Medicaid Members are Exempt from Copayments for COVID-19-Related Treatment and Services

New York State (NYS) Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC) covers Coronavirus Disease 2019 (COVID-19) testing, evaluation, and treatment without copayments, including preventive therapies and specialized equipment. This coverage also includes treatment for post-acute-COVID conditions, which may be described as "long COVID". Long COVID includes a range of symptoms that can last weeks or months after infection. NYS Medicaid FFS and MMC also cover, without copayments, treatments for conditions that may seriously complicate the treatment of COVID-19 for individuals who have, or are presumed to have, COVID-19 during the period when they are diagnosed with, or presumed to have, COVID-19. This includes immunizations, monoclonal antibody infusions, and all lab tests, as well as other treatments provided.

Professional claims submitted for COVID-19 related testing, evaluation, and treatment should be identified as emergencies by reporting with **Emergency Indicator = "Y"**. Institutional providers [Emergency Department (ED), hospital outpatient/Diagnostic and Treatment Centers (D&TCs), Federally Qualified Health Centers (FQHCs), and hospital inpatient] should report **Type of Admission Code = "1"** to indicate emergencies when the purpose of the encounters are related to COVID-19. Previous guidance was provided in the March 2020 Special Edition of the *Medicaid Update* guidance titled *New York State Medicaid Coverage and Reimbursement Policy for Services Related to Coronavirus Disease 2019 (COVID-19)* can be found at: https://health.ny.gov/health_care/medicaid/program/update/2020/docs/mu_no07_2020-03-27_covid-19_reimbursement.pdf.

Pharmacy claims submitted for COVID-19-related testing, evaluation, and treatment that do not adjudicate with a zero copayment can be systematically adjusted by utilizing National Council for Prescription Drug Programs (NCPDP) field 461-EU (Prior Authorization Type Code) using a value of **"04" = exempt copay**. This instruction can be found in the *NCPDP D.0 Companion Guide*, located on the eMedNY "5010/D.0 Transaction Instructions" web page, at: https://www.emedny.org/HIPAA/5010/transactions/index.aspx. Similar guidance can be found in the May 2020 COVID-19 guidance titled *New York State (NYS) Medicaid Fee-for-Service (FFS) Policy and Billing Guidance for COVID-19, Testing and Specimen Collection at Pharmacies As of 12/16/2021*, located at: https://health.ny.gov/health_care/medicaid/covid19/docs/guidance_for_pharmacy_lab_testing.pdf.

Questions and Additional Information:

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

In This Issue…

Reminder: Medicaid Requires Coordination of Benefits

New York State (NYS) Medicaid providers are required to bill applicable third parties that may be liable for a claim before billing NYS Medicaid as **Medicaid is always the payor of last resort and federal regulations require that all other available resources be used before Medicaid considers payment**. The article titled *Reminder to Providers: New York State Requires Coordination of Benefits*, published in the July 2020 issue of the *Medicaid Update*, located at: https://www.health.ny.gov/health_care/medicaid/program/update/2020/docs/mu_no12_jul20.pdf, directed providers to exhaust all existing benefits prior to billing the Medicaid program. If a Medicaid member has third-party insurance coverage, the benefits of that coverage must be fully used before billing the NYS Medicaid program. Providers should always ask a Medicaid member if they have other third-party coverage to ensure the proper coordination of benefits.

All claims submitted for members with Medicare and/or other third-party insurance must accurately reflect payments and denials received from other insurers to allow correct calculation of Medicaid reimbursement amounts. The Explanation of Benefits (EOB) and other documentation supporting Medicare with third-party reimbursement amounts must be kept then made available upon request for audit or inspection by the NYS Department of Health (DOH), the Office of the Medicaid Inspector General (OMIG), the Office of the State Comptroller (OSC), or other state or federal agencies responsible for audit functions.

Additionally, for any claims submitted to Medicaid with zero-fill reimbursement from Medicare or third-party insurer, providers must retain evidence that the claims were initially billed to Medicare and/or third-party insurers then were denied **before** seeking reimbursement from Medicaid. The exception to this policy, in which providers may bill Medicaid directly without first receiving denials, is for items that are statutorily not covered by the Medicare program. Providers are responsible for retaining the statutory exemptions from Medicare for audit or inspection.

Questions and Additional Information:

- Fee-for-service (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.
- Medicaid Managed Care (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, located at: https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers_Managed_Care_Information.pdf.

****

COVID-19 Vaccine Counseling Coverage

Effective December 1, 2021, New York State (NYS) Medicaid fee-for-service (FFS), Medicaid Managed Care (MMC) Plans [including mainstream MMC Plans, Health and Recovery Plans (HARPs), and HIV (Human Immunodeficiency Virus) Special Needs Plans (SNPs)], provides reimbursement for Coronavirus Disease 2019 (COVID-19) vaccination counseling to unvaccinated Medicaid members/enrollees to encourage the administration of the COVID-19 vaccine. MMC Plans must configure their payment systems no later than February 7, 2022 to pay claims for dates of service on or after December 1, 2021.

The provider types listed below may bill for COVID-19 vaccine counseling:
- Physicians
- Nurse Practitioners (NPs)
- Licensed Midwives
- Pharmacists
- Article 28 clinics billing ordered ambulatory
- Federally Qualified Health Centers (FQHCs)
- Other qualified rate-based providers

Reimbursement for COVID-19 vaccination counseling is limited to unvaccinated individuals who have not received an initial/first dose of the COVID-19 vaccine and do not have an appointment to receive an initial/first dose of the COVID-19 vaccine, but who are eligible to receive the COVID-19 vaccination. If providing counseling to parents, guardians, or caregivers regarding vaccination of children, providers must bill NYS Medicaid under the Medicaid Client Identification Number (CIN) of the enrolled children. The counseling must be delivered in the presence of the children and their parents, guardians, or caregivers.

The NYS Medicaid program is designed to provide payment for medical care and services only after all other resources available for payment have been reviewed and used. If a Medicaid member has third-party insurance coverage, the benefits of those coverages must fully be used before billing the NYS Medicaid program. Providers should always ask Medicaid members if they have other or third-party coverage to ensure the proper coordination of benefits. Providers who already receive payments from another source for COVID-19 vaccination counseling (e.g., the New York City COVID-19 Vaccine and Counseling outreach program) are not eligible for reimbursement from Medicaid. Medicaid is the payor of the last resort; federal regulations require that all other available resources be used before Medicaid considers payment.

The COVID-19 vaccine counseling session must be documented in the medical or pharmacy record and must include the following:
- confirming with the patient, or the parent, guardian, or caregiver (if appropriate) that the patient is unvaccinated (the patient has not received an initial/first dose of a COVID-19 vaccine);
- confirming the patient does not already have an appointment scheduled to receive an initial/first dose;
- confirming patient consent of the parent, guardian or caregiver (if appropriate) to receive the counseling;
- confirming vaccination status in the New York State Immunization Information System (NYSIIS), whenever possible*;
- strongly recommending the COVID-19 vaccination (unless medically contraindicated, in which case the counseling session is not billable);
- counseling the patient, along with their parent, guardian, or caregiver (if appropriate) on the safety and effectiveness of COVID-19 vaccines;
- answering any questions that the patient or parent, guardian, or caregiver has regarding COVID-19 vaccination;
- counseling the patient, along with their parent, guardian, or caregiver (if appropriate) for a minimum of eight minutes; *and*
- arranging for vaccination or providing information on how the patient can get vaccinated for COVID-19.

*If there is a pharmacy software limitation, a pharmacist can provide an attestation that the above actions have been met: "Meets NYS Department of Health (DOH) Counseling Criteria for COVID Vaccination".

A provider may only request reimbursement once per unvaccinated member. Counseling on second and subsequent doses is not billable.

Physicians, Nurse Practitioners, and Licensed Midwives

A provider submitting professional claims should bill Current Procedural Terminology (CPT) code **"99429"**, *Unlisted Preventive Medicine Service*, for reimbursement of COVID-19 vaccination counseling.

A provider **may** bill CPT code **"99429"**:
- when COVID-19 vaccine counseling is provided to a member for a minimum of eight minutes and all the other criteria listed above are met and documented; *or*
- in addition to an Evaluation and Management (E&M) code for a visit when all the components of both the E&M and COVID-19 counseling requirements are met and documented.

A provider **may not** bill CPT code **"99429"**:
- if the patient has already received an initial/first dose of a COVID-19 vaccination; *or*
- if the patient already has an appointment scheduled to receive an initial/first dose of COVID-19 vaccination.

Pharmacists

A pharmacist providing COVID-19 vaccination counseling should bill using the National Council for Prescription Drug Programs (NCPDP) D.0 claim format as outlined below. A pharmacy may not bill for **"99429"** if the Medicaid member has received the first dose of a COVID-19 vaccine. When providing a minimum of eight minutes of COVID-19 vaccination counseling to a patient, the pharmacist may bill for counseling.

NCPDP D.0 Claim Segment Field	Value
436-E1 (Product/Service ID Qualifier)	Enter the value of **"09"** [Healthcare Common Procedure Coding System (HCPCS)], which qualifies the code submitted in field 407-D7 (Product/Service ID) as a procedure code
407-D7 (Product/Service ID)	Enter **"99429"**
407-D7 (Product/Service)	Enter the applicable first COVID-19 administration procedure code*
444-E9 (Pharmacist ID)	Enter Pharmacist National Provider Identifier (NPI) number
411-DB (Prescriber ID)	Please leave field blank

*COVID-19 vaccine billing guidance can be found on the NYS DOH "COVID-19 Guidance for Medicaid Providers" web page at: https://www.health.ny.gov/health_care/medicaid/covid19/.

Article 28 Clinics Billing Ordered Ambulatory

Article 28 clinics, including hospital outpatient departments (HOPDs) and Diagnostic and Treatment Centers (D&TCs), should bill an ordered ambulatory claim for COVID-19 vaccine counseling using the CPT code **"99429"**.

HCPCS Code	Code Description	Fee
99429	Unlisted Preventative Medicine	$25.00

Federally Qualified Health Centers

FQHCs should bill their prospective payment system (PPS) rate when providing COVID-19 vaccination counseling but FQHCs are encouraged to perform other evaluation and management, or clinical services included within the PPS rate in connection with the counseling session.

Other Qualified Rate-Based Providers

The rate-based provider types listed below may bill for COVID-19 vaccination counseling using rate code **"5521"** with Category of Service (COS) code **"0268"** when provided to unvaccinated Medicaid members:

- Skilled Nursing Facilities (SNFs)
- Certified Home Health Agencies (CHHAs)
- Hospice
- Adult Day Health Care (ADHC)
- Inpatient Hospitals
- Assisted Living Programs (ALPs)
- Voluntary Foster Care Agencies (VFCAs)

Rate Code	Rate Code Description	Fee
5521	COVID-19 VACCINE COUNSEL TO UNVAC INDV – EIGHT-MINUTE MINIMUM	$25.00

COVID-19 Vaccine Counseling Provided via Audio-Only (Telephonic) Telehealth

Physicians, NPs and licensed midwives should bill the CPT code **"99429"** appended with the GQ modifier to indicate the service was provided via audio-only (telephonic) telehealth. Article 28 clinics (including HOPDs and D&TCs) should bill an ordered ambulatory claim using the CPT code **"99429"** appended with the GQ modifier to indicate the service was provided via audio-only (telephonic) telehealth. Pharmacists may provide audio-only (telephonic) telehealth counseling and must document the counseling in the pharmacy record with the claim that is submitted for CPT code **"99429"**.

The other rate-based providers listed above should bill using rate code **"5521"** with CPT code **"99429"** appended with the GQ modifier to indicate the service was provided via audio-only (telephonic) telehealth. FQHCs should bill the off-site rate code **"4012"** with CPT code **"99429"** appended with the GQ modifier to indicate the service was provided via audio-only (telephonic) telehealth.

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.

****

Expansion of Coverage of Mental Health Counseling Provided by Article 28 Outpatient Hospital Clinics and Free-Standing Diagnostic and Treatment Centers to Pregnant and Postpartum Individuals

New York State (NYS) Medicaid coverage of Licensed Clinical Social Worker (LCSW)/Licensed Master Social Worker (LMSW) mental health counseling services provided to pregnant and postpartum individuals in Article 28 outpatient hospital clinics as well as free-standing Diagnostic and Treatment Centers (D&TCs) will now be reimbursed up to 12 months postpartum (based on the date of delivery or end of pregnancy) when medically necessary. Medicaid continues to reimburse mental health counseling provided by LCSWs/LMSWs in Article 28 clinics, to persons under 21 years of age. **This change is effective January 1, 2022 for NYS Medicaid fee-for-service (FFS) and effective April 1, 2022 for Medicaid Managed Care (MMC).**

Rate Codes

Outpatient Hospital Departments and D&TCs must use the following rate codes to request reimbursement from Medicaid FFS for mental health counseling when provided by LCSWs/LMSWs.

Rate Code	Rate Description	Reimbursement
4257	Individual Brief Counseling (psychotherapy, which is insight oriented, behavior modifying and/or supportive, approximately 20 to 30 minutes face-to-face visit with the patient)	$41.00
4258	Individual Comprehensive Counseling (psychotherapy, which is insight oriented, behavior modifying and/or supportive, approximately 45 to 50 minutes face-to-face visit with patient)	$62.00
4259	Family Counseling (psychotherapy with or without patient)	$70.00

School Based Health Centers (SBHCs) must use the following rate codes to request reimbursement from Medicaid FFS for mental health counseling when provided by LCSWs/LMSWs.

Rate Code	Rate Description	Reimbursement
3257	Individual Brief Counseling (psychotherapy, which is insight oriented, behavior modifying and/or supportive, approximately 20 to 30 minutes face-to-face visit with the patient)	$41.00
3258	Individual Comprehensive Counseling (psychotherapy, which is insight oriented, behavior modifying and/or supportive, approximately 45 to 50 minutes face-to-face visit with patient)	$62.00
3259	Family Counseling (psychotherapy with or without patient)	$70.00

For additional information, providers can refer to previously issued guidance regarding mental health counseling provided by Article 28 outpatient hospital clinics and free-standing D&TCs listed below:

- *Medicaid coverage for mental health counseling provided by LCSW/LMSW in Article 28 certified clinics is delayed* article published in the March 2009 issue of the *Medicaid Update*, located at: https://www.health.ny.gov/health_care/medicaid/program/update/2009/2009-03.htm#med
- *Medicaid Coverage of Mental Health Counseling by LCSWs and LMSWs Approved for Article 28 Outpatient Hospital Clinics and Free-Standing Diagnostic and Treatment Centers* article published in the August 2010 issue of the *Medicaid Update*, located at: https://www.health.ny.gov/health_care/medicaid/program/update/2010/aug10mu.pdf
- *Medicaid Coverage of Mental Health Counseling by LCSWs and LMSWs Approved for Article 28 Outpatient Hospital Clinics and Free-Standing D&TCs* article published in the June 2011 issue of the *Medicaid Update*, located at: https://www.health.ny.gov/health_care/medicaid/program/update/2011/june2011mu.pdf
- *Article Clarification: Medicaid Coverage of Mental Health Counseling by LCSWs and LMSWs Approved for Article 28 Outpatient Hospital Clinics and Free-Standing D&TCs* article published in the August 2011 issue of the *Medicaid Update*, located at: https://www.health.ny.gov/health_care/medicaid/program/update/2011/august2011mu.pdf

Questions and Additional Information:
- 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 claim questions should be directed to the eMedNY Call Center at (800) 343-9000.
- 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.

****

NY State of Health Announces New "Care at Home" Program

The NY State of Health Official Health Plan Marketplace (Marketplace), located at: https://nystateofhealth.ny.gov/, has launched a pilot program known as "NY State of Health, Care at Home" to help New Yorkers shop for safe and reliable home care services for themselves or their loved ones on a "private pay" basis. "NY State of Health, Care at Home" is a simple way to connect with trusted home care professionals from licensed home care services agencies (LHCSAs). The pilot program initially launched to serve Nassau, Suffolk and Westchester counties and will be expanded statewide in the future. This program will allow individuals to more easily connect to "private pay" home care services from LHCSAs. The "NY State of Health, Care at Home" program aligns with the ease and accessibility of the Marketplace, providing consumers with a reliable and trusted resource to connect with home care professionals that meet their specific needs and are available in their area.

Understanding that the choice of a home care provider is highly personal, NY State of Health is collaborating with Carina, a not-for-profit technology organization that provides care-matching service. This program helps New Yorkers access the home care services they need to maintain their independence as well as stay safely in their homes and communities for as long as possible. For more information regarding the "NY State of Health, Care at Home" program, consumers can refer to the Carina web site at: https://www.carina.org/homecare/nysoh.

****

NY State of Health Announces 2022 Enrollment is Open

The NY State of Health Open Enrollment Period for 2022 Qualified Health Plans is underway for coverage starting January 1, 2022. The NY State of Health Official Health Plan Marketplace (Marketplace), located at: https://nystateofhealth.ny.gov/, provides consumers quality, low-cost health insurance options, with a choice of Qualified Health Plans in every county and continues to offer expanded tax credits through the American Rescue Plan Act (ARPA), which can be found at: https://info.nystateofhealth.ny.gov/americanrescueplan.

More than 6.3 million individuals—one in three New Yorkers—are enrolled in health coverage through the Marketplace. Enrollment has sharply risen since the beginning of the Coronavirus 2019 (COVID-19) Public Health Emergency (PHE) and in 2021 due to the increased financial assistance made available through the ARPA, as well as enhancements made to the Essential Plan. On average, consumers are saving $430 per month with ARPA enhanced tax credits to use toward lowering their health insurance costs in New York. As of October 31, 2021, there were 232,477 individuals enrolled in a Qualified Health Plan and 925,588 were enrolled in the Essential Plan. Additional information, in the form of monthly reports, press releases and fact sheets, can be found on the NY State of Health "Enrollment Data" web page at: https://info.nystateofhealth.ny.gov/enrollmentdata.

Enrollment for 2021 coverage across all NY State of Health programs will continue through the end of the year. The 2022 Open Enrollment Period for Qualified Health Plans runs from **November 16, 2021 to January 31, 2022**. ARPA tax credits remain available throughout 2022 to help New Yorkers pay for health insurance. This enhanced financial assistance can lower the cost of premiums for current and new enrollees, including higher-income individuals for the first time.

Individuals and families can apply for coverage through the NY State of Health website at: http://www.nystateofhealth.ny.gov, by calling the Customer Service Center at (855) 355-5777, or by connecting with a free enrollment 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.

****

Medicaid Consumer Fact Sheets Now Available

Medicaid consumer fact sheets, focused on prevention and management of chronic health conditions as well as relevant Medicaid benefits that can be used to help members stay healthy, are available on the New York State (NYS) Department of Health (DOH) "MRT II Policies and Guidance" web page, located at: https://health.ny.gov/health_care/medicaid/redesign/mrt2/policy/index.htm. Topics include chronic kidney disease, sickle cell disease, diabetes, high blood pressure, asthma control, HIV-PrEP (Human Immunodeficiency Virus - Pre-Exposure Prophylaxis), and smoking cessation. Fact sheets are available in English, Spanish, Traditional Chinese, Russian, Haitian Creole, Bengali, and Korean. The most recently added fact sheet *What You Should Know About: Chronic Kidney Disease, Kidney Failure, and Transplantation* is currently only available in English, with translations in the other languages to be added in the future.

****

In Lieu of Service Request Form: Medically Tailored Meals

New York State (NYS) Department of Health (DOH) announces the release of an In Lieu of Service (ILS) request form that will allow Medicaid Managed Care Organizations (MMCOs) to offer Medically Tailored Meals (MTM), as an ILS, to high-volume service utilizers. Food insecurity is associated with poor health and increased use of high-cost health services such as Emergency Department (ED) visits as well as inpatient admissions. Food insecurity and its associated risks are especially applicable for individuals with severe chronic illness. Providing MTM to medically complex individuals is one of the strategies being implemented by Medicaid to address food insecurity and malnutrition.

Definitions:
- **"ILS"** is used to define an alternative physical and behavioral health service or setting, not included in the State Plan, that is a "medically appropriate and cost-effective" substitute for a covered service or setting.
- **"State approved ILS"** signifies an ILS proposed by an MMCO that has been approved by the State.
- **"State Identified ILS"** signifies an ILS that is traditionally not covered under the Medicaid State Plan but identified by the State as a "medically appropriate and cost-effective substitute", under 2016 Federal Rule 42 CFR §438.6(e), for the Medicaid Managed Care (MMC) program.

The use of the ILS is voluntary for MMCOs and MMC enrollees.

State Identified ILS for MTM
The State Identified ILS for MTM is targeted to MMC enrollees with at least one of the following diagnoses: cancer, diabetes, heart failure, and/or HIV (Human Immunodeficiency Virus)/AIDS (Acquired Immunodeficiency Syndrome). It will allow home delivered MTM to be available to individuals 18 years of age or older, living with severe illness, through a referral from a medical professional or healthcare plan. Meal plans will be tailored to the medical needs of the recipient by a Registered Dietitian Nutritionist (RDN) and designed to improve health outcomes, lower cost of care, as well as increase patient satisfaction. MTM services include an initial intake with a RDN, and nutritional therapy, to discuss meal composition. MTM may be provided in lieu of Personal Care Aide (PCA) services hours allotted for meal preparation and food shopping; therefore, authorized PCA hours will be reduced for members receiving MTM services.

MTM services can also be provided to enrollees as preventative intervention to reduce the risk and incidence of high-volume hospital inpatient stays and/or ED visits related to cancer, diabetes, heart failure, and/or HIV/AIDS, without reductions to PCA hours. High-volume service utilization is defined as:

- Two or more hospital inpatient stays related to cancer, diabetes, heart failure, and/or HIV/AIDS within the last 12 months; **or**
- Five or more ED visits related to cancer, diabetes, heart failure, and/or HIV/AIDS within the last 12 months; **or**
- One hospital inpatient stay **with** four ED visits related to cancer, diabetes, heart failure, and/or HIV/AIDS within the last 12 months.

Providers and MMCOs that are interested in making this benefit available to members can refer to additional information on the State Identified ILS for MTM, including the *State Identified Request Form for In Lieu of Services for Medically Tailored Meals,* which can be found on the NYS DOH "Information for Health Plans" web page at: https://www.health.ny.gov/health_care/managed_care/plans/.

Questions and Additional Information:
- Fee-for-Service (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 claim questions should be directed to the eMedNY Call Center at (800) 343-9000.
- MMC reimbursement, billing, and/or documentation requirement questions should be directed to the 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.

****

Ambulette Enrollment Moratorium Lifted

The moratorium on ambulette provider applications to provide ambulette services in New York City (NYC), Nassau, and Suffolk Counties has been lifted, **effective immediately**. This supersedes the previous guidance and allows ambulette companies to apply for enrollment in Category of Service **"0602"** across all counties. Previously denied applications received prior to December 1, 2021, will not be automatically processed. However, ambulette providers that submitted applications for these service areas prior to December 1, 2021 may now reapply.

Additional Information and Questions:
- Additional information including transportation provider enrollment requirements, *Enrollment Form* instructions and transportation-specific forms can be found on the eMedNY "Transportation Provider" web page at: https://www.emedny.org/info/ProviderEnrollment/transportation/Option2.aspx.
- New York State (NYS) Medicaid Transportation questions should be directed NYS Medicaid Transportation by telephone at (518) 473-2160 or by email at medtrans@health.ny.gov.

****

Expanded Accident/Incident Reporting Protocol
for All Transportation Providers

Effective January 1, 2022, all New York State (NYS) Medicaid-enrolled transportation providers must follow expanded accident/incident reporting protocol. The current policy states that transportation providers may report accidents and incidents to the transportation manager in any format. Beginning January 1, 2022, all events must be reported using the NYS Department of Health (DOH) Non-Emergency Medical Transportation (NEMT) Accident and Incident Report.

Ambulance providers may submit the Bureau of Emergency Medical Services (BEMS) *Reportable Incident Form (DOH-4461)* in place of the DOH NEMT Accident and Incident Report. Transportation providers must submit the forms to their transportation managers within 48 hours of the events. The NEMT Accident and Incident Report and additional detail on reporting requirements are found on the transportation managers websites.

Questions and Additional Information
NYS Medicaid Transportation questions should be directed to the NYS Medicaid Transportation by telephone at (518) 473-2160 or by email at medtrans@health.ny.gov.

****

The CMS Emergency Triage, Treat, and Transport Model
with the Department of Health Parallel Model

In late 2020, Centers for Medicare and Medicaid Services (CMS) published a list of ambulance suppliers and providers that had been invited to participate in the CMS innovative "Emergency Triage, Treat, and Transport (ET3) Model". The CMS ET3 program allows selected ambulance services, when responding to 911 calls, to provide treatment in place or transport patients to destinations other than the emergency room. More information on the ET3 model can be found on the CMS "Emergency Triage, Treat, and Transport (ET3) Model" website at: https://innovation.cms.gov/innovation-models/et3. A list of all CMS *ET3 Model Selected Applicants* is available at: https://innovation.cms.gov/files/x/et3-selected-applicants.pdf, and includes twenty-four New York State (NYS) ambulance services.

NYS Department of Health (DOH) invited ambulance services selected by CMS to participate in the NYS DOH parallel model. Application instructions were provided in a December 28, 2020 written notification to these services. Regulatory revisions authorizing the delivery model in NYS under 18 NYCRR Part §505.10 were adopted on November 24, 2021, located at: https://dos.ny.gov/system/files/documents/2021/11/112421.pdf and originally posted on August 25, 2021, located at: https://dos.ny.gov/system/files/documents/2021/08/082521.pdf. Regulations may also be viewed on the NYS DOH unofficial Compilation of the Rules and Regulations of New York (NYCRR) "Recently Adopted Regulations" web page at: https://regs.health.ny.gov/regulations/recently-adopted.

The NYS DOH model will mirror the CMS ET3 model and **CMS ET3 approval is a prerequisite for applying to participate in the NYS DOH model**. To confirm eligibility to participate, obtain an application, or check on the status of an application, providers can contact medtrans@health.ny.gov. Any ambulance service that has been approved to participate in *both* the CMS ET3 model *and* the NYS DOH parallel model may begin billing for ET3 services provided to Medicaid enrollees for dates of service on and after November 24, 2021.

Claims in this category should be billed through eMedNY using the appropriate base rate procedure Healthcare Common Procedure Coding System (HCPCS) code, the mileage code (**"A0425"**) *when applicable*, and the appropriate new destination modifier from the CMS-approved list below:

- **C** – Community Mental Health Center (including Substance Use Disorder Center)
- **F** – Federally Qualified Health Center
- **O** – Physician's Office
- **U** – Urgent Care Facility
- **W** – Treatment in Place by a licensed healthcare practitioner [Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Nurse Practitioner (NP), or Physician Assistant (PA)], either in person or via Telehealth Service (no mileage may be billed with this destination modifier)

Questions
All questions regarding this guidance should be directed to medtrans@health.ny.gov.

****

Attention: 340B Claim Reminder and Clarification for Covered Entities and Contract Pharmacies

Federal law [42 USC 256b(a)(5)(A)(i)] prohibits duplicate discounts, such that drug manufacturers are not required to provide a discounted 340B price and a Medicaid drug rebate for the same drug. To prevent duplicate discounts from taking place, NYS Medicaid exclusively uses claim level identifiers on either National Council for Prescription Drug Programs (NCPDP) or Institutional claim types (837P/837I). Additional information on the use of claim level identifiers, previously stated in the December 2016 issue of the *Medicaid Update*, in the article titled *NYS Medicaid Change in 340B Claim Identification Effective 04/01/2017*, can be found at: https://www.health.ny.gov/health_care/medicaid/program/update/2016/dec16_mu.pdf.

Claim level identifiers are required for any 340B purchased drug billed to Medicaid fee-for-service (FFS), Medicaid Managed Care (MMC) Plan or as a secondary claim. It is the responsibility of the covered entity (CE) and their contracted pharmacies, if applicable, to correctly identify claims dispensed with the 340B stock of the CE for 340B-eligible Medicaid patients to ensure rebates are not collected for these drugs. **If rebates are received by the NYS Department of Health (DOH) for drugs obtained via the 340B program due to incorrect or missing claim level identifiers, the CE is responsible for reimbursing manufacturers the 340B discounts.**

The following table outlines the necessary fields and their values for various claim types to identify 340B-purchased drug claims. **Please note: 340B claims billed to Medicaid FFS as secondary claims also require identifiers, as well as 340B claims billed to MMC Plans.**

Claim Type	Field	FFS Primary Claim	MMC Plan Primary Claim; Medicare or Commercial, when FFS is Secondary
837P/837I	Modifier	**"UD"***	**"UD"**
NCPDP	420-DK, Submission Clarification Code (SCC)	**"20"**	**"20"**
NCPDP	423-DN, Basis of Cost Determination (BCD)	**"08"***	Plan-specific**
NCPDP	409-D9, Ingredient Cost Submitted	340B Acquisition Cost*	Plan-specific**
NCPDP	426-DQ, Usual and Customary Cost (U&C)	Lowest Net Charge to Cash Customers***	Lowest Net Charge to Cash Customers

*All FFS 340B claims must be submitted at acquisition cost, by invoice, inclusive of all discounts.
**MMC Plans should be consulted on their requirements for this field.
***U&C is defined as the lowest price charged to the public after all applicable discounts, including promotional discounts and discounted prices associated with loyalty programs.

Outpatient Dispensed Drugs (NCPDP)

As previously communicated in the August 2019 issue of the *Medicaid Update*, in the article titled *New System Edit to be Implemented to Validate the Ingredient Cost for 340B Drugs*, available at: https://www.health.ny.gov/health_care/medicaid/program/update/2019/aug19_mu.pdf, for a Medicaid FFS primary claim only, system editing will compare the ingredient cost submitted (NCPDP field 409-DK) with the 340B ceiling price for the product, as defined by Health Resources and Services Administration (HRSA), to ensure the ingredient cost submitted is the 340B price. The 340B ceiling price refers to the maximum amount that a manufacturer can charge the CE for the purchase of a 340B covered outpatient drug. A claim submitted to Medicaid should never be higher than the 340B ceiling price. Any pharmacy that submits a 340B drug claim, whenever the ingredient cost submitted is higher than the ceiling price, will be returned the Medicaid Eligibility Verification System (MEVS) Rx Denial code **"708: Exceeds NY Allowed Maximum"** and the NCPDP Reject code **"23: M/I Ingredient Cost"**. Claims that are denied with this reason code may be resubmitted with the correct ingredient cost.

Physician-Administered Drugs (837P/837I)

An accurate National Drug Code (NDC) and **"UD"** modifier must be reported for any physician-administered drug obtained at the 340B price that are billed on the Institutional claim form for either FFS or MMC. A physician-administered drug will not be paid under Ambulatory Patient Groups (APGs) if the claim does not include an accurate NDC. **Please note:** Any APGs fee schedule drug will still require a provider to code the number of units and the acquisition cost for the claim line to be paid.

Non-Drug Items

As communicated in the December 2016 issue of the *Medicaid Update* cited and linked in the beginning of this article, 340B claim level identifiers are required on all 340B purchased drug claims for Medicaid members. Pharmacies should not submit claim level identifiers on non-340B eligible items, such as test strips. Diabetic test strips are not covered outpatient drugs and are not part of the Medicaid Drug Rebate Program (MDRP), and therefore are not eligible for a 340B discount. Only 340B purchased *drugs* should be tagged when claim eligible with the 340B claim level identifiers. Tagging test strips, supplies, or any other non-340B eligible item as a 340B drug causes a false claim which may be recovered during an audit. Additional information regarding MDRP can be found on the Centers for Medicare and Medicaid Services (CMS) "Medicaid Drug Rebate Program (MDRP)" web page at: https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/index.html.

Please note: All 340B claims are subject to audit and investigation; in addition, claims improperly identified as 340B and/or claims with unsubstantiated acquisition cost may be considered fraudulent claims. It is the responsibility of all providers, including pharmacies, 340B covered entities, and their contracted pharmacies to correctly report claims dispensed to Medicaid members as true, accurate, and complete (18 NYCRR §505.4).

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.
- MMC reimbursement, billing, and/or documentation requirement questions should be directed to the 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.
- FFS Pharmacy coverage and policy questions may be directed to the Medicaid Pharmacy Policy Unit by phone at (518) 486-3209 or by email at: PPNO@health.ny.gov.

****

Reminder: Pharmacy Billing for Medicaid Patients with Other Coverage

Federal regulations require that all available resources be used before Medicaid considers payment. Medicaid regulations at 18NYCRR §540.6(e) require a provider to pursue any available other coverage prior to submitting a claim to Medicaid. If there is a responsible third party who should be paying for the Medicaid member's health benefits as primary payor, that responsible third party must pay first. As previously communicated in the October 2020 issue of the *Medicaid Update*, in the article titled *Notification to Providers of Requirement to Attach Explanation of Benefits from Third-Party Payors to Medicaid Claims*, available at: https://www.health.ny.gov/health_care/medicaid/program/update/2020/docs/mu_no15_oct20.pdf, failure to obtain prior authorization does not overcome the responsibility of the primary payor.

Claims for members with other coverage will deny at point of service with National Council for Prescription Drug Programs (NCPDP) response code/message **"717- Client Has Other Insurance"**. Through coordination of benefits, Medicaid will pay the patient responsibility for correctly submitted Medicaid coverable claims or will pay up to the Medicaid allowed amounts for drugs in classes specifically excluded from being covered under the third-party liability (TPL) Plan, including Medicare.

As previously communicated in the December 2020 issue of the *Medicaid Update*, in the article titled *Submission Guidance for Fee-for-Service Claims with Third Party Liability (Medicare or Other Insurance)*, available at https://www.health.ny.gov/health_care/medicaid/program/update/2020/docs/mu_no18_dec20_pr.pdf, a claim submitted to NYS Medicaid with a zero-fill reimbursement from any TPL Plan must be submitted. A pharmacy provider who receives a zero-fill response must ensure that the claim was adjudicated within each TPL Plan claim process requirement. This includes submitting a claim under the appropriate coverage benefit, medical or pharmacy, such as with the Healthcare Common Procedure Coding System (HCPCS) or by National Drug Code (NDC). Additionally, a pharmacy not contracted with member TPL Plans may need to attempt overrides with plans, or enroll with the plans, or advise members and prescribers of the need to change dispensing to network pharmacies.

Prescribers are responsible for prescribing per plan formulary and pursuing any claim issues such as, but not limited to, the following:
- necessary prior authorizations or appeals;
- prescription alternatives (for a non-formulary or non-preferred drug);
- necessary changes (quantity or day supply, etc.);
- selection of an in-network pharmacy that is agreeable to the member; or
- the billing of the appropriate benefit (medical versus pharmacy or HCPCS versus NDC).

Pharmacies are responsible for submitting claims to other coverage before submitting claims to Medicaid. Pharmacies that have difficulty billing primary coverage should advise prescribers and members of potential delays as well as options for resolution. If claim issues are resolved, the pharmacies may then resubmit the claims to Medicaid after the claims are properly adjudicated with the TPL Plans.

Submitting TPL-covered claims that incorrectly bypass the TPL Plan responsibility of payment is considered inaccurate billing and may be subject to audit recoveries. **Reminder: Providers must maintain evidence and documentation, which are subject to audit, for a minimum of six years following the date of Medicaid payment. This evidence should include, but not be limited to, denials of claims by responsible TPL Plans, other applicable TPL Plan responses, and payment information.**

Questions and Additional Information:

- Additional information regarding the submission of coordination of benefit claims can be found in the *ProDUR-ECCA D.0 Provider Manual* and other documents available on the eMedNY "Pharmacy Manual" web page located at: https://www.emedny.org/ProviderManuals/Pharmacy/index.aspx.
- Fee-for-service (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 Medicaid Pharmacy Policy Unit by telephone at (518) 486-3209 or by email at PPNO@health.ny.gov.
- Medicaid Managed Care (MMC) reimbursement, billing, and/or documentation requirement questions should be directed to the 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.

****

Expansion of Guidance for Long-Term Care Pharmacy Providers on Short Cycle Billing of Pharmacy Claims

Effective January 3, 2022, New York State (NYS) Department of Health (DOH) will implement a new system edit **(see Table 1)**, to enforce Long-Term Care (LTC) Pharmacists' use of the appropriate National Council for Prescription Drug Programs (NCPDP) Submission Clarification Code (SCC) value in field 420-DK **(see Table 2)** when submitting claims for members in LTC facilities, for quantities of 14 days' supply or less. This new edit will be an expansion of previously issued guidance:

- January 2018 issue of the *Medicaid Update*, in the article titled *Changes to Medicaid FFS Pharmacy Reimbursement To Be Implemented February 22, 2018*, located at: https://www.health.ny.gov/health_care/medicaid/program/update/2018/jan18_mu.pdf,
- July 2020 issue of the *Medicaid Update*, in the article titled *Reminder: Long Term Care Pharmacy Providers Will Identify Fee-for-Service Short Cycle Pharmacy Claims*, located at: https://health.ny.gov/health_care/medicaid/program/update/2020/docs/mu_no12_jul20.pdf.

Table 1:

eMedNY Edit Number/Message	"02322", Missing/Invalid SCC for days' supply 14 or less
NCPDP Response Code/Description	"34", Missing/Invalid SCC

Table 2: New code additions are highlighted below.

Valid Values	Short Name Description	Long Name Description
"06"	START DOSE	STARTER DOSE
"10"	MT PLN LMT	MEETS PLAN LIMITATIONS (The pharmacy certifies that the transaction is compliant with program policies and rules that are specific to the particular product being billed)
"14"	SHRTLOALTC	SHORT-FILL (Leave of absence from LTC)
"17"	REMANAFTEK	REMAINDER AFT EMERGENCY KIT
"21"	LTC14DAYLS	FOURTEEN DAYS OR LESS NOT APPLICABLE (Fourteen days or less dispensing is not applicable due to CMS exclusion and/or manufacturer packaging may not be broken or special dispensing methodology)
"22"	LTC7DAY	SEVEN DAY SUPPLY
"23"	LTC4DAY	FOUR DAY SUPPLY
"24"	LTC3DAY	THREE DAY SUPPLY
"25"	LTC2DAY	TWO DAY SUPPLY

Valid Values	Short Name Description	Long Name Description
"26"	LTC1DAY	ONE DAY SUPPLY
"27"	LTC43DAY	FOUR THEN THREE-DAY SUPPLY
"28"	LTC223DAY	TWO THEN TWO THEN THREE-DAY SUPPLY
"29"	LTCDAILY3D	DAILY AND THREE-DAY WEEKEND (pharmacy or remote dispensed daily during the week and combines multiple days dispensing for weekends)
"30"	LTCSHIFT	PER SHIFT DISPENSING
"31"	LTCMED	PER MED PASS DISPENSING
"32"	LTCPRN	PRN ON DEMAND
"33"	LTC7ORLES	SEVEN DAYS OR LESS (cycle not otherwise represented)
"34"	LTC14DAY	FOURTEEN DAY DISPENSING
"35"	LTC814DAY	EIGHT TO FOURTEEN DAYS DISPENSING (cycle not otherwise represented)

Abbreviations: "MT PLN LMT" - Meets Plan Limitations; "SHRTLOALTC" - Short-Fill Leave of Absence from LTC; "REMANAFTEK" - Remainder AFT Emergency Kit; "AFT" – After hours or indicates that the transaction is a replacement supply for doses previously dispensed to the patient after hours; "CMS" - Centers for Medicare and Medicaid Services

Please note: Values **"06"**, **"14"**, **"17"** and **"22"** through **"35"** will have a prorated dispensing fee applied. Pharmacists may use SCC **"10"** and **"21"** for scenarios where drugs are dispensed in their original container, as indicated in the Food and Drug Administration (FDA) prescribing information, or those that are customarily dispensed in their original packaging to assist patients with compliance. **Reminder: Medicine cabinet drugs and emergency kit replenishment is included in the LTC rate and may not be separately billed to Medicaid.** The NYS DOH will continue to monitor the use of these codes to ensure compliance.

Questions and Additional Information:

- Fee-for-service (FFS) claim questions should be directed to the eMedNY Call Center at (800) 343−9000.
- 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.
- Medicaid Managed Care (MMC) reimbursement, billing, and/or documentation requirement questions should be directed to the 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.

****

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.