

Medicaid Update

THE OFFICIAL NEWSLETTER OF THE NEW YORK STATE MEDICAID PROGRAM

New Inpatient Psychiatric Exempt Unit Reimbursement Methodology



Background:

Effective for admissions on or after October 20, 2010, Medicaid implemented a new inpatient psychiatric exempt unit reimbursement methodology. This new methodology was based on a per diem rate method which utilizes the APR-DRG (All Patient Refined – Diagnostic Related Group) patient classification system, per diem service intensity weights (SIWs), and various payment factors described below. The new methodology is substantially different from the prior reimbursement methodology which simply reimbursed a hospital the same overall per diem rate for each day of a psychiatric patient's stay.

The new inpatient psychiatric reimbursement method:

- Is applicable to Article 28 psychiatric inpatient exempt units. This methodology does not apply to hospitals licensed solely by the Office of Mental Health pursuant to Article 31 of the Mental Hygiene Law, whose rates will continue to be set in accordance with Part 577 of OMH regulations.
- Involves the update of the operating costs from 1981 to 2005.
- Is intended to pay more appropriately for inpatient psychiatric admissions and address the length of stay variance.

Components:

- The psychiatric payment methodology has its own set of APR-DRG Service Intensity Weights (SIWs) which are different than the Acute APR-DRG SIWs. These psychiatric SIWs are available online at: <http://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/weights/>.
- Operating Per Diem (statewide price adjusted by rural designation, diagnosis, age, presence of mental retardation, comorbidities, and length of stay).
 - Rural Designation: A rural factor of 1.2309 will be applied to the statewide price for rural facilities.
 - Patient Age: An age adjustment payment factor of 1.0872 will be applied to the per diem operating component for adolescents ages 17 and under. For ages 18 and over, the adjustment payment factor of 1.0000 will be applied. This is based on the age in years at the time of admission.

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- Mental Retardation: A payment adjustment factor of 1.0599 will be applied to the per diem operating component for those cases that have a presence of a mental retardation diagnosis.
- Comorbidities: Comorbidities are patient conditions which are secondary to a patient's primary diagnosis and are determined based on data from the claim form. There will be separate payment factors for designated comorbidities or secondary diagnosis. The payment methodology will include one comorbidity factor per stay. If more than one comorbidity is present during a patient's stay, the comorbidity that reflects the highest payment factor during a patient's stay will be used to adjust the per diem operating component.
- Length of Stay (LOS): A variable payment factor for each day of a patient's stay will be applied to the hospital's adjusted operating per diem.

The payment factor scale is as follows:

- Days 1 through 4 is 1.20
 - Days 5 through 11 is 1.00
 - Days 12 through 22 is 0.96
 - Greater than 22 days is 0.92
- Non-Operating Per Diem (capital + DME + transition [see below])
 - Electroconvulsive Therapy (ECT): The ECT payment will be based on a statewide fee of \$281 for 2010, adjusted for each hospital's WEF (wage equalization factor). ECT treatments are limited to one in a 24-hour period and no more than three treatments per patient per week. The count of three begins on the day of the first treatment.

Transition Funds:

- A transition payment is included in the Non-Operating Per Diem if the provider qualifies for the add-on.
- An allocation of the \$25M was calculated based upon 50% of the revenue loss method plus 50% of the payment to cost ratio method.
- In 2010-11, the \$25M investment was allocated to a transition pool. In future years through 12/31/2014, the \$25M transition pool will be reduced and funds reinvested into the statewide price.

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Payment Processing Issues:

- Claims processing currently under review by the Department of Health:
 1. For a claim where a patient is not Medicaid eligible for the entire psychiatric stay:
 - a. When the patient is Medicaid eligible on the date of admission but loses eligibility during the stay, submit a claim to eMedNY for the date of admission through the last date of Medicaid eligibility. This claim will reimburse for the period the patient is Medicaid eligible. If the patient subsequently regains Medicaid eligibility without a time lapse in eligibility, submit a claim adjustment (see Interim Billing below).
 - b. For a claim where the patient is NOT Medicaid eligible on the date of admission and becomes Medicaid eligible during the stay, the eMedNY payment system will currently deny the claim for 00834 - RECIPIENT INELIGIBLE FOR PART OF THE SERVICE PERIOD. A project is being developed to allow reimbursement for the part of the stay that the patient has Medicaid eligibility. While the system is being updated for this processing, claims must continue to be submitted within 90 days of the discharge date as recommended below.
 2. For a claim where a patient's psychiatric stay is contiguous with a non-psychiatric inpatient stay and then the patient returns to the psychiatric unit:
 - Submit a claim for the initial psychiatric stay from the date of admission with a discharge status of 30;
 - Submit a claim for the non-psychiatric portion of the stay for the appropriate payment;
 - Submit a claim for the continuation of the psychiatric stay. If the continuation of the psychiatric stay is within 30 days, the readmission policy will apply or it is considered a new psychiatric stay if greater than 30 days. As a reminder, the admission date and beginning service date must be the same on a psychiatric claim. Therefore, for the claim to be processed as a readmission, it is required that the admission date be changed to be the same as the beginning date of service.
- The above reimbursement issue is currently under review by the Department and further information will be provided when the eMedNY system has been adjusted to accommodate the payment issue.
- **RECOMMENDATION:** Providers must submit the claim for scenario 1b to eMedNY for processing even though the claim may deny. This provides documentation of the original submission to meet claims submission timeliness requirements and aids in system processing solutions related to these issues.

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Other Billing Implications:

- All diagnoses should be properly documented and coded.
- Include all charges on the bill.
- Interim Billing: Each interim claim must be billed as an adjustment to the previously paid claim. This will ensure that the service period will always reflect the correct number of days in the stay from the admission date and allow the correct application of the per diem adjustment factor. In other words, the admission date and the service “from” date must remain the same as on the original claim that is billed for the first part of the patient’s stay.
- Billable Rate Code: 2852 (operating per diem) which is the same rate code as the previous payment method.
- Non-Billable Rate Codes: the non-operating per diem (rate code 2570) and ECT payment per treatment (rate code 2571) have been transmitted to eMedNY for payment purposes. These rate codes are considered ‘non-billable’ as they are not submitted on a claim and are added by the system to a claim that is submitted using rate code 2852. However, the ECT payment is added only if revenue code 0901 is on a claim.
- For readmissions to the same hospital within 30 days of a prior discharge, the 1st day of the readmission will be treated as day 4 for purposes of the LOS payment factor with subsequent days continuing on the LOS scale from that point. Only readmits to the same hospital will be treated as a readmission. Transfers are not included as part of this policy.
- There are no High Cost Outlier claims with this methodology.
- Professional fees for physicians will be reimbursed according to the Medicaid fee schedule.

Alternate Level of Care (ALC) Reimbursement:

The psychiatric ALC reimbursement methodology was NOT revised with the new psychiatric payment method. Therefore, the ALC method of payment remains unchanged and providers should continue to bill the psychiatric ALC as they did prior to the implementation of the new payment method.

If the ALC period falls within the psychiatric stay, providers should NOT submit a claim in the same manner as an Acute DRG with an ALC period within the DRG admit and discharge date. For the psychiatric stay portion of the payment, payment processing issue #2 stated above will result as it is a psychiatric stay that is contiguous with a non-psychiatric stay. For the ALC portion of the stay, providers should submit the ALC claim as previously submitted with the prior psychiatric payment method.

Regulations:

Part 86-1.38(a-n) of the Commissioner of Health’s Rules and Regulations outlines additional details of the inpatient psychiatric method.

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Contact:

For questions regarding the new psychiatric reform payment method, please send an e-mail to: hospFFSunit@health.state.ny.us

Payment Example: 10 Day Stay

| | | |
|--|--|-----------------|
| Principal Diagnosis | APR-DRG 750-1: Schizophrenia SOI-1 | 0.9444 |
| Patient Age | 16 years old | 1.0872 |
| Presence of Mental Retardation (limited to one factor of 1.0599) | 3182, 29901, 75981 | 1.0599 |
| Comorbidities (use highest factor) | Acute Coronary Syndrome | 1.4046 |
| Total Per Diem Adjustment Factor | 0.9444 * 1.0872 * 1.0599 * 1.4046 | 1.5286 |
| Facility Operating Per Diem (adjusted by WEF) | Hospital ABC | \$500.00 |
| Total Adjusted Operating Per Diem | \$500 * 1.5286 | \$764.28 |
| Non-Operating Per Diem: Capital + DME + Transition (if applicable) | | \$50.00 |
| ECT Payment with 2 Treatments during the stay (WEF Adjusted) | \$244 * 2 treatments | \$488.00 |

A rural adjustment factor of 1.23 will be applied to the statewide price for rural facilities and is included in the "Facility operating per diem (adjusted by WEF)" payment rate code 2852 transmitted to eMedNY, if applicable.

Rate code 2852 = Facility operating per diem (adjusted by WEF)

Rate code 2571 = Non-Operating Per Diem

Rate code 2570 = ECT Payment (WEF adjusted)

| Apply variable per diem adjustment for 10 days | Per Diem amount | |
|--|-----------------------|-------------------|
| Day 1 (adjustment factor = 1.20) | \$764.28 * 1.20 | \$917.14 |
| Day 2 (adjustment factor = 1.20) | \$764.28 * 1.20 | \$917.14 |
| Day 3 (adjustment factor = 1.20) | \$764.28 * 1.20 | \$917.14 |
| Day 4 (adjustment factor = 1.20) | \$764.28 * 1.20 | \$917.14 |
| Day 5 (adjustment factor = 1.00) | \$764.28 * 1.00 | \$764.28 |
| Day 6 (adjustment factor = 1.00) | \$764.28 * 1.00 | \$764.28 |
| Day 7 (adjustment factor = 1.00) | \$764.28 * 1.00 | \$764.28 |
| Day 8 (adjustment factor = 1.00) | \$764.28 * 1.00 | \$764.28 |
| Day 9 (adjustment factor = 1.00) | \$764.28 * 1.00 | \$764.28 |
| Day 10 (adjustment factor = 1.00) | \$764.28 * 1.00 | \$764.28 |
| Total Operating Per Diem Payment | | \$8,254.24 |
| Total Non-Operating Per Diem | \$50 * 10 days | \$500.00 |
| ECT Payment - 2 treatments (WEF Adjusted) | | \$488.00 |
| Final Total Payment | | \$9,242.24 |

Adult Day Health Care and AIDS Adult Day Health Care Services

Effective August 1, 2013, Medicaid managed care and HIV Special Needs plans will begin covering Adult Day Health Care (ADHC) and AIDS Adult Day Health Care (AIDS ADHC) Services. Prior to this date, managed care enrollees received these services under the Medicaid fee-for-service (FFS) program.

Scope of Benefit

Adult Day Health Care (ADHC), as defined in regulation (10 NYCRR §425.1), means health care and services provided by the personnel of an ADHC program to an individual, under the medical direction of a physician, in accordance with a comprehensive assessment of care needs and an individualized care plan, including ongoing implementation and coordination of the care plan. An ADHC program is a State Department of Health-approved program located at a licensed residential health care facility or approved extension site. AIDS Adult Day Health Care (AIDS ADHC), as defined in regulation (10 NYCRR Part 759 and 10 NYCRR Part 425) is designed to assist individuals with HIV disease to live more independently in the community or eliminate the need for residential health care services.

Transition

Current Registrants: A managed care enrollee currently receiving ADHC or AIDS ADHC services will receive 90 days of transitional care under the current care plan, or until the managed care plan authorizes an alternate care plan, whichever is later. The managed care plan must allow enrollees currently receiving ADHC or AIDS ADHC services to continue with their current provider as medically necessary, for up to one year beginning August 1, 2013, unless the enrollee elects to change providers. A managed care plan may enter into single case agreements with providers providing services to fewer than five enrollees of the plan.

New Registrants: For one year beginning August 1, 2013, contracted ADHC and AIDS ADHC providers may conduct the assessment (Registrant Assessment Instrument – RAI or Uniform Assessment System – UAS, when implemented) for enrollees newly referred for these services. The provider will be allowed up to two visits to complete the assessment, to be reimbursed at the per diem Medicaid fee-for-service rate. Managed care plans must cover up to two visits even if they do not authorize the enrollee for placement in ADHC or AIDS ADHC.

Authorization of Services

Initial Assessment: Enrollees must have an order from a physician for ADHC or AIDS ADHC services to be assessed for participation in these programs. The managed care plan must arrange for the enrollee to attend a participating ADHC or AIDS ADHC for up to two visits for initial assessment. If more visits are needed to complete a comprehensive assessment, the ADHC or AIDS ADHC may request the managed care plan to authorize up to a total of five visits within 30 days (including those visits required for the initial assessment) to complete the assessment and develop a person-centered comprehensive care

plan. Upon completion of the assessment, if the ADHC or AIDS ADHC provider agrees the member is in need of these services, the provider must request authorization of services from the managed care plan, following managed care plan procedures. The managed care plan will review the request and make a determination for ongoing services (number of visits per week, duration, and types of service). For purposes of service authorization, the timeframe for review begins when the managed care plan receives the completed assessment, and will be determined and noticed as required by Appendix F of the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract.

Reassessment: The managed care plan must ensure that the need for ADHC or AIDS ADHC services is reassessed at least once every six months. A new physician order is not required to continue ADHC or AIDS ADHC services. Reassessments are conducted by the ADHC or AIDS ADHC provider. If the provider believes services should continue, a new assessment and person centered care plan must be submitted to the managed care plan for authorization of services for the new period. The ADHC or AIDS ADHC provider must notify the managed care plan if it is recommending the member be discharged from the program. The managed care plan must notify the provider if they are not authorizing continued treatment and will issue required notices.

Provider Responsibilities

For existing registrants, the ADHC or AIDS ADHC provider must:

- verify eligibility on the 1st and 15th of each month to ensure the enrollee's managed care plan has not changed;
- notify the managed care plan as soon as possible that their enrollee is receiving services;
- share the most recent assessment and care plan to secure authorization for services beyond the applicable transitional care period; and
- follow the managed care plan provider contract and/or the provider manual for prior authorization and billing requirements.

For new registrants, the ADHC or AIDS ADHC must:

- check eligibility prior to performing the assessment or admission;
- During the transition year, notify the managed care plan if the enrollee presents with a physician order for services, and if participating in the managed care plan's network, arrange for coverage for assessment (within two visits); or if not participating in the managed care plan's network, have the managed care plan arrange for the enrollee to be seen at a participating ADHC or AIDS ADHC for assessment;
- if participating with the managed care plan's network, coordinate with the managed care plan to develop a person centered comprehensive care plan within five visits and 30 days; and
- obtain authorization from the managed care plan for the number of visits per week and duration of authorization, according to the approved care plan.

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Right to Appeal

If there is a disagreement with the managed care plan determination, the provider may appeal on behalf of the enrollee. The enrollee will also have the right to a state fair hearing and may be eligible for external appeal. The provider has appeal rights on their own behalf.

Payment

For one year beginning August 1, 2013, managed care plans will pay the Medicaid fee-for-service (FFS) rate for their enrollees (new and existing enrollees) receiving ADHC and AIDS ADHC services during the transition year. Upon completion of the one-year transition period, managed care plans may negotiate different payment rates with ADHC and AIDS ADHC providers. ADHC rates exclude transportation. Transportation related to ADHC will continue to be paid through Medicaid FFS. The Medicaid FFS rate for AIDS ADHC includes transportation. Managed care plans are required to pay AIDS ADHC providers the Medicaid FFS rate inclusive of transportation during the transition period. After the transition year, plans and providers will negotiate rates exclusive of transportation, and transportation will be covered through Medicaid FFS.

Optional/Suggested Claims Coding

Participating ADHC and AIDS ADHC providers must follow managed care plan procedures for claims processing. Managed care plans were provided the following suggested codes for claiming of these services but may require participating providers to use alternate or additional coding.

| Service | HCPCS/ ICD-9 | HCPCS/ICD-9 Description | Modifier | Units | Provider Specialty Code | MEDS COS | FFS Rate Codes |
|----------------------------------|-----------------|---------------------------------------|----------|-------|-------------------------------|-------------|----------------------|
| Adult Day Health Care | S5102 | Day care services, adult; per diem | NA | 1 | 664 | 12 or 15 | 2800, 3800 |
| AIDS Adult Day Health Care | S5102 | Day care services, adult; per diem | U1 | 1 | 355 | 12 or 15 | 1850 |

Tuberculosis Directly Observed Therapy

Effective August 1, 2013, Medicaid managed care and HIV Special Needs plans will begin covering Directly Observed Therapy for Tuberculosis (TB/DOT).

Scope of Benefit

Directly Observed Therapy for Tuberculosis (TB/DOT) is the direct observation of oral ingestion of tuberculosis medications to assure patient compliance with the prescribed medication regimen. Directly observed therapy is the standard of care for every individual with active tuberculosis. TB/DOT may be provided on an outpatient basis in a community setting (including the home) or on an inpatient basis.

Outpatient TB/DOT involves the dispensing of medication and observation thereof, assessing any adverse reactions to the medications, and case follow up.

- In New York City, TB/DOT is provided in New York City Department of Health and Mental Hygiene (DOHMH) clinics, approved Health and Hospitals Corporation (HHC) hospitals (Bellevue, Elmhurst, Kings County), or in the home or other community setting.
- In the rest of the state, TB/DOT is provided in the local health department (LHD) or in the home or other community setting.

Inpatient long term treatment may be indicated where the LHD has determined the patient has a poor treatment response, has medical complications, remains infectious with no other appropriate residential placement available, or other intensive residential placement is not possible.

Managed care plans will continue to be responsible for clinical management of tuberculosis, in cooperation with the TB/DOT provider.

Provider and Managed Care Plan Responsibilities

- Providers must follow managed care plan guidelines for submission of claims.
- Participating providers/LHDs must follow requirements for notification.
- Managed care plans may not require prior authorization for TB/DOT services if the services are provided under the authority of the Local Health Department.
- Managed care plans may not mandate the location of TB/DOT services or which provider will provide TB/DOT services, however, the local districts/local health departments will work with the plans and try to utilize network providers whenever possible.
- Managed care plans may amend existing provider contracts or enter into new provider contracts for TB/DOT services.
- Managed care enrollees may self-refer to the local public health department for diagnosis and/or treatment of tuberculosis.

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Claims Payment

- Managed care plans must provide coverage of and payment for TB/DOT beginning August 1, 2013.
- Managed care plans must pay the Medicaid fee-for-service (FFS) rate for TB/DOT if the provider is not contracted with the managed care plan.
- The TB/DOT FFS rate is \$82.58 upstate and \$95.90 downstate (New York City, Westchester, Nassau and Suffolk Counties). The rate is a weekly rate, regardless of the frequency of treatment (daily, twice or three times weekly). If there is a revision of the FFS rates within the first year (August 1, 2013 through July 31, 2014), managed care plans will be required to pay the revised FFS rates for the balance of the first year.
- The rate does not include TB medications, which are also the responsibility of the plan. The patient may fill TB/DOT prescriptions and keep medications, and remain in receipt of TB/DOT care.

Optional/Suggested Claims Coding

| Service | HCPCS/ECD-9 Code | HCPCS/ICD-9 Description | Modifier | Units | Provider Specialty Code | MEDS COS | FFS Rate Codes |
|--|----------------------|--|----------|-------|-------------------------|----------|------------------------|
| TB/DOT (see notes below regarding medications) | H0033 | Oral medication administration, direct observation | U1 | 1 | Varies | Varies | 5312, 5313, 5317, 5318 |
| Inpatient TB Therapy (ordered by LDSS) | ICD-9 Dx 01000-01286 | Various TB diagnoses. The Dx codes shown all group to APR-DRG 137, but other Dx and DRGs are possible for TB and may apply. The full range of codes extends up to ICD-9 Dx code 01896. | | | Varies | 11 | |

The first-line medications used in TB/DOT treatment are isoniazid (INH), rifampin (RIF), ethambutol and pyrazinamide. These are all oral medications. There are other oral medications that may be used, but these are used on a less frequent basis.

In some cases, patients may require injectable/infused medications. The standard injectable medications for TB are Streptomycin (J3000), Kanamycin (J1850), Amikacin (J0278) or Capreomycin (J3490). Managed care plans are responsible for oral and injectable tuberculosis medications regardless of the setting of drug administration.

Reminder of Upcoming UAS-NY Milestone for Managed Long Term Care Plans

No later than October 1, 2013, **Managed Long Term Care (MLTC) Plans** and their respective provider networks will use the Uniform Assessment System for New York (UAS-NY) in place of the Semi-Annual Assessment of Members (SAAM).

By this time, all MLTC plans and their respective networks should have submitted requests for Health Commerce System (HCS) user accounts to the Commerce Accounts Management Unit (CAMU).

Below are critical **August 2013** milestones that all MLTC Plans and their respective networks should adhere to in order to meet the October 1, 2013, implementation date.

Milestone Two

Trust Level 3 assurance and UAS role assignments must be established by *no later than* **August 1, 2013**.

Milestone Three

All staff (assessors and support staff alike) must complete the required online training and begin using the UAS-NY in preparation for conducting assessments by **August 15, 2013**.

Milestone Four

Plans must use the UAS-NY for all new members who are scheduled to enroll effective **October 1, 2013**. This will require Plans to use the UAS-NY as early as **mid-August 2013**.

Milestone Five

The UAS-NY must be used for all reassessments beginning **October 1, 2013**. MLTC Plans and their respective networks must ensure adherence to these milestones.

Questions concerning this e-mail and the UAS-NY should be directed to the UAS-NY Project Team at uasny@health.state.ny.us or (518) 408-1021.

UAS-NY Implementation Update

Beginning **September 1, 2013**, all home and community-based long term care Medicaid programs in the following counties will begin activities to transition to the Uniform Assessment System for New York (UAS-NY).

- Nassau
- Suffolk
- New York City
- Westchester

All organizations that manage, conduct assessments, or provide services for any of following programs will be required to use UAS-NY.

- Adult Day Health Care
- Assisted Living Program
- Care at Home I/II Waiver
- Consumer Directed Personal Assistance Program
- Long Term Home Health Care Program
- Nursing Home Transition and Diversion Waiver
- Personal Care Services Program
- Traumatic Brain Injury Waiver

Once the transition activities are completed, organizations in these counties will use the UAS-NY to conduct assessments for these programs. Organizations in these counties will achieve full implementation of the UAS-NY no later than **February 1, 2014**. Organizations that are responsible for the client assessment must ensure that any contractors are identified and notified of this change.

UAS-NY Implementation Overview Webinar

The UAS-NY Project Team will conduct an overview of the UAS-NY, the transition activities, and timeline for organizations in these counties on **August 13, 2013**. The one-hour webinar will begin at **11:00 AM**. All organizations in these counties are strongly encouraged to participate as important information about the transition activities will be presented.

Register for the event online at: <https://uasny.webex.com/uasny/onstage/g.php?t=a&d=667631757>.

Upon completion of your registration, you will receive an email with details to access the webinar. This email will include the link and password for the actual event.

Prior to the webinar, staff is encouraged to visit the Department's website for additional information concerning the UAS-NY. The website includes all previously recorded webinars and includes a summary of assessment instruments that will be replaced. All materials are available online at: http://www.health.ny.gov/health_care/medicaid/redesign/uniform_assessment_system/index.htm

Questions concerning the transition and implementation of the UAS-NY may be sent to: uasny@health.state.ny.us.

Medicaid Primary Care Rate Increase Is Here!

New York State received State Plan Amendment approval on May 30, 2013, from CMS to implement the Primary Care Rate Increase (PCRI). Fee-for-service payment began within payment cycle 1872 (July 4, 2013).

Beginning in September 2013, eMedNY will reprocess claims for dates of service on and after January 1, 2013, at the increased rate to providers who have submitted complete attestations by August 1, 2013. For attestations received after August 1, 2013, the increased rate will be paid effective the date the attestation is received.

Further information on managed care implementation will be forthcoming.

Additional resources:

- The physician, nurse practitioner and midwife PCRI fee schedules:
<https://www.emedny.org/ProviderManuals/index.aspx>.
- The PCRI FAQ's, webinar presentation and attestation form:
<https://www.emedny.org/info/ProviderEnrollment/physician/Option1.aspx>
- The list of qualified PCRI providers:
http://www.health.ny.gov/health_care/medicaid/fees/
- PCRI questions: pcri@health.state.ny.us
- Fee-for-service Medicaid billing assistance: eMedNY call Center (800) 343-9000.
- To keep up to date, sign-up for the:

eMedNY Physician Listserv:

https://www.emedny.org/Listserv/eMedNY_Email_Alert_System.aspx

NYS PCRI Listserv: PCRI-L@listserv.health.state.ny.us

New York Medicaid Electronic Health Records Incentive Program Update

The New York Medicaid EHR Incentive Program provides financial incentives to eligible practitioners and hospitals to promote the transition to electronic health records (EHR). Providers who practice using EHRs are in the forefront of improving quality, reducing costs, and addressing health disparities. Since December 2011 over \$404 million in incentive funds have been distributed to over 7,950 New York State Medicaid providers.

For more information about the EHR Incentive Program, we encourage you to visit the program website at <https://www.emedny.org/meipass/> or attend one of the informational webinars hosted by the NYS Department of Health. To see the complete schedule of events and webinars, please view our **Upcoming Event Calendar** at <https://www.emedny.org/meipass/info/Events.aspx>.

Taking a closer look: New York Medicaid EHR Incentive Program Support Team

Our Support Team takes great pride in offering providers free high quality program support. Don't take our word for it, **call us at (888) 646-5410** with any program question(s) and see for yourself!

“They have provided the **help** for all my doubts, very promptly and to the point.”

“Prompt, **courteous**, informative service provided. Offering guidance and support to help find a **resolution**”

“This is a **fantastic** group to work with. Professional and knowledgeable. My staff could learn from them.”

“We felt like the Support Services were on **"our team"** in getting our questions answered. Excellent customer relations.”

“What I have found **absolutely impressive** is how well your staff understands the Medicaid EHR **incentive process** AND how well they can **explain it** to others.”

“The **support center** provides a **vital service!**”

Our service portfolio is hosted at <https://www.emedny.org/meipass/>:
Tier 1 & 2 Support Analysts - Webinars - How-To Pages - FAQs - Walkthroughs - LISTSERV

Have Questions? Contact hit@health.state.ny.us for program clarifications and details.

Family Planning Benefit Program (FPBP) Update

The Family Planning Extension Program (FPEP) provides 24 months of family planning services to women who were in receipt of Medicaid while pregnant (regardless of how the pregnancy ended), but who are no longer eligible for Medicaid after their 60 day post-partum period. The family planning services available through the FPEP are the same as those available through the Family Planning Benefit Program (FPBP), except transportation, which is not a service available through the FPEP.

A November 2012 Medicaid Update article, http://www.health.ny.gov/health_care/medicaid/program/update/2012/2012-11.htm, explained that Medicaid was automating how FPEP services are administered and processed. Prior to the automation, women who accessed services through the FPEP did not have an active Medicaid case or use a Common Benefit Identification Card (CBIC). The administration of the FPEP, including claiming, was performed manually by the NYSDOH.

Upstate FPEP recipients transitioned to the automated process effective November 1, 2012. In July 2013, the automated process became available to recipients who reside in New York City. As of July 1, 2013, all women who become eligible for services through the FPEP, will have coverage on the eMedNY system and will use a CBIC to access services from any Medicaid enrolled family planning service provider. Providers will submit claims for those FPEP recipients in the same manner as any other Medicaid claim.

It's important to note that women, who were eligible for FPEP services prior to the automation, will continue to access services using the manual process. Providers will continue to process claims for those individuals using the manual method.

New York State Medicaid Managed Care and Family Health Plus Pharmacy Benefit Information Website Update

The Department of Health (NYSDOH), in partnership with the State University of New York at Stony Brook, will be releasing Phase II of The New York State Medicaid Managed Care and Family Health Plus Pharmacy Benefit Information website on **July 31, 2013**. Phase II will allow patients and providers to perform a formulary drug search across Medicaid Managed Care Plans and see whether a drug has quantity limits, step therapy or prior authorization (PA) requirements. Below is an illustration of where this additional functionality will be presented on the enhanced site.

NEW YORK
state department of
HEALTH

New York State Medicaid Managed Care
and Family Health Plus
Pharmacy Benefit Information Center

This website is designed to provide easy access for members and providers looking for information on the drugs and supplies covered by different Medicaid and Family Health Plus health care plans. While pharmacy benefits and participating pharmacies vary among health plans, all plans maintain their own web sites and customer service call centers.

To use this website, you should first check your health plan identification card and match it to the one presented on this website. By clicking on the appropriate identification card/logo you will be provided with contact numbers and links to your health plan's website including links to prior authorization (PA) forms and drug look-up options. If you do not have your health plan identification card or do not know what health plan you are enrolled in, call the Medicaid Helpline at 1-800-541-2831 from 8am through 8pm, Monday through Friday and from 9am to 1pm on Saturday.

Each managed care plan has its own list of covered drugs (called a formulary). If you would like to find out if a drug is covered, click [here](#) to perform a drug formulary search.

Managed Care Plans

Affinity Health Plan
Dedicated to Excellence

AMIDACARE
LIVE YOUR LIFE

BlueCross BlueShield
of Western New York

CDPHP

EmblemHealth

Excellus

FIDELIS CARE

healthfirst

Health Plus
Amerigroup
RealSolutions

Hudson Health Plan

Independent Health
Dedicated to
Making a Difference

MetroPlus Health Plan

MVP
HEALTH CARE

TOTAL CARE

UnitedHealthcare
Community Plan

univera
Community Health

VISITING NURSE SERVICE
OF NEW YORK

CHOICE
Health Plans

WellCare

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The Medicaid Managed Care and Family Health Plus Pharmacy Benefit Information website is available at: <http://pbic.nysdoh.suny.edu>.

In addition, you can link to the website from the following web pages:

New York State Department of Health Medicaid Managed Care Page at:

http://www.health.ny.gov/health_care/managed_care/.

Click on: Medicaid Managed Care and Family Health Pharmacy Benefit Information Center

The eMedNY home page under 'Featured Links' at: <https://www.emedny.org/index.aspx>.

Click on: New York State Medicaid Managed Care and Family Health Plus Pharmacy Information Center

Redesigning New York's Medicaid Program Page under supplemental information on specific MRT proposals at: http://www.health.ny.gov/health_care/medicaid/redesign/

Click on: MRT 11 & MRT 15, Pharmacy Related Proposals & then click on: Managed Care Plan Pharmacy Benefit Manager and Formulary Information.

Implementation of Claims Editing for Ordering/Prescribing/Referring/Attending OPRA Providers

As stated in previous articles on the topic, Section 6401(a) of the Affordable Care Act (ACA) established new requirements surrounding provider enrollment. 42 CFR, Section 455.410(b) requires providers to be enrolled in state Medicaid programs if they continue to order or refer services reimbursed by the fee-for-service (FFS) Medicaid program. The ordering/referring enrollment requirement does not apply to services paid through a Medicaid managed care plan. However, if the service is carved out of the plan benefit package and is paid fee-for-service, the requirement applies. **Effective for services provided on and after October 1, 2013, claims will be denied if they include the NPI of a non-enrolled ordering, prescribing or referring provider.**

Earlier this year, New York Medicaid implemented a streamlined enrollment process for these non-billing practitioners. We are pleased to report that process has resulted in many newly enrolled providers. However, claims activity shows that more providers need to enroll.

In September 2013, a series of claim edits will be placed on a schedule of one week payment holds to assist servicing providers with identifying non-enrolled ordering, referring and attending providers. Claims failing these edits will be released for processing after the one week payment hold. The remittance advice will indicate the edit failed and the pend status of these claims. Pharmacy claims will not be subject to the one week payment hold.

OPRA Claims Processing Edits with HIPAA Description

- **Edit 02216** - Adjustment Reason Code CO 208 (NPI - NOT MATCHED), Remark Code N286 (MISSING/INC/INV REF. PROVIDER PRIMARY IDENTIFIER)
- **Edit 02218** - Adjustment Reason Code CO 208 (NPI - NOT MATCHED), Remark Code N31 (MISSING/INCOMPLETE/INVALID PRESCRIBING PROVIDER IDENTIFIER)
- **Edit 02219** - Adjustment Reason Code CO 208 (NPI - NOT MATCHED), Remark Code N265 (MISSING/INCOMP/INVALID ORDERING PROV PRIMARY IDENTIFIER)

Servicing providers should continue to use the OPRA Provider Search feature found on www.eMedNY.org. The link to the OPRA Provider Search feature is accessed from the Information tab on the Home Page. Be sure to verify at the time of service that the ordering, prescribing or referring practitioner is actively enrolled in the FFS program.

For more information, please see the Frequently Asked Questions found here: https://www.emedny.org/info/ProviderEnrollment/ProviderMaintForms/Core_OPRA_FAQs.pdf.

NYS Medicaid Ordering, Prescribing, Referring, and Attending (OPRA) Provider Enrollment Impact on Pharmacy Claims

As has been reported in previous Medicaid Updates (April 2011 and June 2012), provisions of the Affordable Care Act (ACA) require prescribers to be enrolled in state Medicaid programs to be eligible to order or refer services reimbursed by the fee-for service (FFS) Medicaid program. This means that any practitioner not currently enrolled in NYS Medicaid must do so to continue to order or refer services for FFS beneficiaries.

Effective October 2013, prescriptions written by prescribers that are not enrolled in NYS FFS Medicaid will deny at the point-of-service. Failure to enroll will impact your patients' ability to obtain their medications.

The Department has identified non-enrolled prescribers with high volumes of prescriptions for FFS beneficiaries. Staff members are proactively reaching out to those prescribers in an effort to facilitate enrollment in an effort to ensure that patient care is not disrupted.

The ordering/referring enrollment requirement does not apply to services paid through a Medicaid managed care plan. However, if the service is carved out of the plan benefit package and is paid fee for service, the requirement applies.

Non-enrolled providers should visit the eMedNY website at:

<https://www.emedny.org/info/ProviderEnrollment/index.aspx>

NOTE: Scroll to the bottom of the page and click on the specific provider type to begin the enrollment process.

OPRA Pharmacy-Related Frequently Asked Questions

1. Why do non-billing physicians and healthcare professionals need to enroll in the NYS Medicaid program?

The Affordable Care Act and subsequent federal regulations (42CFR 455.410) include provisions requiring additional screening of Medicaid providers to improve the integrity of the Medicaid program and to reduce fraud, waste and abuse.

2. What professions must enroll in fee for service Medicaid?

Physicians and other healthcare professionals ordering/referring services provided under the state plan or under a waiver of the state plan must enroll in Medicaid. The order or referral must be within the professional's scope of practice and comply with program rules regarding ordering/referrals.

3. Do the ordering/referring requirements apply to prescriptions and pharmacy claims?

Yes, the prescriber listed on the fee for service drug claim must be enrolled in NYS Medicaid.

4. Do out of state ordering/referring professionals need to be enrolled in NYS Medicaid?

Yes, out of state professionals ordering/referring for services paid by fee for service Medicaid must enroll.

5. What messaging will the Pharmacist receive, via NCPDP transaction, if the prescriber is not enrolled?

Pharmacies will receive a Reject Code of "56"- (Non matched Prescriber ID) in NCPDP field number 51 1-FB.

6. Can a pharmacist override a rejected transaction if the prescriber is not enrolled?

No.

7. What should a pharmacist do once a transaction is rejected?

Pharmacists can either contact the prescriber or return the prescription to the member to contact the prescriber.

8. I have an order or prescription from a healthcare professional. How do I know if he/she is enrolled in NYS Medicaid?

Refer to the search tool available at <https://www.emedny.org/info/opra.aspx>

PHARMACY UPDATE

9. What should a patient do if they are told their prescriber is not enrolled in Medicaid and therefore their prescription is not covered?

Members should contact their prescriber.

10. How does a prescriber enroll as ordering/referring?

Visit the eMedNY website: <https://www.emedny.org/info/ProviderEnrollment/index.aspx> and click on the provider type's Provider Enrollment page for the OPRA form. Be sure to complete all required fields, answer all questions and provide all required documentation. For assistance with enrollment application questions, call CSC at (800) 343-9000.

11. Does this requirement apply to managed care providers?

The ordering/referring enrollment requirement does not apply to services paid through a Medicaid managed care plan. However, if the service is carved out of the plan benefit package and is paid fee for service, the requirement applies.

12. When must the attending professional be enrolled (institutional claims)?

The attending professional must be enrolled if the Referring NPI field is blank on the institutional (837I) claim. This is because the Attending NPI is considered the ordering/referring provider in the absence of a Referring NPI.

13. In a clinic there are nurses and other health professionals that support the physician; do these professionals need to enroll as ordering/referring providers?

In medical clinics, nurses and health professional support staff are not typically ordering or referring services, so they would likely not need to enroll as ordering/referring professionals. Note that if these staff are reported in the Attending NPI field on the clinic claim, the medical practitioner who is responsible for ordering/referring should be reported in the Referring NPI field.

New Requirements for All Billing Providers to Begin on August 22, 2013

IMPORTANT: Billing Providers are urged to read the following notice. Failure to follow the new requirements outlined below will result in claim rejection and jeopardize payments.

As previously announced the NYS Department of Health will soon require all billing providers to sign up for EFT payments and either ERA or PDF remittances.

Existing Enrolled Providers

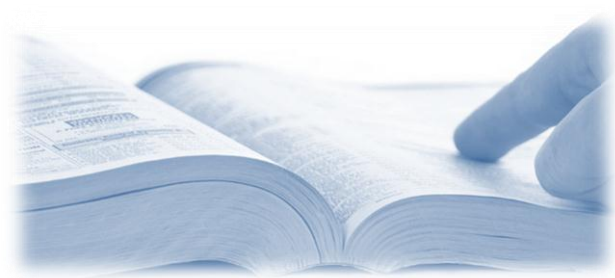
Beginning on August 22, 2013, and for the following 12 months, as your Electronic Transmitter Identification Number (ETIN) approaches its yearly expiration date, providers will be sent notifications instructing them to complete either or both of the application forms (EFT and ERA or PDF). If you are already signed up for both EFT and ERA or PDF remittances, you need only return the signed/notarized certification form. Complete instructions will be included with the certification renewal notification. Note: Failure to return the appropriate form(s) with the required Certification form will cause claims to be rejected.

New Non-enrolled Providers

As of August 22, 2013 providers enrolling in the NY Medicaid Program will be required to submit a Certification Statement and an EFT Application form with their enrollment applications. Failure to submit the required forms will result in rejection of the enrollment application. Once enrolled, providers will be notified of the assigned ETIN and will be given 60 days to submit the ERA/PDF application. The notification will provide complete instructions on where to find and send the form. If the forms are not received within 60 days, the ETIN will expire and claims will be rejected. The required forms will be available on www.emedny.org on the Provider Maintenance page and on each Provider Enrollment page prior to the August 22 implementation date.

Questions may be directed to the eMedNY Call Center at (800) 343-9000.

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, (877) 873-7283, or visit www.omig.ny.gov.

Provider Manuals/Companion Guides, Enrollment Information/Forms/Training Schedules:

Please visit the eMedNY website at: www.emedny.org.

Providers wishing to listen to the current week's check/EFT amounts:

Please call (866) 307-5549 (available Thursday PM for one week for the current week's amount).

Do you have questions about billing and performing MEVS transactions?

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

Provider Training:

To sign up for a provider seminar in your area, please enroll online at: <http://www.emedny.org/training/index.aspx>. For individual training requests, call (800) 343-9000 or e-mail: emednyproviderrelations@csc.com.

Enrollee Eligibility:

Call the Touchtone Telephone Verification System at (800) 997-1111.

Need to change your address? Does your enrollment file need to be updated because you've experienced a change in ownership? Do you want to enroll another NPI? Did you receive a letter advising you to revalidate your enrollment?

Visit www.emedny.org/info/ProviderEnrollment/index.aspx and choose the link appropriate for you (e.g., physician, nursing home, dental group, etc.)

Medicaid Electronic Health Record Incentive Program questions?

Contact the New York Medicaid EHR Call Center at (877) 646-5410 for assistance.

Do you have comments and/or suggestions regarding this publication?

Please contact Kelli Kudlack via e-mail at: medicaidupdate@health.state.ny.us.