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Medicaid Update

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THE OFFICIAL NEWSLETTER OF THE NEW YORK STATE MEDICAID PROGRAM

Medicaid Expands Coverage for Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Medicaid currently covers SBIRT services for all Medicaid beneficiaries who are 10 years of age and older in hospital outpatient and emergency departments and free-standing diagnostic and treatment centers (D&TCs), including School-Based Health Centers (SBHCs). Under the authority of amendments passed as part of the 2011 Executive Budget, coverage will be extended to SBIRT services provided by office-based primary care practitioners effective September 1, 2011. Reimbursement in other clinic settings, including clinics licensed or operated by the Office of Mental Health (OMH) or the Office of Alcoholism and Substance Abuse Services (OASAS) will be available once Ambulatory Payment Groups (APGs) have been fully implemented in these settings.

What is SBIRT? SBIRT is an evidence-based practice model which has proven to be successful in modifying the consumption/use patterns of at-risk substance users, and in identifying individuals who need more extensive, specialized treatment. SBIRT is a comprehensive, integrated, public health approach that provides opportunities for early intervention before more severe consequences occur. Evidence-based tools that are demonstrated to be valid and reliable in identifying individuals with problem use or at risk for a Substance Use Disorder (SUD) must be used. Based on implementation of this model nationally, of 459,599 patients screened, 22.7% screened positive for a spectrum of use (risky/problematic, abuse/addiction). Of those who screened positive, 15.9% were recommended for a brief intervention, with a smaller percentage recommended for brief treatment (3.2%) or referral to specialty treatment (3.7%).

SCREENING: The screening tools identify substance use/abuse risk and the appropriate level of intervention for indicated individuals. Providers must explain the screening results to the patient and, if the patient has screened positive, the provider must be prepared to deliver or obtain on-site brief intervention services for the patient within the same visit.

OASAS has a list of evidence-based screening tools available online at: http://www.oasas.ny.gov/AdMed/sbirt/index.cfm. Upon prior approval from OASAS, providers may choose tools that are not included on the list as long as they meet specified criteria and the tool is simple enough to be administered by a wide range of health care professionals. Requests for review of alternate screening tools may be emailed to: AddictionMedicine@oasas.ny.gov.

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PLEASE NOTE: Medicaid Helpline Area Code 518 Phone Number Being Phased Out

The Medicaid Helpline (518) 486-9057 phone number is currently being phased out. Over the next several months, any calls to this number will receive a message directing the caller to (800) 541-2831. Please update your phone directories accordingly.

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The screening tools must provide enough information to tailor an appropriate intervention to the identified level of substance use and must include:

- An in-person interview;
- Quantity/frequency of substance use over a particular time frame (generally 1-12 months);
- Problems related to substance use;
- Dependence symptoms; and
- Injection drug use.

BRIEF INTERVENTION

Brief intervention services are appropriate for individuals who are identified through SBIRT screening as being at risk for a SUD. A brief intervention is a single or multiple session preventive health procedure conducted during the same visit as the screening and at follow-up visits, if necessary. It incorporates effective counseling and prevention strategies intended to motivate individuals to decrease or abstain from alcohol or drug use by increasing insight and awareness of substance use. New York does not endorse a specific approach, however, providers are required to use effective strategies for intervention and counseling services.

Effective strategy examples are available online through the Substance Abuse and Mental Health Services Administration (SAMHSA) Web site at: http://www.samhsa.gov/prevention/sbirt/ and the National Institutes of Health (NIH): "Helping Patients Who Drink Too Much," A Clinician's Guide (Updated 2005) at: http://www.niaaa.nih.gov/Publications/EducationTrainingMaterials/Pages/guide.aspx.

REFERRAL TO TREATMENT

SBIRT has been effective in identifying individuals who should be referred to specialized SUD treatment for further assessment and a level of care determination. Assessment of SUD and level of care determinations are comprehensive processes that are not part of SBIRT and should be done by those who have specialized training.

For individuals who screen at high risk for SUD, SBIRT can be appropriately used to motivate the individual to accept a referral to a treatment program. SBIRT also supports the health care practitioner by ensuring that a referral network is established for those patients who need more extensive, specialized treatment from an appropriate, OASAS-certified treatment program, or appropriate practitioners with specialty training in SUD. Any provider proposing to implement SBIRT must have at least one current referral agreement with an accessible OASAS-certified treatment provider to meet the needs of individuals who require such referrals.

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PROVIDERS REIMBURSED UNDER MEDICAID

Licensed practitioners must complete an OASAS approved SBIRT training of at least four hours; however, if the licensed practitioner holds certification as indicated in Table 1 or 2, then the training is recommended, but not required. Licensed practitioners who do not hold certification as indicated in Table 1 must complete four hours of OASAS approved SBIRT training to bill beyond September 1, 2012. Health educators and unlicensed practitioners must complete at least 12 hours of training facilitated by an OASAS approved SBIRT training provider prior to offering SBIRT services. Providers listed in Table 1 may bill for SBIRT directly. Providers listed in Table 2 may not bill Medicaid independently for the services, however, they may bill Medicaid under the provider number of a licensed provider or facility such as a hospital or clinic.

Table 1: Provider types eligible to bill for office-based SBIRT services

Provider Type	Required OASAS Approved Training/Certification
Physicians (services may be performed by another provider type under the supervision of the physician)	4 hours, unless certified by the American Society of Addiction Medicine (ASAM), the American Board of Ambulatory Medicine (ABAM), the American Academy of Addiction Psychiatry (AAAP) or the American Academy Osteopathic Association (AOA)
Nurse Practitioners	4 hours, unless qualified as a Certified Addictions Registered Nurse (CARN)
Nurse Midwives	4 hours
Psychologists	4 hours

Table 2: Provider types eligible to perform SBIRT and bill under a licensed provider/facility (Includes provider types listed in Table 1)

Provider Type	Required Training/Certification
Physician Assistants	4 hours
Registered Nurses	4 hours, unless qualified as a CARN
Licensed Practical Nurses	4 hours
Licensed Master Social Worker (LMSW) or Licensed Clinical Social Worker (LCSW)	4 hours
Licensed Mental Health Counselors	4 hours
Licensed Marriage and Family Therapist	4 hours
Certified School Counselor	4 hours
Certified Rehabilitation Counselor	4 hours
OASAS-credentialed professionals including Credentialed Alcoholism and Substance Abuse Counselors (CASACs), Credentialed Prevention Professionals (CPPs) and Credentialed Problem Gambling Counselors	4 hours
Health Educators and unlicensed individuals (may only provide SBIRT services under the supervision of a licensed health care professional, following consistent protocols)	12 hours

DOCUMENTATION REQUIREMENTS

Patient records must include information on the service provided, the score on the screening tool and a copy of the screening tool. Additional information on documentation requirements, examples of effective brief intervention strategies and a specific training curriculum is available on the OASAS Web site at: http://www.oasas.ny.gov/AdMed/cme.cfm.

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Providers are required to retain documentation that personnel performing SBIRT meet the OASAS required training, education and supervision requirements. Unlicensed providers must be supervised by a licensed health care professional listed in Table 1 and must follow established written or electronic protocols for evidence-based practice during the delivery of screening and intervention services. Protocols must be consistently followed and a licensed health care professional listed in Table 1 must ensure that quality assurance procedures are in place. Providers must have at least a high school diploma or GED and knowledge of alcohol and other drug use, which may be demonstrated through the recommended training, to be considered a qualified provider.

MEDICAID FEE FOR SERVICE (FFS) BILLING GUIDELINES

SBIRT may be billed to Medicaid using the following Healthcare Common Procedure Codes System (HCPCS) procedure and diagnosis codes:

- Procedure code H0049 (alcohol and/or drug screening) is used for the substance use screening. Diagnosis code V82.9 (Unspecified condition) is required on claims for procedure code H0049.
- Procedure code H0050 (alcohol and/or drug service, brief intervention) is used for substance use brief intervention services. Diagnosis code V65.42 (Counseling on substance use and abuse) is required on claims for procedure code H0050.

Physicians and other health care practitioners listed in Table 1 may bill directly for SBIRT in authorized practice settings. SBIRT services do not require prior authorization or copayment under Medicaid FFS. The following fee schedule will apply:

Codes	Setting	Physician	Psychologist	Nurse Practitioner	Mid Wife
H0049 or H0050	Office	$24.00	$24.00	$20.40	$20.40
	Facility	$15.00	-------	-------	-------

Medicaid patients who are seen in hospital outpatient and emergency departments and free-standing clinics may receive SBIRT services from any of the providers listed in Table 1 or Table 2. Payment in these settings is calculated as part of the established ambulatory payment group (APG) methodology. Reimbursement in other clinics, including those operated by or licensed by OMH and OASAS, will be available once Ambulatory Payment Groups (APGs) have been fully implemented in these settings. SBIRT reimbursement is also authorized for services provided by federally qualified health centers that have opted in to the APG reimbursement methodology for their clinic services. The same HCPCS and diagnosis codes are used; both will group to APG 324, Mental Health Screening & Brief Intervention.

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APG rates will vary depending on region and facility with an average rate of $45 per service; representative rates are illustrated here:

Codes	Setting	Region	Estimated APG Rate
H0049 or H0050	OPD	Downstate	$ 57.27
	OPD	Upstate	$ 44.03
	ED	Downstate	$ 51.85
	ED	Upstate	$ 40.49
	Clinic	Downstate	$ 43.94
	Clinic	Upstate	$ 36.82

For additional information on APGs, please see: http://nyhealth.gov/health_care/medicaid/rates/apg/index.htm. OASAS certified 822 and 828 clinics should reference the OASAS APG Clinical and Medicaid Billing Manual at: http://www.oasas.ny.gov/admin/hcf/APG/Index.cfm#CLINICALANDBILLINGMANUAL.

MEDICAID MANAGED CARE BILLING GUIDELINES

SBIRT services are covered benefits under Medicaid Managed Care and Family Health Plus (FHPlus) when provided by hospital outpatient and emergency departments and free-standing clinics that participate in the plan's network, or provide services by referral, and effective September 1, 2011, by licensed in-network private practitioners. Reimbursement rates for plan members receiving SBIRT services from in-network providers will be established in provider agreements. Out-of-network providers will be reimbursed at negotiated rates, except for out-of-network emergency departments which will be reimbursed according to the Medicaid FFS methodology described above. Reimbursement will be made by managed care plans without regard to the SSI status of the enrollee or the nature of the visit.

Since SBIRT is classified as a preventive health or emergency service benefit it is not subject to the FHPlus calendar year benefit limit for behavioral health services. FHPlus co-payments are not applicable to SBIRT. Receipt of SBIRT services does not preclude Medicaid Managed Care and FHPlus members from self referring for one chemical dependence assessment in any calendar year (see Appendix K of the Medicaid Managed Care/FHPlus Model Contract for further information). For questions about a specific plan's payment mechanism or prior authorization requirements related to SBIRT, participating providers should contact the health plan.

COVERAGE LIMITS

Medicaid FFS will reimburse for two screenings and six brief intervention sessions per year. The screenings may be provided by the same provider, or by different providers and at different reimbursable locations. The first brief intervention session must be provided during the same visit as the screening with follow up sessions as necessary.

Medicaid Managed Care and FHPlus plans must also allow two screenings per calendar year in the allowable reimbursable settings without prior authorization. Plans may apply medical necessity criteria for SBIRT screenings beyond the two screening limit. Plans are responsible for up to six brief intervention sessions per calendar year, irrespective of provider, without prior approval. The first brief intervention session must be provided during the same visit as the screening, with follow-up sessions as necessary. Plans may establish prior authorization requirements for additional brief interventions in order to assess whether further brief interventions or a referral for a formal chemical dependency assessment would be medically appropriate. Enrollees who receive a screening and initial intervention in an out-of-network emergency department may be required to receive subsequent interventions from an in-network provider.

Medicaid Coverage of Mental Health Counseling by LCSWs and LMSWs Approved for Article 28 Outpatient Hospital Clinics and Free-Standing D&TCs

Medicaid payment for mental health counseling provided by a licensed clinical social worker (LCSW) or a licensed master social worker (LMSW) in Article 28 outpatient hospital clinics (OPD) and free-standing diagnostic and treatment centers (D&TCs) was recently approved by the Centers for Medicare & Medicaid Services (CMS). Payment is retroactive to September 1, 2009. The LCSW and LMSW rate codes are in the process of being assigned to Article 28 clinic locations that are authorized pursuant to their operating certificate to provide mental health services. Providers will be notified by letter when the new rate codes have been assigned to their facility. Providers who have previously billed for LCSW/LMSW services through APGs will need to adjust previously paid claims using the newly assigned rate codes. Please note that group counseling sessions by an LCSW/LMSW are neither billable nor permitted by law.

Recipient Eligibility

Medicaid will reimburse for mental health counseling provided by LCSWs/LMSWs to children and adolescents up to 21 years of age and pregnant women up to 60 days postpartum (based on the date of delivery or end of pregnancy).

LMSW Supervision Requirements

According to Education Law, Article 154 and Regulations of the Commissioner, Part 74, a licensed master social worker shall provide services under the supervision of a licensed clinical social worker, a psychologist, or a psychiatrist. Pursuant to State Education regulations, supervision of the clinical social work services provided by the LMSW requires that:

- the LMSW apprises the supervisor of the diagnosis and treatment of each client;
- the LMSW's cases are discussed with the supervising LCSW;
- the supervisor provides the LMSW with oversight and guidance in diagnosing and treating patients;
- the supervisor regularly reviews and evaluates the professional work of the LMSW;
- the supervisor provides at least one hour per week or two hours every other week of in-person individual or group clinical supervision, provided that at least two hours per month shall be individual clinical supervision.

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Reimbursement Requirements for LCSW/LMSW

- A facility must have a psychiatry or psychology certification on its operating certificate;
- FFS enrollees who are up to the age of 21 are eligible;
- FFS pregnant women are eligible. There must be a primary or secondary diagnosis of pregnancy (ICD-9 codes: 630-677, V22, V23, and V28) on the claim. Mental health services are also available up to 60 days postpartum with a primary or secondary diagnosis of postpartum depression (ICD-9 codes 648.40 - 648.44); and
- Mental health counseling by LCSWs and LMSWs is only available on an individual basis or with family.

Ordering/Documentation Requirements

Mental health counseling by a LCSW/LMSW must be supported by a written referral from:

- The beneficiary's personal physician, other licensed medical practitioner, or a medical resource, such as a clinic, acting as the beneficiary's physician;
- An appropriate school official; and
- An official or voluntary health or social agency.

Children, pregnant women, and families treated via counseling in Article 28 clinics require assessment and treatment for less complex emotional disturbances. As such, the typical course of treatment would be expected to be solution-focused and short-term. Children, pregnant women, and families presenting with more complex needs or severe emotional disturbance should be referred to a specialist (i.e., child psychiatrist, licensed psychologist, primary care physician with specialty training/consultation or a clinic licensed by the Office of Mental Health under Article 31 of the Mental Hygiene Law).

In addition to the items that must be maintained in the beneficiary case record as specified in the Clinic Provider Manual, case records must also include at a minimum the following information:

- A treatment plan developed, signed and dated by the social worker that includes, but is not limited to, the beneficiary's diagnosis (only a LCSW can diagnose), the beneficiary's treatment goals, and the number of sessions planned;
- Progress notes signed and dated by the social worker for each visit/contact identifying the session content and duration, as well as changes in goals, objectives, and services;
- Periodic assessment signed and dated by the social worker documenting the beneficiary's progress towards goal; and
- Documentation of referral for specialty behavioral health care.

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Rate Codes

New rate codes have been established for **Hospital Outpatient Department** and **Diagnostic and Treatment Center** reimbursement for mental health counseling when provided by a LCSW/LMSW.

4257	**Individual Brief Counseling** (psychotherapy which is insight oriented, behavior modifying and/or supportive, approximately 20-30 minutes face-to-face visit with the patient)	$41
4258	**Individual Comprehensive Counseling** (psychotherapy which is insight oriented, behavior modifying and/or supportive, approximately 45-50 minutes face-to-face visit with patient)	$62
4259	**Family Counseling** (psychotherapy with or without patient)	$70

New rate codes have been established for **School Based Health Center** reimbursement for mental health counseling when provided by a LCSW/LMSW.

3257	**Individual Brief Counseling** (psychotherapy which is insight oriented, behavior modifying and/or supportive, approximately 20-30 minutes face-to-face visit with the patient)	$41
3258	**Individual Comprehensive Counseling** (insight oriented psychotherapy, behavior modifying and/or supportive, approximately 45-50 minutes face-to-face visit with patient)	$62
3259	**Family Counseling** (psychotherapy with or without patient)	$70

Note: Per state statute, free-standing diagnostic and treatment centers that billed and received Medicaid payment for mental health counseling services provided by licensed social workers in calendar year 2007 may continue to bill Medicaid for such services. Mental Health counseling provided by such clinics is available to all eligible Medicaid enrollees regardless of age or pregnancy status.

Note: Facilities who plan to submit claims retroactively that will be more than 90 days old when submitted should use the following delay reason code "4". **Delay in Certifying Provider/Administrative Delay (Enrollment Process, Prior Approval Process, Rate Changes, etc.) by the Department or other State Agency**."

Policy questions? Please contact the Division of Financial Planning and Policy at (518) 473-2160.

Provider enrollment and rate code assignment questions? Please contact the Division of Provider Relations and Utilization Management at (518) 474-8161.

Billing and claims submission questions? Please contact the eMedNY Call Center at (800) 343-9000.

New Ancillary Billing Policy for Free-Standing Diagnostic and Treatment Centers (DTCs), including Renal Clinics and School Based Health Centers (SBHCs)

Effective July 1, 2011, with the exception of APG carve outs, all ancillaries, whether ordered or provided in-house, must be coded on the APG claim. Additionally, the DTC must code modifier U6 at the line level for each ancillary for which they are requesting direct reimbursement. DTCs should code modifier U6 with an ancillary only if they provided the ancillary on-site or have a contract with an ancillary services provider who will not be billing Medicaid directly for the ancillary, but rather will be reimbursed by the DTC. Modifier U6 should not be reported if the DTC did not provide the ancillary service on-site and does not plan to reimburse the ancillary vendor directly. In that case, the clinic provider would still report the ancillary on the clinic claim, but without modifier U6. By not coding the U6 modifier, the clinic is indicating to DOH that an ancillary services provider will be billing Medicaid directly, fee-for-service, for the ordered ancillary.

Providers were previously notified that modifier 90 would be the modifier used to identify ancillary services for which they were requesting payment. However, it has now been determined the state-defined modifier U6 will be used instead of AMA modifier 90. Please note that coding modifier U6 on an APG claim prior to July 1, 2011 will not affect payment.

Generally, ancillary services should not be coded on an APG claim until confirmation has been received that the ancillary service was actually performed. DOH had initially indicated that DTCs would have two billing options for reporting ancillary services on their APG claim:

- Submit the entire APG claim (medical visit/significant procedure with all ancillaries) upon confirmation that all ancillary services have been completed. The provider has 90 days after the receipt of the billing information related to the last ancillary completed to submit the claim.

- Submit the APG claim for the medical visit/significant procedure and in-house ancillaries only. After confirmation that all ordered ancillary services have been completed, the clinic would then submit a claim adjustment that adds the completed ordered ancillaries to that which has already been billed. This method is recommended if it is likely that cash flow or other issues would arise under the first billing option. The rule mandating that claims must be submitted within 90 days does not apply to adjustments. However, a claim adjustment must be submitted within 30 days of the date the billing information on the completed ancillary came under the control of the DTC.

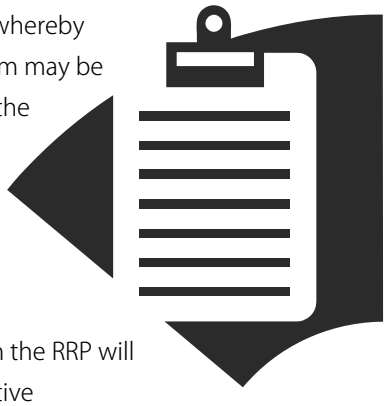
A third option is now available for ancillaries that package under APG reimbursement. Providers may code packaging ancillaries that are ordered from an outside vendor as soon as the ancillaries are ordered if the provider does not code modifier U6 with the packaging ancillary (not coding U6 indicates that the ancillary vendor will be billing Medicaid directly for the ancillary).

DTCs should not include procedures that have been carved out of APGs on their APG claim. These should be billed fee-for-service (as fee schedule services) directly to Medicaid by the DTC or the ancillary vendor (not both). All other ancillaries, whether performed in-house or ordered, must appear on the APG claim, with modifier U6 used as appropriate. A complete list of APG carves outs is available on the DOH Web site.

The episode rate codes will be loaded to provider rate files with an effective date of July 1, 2011 to coincide with the implementation date of the ancillary billing policy. Under the episode rate codes, providers will be able to bill for medical services and associated ancillaries and report, at the line level, the actual date of each service rendered. The applicable episode rate codes are; DTC – 1422, DTC MR/DD/TBI – 1425, SBHC – 1453, Renal Clinic – 1456. The new ancillary policy is applicable to both episode-based and visit-based rate codes, with the use of episode-based rate codes being recommended by DOH.

Additional information on the DTC ancillary policy is available online at:
http://www.health.ny.gov/health_care/medicaid/rates/apg/docs/dtc_ancillary_policy.pdf.

Recipient Restriction Program Update



The Recipient Restriction Program (RRP) is a medical review and administrative mechanism whereby selected enrollees with a demonstrated pattern of abusing or misusing the Medicaid program may be restricted to one or more health care providers. The objectives of the RRP include reducing the cost and inappropriate utilization of health care by identifying Medicaid enrollees exhibiting abusive or fraudulent behavior; providing Medicaid enrollees with coordinated medical services, thus improving the quality of their care; and utilizing local district and community providers to provide specific specialty and case management services.

As part of the 2011 Medicaid Redesign Team (MRT) initiative, individuals currently enrolled in the RRP will now be required to enroll in Medicaid managed care programs in mandatory counties effective August 1, 2011. These populations had previously been excluded from Medicaid managed care. Individuals currently in a restriction program imposed by the Office of the Medicaid Inspector General (OMIG) will be given 60 days to choose a plan, 90 days if they are categorized as SSI. If a plan is not selected, they will be assigned to a Medicaid managed care plan. Individuals currently in a restriction program will continue to be restricted once they enroll in a health plan. The health plan will be responsible for managing all health care services covered in the Medicaid managed care program. If the member is restricted due to pharmacy or other carved out services, he/she will remain in the pharmacy restriction program while enrolled in the plan. Restriction identification and procedures will remain the same. Effective October 2011, once the pharmacy is transitioned to the managed care plan's benefit package, the plan will assume responsibility for ensuring that the member remains in a pharmacy restriction program.

Upon enrollment, members may be required to select or be assigned to new participating providers to access services. Providers who are currently treating restricted recipients under the fee-for-service program, are encouraged to discuss with their patients how to choose a plan to best meet their medical needs. If the patient wishes to continue to maintain a relationship with a provider, he/she must choose a Medicaid managed care plan that the provider participates with. Going forward, the managed care plan will assume the responsibility for restriction of pharmacy and other primary care services and OMIG RRP will continue to administer the restriction of plan carved out services.

Prenatal Care Providers Update

Effective October 1, 2011, the exemption for pregnant women who are under the care of a prenatal care provider who does not participate in any managed care plans will be phased out. Unless otherwise eligible for an alternate exemption from managed care enrollment, all pregnant women must be enrolled in a managed care plan.

A Medicaid eligible woman who is confirmed pregnant and is not in a Medicaid managed care plan must choose a health plan. If a pregnant woman is under the care of a non-participating provider and is in her second trimester as of the effective date of enrollment into a health plan, the plan must allow the woman to continue to see the non-participating prenatal care provider for a transitional period that lasts through the remainder of the pregnancy, including delivery and the provision of postpartum care directly related to the delivery for up to 60 days after the pregnancy ends.

If the woman elects to continue to receive care from the non-participating provider, such care will be authorized by the plan for the transitional period only if the non-participating provider agrees to: ***a)*** *accept reimbursement from the plan, at rates established by the plan, as payment in full (rates may be no more than the level of reimbursement applicable to similar providers within the plan's network for such services);* ***b)*** *adhere to the plan's quality assurance requirements and agree to provide necessary medical information related to the enrollee's care to the plan; and* ***c)*** *otherwise adhere to the plan's policies and procedures including, but not limited to procedures regarding referrals and obtaining pre-authorization for covered services according to a treatment plan approved by the plan.*

After the 60-day postpartum period, the woman will be required to begin utilizing OB/GYN providers that participate in her health plan. For subsequent pregnancies, no other transitional periods will be granted.

All prenatal care providers are strongly encouraged to obtain provider contracts with the Medicaid managed care plans in the prenatal care provider's service area. For a list of managed care plans by county, please visit: http://www.nyhealth.gov/health_care/managed_care/pdf/cnty_dir.pdf.

Further information related to the New York State Prenatal Care Standards is available online at: http://health.ny.gov/health_care/medicaid/program/update/2010/2010-02_special_edition.htm.

Presumptive Eligibility Update

Presumptive eligibility (PE) for pregnant women provides immediate Medicaid coverage for prenatal care services pending a full Medicaid eligibility determination. At this time, it is a requirement for all PE providers to assist pregnant women applying for Medicaid through the PE process to choose a managed care plan.

Effective October 1, 2011, pregnant women residing in counties that have implemented mandatory managed care will be required to choose a Medicaid managed care plan at the point of application for presumptive eligibility. This procedure will allow for a more expedited enrollment in a managed care plan once Medicaid eligibility is determined.

If the woman chooses a managed care plan on the Medicaid application form, the effective date of enrollment into the plan of choice will be the first of the month following the full Medicaid eligibility determination. Failure to choose a plan on the Medicaid application will result in the state assigning the woman into a plan effective the first day of the month after determination of Medicaid eligibility.

All PE providers are strongly encouraged to obtain provider contracts with the Medicaid managed care plans in the PE provider's service area. For a list of managed care plans by county, please visit: http://www.nyhealth.gov/health_care/managed_care/pdf/cnty_dir.pdf.

The PE provider online training has been updated to reflect the new requirements for managed care plan choice at initial application. As required, prenatal care provider designated staff must be trained in the PE process prior to performing these determinations. Online training is available at http://www.bsc-cdhs.org/eLearning/.

For further information regarding presumptive eligibility, please refer to the February 2010 Medicaid Update Prenatal Care Special Edition at: http://www.nyhealth.gov/health_care/medicaid/program/update/2010/2010-02_special_edition.htm.

Personal Care Benefit Update

Effective August 1, 2011, the personal care benefit will move from a fee-for-service (FFS) benefit to an in-plan benefit for any beneficiary enrolled in a Medicaid managed care plan (MCP). This does not include dually eligible individuals nor those in the Consumer Directed Personal Care Program (CDPCP).

Managed care enrollees currently authorized and receiving personal care services will receive a notice from the state that personal care services will no longer be authorized by the local social services personal care program. Members will be informed that they are to direct any requests or concerns with personal care services or service providers to their managed care plan.

Personal Care Providers (e.g., Licensed Home Care Services Agencies and Certified Home Health Agencies) under contract with a local department of social services (LDSS) are advised to determine which MCP a patient is enrolled with and to contact the plan to inform them that their agency is the provider of services, if the plan has not already contacted their agency.

On August 1, 2011, there will be a transitional period, up to 60 days, for providers who have not contracted with an MCP to continue to provide services to members. During this period, MCPs are required to pay for services authorized by the local district until the MCP can conduct its own assessment and care plan. Providers should determine which patients in their current caseload are enrolled in a MCP and reach out to the respective MCP to discuss plan procedures for payment of claims during the transitional period.

After the transitional period, payment for personal care services will be dependent upon a contract between the MCP and the provider. Payment may be denied even with an existing LDSS authorization if there is no contract between the provider of personal care and the MCP. Information about contracting with MCPs can be found at the following link: http://www.nyhealth.gov/health_care/managed_care/providers/index.htm.

Questions? Please contact Nina Daratsos via email at: nmd04@health.state.ny.us.

New York Health Options Enrollment Center Begins Processing Medicaid Renewals

New York Health Options is a new centralized public health insurance enrollment center established by the New York State Department of Health (NYSDOH). Effective June 2011, New York Health Options began processing renewals for a subset of current public health insurance enrollees. Medicaid providers should note that some of their patients will now have renewals processed at New York Health Options instead of their local department of social services.

New York Health Options will process renewals for certain Medicaid, Family Health Plus, and Family Planning Benefit Program recipients who live in counties outside of New York City. These enrollees will receive a regular Medicaid, Family Health Plus, or Family Planning Benefit Program renewal packet, however, the cover letter will instruct the enrollee to mail their renewal form to the New York Health Options office in Albany instead of their local department of social services.

Recipients who are blind, disabled, or aged 65 and older will continue to renew their coverage with their local department of social services, and recipients who live in New York City will continue to renew coverage with the New York City Human Resources Administration (HRA).

Medicaid, Family Health Plus, and Family Planning Benefit Program applicants should continue to submit new applications to their local departments of social services or facilitated enrollers.

Questions? Please contact (518) 408-1817.

HIV Counseling and Testing Rate Codes to be Subsumed into APGs

Effective July 1, 2011, the rate codes for HIV counseling and testing services in hospital outpatient departments (2983, 3111, 3109) and diagnostic and treatment centers (1695, 1802, 3109) will be subsumed into the APG payment system, and will be reimbursed based on the procedures rendered and patient diagnosis (for evaluation and management services) coded for the visit/episode. Accordingly, providers billing under APGs (non-FQHCs and FQHCs that bill under APGs) should use APG rate codes (e.g., 1400 or 1432 for hospital outpatient and 1407 or 1422 for DTCs) instead of the HIV counseling and testing rate codes referenced above. If other APG services are provided on the same date of service as the HIV counseling service, all services (including the counseling) should be combined on the same claim.

For additional information or assistance regarding Medicaid coverage of HIV counseling and testing, please contact the following:

For APG policy and reimbursement questions, please email apg@health.state.ny.us or call the Division of Financial Planning and Policy at (518) 473-2160.

For further billing and reimbursement guidance please visit: http://health.ny.gov/health_care/medicaid/rates/apg/index.htm.

For billing and claims submission questions, please contact the eMedNY Call Center at (800) 343-9000.

Free-Standing Rate Codes Subsumed by APGs to be Zeroed-Out

The Ambulatory Payment Group (APG) payment methodology took effect for free-standing diagnostic and treatment centers and free-standing ambulatory surgery centers on September 1, 2009. On September 15, 2011, the NYS Department of Health will zero out the free-standing rate codes that were subsumed (eliminated) under the APG methodology (see link below for a list of subsumed rate codes). The subsumed rate codes will be zeroed out with an effective date of September 1, 2009. When these rates are zeroed out, all payments for claims billed under the subsumed rate codes with a date of service on or after September 1, 2009 will be recovered from the biller.

Any claims submitted under the subsumed rate codes with a date of service on or after September 1, 2009 should be adjusted using the appropriate APG rate code by September 15, 2011. In some cases, providers may have already submitted equivalent claims under the APG rate codes and are now just waiting for the claims under the old rate codes to be zeroed out. In those cases, the billing provider need not take any further action. Providers with a significant number of claims under the subsumed rate codes with dates of service post September 1, 2009 will be notified by email that the claims billed with subsumed rate codes and dates of service on or after September 1, 2009 should be resubmitted with the APG rate code, where appropriate.

For billing and claims submission questions, please contact the eMedNY Call Center at (800) 343-9000.

Billing and reimbursement guidance please visit: http://health.ny.gov/health_care/medicaid/rates/apg/index.htm.

For APG policy and reimbursement questions, please email apg@health.state.ny.us or call the Division of Financial Planning and Policy at (518) 473-2160.

Statutorily Required Breast Cancer Treatment Booklet Available

The New York State Department of Health (NYSDOH) has developed a booklet titled *Breast Cancer Treatment – What You Should Know,* which summarizes information about treatment options, insurance coverage, public insurance options for the uninsured, and steps to stay healthy after treatment is completed. The booklet satisfies the requirements of Section 2404 of the New York State Public Health Law, which requires that physicians provide each patient, under their care, diagnosed with breast cancer, with a summary of breast cancer treatment options. The booklet is available online at: http://www.health.ny.gov/publications/0401/.

The printed booklet can also be used to accommodate section 2803-o of the Public Health Law, which was amended to require that general hospitals provide written information to breast cancer surgery patients about reconstructive surgery options and the availability of insurance coverage, before obtaining consent to the surgical procedure.

The booklet and a card directing patients to the electronic version of this booklet on the NYSDOH Web site can be ordered in bulk, free of charge by visiting http://www.health.ny.gov/forms/order_forms/cancer.pdf. If you have any questions about these materials, please contact Sheri Scavone, Cancer Services Program Director, at (518) 474-1222 or via email at: sls19@health.state.ny.us.

Please Note: The New York State Department of Health Cancer Service Program (CSP) provides free comprehensive breast, cervical and colorectal cancer screening and diagnostic services to eligible New York State residents and facilitates patient enrollment into the New York State Medicaid Cancer Treatment Program. New York State residents may call the CSP toll-free referral line, 1-866-442-CANCER (2262), 24 hours a day, seven days a week, to be connected to the CSP in their area.

Medicaid Obstetrical and Maternal Services (MOMS) Update

The purpose of this article is to advise providers of changes in the New York State Department of Health (DOH) administration, management and oversight for the Medicaid Obstetrical and Maternal Services (MOMS) program.

The MOMS program was developed in 1992 to provide comprehensive prenatal care services to low-income women, primarily in rural settings. The MOMS program is comprised of two components:

- the clinical services component consists of physicians, licensed midwives and nurse practitioners who meet program qualifications to provide clinical aspects of prenatal care and agree to refer pregnant women to health supportive services agencies for additional supportive services to ensure women have access to the comprehensive package of prenatal care services.

- the health supportive services (HSS) component consists of providers who offer women the components of comprehensive prenatal care services not available in the clinicians' offices. These additional services include outreach, presumptive eligibility determination, assistance with the full Medicaid application, nutrition screening and counseling, health education, psychosocial assessment and counseling, HIV services, records and reports, internal quality assurance and non-clinical aspects of postpartum care.

The MOMS program was a companion program to the former Prenatal Care Assistance Program (PCAP) for prenatal care provided in Article 28 facilities, with MOMS providers primarily located in areas of NYS where there were no PCAPs. In the past few years there have been several key legislative and policy changes that affected prenatal care services paid for through the state's Medicaid Program. New legislation was passed in 2009 to expand access to comprehensive, quality prenatal care to all pregnant women enrolled in Medicaid, regardless of where they obtain care. Based on this legislation, the designation of PCAP for Article 28 providers was eliminated and all Medicaid providers of prenatal care are required to adhere to the new Medicaid Prenatal Care Standards.

The Medicaid Prenatal Care Standards is available online at: http://nyhealth.gov/health_care/medicaid/standards/prenatal_care/.

The responsibility for the administration and management of the Medicaid Prenatal Care Program is with the DOH Office of Health Insurance Programs (OHIP). In an effort to ensure changes in Medicaid prenatal care are consistent among all prenatal care providers, the MOMS program will also be administered by OHIP, including management and oversight of the Practitioner and Health Supportive Services Provider applications. The goal is to ensure that all Medicaid providers adhere to Medicaid Prenatal Care Standards for comprehensive prenatal care.

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The main highlights for this transition of MOMS to OHIP are:

Effective March 18, 2011 the OHIP, Bureau of Provider Enrollment, assumed responsibility for the review and processing of MOMS Practitioner applications. This includes applications for individual physicians, licensed midwives and nurse practitioners. Practitioner applications can be obtained at the link below.

http://www.emedny.org/info/ProviderEnrollment/FFS%20Enrollment%20Packets/4050-MOMS%20Program/4050-MOMS.pdf.

Submit Practitioner applications to:

Computer Sciences Corporation (CSC)
PO Box 4610
Rensselaer, NY 12144-4610

For questions regarding the application process, please contact the OHIP, Provider Enrollment Unit at (518) 402-7032.

Effective April 1, 2011 the OHIP, Rate-Based Provider Bureau, assumed responsibility for the MOMS HSSP application and certification process.

Submit HSSP applications to:

OHIP, Rate-Based Provider Bureau
Riverview Center, Suite 6E
150 Broadway
Albany, NY 12204-2736

For questions regarding the HSSP application process, please contact the OHIP, Rate-Based Provider Bureau at (518) 474-8161.

Questions regarding the MOMS program? Please contact the Division of Financial Planning and Policy at (518) 473-2160.

Medicaid Provider Documentation Request

The Centers for Medicare & Medicaid Services (CMS), in partnership with the New York State Office of the Medicaid Inspector General (OMIG), is measuring improper payments in the Medicaid and State Child Health Insurance programs under the **Payment Error Rate Measurement (PERM)** program.

CMS, their contractor, and the OMIG have the authority to collect this information under sections 1902(a)(27) and 2107(b)(1) of the Social Security Act. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) statutes and regulations require the provision of such information upon request, and the information can be provided without patient consent.

Documentation for medical review of randomly selected claims will be requested by **A+ Government Solutions, Inc.** the CMS contractor. If claims you submitted are selected, the CMS contractor will request from you, in writing, documentation to substantiate claims paid in federal fiscal year 2011 (October 1, 2010 - September 30, 2011) . Your cooperation and a timely response are requested. Submit the specific medical documents for the patient, as requested in the letter you receive from the CMS contractor, **directly** to the CMS contractor with a copy to the OMIG.

Requests for documentation will begin in **August 2011.** Requests and subsequent receipt/non-receipt of documentation will be tracked.

Failure to provide requested records will result in a determination of erroneous payment, and the OMIG will pursue recovery.

Questions? Please contact PERM Project staff at (518) 402-0066 or (518) 486-7153.

New York State Executive Budget Includes Changes in EPIC Program

Effective July 1, 2011, the EPIC deductible credit for those enrolled in Medicare Part D plans will be eliminated and deductibles will be raised back to their original level, prior to the deductible credit being applied. This annual credit to offset Medicare Part D premiums lowered the EPIC deductible amount that a member was required to pay before receiving EPIC benefits.

Note: All EPIC deductible plan members enrolled in Part D plans will have to spend up to an additional $464 out-of pocket for drugs purchased through December 31, 2011, including those members who previously met their deductible and paid co-payments for drugs. All affected EPIC members have been notified.

Questions? Please contact the EPIC Provider Helpline at (800) 634-1340

New ePACES Training Schedule and Registration

With the July 21, 2011 implementation of changes for HIPAA-compliant electronic submissions, including ePACES, CSC Regional Representatives have scheduled educational sessions to demonstrate the new ePACES screens and functionality. These sessions will be held in the Month of June and continue through the summer.

ePACES is the electronic Provider Assisted Claim Entry System which allows enrolled providers to submit the following type of transactions:

- Claims
- Eligibility Verifications
- Claim Status Requests
- Prior Approval/DVS Requests

Physician, Nurse Practitioner, DME and Private Duty Nursing claims can even be submitted in "REAL-TIME" via **ePACES.** Real-time means that the claim is processed within seconds and professional providers can get the status of a real-time claim, including the paid amount without waiting for the remittance advice.

Fast and easy seminar registration, locations, and dates will soon be available on the eMedNY Web site at:
http://www.emedny.org/training/index.aspx

CSC Regional Representatives look forward to meeting with you at upcoming seminars!

If you are unable to access the Internet to register or have questions about registration, please contact the eMedNY Call Center at (800) 343-9000.

eMedNY Front-End (Pre-Adjudication) Edits

Effective July 21, 2011, several claim edits will be implemented in the eMedNY front end. These edits will be performed prior to claim adjudication, and will provide much faster turnaround for notification of these error conditions. Claims rejected by the front end process will not be reported in the Remittance Advice. Front end error conditions will be returned in outbound responses to claim submissions: 277CA for 5010 submissions and U277 for 4010. Claims that have passed all "pre-adjudication" edits and do not have errors indicated will be reported on a future remittance advice.

It is important that your billing staff sees the responses returned in the 277CA or U277 so they can identify and correct exceptional conditions with submitted claims. Contact your technical staff or vendor to be sure they are planning to provide your billing staff with a report of this information.

Specifications for the 277CA and U277 are published by Accredited Standards Committee X12 and are available at: http://www.wpc-edi.com and http://www.X12.org/store.

A list of pre-adjudication edits and associated claim status codes is available online at: www.emedny.org in the eMedNY HIPAA Support section. Click on "5010 Crosswalks."

Or, click here for the list: http://www.emedny.org/HIPAA/5010/transactions/crosswalks/eMedNY%20Pre-Adjudication%20Crosswalk%20(837%20Health%20Care%20Claims).pdf

Note: There are differences on the list based on whether you've submitted claims with version 4010 or version 5010, so be careful to reference the proper column on the right side of the chart.

As of July 21, 2011, ePACES will only send version 5010 to eMedNY. ePACES users will be provided with the 5010 pre-adjudication edit responses.

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

■ Provider Enrollment and Screening Regulations

New federal rules and regulations require that all ordering or referring physicians or other professionals providing services under the state plan or under a waiver of the plan must be actively enrolled as participating providers. The most current enrollment forms are available at www.emedny.org. For questions regarding the enrollment status of an ordering or referring provider, please contact the eMedNY Call Center at (800) 343-9000.

■ Updated Medicaid Eligibility Verification System (MEVS) and Dispensing Validation System (DVS) Manual Now Available

Effective July 21, 2011, major changes will be made to the Medicaid Eligibility Verification and Dispensing Validation Systems. Some of these changes include:

- Substantial changes to the responses to eligibility requests,
- Elimination of the current Service Authorization (SA) process, and
- Changes in co-pay handling.

These changes will affect all methods of accessing eligibility on eMedNY, including ePACES, telephone (Audio Response Unit), VeriFone POS terminal, or X12 270 or 278 transaction requests. To download the new MEVS/DVS manual please visit: http://www.emedny.org/ProviderManuals/AllProviders/supplemental.html#MEVS/DVS .

For questions, please contact the eMedNY Call Center at (800) 343-9000.

■ Point of Service Website Redesign & POS 5010 Software Upgrade

eMedNY has launched a redesigned Point of Service (POS) Web site. If you are in possession of an OMNI3750, Vx570 or VX610 terminal please visit www.emedny.org/pos. Self help documents and step-by-step video presentations have been posted on the Web site to assist providers with terminal functions and programming. The latest version of New York State Medicaid software for your POS device will be available on July 21, 2011. Computer Sciences Corporation (CSC) is attempting to make this update as smooth and easy as possible. In order to facilitate the automatic download of the new software release occurring in July, please leave your device(s) turned on when not in use. We will attempt to download from July 20, 2011 at 6:00 p.m. through July 21, 2011 8:00 a.m.

Please visit www.emedny.org/pos for all information regarding your POS terminal. You may also subscribe to the POS eMedNY LISTSERV® at www.emedny.org.

eMedNY Provider Test Environment 5010/D.0 Testing

The eMedNY Provider Testing Environment (PTE) is open to all NYS Medicaid trading partners to test batch and real-time Electronic Data Interchange (EDI) transactions using the same validation and adjudication logic methods as the production environment. Effective June 13, 2011, the Provider Testing Environment began accepting and processing 5010 HIPAA X12 and NCPDP D.0 transactions.

eMedNY PTE will support batch file submission and subsequent processing for ASC X12 transactions (versions 4010 and 5010), and NCPDP transactions (versions 1.1/5.1 and 1.2/D.0). Trading Partners may also conduct real-time testing (only supported transactions) in eMedNY PTE. **Note:** If the test transaction is submitted in version 4010 or 5.1, the response should be expected in the same version. Similarly, if the test transaction is submitted in version 5010 or D.0, you should expect the response returned in version 5010 or D.0 respectively.

Trading partners may utilize any of their existing eMedNY access method(s) to submit test files into the eMedNY PTE. Testing in eMedNY PTE will be supported via FTP (batch dial-up or VPN), CPU to CPU (real-time), PC-to-Host (real-time), eMedNY eXchange (batch), eMedNY SOAP (real-time or batch)

PC-to-Host and CPU-to-CPU testing in PTE will have limited availability. CPU-to-CPU users will be scheduled for testing, by eMedNY, on an individual basis. All test transactions undergo the same processes to verify data structure and content as if it were submitted to the production environment. Responses, for the most part, will mirror a production response.

The only difference between transactions to be routed to the Provider Test Environment or those sent to the eMedNY production environment is the value of a test indicator in the transaction. For ASC X12 transactions, Data Element ISA15, the Usage Indicator, will be a T to indicate a test transaction as shown below.

(4010 transaction) ISA*00* *00* *ZZ*1234 *ZZ*EMEDNYBAT
*110504*1428*U*00401*000000485*0*T*:~

(5010 transaction) ISA*00* *00* *ZZ*1234 *ZZ*EMEDNYBAT
*110504*1428*^*00401*000000485*0*T*:~

For NCPDP D.0 transactions, Field 702 in the Batch Transmission Header Record will be T to indicate a test transaction as shown below.

ØØT123456789Ø123456789Ø22229876747199412Ø11632T12ABCDEFGHYTEWQASDXZAQ1234

Questions? Please contact the eMedNY Call Center at (800) 343-9000 or via email to: emednyproviderservices@csc.com or emednyhipaasupport@csc.com.

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.ny.gov.

Provider Manuals/Companion Guides, Enrollment Information/Forms/Training Schedules:
Please visit the eMedNY Web site at: www.emedny.org.

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 email: 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 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

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