table below lists the current PET scan professional/technical fee, the new PET scan fees effective September 1, and the CPT billing codes for tracers:

CODE	DESCRIPTION	ORDERED AMBULATORY FEE SCHEDULE, (EFFECTIVE APRIL 1, 2015)	REVISED ORDERED AMBULATORY FEE SCHEDULE, (EFFECTIVE SEPTEMBER 1, 2015)
PET Scan Procedures			
78459	MYOCARDIAL IMAGING, PET, METABOLIC EVALUATION	$ 1,634	$ 600
78491	MYOCARDIAL IMAGING, PET, PERFUSION; SINGLE STUDY AT REST OR STRESS	$ 1,634	$ 604
78492	MYOCARDIAL IMAGING, PET, PERFUSION; MULTIPLE STUDY REST AND/OR STRESS	$ 1,634	$ 991
78608	BRAIN IMAGING, PET; METABOLIC EVALUATION	$ 1,634	$ 742
78609	BRAIN IMAGING, PET; PERFUSION EVALUATION	$ 1,634	$ 743
78811	PET IMAGING; LIMITED AREA (EG, CHEST, HEAD/NECK)	$ 1,634	$ 712
78812	PET IMAGING; SKULL BASE TO MID-THIGH	$ 1,634	$ 319
78813	PET IMAGING; WHOLE BODY	$ 1,634	$ 1,059
78814	PET WITH CONCURRENTLY ACQUIRED COMPUTED TOMOGRAPH; (EG, CHEST, HEAD/NECK)	$ 1,718	$ 387
78815	PET WITH CONCURRENTLY ACQUIRED COMPUTED TOMOGRAPH; (SKULL BASE TO MIDTHIGH)	$ 1,970	$ 676
78816	PET WITH CONCURRENTLY ACQUIRED COMPUTED TOMOGRAPH; (WHOLE BODY)	$ 2,222	$ 870
Radioactive Tracers			
A9526	NITROGEN N-13 AMMONIA, DIAGNOSTIC, PER STUDY DOSE, UP TO 40 MILLICURIES		BY REPORT
A9552	FLUORODEOXYGLUCOSE F-18 FDG, DIAGNOSTIC, PER STUDY DOSE, UP TO 45 MILLICURIES		BY REPORT
A9555	RUBIDIUM RB-82, DIAGNOSTIC, PER STUDY DOSE, UP TO 60 MILLICURIES		BY REPORT
A9580	SODIUM FLUORIDE F-18, DIAGNOSTIC, PER STUDY DOSE, UP TO 30 MILLICURIES		BY REPORT

Note: Federal National Correct Coding Initiative (NCCI) edits apply.

Questions regarding this policy and/or the Fee Schedule for Professional Services should be directed to the Division of Program Development and Management at (518) 473-2160.

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Billing Changes for Personal Care Services, Home Health Aide Services, Homemaker Services, Consumer Directed Personal Assistance Programs and Supplemental Day Habilitation Provided to Individuals Living in OPWDD Certified Residences

On October 1, 2015 changes in reimbursement will affect the following services through the Office for People With Developmental Disabilities (OPWDD) Comprehensive Home and Community Based Services (HCBS) Waiver: personal care services, home health aide services, homemaker services, consumer directed personal assistance programs, and supplemental day habilitation.

Effective October 1, 2015, OPWDD has changed the reimbursement methodology for certain services for people who live in Supervised and Supportive Individual Residential Alternatives (IRAs), Community Residences (CRs) and Family Care (FC) Homes. The services for individuals will not decrease; rather, the funding mechanisms for some of these services will be changing. These changes are made in an effort to streamline and align the HCBS Medicaid Waiver program funding requirements and to honor commitments made to the Centers for Medicare and Medicaid Services (CMS).

Changes to OPWDD Supportive IRAs, CRs and FC Homes

There are several changes related to the funding of services for individuals who live in Supportive IRAs, CRs, and FC Homes effective 10/1/15:

1. Residential Habilitation providers must pay for all aide services in the residence including personal care services, home health aide services, homemaker services, and consumer directed personal assistance programs. The provider may not bill Medicaid separately for these services. The residential provider is also responsible for these services that are delivered on weekends and weekday evenings in the residence and in community locations.

2. Residents can continue to attend Supplemental Group Day Habilitation services provided on weekday evenings or on weekends, but the service must be reimbursed by the residential provider.

3. Residents can continue to receive Community Habilitation services on weekends and weekday evenings, but the service must be reimbursed by the residential provider. There is an exception for Community Habilitation and personal care services that support the person at an integrated job site where he/she is competitively employed. When these services support the individual to maintain competitive employment, the service may be delivered on weekends and weekday evenings and be separately billed to Medicaid.

Changes to OPWDD Supervised IRAs and CRs

Effective 10/1/15, providers of Supervised IRAs and CRs are responsible for:

1. Providing or paying for nutrition services for residents in these settings if these services are related to the person's Residential Habilitation plan;
2. Providing or paying for certain psychological services (behavioral intervention and support services) that are related to the person's Residential Habilitation plan. The provider may not bill Medicaid separately for these clinical services. These behavioral intervention and support services must be delivered by licensed psychologists, licensed clinical social workers, or behavior intervention specialists.

Questions concerning this article can be directed to the OPWDD Waiver Unit at peoplefirstwaiver@opwdd.ny.gov or (518) 486-6466.

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Termination of Individual Day Habilitation under the OPWDD Comprehensive HCBS Waiver

Effective October 1, 2015, Individual Day Habilitation (IDH) and Supplemental Individual Day Habilitation (SIDH) will be terminated. The termination of IDH is necessary due to the 10/1/14 expansion of Community Habilitation (CH) services that results in no significant difference between the scope of services and activities included in IDH and the scope of services and activities that can be funded through either CH and/or Group Day Habilitation (GDH).

On October 1, 2014, eligibility for CH services was expanded to include not only individuals residing outside of OPWDD certified settings, but also individuals who live in OPWDD-certified IRAs, CRs or FC Homes. This expansion of eligibility will allow individuals residing in OPWDD-certified settings to utilize CH services in lieu of part or all of their day services.

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Nurse Practitioner Collaboration Requirements
New York State Medicaid eMedNY System Changes Being Made

Modifications are currently being made to the fee-for-service Medicaid eMedNY claiming system to reflect the recent changes made to the Nurse Practitioner collaboration requirements.

Pursuant to changes to New York State Education Law Section 6902(3) (see 8 NYCRR Sections 29.14 and 64.5), nurse practitioners (NPs) practicing for more than 3,600 hours may, in lieu of obtaining a written practice agreement with a physician, document that they have collaborative relationships with one or more licensed physicians qualified to collaborate in the specialty involved or with a hospital, licensed under Article 28 of the Public Health Law, that provides services through licensed physicians qualified to collaborate in the specialty involved and having privileges at that institution.

This change was part of the Nurse Practitioners Modernization Act, which was enacted in 2014 as Chapter 56 of the Laws of 2014, Part D. The law does not change the rules for NPs practicing for 3,600 hours or less. They continue to be required to have a written practice agreement with a collaborating physician who is qualified to practice in the NP's specialty area of practice.

As noted, the eMedNY claiming system is currently being modified to reflect this change in collaboration requirements. In the interim, in order for claims to process correctly, the NPI of a collaborating physician must be on file with NYS Provider Enrollment.

Additional details and instructions will be published in an upcoming Medicaid Update.

Questions about Provider Enrollment should be addressed to Computer Sciences Corporation at 1-800-343-9000.
Policy questions should be directed to OHIP Division of Program Development and Management at (518) 473-2160.

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Clarification of Policy for Practitioner, Ordered Ambulatory, and APG Reimbursement

- and -

New Billing Instructions for Wasted Drugs Using Modifier JW

Medicaid fee-for-service (FFS) will reimburse providers for the unused portion of a single-use vial of J code drugs when the provider uses the JW modifier. This policy was effective for practitioner and ordered ambulatory care billing June 1, 2015 and for APG billing January 1, 2015. See updated APG modifier list (effective 1/1/2015):
http://www.health.ny.gov/health_care/medicaid/rates/methodology/modifiers.htm

Modifier JW is defined as "drug or biological amount discarded/not administered to any patient." Practitioners, hospitals and other providers may append modifier JW to a drug line on a claim to indicate drug wastage for non-inpatient physician-administered drugs when a single use vial/package is opened but the entire dose/quantity is not administered and the remainder is discarded.

The majority of drugs and biologicals are issued in multi-use vials. However, some pharmaceutical agents do not have the stability required to be packaged in multi-use vials and instead must be packaged in single-use vials.

Multi-use vials are not subject to reimbursement for discarded amounts of drugs.

Policy:

Some drugs are only supplied in single-use vials or other single-use packaging. After administering a dose/quantity of the drug to a Medicaid beneficiary, NYS Medicaid provides payment for the amount of drug discarded along with the amount administered, up to the amount of the drug as indicated on the vial or package label.

Reimbursement for drugs furnished by practitioners to their patients is based on the acquisition cost of the drug. If the whole single-use vial is not used, and if the provider has made a good faith effort to obtain the correct dosages/packaging, they can bill the unused portion.

This is consistent with Medicare's policy, which requires providers to include the unused portion of a drug (except for Part B drugs and biologicals provided under the Competitive Acquisition Program) on a second claim line with the JW modifier appended.

In accordance with the CMS National Correct Coding Initiative (NCCI), "Physicians must report units of service correctly. Each HCPCS/CPT code has a defined unit of service for reporting purposes. A physician should not report units of service for HCPCS/CPT code using a criterion that differs from the code's defined unit of service."

NYS Medicaid FFS will not reimburse for unused drugs or biologicals that result from a missed patient appointment.

Fee-for-Service Billing Guidance:

In order for a provider to bill for unused (wasted) drug(s) or biologicals, the provider must indicate both the portion of the drug that was administered along with the portion that was wasted. The drug information should be reported on two lines:

- Line one – J code and units administered (payment provided for the units administered).
- Line two – J code with units NOT administered (wasted) with modifier JW appended to the associated HCPCS code (payment provided for the units NOT administered).

APG Billing Guidance:

The JW modifier's impact on payment will vary depending on whether a drug is paid based on an APG Group or the APG fee schedule.

APG Group Payment with Modifier JW:

Procedure Code	Procedure Code Description	Modifier	Units of Svce	Expected APG	APG Description	Payment Action	Allowed Weight	Add-on Pymt	Full APG Pymt	Total Pymt
99212	Office/outpatient visit est			871	SGINS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS	Full Pymt	0.6968	$0.00	$139.28	$139.28
J9302	Ofatumumab injection			439	CLASS V PHARMACOTHERAPY	Full Pymt	2.7455	$25.42	$439.28	$464.70
J9302	Ofatumumab injection	JW		439	CLASS V PHARMACOTHERAPY	No Pymt	0.0000	$0.00	$0.00	$0.00
								Total Paid		$603.98

Drugs that map to an APG Group (e.g., APG 436 CLASS II PHARMACOTHERAPY, APG 437 CLASS III PHARMACOTHERAPY) will pay as follows:

- Line 1 – the first J code line will pay in full; and,
- Line 2 – the second J code line with the same drug and the JW modifier will consolidate and pay $0.00.

Note: The APG Group service intensity weight (SIW) is based on the average cost and units utilized per episode/encounter for all drugs that map to the Group, so the payment reflects both used and wasted drug amounts.

APG Fee Schedule Payment with Modifier JW:

Procedure Code	Procedure Code Description	Modifier	Units of Svce	Expected APG	APG Description	Payment Action	Allowed Weight	Add-on Pymt	Full APG Pymt	Total Pymt
99212	Office/outpatient visit est			871	SGINS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS	Full Pymt	0.6968	$0.00	$139.28	$139.28
J3489	Injection, zoledronic acid		4	436	CLASS II PHARMACOTHERAPY	Full Pymt	2.6355	$25.42	$421.68	$447.10
J3489	Injection, zoledronic acid	JW	1	436	CLASS II PHARMACOTHERAPY	Full Pymt	0.6589	$0.00	$105.42	$105.42
								Total Paid		$552.52

Drugs that map to the APG fee schedule (e.g., J9306 Injection, Pertuzumab, J9041 Bortezomib injection, J2997 Alteplase recombinant) will pay as follows:

- Line 1 – the first J code line will pay in full based on the unit price and number of units administered to patient; and,
- Line 2 – the second J code line (with the same drug) and the JW modifier will pay in full based on the unit price and number of units wasted or discarded.

Note: Existing APG Group Pricer logic, which applies to APG Group payments, does not apply to drugs that map to the APG fee schedule. Therefore, each line in which a drug is coded will pay. However, the total number of units coded by the billing provider for both lines (used and discarded) should not exceed the unit maximum indicated on the APG fee schedule. For a complete list of drugs on the APG fee schedule please visit: http://www.health.ny.gov/health_care/medicaid/rates/methodology/history_and_fee_schedule.htm

Policy questions regarding Medicaid fee-for-service may be directed to OHIP Division of Program Development and Management at (518) 473-2160. Questions regarding Medicaid Managed Care billing and reimbursement should be directed to the enrollee's Medicaid Managed Care Plan. Questions on billing or claims should be directed to Computer Sciences Corporation at 1-800-343-9000.

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New York State Medicaid Clarification of Coverage for HIV and Hepatitis C Laboratory Billing for Reflex Testing

New York State (NYS) Medicaid reimburses laboratories for reflex testing for confirmation of reactive HIV screenings and reactive HCV antibody screening tests. National guidelines for HIV and HCV testing algorithms now include nucleic acid tests to be used for confirmation following reactive HIV and HCV screening results without additional written orders from the physician (reflex testing). Reflexed tests are any secondary test automatically performed based on criteria applied to the results of an initial screening test to provide additional diagnostic information. For Medicaid reimbursement of reflex tests, the preprinted requisition form must indicate that this test will be used in the reflex algorithm, making the ordering provider aware of all the tests being ordered and performed. NYS Medicaid only covers tests used by laboratories that are approved by the FDA or the NYSDOH Wadsworth Center. Any modification to an FDA-approved test, including the manufacturer's intended use, must be validated by the laboratory and approved by the NYSDOH Wadsworth Center (see link below).
http://www.wadsworth.org/docs/overview_lab_quality.shtml

HIV Reflex Testing

To ensure complete and timely diagnosis of HIV infection, reflex testing is recommended following a reactive 3rd or 4th generation screening test (antibody only or antigen/antibody). Reflex testing may include antibody differentiation testing and for indeterminate results, HIV RNA testing. The laboratory may perform necessary testing for confirmation of HIV diagnosis without obtaining an additional order from the physician (reflex testing) if indicated on the requisition. The laboratory will report all results to the physician.

Due to regulatory restrictions regarding any modification to an FDA-approved test, laboratories must validate the currently available FDA-approved quantitative HIV RNA tests for diagnostic use and obtain approval from the NYSDOH Wadsworth Center prior to using the test for the purpose of diagnosing HIV infection (i.e., as a reflex test in a diagnostic algorithm).

HCV Reflex Testing

To ensure complete and timely diagnosis of HCV, HCV reflex testing is recommended following a reactive hepatitis C antibody screening test. The laboratory may perform a HCV RNA test to confirm a current HCV infection without obtaining an additional order from the physician (reflex testing) if indicated on the requisition. The laboratory will report all results to the physician.

Due to regulatory restrictions regarding any modification to an FDA-approved test, laboratories must validate the currently available FDA-approved quantitative HCV RNA tests for diagnostic use and obtain approval from the NYSDOH Wadsworth Center prior to using the test for the purpose of diagnosing HCV infection (i.e., as a reflex test in a diagnostic algorithm).

For Medicaid policy questions, please contact the Division of Program and Management at (518) 473-2160.

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Reflex Testing for HIV and Hepatitis C
Update for Health Care Practitioners

Human Immunodeficiency Virus Reflex Testing

Recommendations for Human Immunodeficiency Virus (HIV) testing have been revised by the Centers for Disease Control and Prevention (CDC) in recent years, because of the relatively poor sensitivity of the Western Blot and its inability to detect acute HIV infection.[1] As with current testing, if an initial screening test for HIV is negative, then HIV is considered ruled out unless a recent exposure to HIV has occurred. However, with traditional screening, if the test result was reactive, then a Western Blot was performed to determine if the person was truly infected. Problems with the Western Blot include a relatively low sensitivity for early detection, an inability to diagnose acute HIV infection and an inability to differentiate HIV-1 from HIV-2 infection.

Confirmation of HIV infection from the same sample obtained for a screening result is supported by the CDC's new algorithm for HIV testing.[1] Since this reflex testing can be done on the same sample used for screening, it does not require the patient to return for additional blood work. The screening tests assess for HIV-1 **and** HIV-2 (HIV1/2) antibodies, either with the p24 viral core protein-antigen (fourth generation test) or without p24 antigen (third generation test). In the revised HIV testing algorithm, if the initial screening test is reactive, then reflexed supplemental antibody testing is now recommended on the same sample to distinguish between HIV-1 and HIV-2 infection. Although the vast majority of HIV infections in the United States are HIV-1 infections, both types are found in the United States and differentiation is important for appropriate medical care.

The revised HIV testing algorithm also enables testing for acute HIV infection. Reflex HIV-1 RNA testing is performed to assess for acute HIV infection when there is an initial HIV-1/2 antibody or combination antigen/antibody screening test result that is reactive, but the subsequent, supplemental test for HIV-1 and HIV-2 antibodies is either negative or indeterminate. If HIV-1 RNA is present, this person is likely seroconverting to HIV-1 infection. If no HIV-1 RNA is found, then the reactive screening test result is likely a false positive.

Hepatitis C Virus Reflex Testing

Confirmation of Hepatitis C Virus (HCV) infection from the same sample obtained for a screening result is supported by the new streamlined HCV reflex testing recommendations.[2] For hepatitis C virus screening, a negative antibody test result effectively rules out HCV infection with two notable exceptions:

- If the patient was very recently infected and thus may not yet have developed a sufficient antibody response to be detectable by the immunoassay, or

- If the patient had advanced immune suppression from HIV infection, where chronic HCV can co-exist with a negative HCV antibody result.[3]

Reflex testing is now recommended by the CDC for HCV testing, when the initial HCV antibody screen is reactive.[2] This further testing enables confirmation of HCV viremia to diagnose active HCV infection. If the subsequent polymerase chain reaction (PCR) or similar nucleic acid test (NAT) is negative for HCV RNA, HCV infection is effectively ruled out for most patients. This obviates the need for the patient to return for follow-up testing, unless there is concern for recent HCV infection or the individual is HIV-positive, with a low CD4 cell count, below the AIDS-defining threshold of 200 cells/mm^3, and typically below 100 cells/mm^3.[3]

If the reflex HCV RNA test is positive, a diagnosis of active HCV infection has been confirmed, and the individual should be referred directly for HCV care and treatment. This ability to distinguish someone with acute or chronic HCV infection from an individual with a false positive HCV antibody result or someone with a previous HCV infection that has successfully cleared, either spontaneously or with treatment, is helpful in interpreting the test results. The patient additionally benefits, because if the RNA test is negative, the work-up is done, and the patient may be reassured. The patient should be advised that any antibody to HCV is not protective against future infection or re-infection with HCV.

Acute hepatitis C cannot be distinguished from chronic HCV infection based on PCR (viral load) alone. Eradication of hepatitis C viremia is now highly achievable for most people with chronic HCV infection by any HCV genotype, with several oral, interferon-free regimens that are now available.[4]

References

[1]Centers for Disease Control and Prevention and Association of Public Health Laboratories. Laboratory Testing for the Diagnosis of HIV Infection: Updated Recommendations. Published June 27, 2014. Accessed June 18, 2015. Available at http://www.cdc.gov/hiv/pdf/hivtestingalgorithmrecommendation-final.pdf

[2] Centers for Disease Control and Prevention. Testing for HCV infection: an update of guidance for clinicians and laboratorians. *MMWR.* 2013;62(18):362-365.

[3]Hadlich E *et al.* Hepatitis C virus (HCV) viremia in HIV-infected patients without HCV antibodies detectable by third-generation enzyme immunoassay. *Journal of Gastroenterology and Hepatology.* 2007;22(9):1506-1509.

[4]HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C. Published on-line September 25, 2014, and updated June 28, 2015. Accessed July 20, 2015. http://www.hcvguidelines.org/full-report-view

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Reasonability Edits for Practitioner-Administered Drugs

REMINDER

This is a reminder that New York State Medicaid fee-for-service (FFS) limits payment for practitioner-administered drugs to the provider's acquisition cost by invoice. This reimbursement policy applies to claims submitted by private practitioners (physicians, nurse practitioners, licensed midwives) as well as Article 28 clinics billing ordered ambulatory (Note: This does not apply to clinic APG claims). To enforce this payment policy, Medicaid maintains a maximum fee on file for each drug.

Overpayments for practitioner-administered drugs have been identified due to providers submitting their "charges" rather than the actual acquisition cost of the drugs. In order to prevent overpayment for physician-administered drugs, reasonability edits have been established.

Reasonability edits have been turned on. If the acquisition cost submitted to FFS Medicaid for a practitioner-administered drug exceeds the cost on file for the drug, the claim will deny. This applies to drugs purchased at both 340B and non-340B prices. In order to be paid, providers must resubmit the claim reporting their actual acquisition cost as found on the invoice.

Claims failing the edits will have the following messages on their remittance statements:

Providers receiving an *electronic* remittance will see the following message:

16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION.	**M79**	MISSING/INCOMPLETE/INVALID CHARGE.

Providers receiving a *paper* remittance or PDF file of their remittance will see the following message:

02235	ACQUISITION COST REPORTED BY PROVIDER EXCEEDS PRICE ON FILE/ACQUISITION COST IS > THE GLOBAL % OF THE MAX FEE ON FILE
02236	ACQUISITION COST REPORTED BY PROVIDER EXCEEDS PRICE ON FILE/ACQUISITION COST IS > PRE DESIGNATED % OF THE MAX FEE ON FILE
02237	ACQUISITION COST REPORTED BY PROVIDER EXCEEDS PRICE ON FILE/ACQUISITION COST IS > THE GLOBAL % OF THE MAX FEE ON FILE – 340B DRUGS
02238	ACQUISITION COST REPORTED BY PROVIDER EXCEEDS PRICE ON FILE/ACQUISITION COST IS > THE PRE DESIGNATED % OF THE MAX FEE ON FILE – 340B DRUGS

Questions? Billing questions should be directed to the eMedNY Call Center at (800) 343-9000. Policy questions should be directed to the Division of Program Development and Management at (518) 473-2160.

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All Providers

The New York State Medicaid Management Information System Project Update

The New York State Department of Health and Xerox Healthcare, LLC are continuing work on the design and development of the new Medicaid Management Information System, NYMMIS.

As previously advised in the June 2015 Medicaid Update, an interim website, www.interimnymmis.com, exists to relay the most current information to the provider community and interested parties. The interim NYMMIS website will not have an effect on the current eMedNY system, nor will it be utilized for any provider transactions. As previously stated, a ListServ sign-up option exists for timely dissemination of information.

Currently, activities are underway to create a training strategy for those who will be using the new system. All efforts are being taken to develop this in a manner that will maximize learning and minimize impact to the provider. Training opportunities will be available in a variety of methods including self-taught computer based training and on-site provider training by field representatives from Xerox.

As information becomes available, it will be posted on the interim website. Any questions can be addressed by using the "Contact Us" option from the website.

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<<<Correction>>>

A correction has been made to the July 2015 Special Edition (Behavioral Health) Medicaid Update article, titled "Children's Update". On page 14 a service was omitted from the list of indicated HCBS benefits. It should have included Respite (Crisis and Planned). You can see the updated list from the following link:

http://www.health.ny.gov/health_care/medicaid/program/update/2015/jul15_mu_speced.pdf

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All Providers

New York State 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 $699 million*** in incentive funds have been distributed ***within 19,810*** payments to New York State Medicaid providers.

19,810 Payments	$699+ 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 participation years.

Register for our webinar sessions to learn about program requirements.

Program Eligibility and Support Services

For each participation year, EPs must demonstrate that at least 30% of their patient volume is attributed to Medicaid during a continuous 90-day reporting period. Pediatricians have the reduced option of demonstrating 20-30% Medicaid patient volume but will only receive two-thirds of the incentive payment when their percentage is below 30%.

Acceptable Medicaid encounter types include:

- ✓ Medicaid Fee-For-Service
- ✓ Medicaid Managed Care
- ✓ Family Health Plus

Need guidance calculating your Medicaid patient volume? Providers may contact our Support team at hit@health.ny.gov to request a summary of Medicaid fee-for-service and managed care claims under their individual or organization NPIs. Please include in your request the provider's NPI and a specific time period (e.g. calendar year 2014).

MEIPASS Updated

Need to correct your attestation? A new Self-Retraction function is now available in MEIPASS that allows Eligible Professionals and Eligible Hospitals to retract their attestations and resubmit with changes. Providers no longer have to contact hit@health.ny.gov to request manual rejections in order to make changes to submitted attestations.

Please refer to the Self-Retraction User Guide for assistance or contact our Support team at 877-646-5410.

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

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All Providers

ICD-10 is less than 40 days away!
Are you ready?

Starting October 1, 2015, NYS Medicaid will begin accepting and processing claims using ICD-10 diagnosis and procedure codes.

What does ICD-10 mean for everyone?

- Claims for dates of service on or after October 1, 2015 require ICD-10 codes.
- ICD-10 is an expanded code set and eMedNY will not publish an ICD-9 to ICD-10 crosswalk: Use the many resources available through https://www.emedny.org/icd to explore your options and to train your office.
- All provider types who bill Medicaid are impacted: See the FAQs to see how your NY Medicaid claims will need to be submitted.
- ICD-9 and ICD-10 coding are not allowed within the same claim.
- Possible interruption in payment: Submitting claims with ICD-9 codes for dates of services on and after October 1 will be rejected by pre-adjudication edits.

In the meantime…

- Electronic Claims Submitters: After researching your applicable ICD-10 codes, don't hesitate to test using eMedNY's Provider Test Environment with the detailed instructions on emedny.org.
- Paper and ePACES Claims Submitters: eMedNY does not provide a method to test claims submitted with these methods. ePACES features an ICD Version radio button which you will be required to select after October 1. This field currently defaults to ICD-9 as shown in our ePACES Claim Quick Reference Guides.
- Submitters using Vendors, Clearing Houses and Service Bureaus: Be sure to communicate with your vendors to understand what steps you will need to complete to be ready on October 1 and coordinate testing in eMedNY's Provider Test Environment.

If you have further questions after reviewing emedny.org/icd, call the eMedNY Call Center at 1-800-343-9000

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New York State Medicaid FFS Program
Pharmacists as Immunizers Fact Sheet
(Updated 7-24-15)

NYS Education Law (6527, 6801, 6909) and regulations (8NYCRR63.9) permits licensed pharmacists who obtain additional certification to administer the following vaccines: Influenza, pneumococcal, meningococcal, tetanus, diphtheria, and pertussis vaccines when administered to patients 18 or older, and Zoster vaccines when administered to patients 50 or older, pursuant to either a patient specific order or a non-patient specific order.

Administration of select vaccines by qualified pharmacists employed by, or under contract with, Medicaid enrolled pharmacies is reimbursable under NYS Medicaid.

The following conditions apply:

- Only Medicaid enrolled pharmacies that employ or contract with NYS certified pharmacists to administer vaccines will receive reimbursement for immunization services and products. Pharmacy interns cannot administer immunizations in New York State.

- Services must be provided and documented in accordance to NYS Department of Education laws and regulations. Visit http://www.op.nysed.gov/prof/pharm/pharmimmunizations.htm for additional information.

- Pharmacies will only be able to bill for Medicaid fee-for-service non-dual enrollees. Medicaid managed care enrollees will continue to access immunization services through their health plans. Dual eligible enrollees will continue to access immunization services through Medicare.

- Reimbursement for these vaccines will be based on a patient specific order or non-patient specific order. These orders must be kept on file at the pharmacy. The ordering prescriber's NPI is required on the claim for the claim to be paid.

- Consistent with Medicaid immunization policy, for administration of vaccines ages 19 and over, pharmacies will bill the administration and acquisition cost of the vaccine using the appropriate procedure codes listed below. Please note that **NDCs are not to be used** for billing the vaccine product. Reimbursement for the product will be made at no more than the *actual* acquisition cost to the pharmacy. No dispensing fee or enrollee co-payment applies. Pharmacies will bill with a quantity of "1" and a day supply of "1".

Billing Instructions for 19 years of age and older: Providers must submit via NCPDP D.0, in the Claim Segment field 436-E1 (Product/Service ID Qualifier), a value of "09" (HCPCS), which qualifies the code submitted in field 407-D7 (Product/Service ID) as a Procedure code. Lastly, in field 407-D7 (Product/Service ID), enter the Procedure code. Providers may submit up to 4 claim lines with one transaction. For example, providers may submit one claim line with the Procedure code 90656 (Influenza Virus Vaccine), and another claim line for Procedure code 90471 (Immunization Administration through 19 years of age and older). For administration (ages 19 and older) of multiple vaccines on the same date, code 90471 should be used for the

first vaccine and 90472 for ANY other vaccines administered on that day. One line will be billed for 90472 indicating the additional number of vaccines administered (insert 1 or 2).

Vaccines For Childern (VFC) Billing Instructions through 18 years of age: Providers must submit via NCPDP D.0, in the Claim Segment field 436-E1 (Product/Service ID Qualifier), a value of "09" (HCPCS), which qualifies the code submitted in field 407-D7 (Product/Service ID) as a Procedure Code. Lastly, in field 407-D7 (Product/Service ID), enter the Procedure Code. Providers may submit up to 4 claim lines with one transaction. For example, providers may submit one claim line with the Procedure Code 90656 (Influenza Virus Vaccine), and another claim line for Procedure Code 90460 (VFC Immunization Administration through 18 years of age). For administration (through 18 years of age) of multiple VFC vaccines on the same date, code 90460 should be used for each vaccine administered.

- Vaccines for individuals under the age of 19 are provided free of charge by the VFC program. Medicaid **WILL NOT** reimburse providers for vaccines for individuals under the age of 19 when available through the VFC program. For reimbursement purposes, the administration of the components of a combination vaccine will continue to be considered as one vaccine administration.
- Providers have an obligation to participate in VFC if they want to offer vaccinations to patients less than 19 years of age. Although pharmacies are not required to join the VFC program when limiting their vaccine administrations to beneficiaries 19 and older, please remember that during times of flu season, the Governor often issues an executive order allowing pharmacies to immunize patients less than 19 years of age. Vaccine administration for the VFC population is at an enhanced reimbursement fee of $17.85. By not enrolling in the VFC program, these pharmacies **will not** be able to administer to this population.

The following procedure codes should be billed for pharmacist administration of select influenza, pneumococcal and meningococcal vaccines for age 18 and over, and zoster for age 50 and over:

Procedure Code	Procedure Description
90620	Meningococcal recombinant protein and outer membrane vesicle vaccine, Serogroup B, 2 dose schedule, for intramuscular use
90621	Meningococcal recombinant lipoprotein vaccine, Serogroup B, 2 or 3 dose schedule, for intramuscular use
90656	Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years of age and above, for intramuscular use
90658	Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use
90661	Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use
90670	Pneumococcal conjugate vaccine, 13-valent, for intramuscular use
90672	Influenza virus vaccine, quadrivalent, live, for intranasal use in individuals 2 years of age through 49
90673	Influenza virus vaccine, trivalent, derived from recombinant DNA, preservative free, for intramuscular use for 18 years through 49 years for use in patients with an egg allergy. (The use in patients over the age of 50 is currently pending FDA approval, so eMedNY would indicate a maximum age of 49.)
90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use
90688	Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, with preservative, for intramuscular use
90703	Tetanus toxoid adsorbed, for intramuscular use
90714	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, for use in individuals seven years or older, for intramuscular use

90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), for use in individuals 7 years or older, for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years of age or older, for subcutaneous or intramuscular use
90733	Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use, age 2 years of age and older
90734	Meningococcal conjugate vaccine, Serogroups A,C,Y and W-135 (trivalent), for intramuscular use, age 11 through 55
90736	Zoster (shingles) Vaccine, live, for subcutaneous injection, age 50 and older
90460	Immunization **administration through 18 years of Age** via Any Route of Administration with Counseling; First or Only Component of Each Vaccine or Toxoid Administered (to be used by VFC enrolled pharmacies when administering vaccines obtained from VFC Program) **$17.85**
90471	Immunization **administration ages 19 and older** (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid) **$13.23**
90472	Immunization **administration ages 19 and older** (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure) **$13.23**
90473	Immunization **administration ages 19 and older** of seasonal influenza intranasal vaccine **$8.57**

NOTE: The maximum fees for vaccine drugs are adjusted periodically by the State to reflect the estimated acquisition cost. Insert acquisition cost per dose in amount charged field on claim form.

For VFC enrollment information, go to:
http://www.health.ny.gov/prevention/immunization/vaccines_for_children.htm

Questions regarding Medicaid reimbursement of immunizations may be directed to the Medicaid Pharmacy Program at 518 486-3209 or PPNO@health.ny.gov

Additional information on influenza can be found at NYS Department of Health's website at
http://www.health.ny.gov/diseases/communicable/influenza/

CDC vaccine and immunization information can be found at http://www.cdc.gov/vaccines/

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New Edit for Orally Prescribed Controlled Substances to be Implemented

Medicaid Fee-for-Service

Effective August 27, 2015 the Department implemented a new edit on prescription claims for orally prescribed controlled substances to ensure the proper days' supply is submitted on the claim. Per 10 NYCRR Section 80.68 and 80.70, in an emergency, a practitioner may orally prescribe up to a 5-day supply of a Schedule II controlled substance or benzodiazepine and a Schedule III or Schedule V controlled substance.

This means if a claim is submitted with an origin code of "2" in field 419-DJ, and it is for a controlled substance, as listed above, a new edit will trigger a rejected claim when the day supply has been exceeded per regulation. The new codes are returned in the Response Status Segment as follows:

New MEVS Rx Denial Code 733- which means (Controlled Substance Oral Prescription Exceeds the Emergency 5 Day Supply Limit) will be returned in field 526-FQ (Additional Message Information).

New NCPDP Reject Code 7X – which means (Days Supply Exceeds Plan Limitations) will be returned in field 511-FB- Reject code.

Code descriptions can be found also in the ProDUR-ECCA D.0 Provider Manual:
https://www.emedny.org/ProviderManuals/Pharmacy/ProDUR-D.0-ECCA_Provider_Manual/Pro%20DUR%20ECCA%20Provider%20Manual%20(D.0).pdf

Please contact the eMedNY Call Center at (800) 343-9000 for questions regarding this billing requirement or any billing issue.

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Retroactive Prior Authorization (PA) for Point-of-Service Medicaid Fee-for-Service Pharmacy claims

Effective August 27, 2015, the Department implemented a system change that will allow for processing of a retroactive claim with PA criteria when the date of service is 90 days or less from the date of submission (current date). This means that a claim with PA criteria can be submitted or adjusted for up to 90 days in the past from the current date.

For drug claims that pass PA criteria, an automated PA will be applied to the claim within the system and no further action will need to be taken regarding the PA. For drug claims that fail criteria the pharmacy will receive the message: "Unable to Process a Pharmacy PA. Please Call Magellan at **(877) 309-9493**", in the claim response. This means when a claim for a drug fails criteria, the prescriber or their authorized agent would have to contact Magellan Medicaid Administration and complete a PA request via the phone (at the above phone number) or fax process at: https://newyork.fhsc.com/

The new functionality explained above supplements the policy found in the February 2014 Medicaid Update referenced below which instructs on performing Prospective Drug Utilization Review (Pro-DUR) and the process for drugs subject to PA criteria:
http://www.health.ny.gov/health_care/medicaid/program/update/2014/feb14_mu.pdf

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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