

Medicaid Update

THE OFFICIAL NEWSLETTER OF THE NEW YORK MEDICAID PROGRAM



SEPTEMBER 2010 MEDICAID UPDATE

■ Volume 26 - Number 11
■ www.nyhealth.gov

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

DAVID A. PATERSON
GOVERNOR
State of New York

RICHARD F. DAINES, M.D.
COMMISSIONER
New York State DOH

DONNA J. FRESCATORE
MEDICAID DIRECTOR &
DEPUTY COMMISSIONER
*Office of Health
Insurance Programs*

State to Implement Across the Board Medicaid Payment Reductions

The final 2010-11 State Budget (Chapter 313 of the Laws of 2010) requires across the board reductions to most undisbursed general fund and state special revenue aid to localities appropriations (including Medicaid, school aid, social services, etc.) effective September 16, 2010. These provisions were enacted to address financial plan deficiencies related to reductions to the enhanced Federal Medical Assistance Percentage (FMAP) authorized by Congress. Based on this recently enacted statute, the State is implementing a 1.1% across the board reduction to all Medicaid payments that are processed on or after September 16, 2010. The reduction will remain in effect through March 31, 2011. Services exempt from the reduction include:

PAYMENTS WHEREBY FEDERAL LAW PRECLUDES SUCH REDUCTION, INCLUDING:

- > Federally Qualified Health Center services;
- > Health services provided to Native Americans who reside on reservations and receive services at one of four tribal clinics affiliated with the federal Indian Health Program;
- > Supplemental Medical Insurance - Part A and Part B;
- > State Contribution for Prescription Drug Benefit (aka Medicare Part D payments);
- > Any local share cap payment required by the Federal medical assistance percentage (FMAP) increase legislation;
- > Required payments related to the School Supportive Health Services Program and Preschool Supportive Health Services Program settlement agreement;
- > Hospice services; and
- > Services provided to American citizen repatriates.

PAYMENTS THAT ARE FUNDED EXCLUSIVELY WITH FEDERAL AND/OR LOCAL FUNDS, INCLUDING:

- > Upper payment limit payments to non-state owned or operated governmental providers certified under Article 28 of the NYS Public Health Law;
- > Certified public expenditure payments to the NYC Health and Hospital Corporation;
- > Certain disproportionate share payments to non-state operated or owned governmental hospitals; and
- > Services provided to inmates of local correctional facilities.

Beginning in Cycle 1727 (check date 9/27/10 with a release date of 10/13/2010), the Medicaid check or EFT amount will reflect the 1.1% reduction. Paper remittances will display the actual reduction amount as a recoupment identified by Financial Reason Code 'FCF' and the corresponding description of 'FMAP CONTINGENCY FUND'. Similarly, the 835 electronic remittances will carry the reduction amount in the PLB segment with the qualifier J1.



SEPTEMBER 2010 IN THIS ISSUE ...

POLICY AND BILLING GUIDANCE

State Implementing Across the Board Medicaid Payment Reductions	cover + page 3
Mandatory Medicaid Managed Care Expanding To Additional Counties	page 4
Medicaid Managed Care Now Available in Lewis and Wyoming Counties	page 5
Medicaid to Activate Edit 00152 for Home Health Care Providers	page 6
Rate Codes: Hospital Based (HB) & Residential Health Care Facility (RHCF)	page 7
Advanced Life Support First Response Service Billing Policy	pages 8-10
Payment Error Rate Measurement Program Request for Medicaid Provider Documentation	page 11
Palivizumab (Synagis®) Guidelines for Children at Risk of Respiratory Syncytial Virus Infections	page 13
Practitioner Reimbursement for Palivizumab (SYNAGIS®)	page 14
Clinic Reimbursement for Palivizumab (SYNAGIS®)	page 14

PHARMACY UPDATES

Palivizumab (Synagis) Clinical Drug Review Program (CDRP) Process	page 15
Delayed Implementation - Carve-Out of Nursing Home Prescription Drugs	page 16

ALL PROVIDERS

Large Submitters Need To Reduce File Size	page 17
---	---------

SPECIAL ADDENDUM

EPIC 2010 Legislative Changes	page 18-20
-------------------------------------	------------



POLICY & BILLING GUIDANCE

-continued from cover-

State Implementing Across the Board Medicaid Payment Reductions

On March 31, 2011, the Director of the Budget shall calculate the difference, if any between the actual closing balance in the General Fund on March 31, 2011 and the closing balance projected by the Division of the Budget in the 2010-11 Financial Plan. The Financial Plan Report is available for viewing at: <http://publications.budget.state.ny.us/budgetFP/2010-11FinancialPlanReport.pdf>

If the actual closing balance is in excess of the projected balance, the amount of the difference will be used to uniformly reimburse the across-the-board reductions taken pursuant to the FMAP Contingency Allocation Plan. In this event, the State will return funds to providers as soon as practical following the receipt of all necessary Federal approvals.

As information becomes available, it will be posted on the Department's Website at: http://www.health.ny.gov/health_care/state/fmap_contingency_plan. Additional questions may be submitted via e-mail to: b1191@health.state.ny.us.



POLICY & BILLING GUIDANCE

Mandatory Medicaid Managed Care Expanding To Additional Counties

Effective October 1, 2010, managed care enrollment will be required for most Medicaid beneficiaries residing in **Cayuga, Essex, Hamilton, Madison, Schoharie, Tompkins, and Wayne Counties**. Once a mandatory managed care program is implemented in a county, it is expected that the enrollment of all eligible Medicaid beneficiaries will take up to 18 months to complete.

Providers should check the Medicaid Eligibility Verification System (MEVS) prior to rendering services to determine Medicaid eligibility and the conditions of Medicaid coverage. Providers are strongly encouraged to check eligibility **at each visit** as eligibility and enrollment status may change at any time. If the Medicaid beneficiary is enrolled in a Medicaid managed care plan, the first coverage message will indicate "Managed Care Coordinator" or "Eligible PCP" (depending on the device used).

MEVS will identify the scope of benefits a Medicaid beneficiary's Medicaid managed care organization provides through specific coverage codes. When using a touch-tone telephone you will hear the "Description" of each covered service. When using either the Point of Service (POS) or ePACES the "coverage codes" will be displayed. If the message "All" appears, all services will be covered.

Medicaid will not reimburse a provider on a fee-for-service basis if MEVS indicates that the service is covered by the plan.

Providers may call the eMedNY Call Center at (800) 343-9000 with any Medicaid billing issues. Medicaid beneficiaries may contact their local department of social services to learn more about managed care.

Questions? Please contact the Division of Managed Care, Bureau of Program Planning & Implementation at (518) 473-1134.



Medicaid Managed Care Now Available in Lewis and Wyoming Counties

Most Medicaid beneficiaries residing in **Lewis** and **Wyoming** counties now have the option to enroll in Medicaid Managed Care. New York State Catholic Health Plan (Fidelis) is now available in these counties for both Medicaid Managed Care and Family Health Plus.

Providers should check the Medicaid Eligibility Verification System (MEVS) prior to rendering services to determine Medicaid eligibility and the conditions of Medicaid coverage. Providers are strongly encouraged to check eligibility *at each visit* as eligibility and enrollment status may change at any time. If the Medicaid beneficiary is enrolled in a Medicaid managed care plan, the first coverage message will indicate "Managed Care Coordinator" or "Eligible PCP" (depending on the device used). If they are enrolled in a Family Health Plus (FHP) plan, the first coverage message will indicate "Family Health Plus."

MEVS will identify the scope of benefits a Medicaid beneficiary's Medicaid Managed Care Organization provides through specific coverage codes. When using a touch-tone telephone you will hear the "Description" of each covered service. When using either the Point of Service (POS) or ePACES the "Coverage Codes" will be displayed. If the message "All" appears, all services will be covered.

Medicaid will not reimburse a provider on a fee-for-service basis if MEVS indicates that the service is covered by the plan.

Providers may call the eMedNY Call Center at (800) 343-9000 with any Medicaid billing issues. Medicaid beneficiaries should contact their local department of social services to learn more about managed care.

Questions? Please contact the Bureau of Program Planning & Implementation at (518) 473-1134.



POLICY & BILLING GUIDANCE

Medicaid to Activate Edit 00152 for Home Health Care Providers

Effective October 1, 2010, Edit 00152 (Recipient File Indicates Medicare/No Medicare Present on Claim) will be set to deny certain home health care claims that are processed by eMedNY. The electronic HIPAA Claim Adjustment Reason Code is 22. Edit 00152 will fail if the Medicaid file indicates the beneficiary has Medicare Part A or C coverage **and the claim has one of the rate codes listed in the chart**, but the **“Medicare Paid”** amount is blank.

To avoid failing Edit 00152 on electronic claim submissions, providers should enter Medicare information in either the claim level or service level segments of the 837 transaction. If Medicare has denied payment, then enter 'OFILL' to indicate that a prior payer has denied the claim or has paid zero. Refer to pages 12-13 of the 837 Institutional Supplemental Companion Guide found at www.emedny.org for more detailed information on Avoidance Override/Zero Fill.

Activation of Edit 00152 will also impact paper claims submissions. Paper claim instructions can be found in the Home Health provider manual located at www.emedny.org. See pages 14-15 of the Billing Guidelines for Value Codes (Form Locators 39-41).

Questions? Please contact the eMedNY Call Center at (800) 343-9000.

(Rate Code Chart continued
on next page)



POLICY & BILLING GUIDANCE

Rate Codes: Hospital Based (HB) & Residential Health Care Facility (RHCF)

Rate Code	Description
2499	Home Health Shared Aide
2610	Home Health Aide
2611	Long Term Home Health Aide
2620	Nursing
2621	Long Term Nursing
2637	Long Term Medical Social Services
2640	Occupational Therapy
2641	Long Term Occupational Therapy
2650	Physical Therapy
2651	Long Term Physical Therapy
2661	Long Term Speech Therapy
2662	Speech Pathology
2668	HHA/AIDS Home Health Aide Hourly
2669	Home Health Aide Per Hour
2677	HHA/AIDS Physical Therapy
2678	HHA/AIDS Occupational Therapy
2679	HHA/AIDS Speech Therapy
2686	Nursing AIDS
2687	HHA/AIDS Nursing
2810	Long Term Home Health Aide HB
2811	Long Term Nursing HB
2812	Long Term Occupational Therapy HB

Rate Code	Description
2813	Long Term Physical Therapy HB
2814	Long Term Speech Therapy HB
2832	Long Term Medical Social Services HB
2841	Home Health Aide HB
2842	HHA Nursing HB
2844	Occupational Therapy HB
2845	Physical Therapy HB
2847	Speech Pathology HB
2849	Physical Therapy Evaluation HB
2878	Home Health Aide HB
3850	Long Term Home Health Aide RHCF
3851	Long Term Nursing RHCF
3852	Long Term Occupation Therapy RHCF
3853	Long Term Physical Therapy RHCF
3854	Long Term Speech Therapy RHCF
3871	Long Term Medical Social Services RHCF
3876	Home Health Aide RHCF
3877	Nursing RHCF
3878	Occupational Therapy RHCF
3879	Physical Therapy RHCF
3880	Speech Pathology RHCF
3967	Nursing AIDS RHCF



POLICY & BILLING GUIDANCE

Attention: Ambulance Service Providers

Advanced Life Support First Response Service Billing Policy

What is an Advanced Life Support First Response Service? Per Article 30, §3001 of the Public Health Law, an advanced life support first response service (ALSFR) is an organization which provides advanced life support care, but does not transport patients.

What is an Ambulance Service? Ambulance services can provide either basic life support (BLS), advanced life support (ALS), or both, per their license granted by the Department of Health; **and** provide necessary transportation (e.g., to a hospital).

Evolution of Ambulance Service: Due to advancing technology, ambulance service has enabled the provision of emergency care to move out of the emergency department to the scene of the emergency. Advanced trained personnel (paramedics) can provide invasive procedures (advanced life support) such as administering drugs, starting intravenous solutions, and shocking the heart while in communication with emergency department medical personnel. This onsite and en route care has improved patient outcomes.

The Department's Bureau of Emergency Medical Services now licenses entities called "Advanced Life Support –First Responders (ALSFR)," paramedic-level individuals who can provide advanced life support services but **not** the transportation as the transportation is provided by an ambulance service. Often these ALSFR are municipal fire departments or privately-owned companies. This practice now occurs in rural areas which are covered by volunteer ambulance services and in some cities which are covered by proprietary ambulance services.

Note: ALS-FR is not the same service as Paramedic ALS-Assist. Both are distinct services under Medicaid. Please review your Transportation Provider Manual, or e-mail any questions to MedTrans@health.state.ny.us.

-continued on
next page-



POLICY & BILLING GUIDANCE

(continued from page 8)

Advanced Life Support First Response Service Billing Policy

Ambulance Services Must:

1. Complete and submit to the Department the following form to effectuate affirmation of contract/agreement in place between ALSFR and transporting ambulance service to the Department.
2. Retain copies of any such contracts/agreements to be presented upon request to officials of the Department.
3. Ensure the ALSFR maintains a copy of the same agreement to be presented upon request to officials of the Department.
4. Ambulance services certified for basic life support will only submit claims for ALS service when service is rendered by the ALSFR, and will reimburse the ALSFR according to the contract/agreement.
5. Only ambulance services that have submitted affirmation of contract/agreement to the Department will be allowed to submit a claim for ALS rendered by an ALSFR.
6. For auditing purposes, maintain complete records, including, but not limited to, claims, contracts/agreements and the amount paid to the ALSFR.

Regulation at 18 NYCRR §505.10 and the Transportation Provider Manual will be updated to indicate the items above.

Policy questions? Please contact the Medicaid Transportation Policy Unit at (518) 473-2160, or via email to MedTrans@health.state.ny.us.

(form continued on next page)



AFFIRMATION OF CONTRACT/AGREEMENT BETWEEN AMBULANCE SERVICE AND ADVANCED LIFE SUPPORT FIRST RESPONSE SERVICE

Please complete the following form if your company is currently engaged in a contract or agreement with an Advanced Life Support First Response Service (ALSFR). This form should be completed only by representatives of the ambulance service. This information must be submitted annually by January 31, and anytime changes or additions are necessary; and will serve as affirmation of such contract or agreement; a copy of which shall be retained by the ambulance service to be provided upon request to representatives of the Department. Please send the completed form to: Director of the Medicaid Transportation Policy Unit, Office of Health Insurance Programs, One Commerce Plaza, Suite 720, Albany, NY, 12210; or via e-mail to MedTrans@health.state.ny.us.

DATE:		
AMBULANCE SERVICE NAME:	PROVIDER NPI#:	
AMBULANCE SERVICE DOH LICENSE #:		
SERVICE ADDRESS:		
PERSON COMPLETING THIS FORM:	TELEPHONE #	EMAIL ADDRESS:

	ALSFR NAME	ALSFR DOH LICENSE NUMBER	AGREEMENT TIME PERIOD	
			From	To
1.				
2.				
3.				

This information must be submitted to the Department annually by January 31, and whenever an addition or change is necessary.



POLICY & BILLING GUIDANCE

Payment Error Rate Measurement Program Request for Medicaid Provider Documentation

The Centers for Medicare & Medicaid Services (CMS) implemented the Payment Error Rate Measurement (PERM) program to measure improper payments in New York Medicaid and the Children's Health Insurance Program (CHIP).

PERM is designed to comply with the Improper Payments Information Act of 2002 (IPIA; Public Law 107-300). CMS uses a national contracting strategy, consisting of contractors, to perform various steps in the process, including a medical review of selected Medicaid fee-for-service claims throughout Fiscal Year (FY) 2011.

This will be New York State's second time participating in the PERM program. The State also participated in the PERM program in Federal FY 2008. For more information on the PERM project, please visit: <http://www.cms.gov/PERM/>.

Under PERM, reviews will be conducted in three areas:

1. Fee-for-service claim payments,
2. Managed Care payments, and
3. Beneficiary eligibility for both the Medicaid Program and CHIP.

Impact on New York State:

New York State is one of 17 states included in the Federal Fiscal Year 2011 review of payments made from October 1, 2010, through September 30, 2011.

New York State has assigned PERM project oversight for Medicaid fee-for-service payments and managed care capitation payments to the Office of the Medicaid Inspector General (OMIG). PERM project oversight of eligibility for both the Medicaid and CHIP programs is assigned to the Office of Health Insurance Programs (OHIP).

-continued on
next page-



POLICY & BILLING GUIDANCE

(continued from page 11)

Payment Error Rate Measurement Program Request for Medicaid Provider Documentation

The Process:

CMS has contracted with A+ Government Solutions, Inc., to serve as their documentation/database contractor. A+ Government Solutions, Inc., will request documentation from a sample of providers to substantiate claims paid in FFY 2011. They will also operate as the review contractor.

The OMIG requests that providers also send a copy of the documentation to their attention in order to confirm documentation is complete. In New York State's 2008 PERM project this step eliminated a major problem that other States had with incomplete documentation. By mirroring the federal review, New York State was able to contact the provider to secure missing documentation before an error was assigned. It also enabled New York State to appeal claims that were erroneously disallowed and have the disallowances overturned.

The first requests for documentation by the federal contractor should be mailed to the providers in February 2011. If you are contacted, we ask for your cooperation and a timely response. Receipt of the documentation is essential to the success of the PERM program.

Requests and subsequent receipt/non-receipt of documentation will be tracked. Your timely response will facilitate the PERM process and minimize the need for further follow-up action by the OMIG.

Questions? Please contact the Payment Error Rate Measurement project staff via e-mail at: PERMNY@omig.state.ny.us or by phone at (518) 408-0485 or (518) 486-7153.



POLICY & BILLING GUIDANCE

Palivizumab (Synagis[®]) Guidelines for Children at Risk of Respiratory Syncytial Virus Infections

Palivizumab is an intramuscular injection used as prophylaxis for respiratory syncytial virus (RSV). It is used in certain high-risk infants and children with histories of prematurity (35 weeks or less), chronic lung disease (CLD), or congenital heart disease. RSV is a leading cause of bronchiolitis and pneumonia in infants. Palivizumab is usually administered in five monthly doses throughout the RSV season, typically beginning in November or December. Palivizumab should not be used for the treatment of established RSV disease.

Guidelines:

The following guidelines include the major points used to identify infants and children who should be considered for RSV prophylaxis. These guidelines have been adapted from the evidence-based recommendations for the prevention of RSV with palivizumab in children less than two years of age published by the American Academy of Pediatrics (AAP):

- > Children who are 24 months of age or younger with hemodynamically significant cyanotic and acyanotic congenital heart disease.
- > Infants and children less than 24 months of age with CLD of prematurity who have required medical therapy for CLD within the past six months before the anticipated start of the RSV season.
- > Certain other neonates born prematurely, who are within the first year of life at the start of RSV season, with considerations for gestational age at birth, age at start of RSV season, and other risk factors.

References:

American Academy of Pediatrics, Subcommittee on Diagnosis and Management of Bronchiolitis. Diagnosis and Management of Bronchiolitis. *Pediatrics*. 2006;118:1774-1793.
McEvoy, G.K. (Ed.). (2010). *American Hospital Formulary Service Drug Information*. (pp. 798-801). Bethesda, MD: American Society of Health System Pharmacists.
Meissner H.C., et al. Prevention of RSV Infection in High Risk Infants: Consensus Opinion on the Role of Immunoprophylaxis with Palivizumab, a Humanized Respiratory Syncytial Virus Monoclonal Antibody for Prevention of Respiratory Syncytial Virus Infection in High Risk Infants. *Pediatric Infectious Disease Journal*. 1999; 18 (3):223-231.
Synagis[®] (palivizumab) prescribing information. Medimmune, Inc., Rev. Date March 23, 2009.
United States Pharmacopeia-Drug Information. (2007). *Vol. 1. Drug Information for the Healthcare Professional* (27th ed., pp. 2256-2258). Greenwood Village, CO: Thomson Micromedex.



POLICY & BILLING GUIDANCE

Practitioner Reimbursement for Palivizumab (Synagis®)

Medicaid reimburses for palivizumab when billed by Medicaid-enrolled physicians and nurse practitioners and should be billed as follows:

- > **Use code 90378 - Respiratory syncytial virus immune globulin.**
- > **Submit the valid 11 digit NDC, quantity, and units on the claim.**
- > **Insert the acquisition cost plus a two-dollar (\$2.00) administration fee in the "amount charged" field.**
- > **If administering palivizumab outside the guidelines, a paper claim with medical justification must be submitted.**

For more information on practitioner billing, please review the Physician Provider Manual, Procedure Code and Fee Schedule, Procedure Codes Drugs, Section 3, Version 2009-1 (4/1/2009), available at: www.emedny.org/ProviderManuals/Physician/index.html.

Please call the eMedNY Call Center at (800) 343-9000 with billing questions.

Clinic Reimbursement for Palivizumab (Synagis®)

Palivizumab is reimbursable to hospital based and free-standing clinics and is reimbursed under Ambulatory Patient Groups (APGs).

When billing the cost and administration of palivizumab for registered clinic patients under APGs:

- > **For the immune globulin, use CPT procedure code 90378, Respiratory syncytial virus, immune globulin (RSV-IgIM), for intramuscular use, 50mg, each. This will group to APG 416, Level III Immunization.**
- > **For the administration, use CPT 90465 Immunization administration younger than 8 years of age (includes percutaneous, intradermal, subcutaneous or intramuscular injections) when the physician counsels the patient/family; first injection. This will group to APG 490 and will not pay at the line level.**

No prior authorization is required when palivizumab is purchased and administered by a physician or clinic.

Please call the eMedNY Call Center at (800) 343-9000 with billing questions.



PHARMACY UPDATES

Palivizumab (Synagis) Clinical Drug Review Program (CDRP) Process

As respiratory syncytial virus (RSV) season approaches, Medicaid pharmacy providers should be aware that prescriptions obtained for Synagis are subject to Clinical Drug Review Program (CDRP) prior authorization requirements. Prior authorization requirements are intended to ensure that utilization of prescriptions written for RSV occur within the RSV season and for children less than two years of age at the onset of the RSV season.

- > **Prescriptions for children less than two years of age at the onset of the RSV season may be dispensed and billed (on-line) between October 16 and March 31 without prior authorization.**
- > **Prescriptions obtained between April 1 and October 15 will require prior authorization.**
- > **Prescriptions obtained for children two years of age and over at the onset of RSV season will require prior authorization.***

Prior authorizations must be initiated by the prescriber by calling (877) 309-9493 and following the appropriate prompts. Prescription refills are limited to four per patient.

Pharmacy providers must submit POS claims at the time of dispensing to ensure appropriate payment.

The [CDRP Prescriber Worksheet and Instructions](#) provides step-by-step assistance in completing the prior authorization process.

For clinical information on bronchiolitis, please visit:

http://www.nyhealth.gov/health_care/medicaid/program/prescriber_education/presceducationprog.

*DOH determines RSV season based on information from the CDC.

For Medicaid Pharmacy prior authorization program questions, please call (877) 309-9493.
For billing questions, please call the eMedNY Call Center at (800) 343-9000.



PHARMACY UPDATES

Delayed Implementation – Carve-Out of Nursing Home Prescription Drugs

Implementation of the carve-out of nursing home prescription drugs has been **delayed** pending Federal approval.

Once implemented, prescription drugs for Medicaid beneficiaries residing in nursing homes will be carved-out of the nursing home reimbursement rate and covered on a Fee-For-Service basis. Over-the-counter (OTC) drugs and supplies will continue to be included in the nursing home reimbursement rate.

Additional details will be published in a future Special Edition of the Medicaid Update.





ALL PROVIDERS

Large Submitters Need To Reduce File Size

The eMedNY processing system has recently been inundated with an excessive volume of large files often containing over 100,000 records. As a result, providers and vendors have experienced delays in having their requests processed.

It is imperative that providers who submit large files limit the size to less than 100,000 records. Providers should note that when submitting a single file with an excessively large number of records, eMedNY will process the records serially, one at a time, until the entire file has been processed. In some cases, the process may take several days. Although the HIPAA Companion Guides allow for the construction of any number of multiple functional groups within one Interchange, providers and vendors are urged to limit a single Interchange to less than 100,000 records. This will allow eMedNY to process the records in parallel format and will enhance the chances a file will meet the processing cycle deadline.

The submission of smaller files will allow eMedNY to process all transactions in a more efficient and timely manner, resulting in quicker 997 responses.

Please contact the eMedNY Call Center at (800) 343-9000 with assistance in determining a best approach for reducing file size.



SPECIAL ADDENDUM

Attention: Prescribers and Pharmacists

EPIC 2010 Legislative Changes

The following is a recap of the information contained in the Provider and Prescriber Bulletins that were distributed at the end of July. Copies of these bulletins are available online at: http://nyhealth.gov/health_care/epic/pharmacy_prescriber.htm.

As the result of recent statutory amendments to Title III of the NYS Elder Law, effective October 1, 2010, EPIC members with Medicare Part D will be required to maximize the use of their Part D coverage. This change will result in lower program costs and reduced out-of-pocket expense for members.

Approximately 36,000 EPIC members enrolled in a Part D plan, who in the last 100 days received at least one drug for which EPIC has paid as the primary payer, received a letter in July listing the drug(s) they use that will not be covered by EPIC effective October 1, 2010. Members have been advised to contact their pharmacies to determine why their drug(s) were denied by Part D.

The pharmacist has been instructed to try to resolve the claim denial with the Part D plan. If unsuccessful, the pharmacist or the member will contact the prescriber to suggest that the medication be changed to one that is on the member's Medicare Part D plan formulary or to contact the Medicare Part D plan to request a coverage determination. A coverage determination may be necessary if the drug is not on the Medicare Part D plan formulary, or requires a prior authorization to address dosage, quantity or step therapy.

EPIC will provide members with:

- > Primary coverage for claims denied by the Part D plan only after the members, with assistance from their prescribers, have exhausted two levels of appeal available under Medicare Part D and documentation of the denial at appeal level 2 (Reconsideration) has been received by EPIC.
- > Beginning October 1, 2010, EPIC will cover up to a 90-day temporary supply of the drug through the new EPIC Temporary Coverage Request (TCR) Helpline 1-800-634-1340 if the prescriber agrees to pursue a Part D appeal (see next page).
- > If the pharmacist is unable to reach the prescriber to see if the drug can be changed to one on the Part D formulary or ascertain whether an appeal will be pursued, and the member needs the medication immediately, the pharmacist can obtain approval for a 3-day (72 hour) emergency supply by calling the TCR Helpline.

-continued-



SPECIAL ADDENDUM

Primary coverage for drugs that are excluded from Medicare Part D coverage:

- > Benzodiazepines
- > Barbiturates
- > Prescription vitamins and minerals
- > Drugs for anorexia, weight loss or gain
- > Drugs for cosmetic purposes
- > Drugs to relieve cough and cold symptoms

Secondary (supplemental) coverage for drugs that are first covered by the Part D plan as primary payer. This allows EPIC to help members pay their Part D deductibles, copayments/coinsurance and coverage gap (donut hole) claims for drugs that are covered by the Part D plan.

Prescriber Guidelines:

Before your patient leaves your office, please review their Medicare Part D formulary to determine if the drug you have prescribed is covered. **NOTE:** Some prescription medications may be covered and billed by you under your patient's Medicare Part B benefit (e.g., medications in the chemotherapy drug class).

If you have been contacted by the pharmacy or your patient because the drug prescribed is not covered by the Medicare Part D plan, please consider substituting a therapeutic alternative that is covered. If you determine that there is no suitable clinical alternative available, refer to the steps below:

- > **Please contact the member's Medicare Part D plan, either by phone, fax or by mailing a completed Medicare Coverage Determination Request Form to pursue coverage of the needed medication.**
- > **Please provide a statement of medical necessity that includes any information as to why the medication is needed (e.g., trial and failure of previously used medications, lab values, etc).**

As a result of initiating this formal appeal process you may be required to provide additional pertinent clinical information as requested by the Medicare Part D plan. For complete instructions on how to file a Medicare Part D appeal please see:
<http://www.cms.gov/partnerships/downloads/11112.pdf>.

While your request for coverage of a patient's medication is being reviewed and processed by the Medicare Part D plan, you may request temporary coverage of the drug from EPIC.

October 1, 2010 - EPIC's Temporary Coverage Request (TCR) Helpline (800) 634-1340

-continued-



SPECIAL ADDENDUM

If you determine there is no suitable alternative drug, you or your authorized agent must call EPIC's Temporary Coverage Request (TCR) Helpline and respond to several questions, which will create a "temporary override" in EPIC's claims system that will allow for up to a 90-day supply to be dispensed, depending on how the prescription is written. TCR Helpline questions will require the prescriber, or the prescriber's authorized agent, to register his/her intent to initiate an appeal for Medicare Part D coverage.

In order to accelerate any request for temporary coverage, you should be prepared to provide: member's name, member's EPIC ID number (if available), member's address, your name and phone number, your address and fax number, your NPI number, name of the drug and its strength. Once you have contacted EPIC's TCR Helpline, and registered your intent to pursue Medicare Part D coverage of the denied drug, the prescription can be processed at the pharmacy for up to a 90-day supply. There will be no need for a tracking or authorization number from EPIC to process the claim at the pharmacy.

If the Part D plan still denies coverage of the drug after the first two levels of the Medicare appeal process has been exhausted, EPIC will cover the drug as the primary payer. The member, pharmacist, or prescriber must submit to EPIC a copy of the reconsideration denial letter from the Independent Review Entity (Maximus Federal Services) before EPIC can approve coverage of the drug. You may be contacted by EPIC for additional information. This letter should be faxed to **(800) 562-1126**.

Once the denial documentation is received, and EPIC has confirmed that the first two levels of the Medicare appeals process have been exhausted, an extended override will be granted.

Three-Day Emergency Supply:

If the pharmacist is unable to reach the prescriber to ascertain whether an appeal will be pursued and the member needs the medication immediately, the pharmacist can obtain approval for a three day (72 hour) emergency supply by calling the TCR Helpline.

Questions? Please call the EPIC toll-free Provider Helpline at **(800) 634-1340**.

PROVIDER DIRECTORY

Office of the Medicaid Inspector General:

For general inquiries or provider self-disclosures, please call (518) 473-3782.
For suspected fraud complaints/allegations, call 1-877-87FRAUD
(1-877-873-7283), or visit www.omig.state.ny.us.

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 any of the following numbers:
(800) 997-1111, (800) 225-3040, (800) 394-1234.

Address Change?

Address changes should be directed to the eMedNY Call Center at:
(800) 343-9000.

Fee-for-Service Providers: A change of address form is available at:
<http://www.emedny.org/info/ProviderEnrollment/allforms.html>.

Rate-Based/Institutional Providers: A change of address form is available at:
<http://www.emedny.org/info/ProviderEnrollment/allforms.html>.

Does your enrollment file need to be updated because you've experienced a change in ownership? Fee-for-Service Providers please call (518) 402-7032.
Rate-Based/Institutional Providers please call (518) 474-3575.

Comments and Suggestions Regarding This Publication?

Please contact the editor, Kelli Kudlack, at: medicaidupdate@health.state.ny.us.

Do you suspect that a Medicaid provider or beneficiary has engaged in fraudulent activities?

PLEASE CALL: 1-877-87FRAUD OR (212) 417-4570

Your call will remain confidential. You may also complete a complaint form online at www.omig.state.ny.us.