Dual Energy X-Ray Absorptiometry (DXA) Scans for Screening Purposes - Frequency Limits

Dual-energy x-ray absorptiometry (DXA) is an enhanced x-ray technology that is used to measure bone density and bone loss. It is most often used to diagnose osteoporosis, a condition involving the gradual loss of calcium and particular structural changes that lead to thinner, more fragile bones. Osteoporosis is associated with an increased risk of fractures.

Certain individuals are at a higher risk for osteoporosis. For example, post-menopausal women have a greater risk of osteoporosis. Other risk factors include: family history of osteoporosis; personal history of fractures after the age of 50; poor diet and physical inactivity; smoking; certain medications, including some steroids and chemotherapy agents; and low body weight.

Effective April 1, 2015 New York State fee-for-service Medicaid, and July 1, 2015 Medicaid Managed Care (MMC), will reimburse for medically necessary DXA scans at a maximum of once every two years for women over the age of 65 and men over the age of 70. DXA scans are considered medically necessary and therefore reimbursed at a maximum of once every two years for women and men over the age of 50 with *significant* risk factors for developing osteoporosis. Medicaid does not cover the use of DXA scans to screen for vertebral fractures. The following CPT codes are affected by this frequency limitation:

77080 dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)

77081 dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)

For individuals who are planning to or currently taking Depo-Provera, New York State Medicaid will cover DXA scans once every two years.

For patients with Medicaid Managed Care, providers should check with the individual plan for implementation details. Medicaid fee-for-service policy questions may be directed to OHIP Division of Program Development and Management at (518) 473-2160.

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In This Issue…..

MANDATORY COMPLIANCE PROGRAM REQUIREMENT
Holding Company and Joint Venture Structures
Employee Vested with Responsibility for Day-to-Day Operation of the Compliance Program

THIS IS AN ANNOUNCEMENT FROM THE NEW YORK STATE OFFICE OF THE MEDICAID INSPECTOR GENERAL (OMIG) FOR PROVIDERS WHO ARE REQUIRED TO HAVE A COMPLIANCE PROGRAM AS REQUIRED BY NEW YORK SOCIAL SERVICES LAW SECTION 363-d AND TITLE 18 OF THE NEW YORK CODE OF RULES AND REGULATIONS PART 521.

OMIG's *Compliance Guidance 2015-02 Mandatory Compliance Program Requirement: Holding Company and Joint Venture Structures - Employee Vested with Responsibility for Day-to-Day Operation of the Compliance Program* provides guidance on the employment requirement of compliance officers in a holding company structure. *Compliance Guidance 2015-02* is posted on OMIG's website, www.omig.ny.gov, and can be accessed at http://www.omig.ny.gov/images/stories/compliance_alerts/20150330_Compliance_Guidance_2015-02_final.pdf.

Medicaid Providers subject to the mandatory compliance program requirement of New York State Social Services Law § 363-d (§ 363-d) and Title 18 of the New York Code of Rules and Regulations, Part 521 (Part 521) must designate "… an employee vested with responsibility for the day-to-day operation of the compliance program …". This person is typically referred to as the compliance officer.

Medicaid providers should consult *Compliance Guidance 2015-02* for complete details and guidance. This Medicaid Update is intended to be only a summary notice.

There are a number of compliance related resources and forms available on OMIG's website's Compliance Tab that can be accessed at http://www.omig.ny.gov/compliance.

If you have any questions, please contact the OMIG's Bureau of Compliance at (518) 408-0401 or by using the Bureau of Compliance's dedicated e-mail address at: compliance@omig.ny.gov.

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Continued Medicaid Enrollment for Nursing Homes, Intermediate Care Facilities, and Case Management Providers

Federal regulation 42 CFR, Part 455.414 requires New York State Medicaid providers to revalidate their enrollment every five years. Revalidation involves completion of the enrollment form for Nursing Homes, Intermediate Care Facilities and Case Management Providers.

You can save time and money by coordinating your New York State Medicaid revalidation with Medicare, another state's Medicaid or CHIP program. If you revalidate with New York within 12 months of your Medicare/state Medicaid/CHIP enrollment, the New York application fee will be waived.

The Revalidation process for these providers will begin soon. Revalidation letters will be mailed to facilities and providers actively submitting claims to Medicaid. Find out more about Revalidation by clicking on the links below.

Click here for more information on Revalidation
Click here for the Nursing Home Enrollment Form and Instructions
Click here for the Intermediate Care Facility Enrollment Form and Instructions
Click here for the Case Management Providers Enrollment Form and Instructions
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All Providers

Xerox State Healthcare, LLC has been awarded the new MMIS Contract

The New York State Department of Health is pleased to announce that it has entered into a five year agreement with Xerox State Healthcare, LLC to implement and administer a new Medicaid Management Information System (MMIS). The new system, called the New York Medicaid Management Information System (NYMMIS), will replace eMedNY, the current State Medicaid system.

The NYMMIS will utilize a web-based core platform, called Health Enterprise, as well as commercial off-the-shelf (COTS) rules components configured to meet New York State's requirements. The state of the art solution with its sophisticated technology will provide the New York State Medicaid program with enhanced flexibility, interoperability and data sharing capabilities resulting in improved claims adjudication, fiscal management, and fraud and abuse deterrents. Health Enterprise uses a web-native architecture that is scalable to serve future New York Medicaid needs.

The new agreement will have no immediate impact on eMedNY or providers' billing requirements. Configuration and implementation of the NYMMIS is scheduled to take approximately eighteen months and will consist of two releases. Release One will include provider management, pharmacy benefits management, the MEIPASS EHR Incentive Program and a Xerox run provider call center to assist providers with enrollment issues. Release Two will consist of a member call center, remaining claims processing and related services including prior approval, coordination of benefits, capitation payments and specific benefit carve-outs for Medicaid managed care members.

More information will follow as the Department and Xerox prepare to bring the interim NYMMIS website on-line. The website will serve as the primary source of information for NYMMIS activities that may impact the provider community.

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NY 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 $660 million* in incentive funds have been distributed *within 17,144* payments to New York State Medicaid providers.

17,144 Payments	$660+ Million Paid	Are you eligible?

For more information, visit www.emedny.org/meipass

Taking a closer look: NY Medicaid EHR Incentive EP Program Updates

- May webinar dates on our Upcoming Event Calendar
- **NEW** Frequently Asked Questions

Earlier this year, the Centers for Medicare & Medicaid Services (CMS) announced their intent to modify meaningful use requirements for 2015, including a considered reduction to the EHR reporting period. Stay tuned to the NY Medicaid EHR Incentive Program website and sign up for the email LISTSERV to receive notifications when the 2015 meaningful use requirements have been released.

CMS has also published the proposed rule for Stage 3 meaningful use requirements and criteria for 2017 and beyond. Concurrently, the Office of the National Coordinator (ONC) has published the proposed rule for the 2015 Edition of Certified EHR Technology that will be required for all providers beginning in 2018. Together, these proposed rules will give providers additional flexibility, make the program simpler, drive interoperability among electronic health records, and increase the focus on patient outcomes to improve care.

The proposed rules are open for public comment until May 29, 2015.

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

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ICD-10 Reminder for Providers and Vendors

➢ The eMedNY Provider Testing Environment (PTE) is available for end-to-end testing of Medicaid claims with ICD-10 diagnosis codes (procedure codes for inpatient hospitals). The PTE mirrors the eMedNY production environment, in both content and functionality. Submitters and providers can be assured that successful testing through the PTE will minimize potential issues with submission of their production files come October 1, 2015. All Medicaid partners are urged to test at their earliest convenience.

➢ The https://www.emedny.org/icd/index.aspx website provides an extensive amount of eMedNY related ICD-10 information including FAQs and eMedNY end-to-end testing. The area should be visited regularly to ensure submitters have the most up to date ICD-10 information.

➢ Provider and vendors are encouraged to regularly access the federal CMS ICD-10 website www.cms.gov/Medicare/Coding/ICD10/index.html for the most comprehensive and detailed compilation of ICD-10 resources including Intro Guide to ICD-10, ICD-10 and Clinical Documentation, ICD-10 Official Coding Guidelines, General Equivalence Mappings (GEMs), and many other documents focusing on all aspects of ICD-10 implementation.

➢ Medicaid providers are reminded that they are ultimately responsible for ensuring that the data submitted to New York Medicaid by them, or a third party on their behalf, is correct and compliant with mandated standards and regulations. As such it is of utmost importance that providers take a proactive role and work diligently with their staff, clearinghouse, billing service or software vendor to ensure their practice will be able to successfully submit ICD-10 compliant transactions for services rendered on or after October 1, 2015.

➢ Effective October 1, 2015 New York Medicaid will only accept, recognize and process ICD-10 codes for services rendered on or after October 1, 2015. ICD-9 codes will only be accepted for services rendered prior to October 1, 2015. **Transactions which contain ICD-9 codes, with a date of service of October 1, 2015 or after will be rejected.**

October 1, 2015 is only five months away. Transition to ICD-10 will take time and resources. If you are not yet preparing for transitioning to ICD-10 the time to start is now. Do not put your Medicaid payments at risk by delaying your compliance efforts.

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Handling Prescription Transfers and Non-Patient Specific Orders in Medicaid Fee-for-Service (FFS)
New Guidance for Pharmacists

Effective 3/26/2015, system enhancements were implemented to enable transfers for prescriptions and non-patient specific orders (such as Plan B or pharmacist administered vaccines) performed by qualified pharmacists. All transfers should be submitted using the origin code value of 5 in the origin code field (419-DJ) and should be done in accordance with New York State Education Department (NYSED) prescription requirements: http://www.op.nysed.gov/prof/pharm/part63.htm

In addition to the NYSED requirements, the serial number is still required to be captured on all prescriptions when submitting a claim to Medicaid for a prescription that has been transferred. The Department has approved the value of TTTTTTTT in the serial number field (454-EK), to indicate a prescription transfer, in lieu of reporting the Official Prescription Form Serial Number.

Reminder: Per New York Medicaid policy, a prescription or fiscal order for a drug or supply may be refilled no more than 180 days after it has been initiated by the prescriber.

419-DJ- Prescription Origin Code

CODE	DESCRIPTION
0	Not Known
1	Written – Prescription obtained via paper.
2	Telephone – Prescription obtained via oral instructions or interactive voice response using a telephone.
3	Electronic – Prescription obtained via SCRIPT or HL7 standard transactions, or electronically within closed systems.
4	Facsimile – Prescription obtained via transmission using a fax machine.
5	Pharmacy – This value is used to cover any situation where a new Rx number needs to be created from an existing valid prescription such as traditional transfers, intrachain transfers, file buys, software upgrades/migrations, and any reason necessary to "give it a new number." This value is also the appropriate value for "Pharmacy dispensing" when applicable such as BTC (behind the counter), Plan B, established protocols, pharmacists authority to prescribe, etc.

For billing questions please contact Computer Sciences Corporation at 1-800-343-9000.

For policy questions the provider may contact the Pharmacy Department at (518) 486-3209 or ppno@health.ny.gov.

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Medicaid Pharmacy Prior Authorization Programs Update

On February 26, 2015, the New York State Medicaid Drug Utilization Review (DUR) Board recommended changes to the Medicaid pharmacy prior authorization programs. The Commissioner of Health has reviewed the recommendations of the Board and has approved changes to the fee-for-service pharmacy prior authorization programs:

Effective April 9, 2015, prior authorization (PA) requirements will change for some drugs in the Hepatitis C – Direct Acting Antivirals class:

- Preferred Agents: ribavirin, Viekira*
- Non-Preferred Agents: Copegus, Harvoni, Moderiba, Olysio, Rebetol, Ribapak, Ribasphere, Sovaldi, Victrelis

* Viekira to be excluded from the Hepatitis C Virus clinical criteria** addressing disease prognosis and severity

** http://www.health.ny.gov/health_care/medicaid/program/update/2014/oct14_mu.pdf

In addition, on May 7, 2015, the fee-for-service pharmacy program will implement the following clinical parameters recommended by the DURB:

Topical Antifungals for Onychomycosis
- Step therapy:
  - Trial with an oral antifungal agent prior to use of ciclopirox 8% solution
  - Trial with ciclopirox 8% solution prior to the use of other topical antifungals

Override will require prescriber involvement.

Cystine Depleting Agents
- Confirm diagnosis for cysteamine immediate-release (IR) and delayed-release (DR) products for FDA approved indication, nephropathic cystinosis
  - Absence of covered diagnosis in patient's claim history will require prescriber involvement.

Inhaled Antibiotics for Cystic Fibrosis
- Inhaled aztreonam and tobramycin
  - Confirm diagnosis for the FDA-approved indication, Cystic Fibrosis
    - Absence of covered diagnosis in patient's claim history will require prescriber involvement
  - Quantity Limits
    - Aztreonam inhalation solution (Cayston®)
      - 3 ampules (3 mL) per day
      - 84 ampules (84 mL) per 56 day regimen (28 days on, 28 days off)
    - Tobramycin inhalation solution (Bethkis®, Tobi®, Kitabis Pak™)
      - 2 ampules (8 mL Bethkis, 10 mL Tobi, Kitabis Pak) per day
      - 56 ampules (224 mL Bethkis, 280 mL Tobi, Kitabis Pak) per 56 day regimen (28 days on, 28 days off)
    - Tobramycin capsules with inhalation powder (Tobi® Podhaler™)
      - 8 capsules per day
      - 224 capsules per 56 day regimen (28 days on, 28 days off)

Agents for Pulmonary Fibrosis
- Confirm diagnosis for the FDA-approved indication, Idiopathic Pulmonary Fibrosis (IPF)
  - Absence of covered diagnosis in patient's claim history will require prescriber involvement.

For more detailed information on the DURB recommendations, please refer to:
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 agent, to quickly obtain a PA.

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

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Rebilling Medicaid Pharmacy Fee-for-Service (FFS)
Claims for Adjustments

When Medicaid pharmacy providers submit a claim adjustment for a price change or to correct information previously submitted from their point of service (POS) system to Medicaid, providers should be utilizing the National Council for Prescription Drug Program (NCPDP) B3 claim re-bill transaction.   This transaction should be used to submit an adjustment to a previously captured and paid claim. A B2 transaction reverses the previous transaction, and voids the original claim. If the claim has an associated automated prior authorization (PA) number, the PA most often will also become inactivated using a B2 transaction.

Automated PAs are issued behind the scenes in the claims adjudication system. When a drug meets PA clinical criteria a PA number is created which allows the claim to process and pay. When a drug does not meet PA clinical criteria the provider will receive a message that the drug requires PA and prescriber involvement is required.

The advantage of using a B3 transaction to adjust a claim, is that in most cases claims with an associated automated PA will allow for further processing and therefore payment of the newly adjusted claim will be considered.

Pharmacy providers who reverse and resubmit claims using traditional NCPDP B1 and B2 transactions, risk inactivation of automated PAs (if associated with the claim being adjusted) which will delay the payment of the claim and require additional actions by the provider to resolve.

Pharmacy providers who have software that does not currently support B3 transactions are urged to contact their software vendors.

FIELD	DESCRIPTION
Transaction Code	This field identifies the type of transaction request being submitted. Acceptable codes are: B1 = Rx Billing B2 = Rx Reversal Note: B2 is used to cancel a previous transaction. Please refer to section on Reversals on page 7.0.1 B3 = Rx Rebill Note: B3 is used to adjust a previously paid claim(s). E1 = Eligibility Verification with no claim submitted N1 = Rx DUR only Note: N1 is used to supply DUR information only for purposes of updating a member's drug history file when no claim submission or reimbursement is allowed or expected. N2 = Rx DUR Reversal N3 = Rx DUR Rebill P1 = PA Request and Billing P2 = PA Reversal P4 = Prior Authorization Request Only S1 = Service Billing S2 = Service Reversal S3 = Service Rebill (103-A3)

For billing questions, please contact Computer Sciences Corporation (CSC) at 1-800-343-9000.

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Electronic Prescribing Mandate
- Reminder -

The implementation date for mandatory electronic prescribing has been extended to March 27, 2016. Information regarding requirements can be found at https://www.health.ny.gov/professionals/narcotic/electronic_prescribing/.

Although the effective date of mandated electronic prescribing has been extended, e-prescribing of both controlled and non-controlled substances is currently permissible in New York State. Practitioners must continue their efforts to become compliant with the requirement, including working with their software vendors to implement the additional security requirements needed for e-prescribing of controlled substances, and registering their certified software applications with the Bureau of Narcotic Enforcement.

Below are highlights/key points that may be of particular interest to prescribers and pharmacists.

- A prescription generated on an electronic system that is printed out to the Official New York State Prescription form or faxed is **NOT** an electronic prescription.
- Amendments to Title 10 NYCRR Part 80 Rules and Regulations on Controlled Substances have been adopted and became effective as final regulations on March 27, 2013. The amendments authorize a practitioner to issue an electronic prescription for controlled substances in Schedules II through V and allow a pharmacist to accept, annotate, dispense and electronically archive such prescriptions.

A comprehensive list of Frequently Asked Questions (FAQs) can be found at:
https://www.health.ny.gov/professionals/narcotic/electronic_prescribing/docs/epcs_faqs.pdf.

Sample questions include:

1. Does an electronic prescription for a controlled substance require a follow-up hard copy prescription? See Question 16 of FAQs.
2. Is it mandatory for pharmacies to receive electronic prescriptions for controlled substances? See Question 17 of FAQs.
3. Is the prescription valid for dispensing if the practitioner has not registered their certified Electronic Prescribing of Controlled Substances (EPCS) application with BNE? See Question 26 of FAQs.
4. Is a pharmacist who is presented with a prescription issued on an Official New York State Prescription form after March 27, 2015 required to verify that the practitioner properly falls under one of the exceptions from the requirement to electronically prescribe? See Question 30 of FAQs.

The FAQs provide an explanation of the laws and regulations, pharmacy registration forms, registration for official prescriptions and e-prescribing systems (ROPES), software and data requirements, waivers and exceptions, and resource information and contacts.

Questions? Please contact the Bureau of Narcotic Enforcement at 1-866-811-7957 or via e-mail to narcotic@health.ny.gov.

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Payment Reductions on Elective Delivery
(C-Section and Induction of Labor)
Less than 39 Weeks without Medical Indication

This article is an update to the June 2013 and June 2014 articles "Elective Delivery (C-Section and Induction of Labor) < 39 Weeks without Medical Indication" and "Elective Deliveries (C-Sections or Inductions) Prior to 39 Weeks Gestation." These articles indicated that Medicaid fee-for-service and Managed Care began reducing payments for elective deliveries (both C-section and inductions of labor) under 39 weeks gestation, unless an acceptable medical indication was provided. See previous articles for acceptable ICD-9 diagnosis codes: [June 2013 Medicaid Update](#) and [June 2014 Medicaid Update](#).

Effective April 1, 2015 and July 1, 2015, respectively, Medicaid fee-for-service and Medicaid Managed Care (MMC) will further reduce payment for early elective deliveries without an acceptable medical indication. Claims for elective deliveries prior to 39 weeks, without medical indication, will be reduced by **25%**. The increased penalty reflects the Medicaid Program's commitment to providing high quality prenatal care by ensuring appropriate delivery for both mothers and babies.

Practitioner Claims:

As noted in the June 2013 Medicaid Update, claims submitted by *practitioners* for obstetric delivery will continue to require a modifier. Failure to include one of the two modifiers below on a claim will result in denial of the claim.

- **U8** - Delivery prior to 39 weeks of gestation
- **U9** - Delivery at 39 weeks of gestation or later
- **UB modifier in combination with a U8 modifier** – Spontaneous delivery occurring between 37 and 39 weeks with an ICD-9 diagnosis code of 650 (Normal Delivery) in the primary position

Hospital Inpatient Claims:

As noted in the June 2014 Medicaid Update, claims submitted for hospital inpatient stays associated with delivery will continue to require a condition code for payment.

- **Condition code 81** - C-sections or inductions performed at **less than 39 weeks gestation for medical necessity**. If this condition code is reported with an acceptable primary diagnosis code, the claim will be paid in full. If this condition code is reported with a primary diagnosis code that does not support medical necessity, the claim will be reduced by 25%. For condition code 81 ONLY, diagnosis code 650 (Normal Delivery) will be considered an acceptable diagnosis code, when reported as the primary diagnosis, and the claim should be paid in full.
- **Condition code 82** - C-sections or inductions performed at **less than 39 weeks gestation electively**. If this condition code is reported without an acceptable primary diagnosis code, the claim will be reduced by 25%.
- **Condition code 83** - C-sections or inductions performed at **39 weeks gestation or greater**. If this condition code is reported, the claim will pay in full.

For patients with Medicaid Managed Care, providers should check with the individual plan for implementation details. Medicaid fee-for-service policy questions may be directed to OHIP Division of Program Development and Management at (518) 473-2160. Questions regarding Medicaid Managed Care implementation should be directed to the enrollee's MMC plan.

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Most Common Claim Denial Reasons

A recent review of claims submitted to Medicaid confirms that many providers continue to make basic claiming errors resulting in unnecessary denial of their claims. Listed below are some of the high claim denial reasons.

DUPLICATE CLAIM - MMIS Denial Code 00705

Claim Adjustment Reason Code 97 with Remark Code M86 – Duplicate of a Previously Processed Claim
There is a claim that was previously paid for the same client, provider, date of service and procedure code or rate code. Please review previous remittance information.
If verifying claim status the equivalent codes would be Status Code 54 with no Entity Code.

PREPAID CAPITATION RECIPIENT – SERVICE COVERED WITHIN PLAN - MMIS Denial Code 01172

Claim Adjustment Reason Code 24 with no Remark Code – Charges Covered Under a Capitation Agreement/Managed Care Plan
Verify plan enrollment via the Medicaid Eligibility Verification System (MEVS).
If verifying claim status the equivalent codes would be Status Code 97 with Entity Code PR.

PROCEDURE INACTIVE ON DATE OF SERVICE - MMIS Denial Code 00204

Claim Adjustment Reason Code 181 with no Remark Code – Procedure Code Invalid on Date of Service
Please consult the procedure code on the claim to see if it is listed in the applicable fee schedule located in your Provider Manual at www.emedny.org.
If verifying claim status the equivalent codes would be Status Code 486 with no Entity Code.

CLIENT NOT ELIGIBLE FOR MEDICAID BENEFITS - MMIS Denial Code 00162

Claim Adjustment Reason Code 200 with no Remark Code – Client Not Eligible for Medicaid Benefits
Contact the entity responsible to determine Medicaid eligibility for the client.
If verifying claim status the equivalent codes would be Status Code 88 and Entity Code QC.

SERVICE DATE NOT WITHIN 90 DAYS OF RECEIPT DATE - MMIS Denial Code 00068

Claim Adjustment Reason Code 29 with no Remark Code – the Time Limit for Filing has Expired
The claim was submitted with a date of service over 90 days old and no delay reason code was on the claim. Please refer to detailed information about timely filing located here: https://www.emedny.org/info/TimelyBillingInformation_index.aspx.
If verifying claim status the equivalent codes would be Status Code 187 and no Entity Code.

Providers experiencing a high level of claim denials are encouraged to review the information very closely and make required adjustments to their billing patterns.

Questions related to the description of the edits and the claim denial reasons listed below should be directed to the eMedNY Call Center at 800-343-9000.

For a detailed explanation for other NY Medicaid claim denials visit the EDIT ERROR KNOWLEDGE BASE (EEKB) found here: https://www.emedny.org/HIPAA/5010/edit_error/index.aspx.

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Attention Physicians and Nurse Practitioners Billing Dental Code for Fluoride Application

Effective April 1, 2015 dental code D1206, application of fluoride, is replaced with code 99188. The new code is for use by Physicians and Nurse Practitioners who provide fluoride application. Dental professionals may continue to use D1206 as before.

For questions concerning procedure codes please contact the Bureau of Medical Dental and Pharmacy Policy at (518) 473-2160.

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Reporting of the National Drug Code (NDC) is required for all Physician Administered Drugs for Medicaid Managed Care Plans

Per the Deficit Reduction Act (DRA), Medicaid is required to obtain NDCs on all physician administered drugs (including drugs administered by nurse practitioners, licensed midwives and drugs administered in an ordered ambulatory setting) in order to maximize federal rebates collected. **Original guidance was set forth in the <u>December 2007 Medicaid Update.</u>**

Medicaid managed care plans are also required to obtain NDCs when paying claims for physician administered drugs and are responsible for communicating and providing such billing guidance to their provider networks. Providers who have questions on this requirement should contact the appropriate managed care plan.

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Reporting of the National Drug Code (NDC) is Required for all Physican Administered Drugs Billed to the Ambulatory Patient Group (APG) Fee Schedule

Enforcement Begins July 1, 2015

Beginning July 1, 2015, the eMedNY billing system will begin enforcing the payment policy that requires providers to report the NDC for the APG fee schedule drugs listed below (see page 36 of the APG Provider Manual). If one of the following physician administered drugs billed under APGs does not include an NDC the line will not pay.   However, drugs obtained at the 340B price, indicated by the UD modifier, do not require the NDC for the line to pay.

HCPCS Code	HCPCS Code Description	HCPS Code	HCPCS Code Description	HCPCS Code	HCPCS Code Description
J0129	Abatacept Injection	J1459	Inj IVIG privigen 500 mg	J3489	Injection, zoledronic acid
J0178	Aflibercept Injection	J1561	Gamunex-C/Gammaked	J9000	Doxorubicin HCL Injection
J0475	Baclofen 10 MG Injection	J1568	Octagam Injection	J9041	Bortezcmib Injection
J0490	Belimumab Injection	J1569	Gammagard liquid Injection	J9047	Injection, carfilzomib
J0583	Bivalirudin	J1572	Flebogamma Injection	J9179	Eribulin mesylate injection
J0592	Buprenorphine hydrochloride	J1745	Infliximab injection	J9201	Gemcitabine hcl injection
J0638	Canakinumab injection	J2315	Inj, Naltrexone, Depot Form, 1mg	J9306	Injection, pertuzumab
J0894	Decitabine injection	J2323	Natalizumab injection	J9315	Romidepsin injection
J1050	Medroxyprogesterone acetate	J2353	Octreotide injection, depot	Q2049	Imported lipodox inj
J1453	Fosaprepitant injection	J2997	Alteplase recombinant	S4993	Contraceptive pills for bc

- Note, all APG fee schedule drugs (excluding J0592) also require providers to code the number of units and acquisition cost in order for the claim line to pay.

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

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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.