NEW YORK STATE | Department of Health

Medicaid Update

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Electronic Prior Approval Rosters for Non-Emergency Medical Transportation Services

Providers who currently receive hardcopy prior approval (PA) rosters for non-emergency medical transportation (NEMT) services are encouraged to switch to electronic paper/PDF (Portable Document Format) PA rosters, which offer the following advantages:

- They are delivered in advance of hardcopy rosters, which enable earlier payment and submission of claims;
- They have electronic storage of PA rosters on a personal computer, which make for easy retrieval of historical information;
- They can be received in the electronic Provider Assisted Claim Entry System (ePACES) or the eXchange; ***and***
- Their delivery does not rely on the United States Postal Service (USPS).

Electronic paper/PDF PA rosters are delivered as PDF files that can be viewed via Adobe Acrobat™, available free of charge. Rosters can then be printed, saved on computers for future reference, or saved as electronic records. Weekly rosters for NEMT service providers are posted to the eXchange every Monday. Providers already enrolled in ePACES are automatically enrolled in eXchange. To request electronic paper/PDF PA rosters be delivered through the eXchange, providers must complete the *Electronic PA Request Form*, located at: https://www.emedny.org/info/ProviderEnrollment/ProviderMaintForms/702101_ELECPaFORM_Electronic_Prior_approval_Request_Form.pdf. **Please note:** Providers must be enrolled in ePACES prior to requesting electronic PA advice.

Questions and Additional Information

All questions related to signing up for ePACES and eXchange, as well as Electronic PA Rosters advice, should be directed to the eMedNY Call Center at (800) 343-9000.

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Kathy Hochul
Governor
State of New York

Mary T. Bassett, M.D., M.P.H.
Acting Commissioner
New York State
Department of Health

Brett R. Friedman
Acting Medicaid Director
Office of Health Insurance Programs

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In This Issue…

Reminder: Sign Up for eMedNY Training Webinars

eMedNY offers several online training webinars to providers and their billing staff, which can be accessed via computer and telephone. Valuable provider webinars offered include:

- *ePACES for*: *Dental*, *Durable Medical Equipment (DME)*, *Free-Standing and Hospital-Based Clinics*, *Institutional*, *Physician*, *Private Duty Nursing*, *Professional (Real-Time)*, and *Transportation*
- *eMedNY Website Review*
- *Medicaid Eligibility Verification System (MEVS)*
- *New Provider / New Biller*

Webinar registration is fast and easy. To register and view the list of topics, descriptions and available session dates, providers should visit the eMedNY "Provider Training" web page at: https://www.emedny.org/training/index.aspx. Providers are reminded to review the webinar descriptions ***carefully*** to identify the webinar(s) appropriate for their specific training needs.

Questions

All questions regarding training webinars should be directed to the eMedNY Call Center at (800) 343-9000.

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Reminder: Facilities that Affiliate Practitioners

The article titled *Important Reminder to Hospitals and Clinics: Affiliated Practitioners Must Record Their National Provider Identifiers with eMedNY*, published in the July 2021 issue of the *Medicaid Update*, located at: https://www.health.ny.gov/health_care/medicaid/program/update/2021/docs/mu_no09_jul21.pdf, provides additional information for facilities that affiliate practitioners, listed below:

1. Facilities must ensure that accurate information is entered into eMedNY during the practitioner-facility affiliation process.
2. Facilities are responsible for appropriately screening affiliated furnishing, ordering, referring, prescribing, and attending practitioners to ensure that practitioners in enrollable provider categories are actively enrolled in the New York State (NYS) Medicaid program and are not currently excluded from participation in a federal or state health care program (e.g., Medicare, Medicaid).

Questions

All questions should be directed to the eMedNY Call Center at (800) 343-9000.

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NY State of Health Announces Enrollment in Qualified Health Plan Coverage Remains Open, Enrollment Continues to Climb

Enrollment in a Qualified Health Plan (QHP) through NY State of Health, the Official Health Plan Marketplace (Marketplace), remains open through January 31. 2022. Consumers are encouraged to enroll today to start the new year with coverage. To date, more than 200,000 New Yorkers have enrolled in a QHP since the start of the Open Enrollment Period on November 16, 2021. **Consumers must enroll by January 15, 2022 for health coverage beginning February 1, 2022.**

American Rescue Plan Act (ARPA) tax credits remain available throughout 2022 to help New Yorkers pay for health insurance. This enhanced financial assistance may lower the cost of premiums for current and new enrollees, including higher-income individuals for the first time. In 2021, over 60 percent of QHP enrollees qualified for financial assistance. To learn more about ARPA, providers can visit the *How NY State of Health Enrollees Benefit from the American Rescue Plan* web page at: https://info.nystateofhealth.ny.gov/americanrescueplan.

All health plans offered through NY State of Health cover preventive care, such as routine doctor visits and screenings, at no additional cost. In addition to QHPs, NY State of Health offers eligible New Yorkers the opportunity to enroll into the Essential Plan, Medicaid or Child Health Plus, available year-round.

Individuals and families can apply for coverage through the NY State of Health website at: http://www.nystateofhealth.ny.gov, by meeting with an in-person assistor via the NY State of Health "Find a Broker/Navigator" search tool at: https://nystateofhealth.ny.gov/agent/hx_brokerSearch?fromPage=INDIVIDUAL&lang=en, or by calling the Customer Service Center at (855) 355-5777, Monday through Friday from 8 a.m. to 8 p.m. and Saturdays from 9 a.m. to 4 p.m. Extended customer service hours during the 2022 Open Enrollment Period are Saturday, January 15, 2022 from 9 a.m. to 4 p.m. and Saturday, January 29, 2022, from 9 a.m. to 4 p.m.

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Reminder of Changes Impacting Providers Serving Children

Effective July 1, 2021, New York State (NYS) Medicaid-covered children/youth in the care of Voluntary Foster Care Agencies (VFCAs) or placed in foster homes certified by Local Departments of Social Services (LDSS) were enrolled in Medicaid Managed Care (MMC) Plans, including Mainstream MMC Plans and Human Immunodeficiency Virus (HIV) Special Needs Plans (SNPs), unless otherwise excluded or exempt from mandatory MMC. VFCAs are no longer the payor for services provided to this population; providers will be reimbursed directly by Medicaid fee-for-service (FFS) or the child's/youth's MMC Plan.

MMC Plans have already established, and will continue to offer, contracts with community providers with expertise in working with and treating the foster care population. Pharmacies and other providers serving this population are strongly encouraged to enroll in the NYS Medicaid program and engage with MMC Plans in their area to ensure continued coverage for their patients. LDSS are reminded of the critical importance to verify and/or establish Medicaid immediately upon a child/youth entry into foster care to prevent potential delays in coverage and/or payment below:

- Medicaid coverage for an eligible child/youth will be retroactive to the beginning of the month in which the child/youth enters foster care.
- Enrollment in the child's/youth's selected MMC Plan will be retroactive to the beginning of the month in which the Medicaid case was established.

Upon establishment of Medicaid coverage and issuance of a Medicaid Client Identification Number (CIN), claims for services provided during this retroactive coverage period can be billed to the child/youth MMC Plan for the period during which plan coverage applies, or to eMedNY for the FFS coverage period. Providers are encouraged to work collaboratively with the LDSS and the VFCA if there is a service need prior to the CIN being issued **and** are reminded to honor letters of coverage, as instances may arise where children/youth require immediate and medically necessary services prior to receiving identification (ID) cards.

NYS has recently amended the utilization review guidelines to extend the prohibition on utilization reviews from no earlier than 180 days from the child/youth enrollment in the MMC Plan to no earlier than April 1, 2022 or no earlier than 180 days from the child/youth enrollment in the MMC Plan, whichever is later. Policy requirements for this transition, including continuity of care requirements for transitioning children/youth enrolling in MMC, can be found on the Department of Health (DOH) "29-I Health Facility (VFCA transition)" website at https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/vol_foster_trans.htm. Questions should be directed to BH.transition@health.ny.gov.

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New York Collaborative Care Medicaid Program

Primary care providers not participating in the New York State (NYS) Collaborative Care Medicaid Program (CCMP) are encouraged to do so to qualify for up to $150 per month per Medicaid patient receiving program services. Technical assistance and implementation support is available at no cost to providers. Providers must email NYSCollaborativeCare@omh.ny.gov with questions or for additional information.

The Collaborative Care Model

The Collaborative Care Model (CoCM) is an evidence-based model for integrating behavioral health services into physical health settings. For information on the extensive research-base on the CoCM, providers can refer to the Advancing Integrated Mental Health Solutions (AIMS) Center "Evidence Base for CoCM" web page at: http://aims.uw.edu/collaborative-care/evidence-base-cocm. The CoCM treats common mental health conditions such as depression and anxiety. Based on principles of effective chronic illness care, the CoCM focuses on defined patient populations tracked treatment and outcomes, measurement-based practice, and the treatment to target approach. Trained primary care providers as well as embedded behavioral health professionals provide evidence-based medications or psychosocial treatments, supported by regular psychiatric case consultation and treatment adjustment for patients who are not improving as expected.

NYS Collaborative Care Medicaid Program

Since 2015, the NYS Office of Mental Health (OMH) has supported the adoption of the CoCM in primary care and other physical health practices. There are more than 300 practices that are part of the program today. In addition to Medicaid reimbursement for CoCM services, OMH provides comprehensive technical assistance for practices to help successfully implement and sustain the model. Practices can receive one-on-one coaching, skills training for staff, and assistance with billing to financially support the CoCM.

Practices Required to Bill Medicaid for CoCM:

1. The core evidence-based elements of the CoCM - A primary care provider must provide all the evidence-based elements of the CoCM, which include:

- **A professional on the primary care team** with specialized training in behavioral health who will serve as the Behavioral Health Care Manager (BHCM). To view the duties and responsibilities of the CoCM Behavioral Health Care Manager position, providers can visit the *Care Manager Job Description* document at: https://aims.uw.edu/sites/default/files/CareManagerJobDescription_0.pdf.
- **A prescribing psychiatric provider** [medical doctor (MD), Doctor of Osteopathic Medicine (DO), non-physician practitioner (NPP)] to provide caseload support as well as feedback to the BHCM in a weekly meeting and is a resource for the primary care provider who will serve as the psychiatric consultant. To view the duties and responsibilities of the psychiatric consultant, providers can visit the *Psychiatric Consultant Job Description* document at: http://aims.uw.edu/sites/default/files/Psychiatric%20Consultant%20Job%20Description_062420.pdf.
- **A patient care registry** is key to the treatment-to-target approach pillar of the CoCM in that it allows for the easy identification of patients who are or are not improving by displaying scores like Patient Health Questionnaire 9 (PHQ-9) and Generalized Anxiety Disorder subscale of the Patient Health Questionnaire (GAD-7) over time. For more information, providers can refer to the *Behavioral Health Integration and Collaborative Care Registry Strategies in Medical Settings* document at: http://aims.uw.edu/sites/default/files/Collaborative%20Care%20Registry%20Requirements%20Guide_2019_0.pdf.
- Practices may be eligible to use the AIMS Center Care Management Tracking System registry at no cost for an initial year. Contact OMH by email at NYSCollaborativeCare@omh.ny.gov, for additional information on Care Management Tracking System (CMTS) as a registry option.

2. Approval from the NYS OMH
Practices that have the above elements in place and would like to bill Medicaid for CoCM services must complete the *NYS OMH Provider Certification Application*, found on the CoCM "Resources" web page at: https://aims.uw.edu/nyscc/resources/Medicaid, and be approved by NYS OMH. Once approved, the relevant rates will be loaded to the practice or provider file to enable them to get paid for CoCM claims. **Please note:** CoCM services are carved out of Medicaid Managed Care (MMC), meaning all claims for these services are submitted fee-for-service (FFS) and should not be submitted to MMC Plans.

3. Quarterly data submission
Practices approved to bill Medicaid for CoCM services must submit quarterly process and outcomes metrics to NYS OMH to maintain accountability for fidelity to the evidence base along with use in quality improvement activities as well as support. OMH will provide audit and feedback to sites submitting data to ensure practices are achieving optimal outcomes for their patients. Metrics for these reports will be captured by practice registries.

Medicaid Reimbursement

As mentioned above, reimbursement for CoCM services to Medicaid patients is carved out of MMC. All claims for these services are submitted FFS and should not be submitted to MMC Plans. Providers must be approved to bill Medicaid and have the rates loaded to the proper Medicaid identification numbers to bill for CoCM services. CoCM Medicaid claims pay $112.50 per Medicaid patient receiving CoCM services per month. Clinics licensed under Article 28 are also eligible to receive the additional Quality Supplemental Payment (QSP) of $37.50 per month for achieving certain quality benchmarks. Additional billing information, including information regarding QSP, is available in the *Medicaid Collaborative Care Program Billing Guidance* document at: https://aims.uw.edu/nyscc/sites/default/files/NYS%20Collaborative%20Care%20Medicaid%20Billing%20Guidance%202021%20FINAL%20%282%29.pdf. Reimbursement for CoCM services is also available for Medicare and commercially insured patients in NYS.

Questions and Additional Resources:

- For questions on the CCMP program regarding how to provide CoCM services, gaining access to technical assistance, or reimbursement for CoCM services, providers should email NYSCollaborativeCare@omh.ny.gov.
- Relevant forms and additional resources are available on the AIMS Center "Welcome to the New York Center for the Advancement of Behavioral Health Integration!" web page at: https://aims.uw.edu/nyscc/.

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Update to Dental Clinic Billing Logic in Ambulatory Patient Groups

Effective January 1, 2022, the Ambulatory Patient Group (APG) crosswalk will be updated to version 3.17. This update will result in a change in billing logic to APG 367 – 369 (Level I-III Oral Maxillofacial Procedure) from Type 2 (Significant Procedure) to Type 23 (Dental Procedure). **Please note:** APG 370 (Level IV Oral Maxillofacial Procedure) will be eliminated.

APG	APG Description
367	Level I Oral and Maxillofacial Procedure
368	Level II Oral and Maxillofacial Procedure
369	Level III Oral and Maxillofacial Procedure
370	To be eliminated

The July 2021 issue of the *Medicaid Update* article titled *Change to Dental Clinic Billing Logic in Ambulatory Patient Groups*, available at: https://www.health.ny.gov/health_care/medicaid/program/update/2021/docs/mu_no09_jul21_pr.pdf, instructed providers to use an **"XS"** modifier to subsequent repeat dental code lines on the same APG claim for reimbursement of APG 367-370 (Level I – IV Oral Maxillofacial Procedure). **Effective January 1, 2022, the "XS" modifier will no longer be needed for repeat dental code lines.** Providers are instructed to submit clinic claims for multiple dental code lines without using the **"XS"** modifier. The first line will pay at 100 percent and subsequent lines will pay at 75 percent.

Questions and Additional Information:

- Medicaid Dental Policy questions should be directed to the Office of Health Insurance Programs (OHIP) Division of Program Development (DPDM) by phone at (518) 473-2160 or by email at dentalpolicy@health.ny.gov.
- FFS claim questions should be directed to the eMedNY Call Center at (800) 343-9000.

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Coverage for Developmental Screening, including Autism Spectrum Disorder, in the "First Three Years of Life"

The New York State (NYS) Medicaid program will provide reimbursement for developmental screening in the "First Three Years of Life" of a child, in addition to the payment for an Evaluation and Management (E&M) service, **effective January 1, 2022** for Medicaid fee-for-service (FFS) and **effective April 1, 2022** for Medicaid Managed Care (MMC) Plans, to include mainstream MMC Plans, and Human Immunodeficiency Virus (HIV) Special Needs Plans (SNPs). Developmental screening is a structured process that involves the use of one or more standardized, validated screening tools to identify and refine the recognized risk. The provider scores and documents the objective data including any delay in the attainment of developmental milestones and age-appropriate maturity of speech/language of a child using the measurable parameters of the standardized instrument. Developmental screening recommendations are based on the Bright Futures/American Academy of Pediatrics (AAP) Periodicity Schedule (ages 9, 18, and 30 months for screening for global developmental delay and ages 18 and 24 months for autism spectrum disorder (ASD) screening).

Developmental screening for ASD by a primary care provider using a validated screening tool may be reimbursed up to two times in the child's "First Three Years of Life" of the child, beginning at 18 months of age. Developmental screening for global developmental delay by a primary care provider using a validated screening tool may be reimbursed up to one time per year in the "First Three Years of Life" of the child. Screening can be integrated into the well-childcare schedule.

Billing Guidance

Medicaid FFS

NYS Medicaid will provide reimbursement for developmental screening in the "First Three Years of Life". Developmental screening for ASD may be reimbursed up to two times in the "First Three Years of Life" of the child, beginning at 18 months of age. Developmental screening for global developmental milestone screening services may be reimbursed up to one time per year in the "First Three Years of Life" of a child. The services can be reimbursed in addition to the E&M visit. Primary care providers should bill the services using Current Procedural Terminology (CPT) code **"96110"** (developmental screening, with interpretation and report, per standardized instrument form) **along with** International Classification of Diseases (ICD) ICD-10-CM Code Z13.41 (Encounter for autism screening) ***or*** ICD-10-CM Code Z13.42 (Encounter for screening for global developmental delays – milestones).

MMC

MMC Plans will reimburse for developmental screening in the "First Three Years of Life". The screening services provided to the children are billed to the MMC Plans providing coverage for the children. Providers should follow the billing procedures and requirements of the MMC Plan for each child, including the use if CPT code **"96110"** (developmental screening, with interpretation and report, per standardized instrument form) **along with** ICD-10-CM Code Z13.41 (Encounter for autism screening) ***or*** ICD-10-CM Code Z13.42 (Encounter for screening for global developmental delays – milestones).

Procedure Code	Procedure Description	ICD-10-CM Diagnosis Code	ICD-10-CM Diagnosis Code Description	Rate
96110	Developmental screening, with interpretation and report, per standardized instrument form	Z13.41	Encounter for autism screening	$15.60
96110	Developmental screening, with interpretation and report, per standardized instrument form	Z13.42	Encounter for screening for global developmental delays (milestones)	$15.60

Screening Tools:

There are validated Developmental Screening tools available for use. Examples of recommended screening tools include:

- Ages and Stages Questionnaires, Third Edition (ASQ-3)
- Parents' Evaluation of Developmental Status (PEDS)
- Survey of Wellbeing of Young Children (SWYC) (milestones) and Parent's Observations of Social Interactions (POSI)
- Modified Checklist for Autism in Toddlers, Revised, with Follow-up (M-CHAT-R/F)

Additional information can be found in the *Bright Futures Tool and Resource Kit, 2nd Edition*, located on the American Academy of Pediatrics (AAP) Toolkits website at: https://publications.aap.org/toolkits/pages/bright-futures-toolkit.

Questions and Additional Information:

- FFS claim questions should be directed to the eMedNY Call Center at (800) 343-9000.
- FFS coverage and policy questions should be directed to the Office of Health Insurance Programs (OHIP) Division of Program Development and Management (DPDM) by telephone at (518) 473-2160 or by email at FFSMedicaidPolicy@health.ny.gov.
- FFS Pharmacy coverage and policy questions should be directed to the Medicaid Pharmacy Policy Unit by telephone at (518) 486-3209 or by email at PPNO@health.ny.gov.
- MMC general coverage questions should be directed to the OHIP Division of Health Plan Contracting and Oversight (DHPCO) by email at covques@health.ny.gov or by telephone at (518) 473-1134.
- MMC reimbursement, billing, and/or documentation requirement questions should be directed to enrollee MMC Plans.
- MMC Plan contact information can be found in the eMedNY *New York State Medicaid Program Information for All Providers Managed Care Information* document at: https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers_Managed_Care_Information.pdf.

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Provider Directory

Office of the Medicaid Inspector General:
For suspected fraud, waste, or abuse complaints/allegations, please call 1-877-87FRAUD, (877) 873-7283, or visit the Office of Medicaid Inspector General (OMIG) web site at: 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).

For questions about billing and performing MEVS transactions:
Please call the eMedNY Call Center at (800) 343-9000.

Provider Training:
Please enroll online for a provider seminar at: https://www.emedny.org/training/index.aspx. For individual training requests, please call (800) 343-9000.

Beneficiary Eligibility:
Please 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 web sites:

- DOH Prescriber Education Program page: https://www.health.ny.gov/health_care/medicaid/program/prescriber_education/presc-educationprog.
- Prescriber Education Program in partnership with SUNY: http://nypep.nysdoh.suny.edu/.

eMedNY
For a number of services, including: change of address, updating an enrollment file due to an ownership change, enrolling another NPI, or revalidating an existing enrollment, please visit the eMedNY Provider Enrollment page at: https://www.emedny.org/info/ProviderEnrollment/index.aspx, and choose the appropriate link based on provider type.

NY Medicaid Electronic Health Record (EHR) Incentive Program
Please contact the New York Medicaid EHR Call Center at (877) 646-5410 for assistance.

Comments and Suggestions Regarding This Publication
Please contact the editor, Angela Lince, at medicaidupdate@health.ny.gov.