



Medicaid Update

The Official Newsletter of the New York State Medicaid Program

July 2015

Volume 31 | Number 8

Clarification on Medicaid Reimbursement of Medicare Part B Services Including Pharmacy Items

This article clarifies that the [June 2015 Medicaid Update](#) article entitled, **Revised Reimbursement Methodology for Practitioners Providing Services to Medicare/Medicaid Dually Eligible Individuals**, applies to Medicare Part B services reimbursed by Medicaid, including Medicare Part B services provided by pharmacies.

Pursuant to the recent changes to Social Services Law, the NYS Department of Health (the Department) is revising the Medicaid reimbursement methodology for practitioner claims for Medicare/Medicaid dually eligible individuals. Medicaid will no longer reimburse partial Medicare Part B coinsurance amounts when the Medicare payment exceeds the Medicaid fee or rate for that service. This article clarifies that this change applies to Part B services, including certain drugs and supplies provided by pharmacies.

This change to the reimbursement methodology is effective for dates of service on and after **July 1, 2015**. The Department is in the process of making the necessary eMedNY system changes to enforce the new payment policy. Implementation **will be applied retroactively** pending system support. Previously paid claims will be adjusted automatically to reflect the new cost sharing limits. Providers will be notified prior to claim adjustments being made.

Refer to the [June 2015 Medicaid Update](#) article for additional information. Please refer to the following link from the Centers for Medicare and Medicaid Services (CMS), which gives examples of some of the most frequently occurring scenarios for determining Part B and Part D coverages: <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/downloads/BvsDCoverageIssues.pdf>

Note: *The change in State statute, and thus the reimbursement methodology reducing Medicaid cost sharing for Medicare Part B services, does not affect ambulance and psychologist services. The statute change also does not affect services provided by Federally Qualified Health Centers (FQHCs), or services provided by Office for People with Developmental Disabilities (OPWDD), Office of Mental Health (OMH), and Office of Alcoholism and Substance Abuse Services (OASAS) certified facilities. These providers will continue to be paid full Medicare Part B coinsurance amounts or up to the Medicaid rate as specified in State statute.*

Andrew M. Cuomo
Governor
State of New York

Howard A. Zucker, M.D., J.D.
Commissioner
New York State
Department of Health

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs

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

In This Issue.....

Clarification on Medicaid Reimbursement of Medicare Part B Services *Including Pharmacy Items*cover

ALL PROVIDERS

NY Medicaid EHR Incentive Program Update	3
Continued Medicaid Enrollment for Certified Asthma and Diabetes Educators, Optical Providers, Managed Care Plans and Groups	5
Certification of Compliance with Section 6032 of the Deficit Reduction Act of 2005, Section 1902 of the Social Security Act, and Title 42 of the United States Code Section 1396a (a)(68) - <i>Reminder</i>	6
Mandatory Compliance Program Certification Requirement under 18 NYCRR §521.3(b) – <i>Reminder</i>	7
ICD-10 is less than 80 days away! Are you ready?	9

PHARMACY UPDATE

NYS Medicaid Fee for Service NCPDP D.0 Billing Changes for 340B Drug Claims.....	10
Billing Instructions for 340B Drug Claims.....	10
Prior Authorization Required for Medicaid Coverage of Medication.....	12

POLICY AND BILLING GUIDANCE

New Billing Instructions for Clinics that Bill Ambulatory Patient Groups for Medicaid-only Services Provided to Dual Eligible Beneficiaries <<<Rate Codes 1126 & 1128 Activated>>>.....	13
Correction to NYS Medicaid Updates Regulations	14
NYS Medicaid Coverage of Genetic Counseling.....	14
Radiation Treatment Delivery Services Billing Guidelines 2015	16
NYS Medicaid Coverage of Postpartum Maternal Depression Screening	17

PROVIDER DIRECTORY	20
---------------------------------	----

All Providers

NY Medicaid EHR Incentive Program Update

The NY Medicaid Electronic Health Record (EHR) Incentive Program provides financial incentives to Eligible Professionals (EPs) and hospitals to promote the transition to EHRs. Providers who practice using EHRs are in the forefront of improving quality, reducing costs and addressing health disparities. Since December 2011 **over \$693 million** in incentive funds have been distributed **within 19,469** payments to NYS Medicaid providers.

19,469

Payments

\$693+

Million Paid

Are you
eligible?

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

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

- August webinar dates on our [Upcoming Event Calendar](#)
- **NEW** [Frequently Asked Questions \(FAQs\)](#) about the Public Health objectives

2015 Attestations

Currently, NY Medicaid is only accepting 2015 attestations for:

- Adopt / Implement / Upgrade (AIU)
- First year of Meaningful Use Stage 1 (MU1), which requires a continuous 90-day EHR reporting period

Providers who attest for 2015 as their first year of Stage 1 must meet the existing requirements for the NY Medicaid EHR Incentive Program. Please review the [Stage 1 attestation worksheet](#) for Eligible Professionals.

Please be advised that the Centers for Medicare & Medicaid Services (CMS) has not yet published a final rule to modify meaningful use for 2015 through 2017. Announcements will be posted on the EHR Incentive Program website and LISTSERV when providers may attest to the modified requirements.

EHR Success Story

EPs affiliated with a not-for-profit non-sectarian agency which helps people cope with and conquer the effects of mental, physical, social and educational challenges have received significant Medicaid EHR Incentive payments. Through caring and compassionate programs, the agency serves more than 20,000 adults, children and families each year through approximately 60 sites across the downstate region of NY. Its wide range of services include: clinical and community-based mental health, counseling and specialty programs, home health care services, youth development programs, and services for people with intellectual and developmental disabilities.

As part of its mission to respond to the evolving needs of its surrounding community, the agency deployed electronic medical record (EMR) systems in all of their clinical sites. Doing so has enabled the EPs to manage care for individuals with multiple diagnoses and disabilities as well as provide opportunities to work with clients in measuring their progress and planning of care.

Having used a practice management system with some EMR components for 13 years, the agency implemented a complete EMR system and in 2014 successfully completed MU1 of the Medicaid EHR Incentive Program. There are two years of Stage 1, with the first requiring providers to demonstrate meaningful use for a continuous 90-day period and the second requiring a full calendar year. The objectives of Stage 1 focus on using certified EHR technology to improve patient care by securely capturing patient data and sharing that data either with the patient or with other healthcare professionals. EPs must meet 18 objectives, which include maintaining an up-to-date problem list of current and active diagnoses, generating electronic prescriptions, and providing clinical summaries to patients within three business days. Additionally, EPs must report on clinical quality measures.

The agency's EPs achieved the Stage 1 milestone by utilizing the services offered by the New York eHealth Collaborative (NYeC), one of the state's Regional Extension Centers that focuses on assisting providers with the adoption and meaningful use of electronic health records. NYeC guided the agency through various phases, including: implementation of the certified EMR, workflow design, criteria selection, and attestations for the incentive.

The EPs continue to flex the capabilities of health information technology, working to engage their clients with access to their electronic health records, to provide coordination of care, and to achieve Meaningful Use Stage 2. The agency is also preparing to participate in the NYS Health Homes and Delivery System Reform Incentive Payment (DSRIP) programs.

More information about the services offered by NYeC is available at: www.nyehealth.org.

Has your EHR system made a positive impact on your practice or facility? Please let us know!

Visit <https://nyehrsuccess.questionpro.com> to share your story with us, which could be featured in the monthly Medicaid Update and EHR Incentive Program website.

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

All Providers

Continued Medicaid Enrollment for Certified Asthma and Diabetes Educators, Optical Providers, Managed Care Plans and Groups

Federal regulation 42 CFR, Part 455.414 requires NYS Medicaid to revalidate your enrollment every five years. Revalidation involves completion of the enrollment form for Educators, Optical Providers, Managed Care Plans and Groups. Please note that the annual recertification of your Electronic Transmitter Identification Number (ETIN) does NOT exempt a provider from revalidation.

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

The Revalidation process for Asthma and Diabetes Educators, Optical Providers, Managed Care Plans and Groups has begun. Revalidation letters have been mailed to providers actively submitting claims to Medicaid. Find out more about Revalidation by clicking on the links below.

Click Here for more Information on Revalidation

Click Here for the Certified Asthma Educator Form and Instructions

Click Here for the Certified Diabetes Educator Form and Instructions

Click Here for the Optical Establishments Form and Instructions

Click Here for the Opticians/Ophthalmic Dispensers Form and Instructions

Click Here for the Optometrist Form and Instructions

Click Here for the Managed Care Plan Form and Instructions

Click Here for the Group Form and Instructions

All Providers

Certification of Compliance with Section 6032 of the Deficit Reduction Act of 2005, Section 1902 of the Social Security Act, and Title 42 of the United States Code Section 1396a (a)(68)

THIS IS A REMINDER FROM THE NYS OFFICE OF THE MEDICAID INSPECTOR GENERAL (OMIG) FOR ALL PROVIDERS WHO ARE SUBJECT TO THE REQUIREMENTS UNDER TITLE 42 OF THE UNITED STATES CODE SECTION 1396a (a)(68), [42 USC §1396a (a)(68)].

On December 1, 2015, OMIG will make available on its website, the Federal Deficit Reduction Act (DRA) of 2005 DRA Certification Form (Certification Form) for 2015.

OMIG will host a webinar in November 2015 to explain the new 2015 certification form. Please check OMIG’s listserv, Facebook page or Twitter feeds for when registration for this session will be available.

42 USC §1396a provides in relevant part that:

(a) A State plan for medical assistance must—

(68) provide that any entity that receives or makes annual payments under the State plan of at least \$5,000,000, as a condition of receiving such payments, shall—

(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1320a-7b(f) of this title);

(B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; ...

OMIG addresses this mandate by monitoring a provider’s certification of compliance status and conducting compliance program reviews of required providers.

The certification form and frequently asked questions (FAQs) will be available on the OMIG website. OMIG’s listserv subscribers will be notified when the new forms are posted.

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

All Providers

Mandatory Compliance Program Certification Requirement under 18 NYCRR §521.3(b)

THIS IS A REMINDER FROM THE NYS OFFICE OF THE MEDICAID INSPECTOR GENERAL (OMIG) FOR ALL REQUIRED PROVIDERS WHO ARE SUBJECT TO THE NYS SOCIAL SERVICES LAW SECTION 363-d MANDATORY COMPLIANCE PROGRAM REQUIREMENT.

On December 1, 2015, OMIG will make available on its website, the NYS Social Services Law Compliance Program Certification Form (Certification Form) for 2015. The Certification Form for 2014 will remain active on OMIG's website until December 1, 2015 for newly enrolling and revalidating Medicaid providers.

OMIG will host a webinar in November 2015 that will explain the new certification form. Please check OMIG's listserv, Facebook page or Twitter feeds for registration information. You can subscribe to OMIG's listserv at www.omig.ny.gov.

The following required providers must have compliance programs. If you are required to have a compliance program, you are also required to certify on OMIG's website at www.omig.ny.gov, that your compliance program meets the requirements of the applicable law and regulations. The certification must occur in December of each year.

OMIG has actively enforced Social Services Law §363-d and Part 521, of Title 18 of the NYS Codes, Rules and Regulations since 2009. The regulation mandates all required providers under the Medicaid program who fall under the following categories to **certify in December of each year** that they have adopted, implemented and maintain an effective compliance program:

- *persons subject to the provisions of articles 28 or 36 of the NYS Public Health Law;*
- *persons subject to the provisions of articles 16 or 31 of the NYS Mental Hygiene Law;*
- *other persons, providers or affiliates who provide care, services or supplies under the Medicaid program, or persons who submit claims for care, services or supplies for or on behalf of another person or provider for which the Medicaid program is or should be reasonably expected by a provider to be a substantial portion of their business operations.*

Under 18 NYCRR § 521.2 (b), "substantial portion" of business operations means any of the following:

- (1) *when a person, provider or affiliate claims or orders, or has claimed or has ordered, or should be reasonably expected to claim or order at least \$500,000 in any consecutive 12-month period from the Medical Assistance Program;*

(2) when a person, provider or affiliate receives or has received, or should be reasonably expected to receive at least \$500,000 in any consecutive 12-month period directly or indirectly from the Medical Assistance Program; or

(3) when a person, provider or affiliate who submits or has submitted claims for care, services, or supplies to the Medical Assistance Program on behalf of another person or persons in the aggregate of at least \$500,000 in any consecutive 12-month period.

Each compliance program must contain the eight elements required under SSL §363-d and 18 NYCRR §521.3(c). **Upon applying for enrollment in the medical assistance program, and during the month of December each year thereafter**, 18 NYCRR §521.3 (b) requires those subject to the mandatory compliance program obligation to certify to the NYS Department of Health and OMIG that a compliance program meeting the requirements of the regulation is in place.

Please note that the DOH is revalidating Medicaid providers' enrollment in the medical assistance program. As part of the DOH's revalidation process, required providers will be asked to submit evidence that they met the December certification obligation. Certifying in December and retaining a copy of the Certification Confirmation and/or confirmation emails will help Medicaid required providers complete the revalidation process.

The regulation and Frequently Asked Questions (FAQs) are available on the OMIG Web site. OMIG's listserv subscribers will be notified when the new forms are posted.

It is the responsibility of required providers to determine if:

- a. it has a compliance plan that meets the requirements of SSL §363-d and 18 NYCRR §521.3 (c); and
- b. its compliance program is effective.

Required providers must assess their compliance programs to determine whether the required provider can certify that its compliance program is effective or is not effective.

Additionally, OMIG recommends a regular visit to its website to review the information and resources that are published under the Compliance tab on OMIG's home page. The Compliance Library under the Compliance tab provides copies of current forms, publications and other resources that could prove helpful in conducting a self-assessment and completing the certification form in December.

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

All Providers

ICD-10 is less than 80 days away! Are you ready?

Starting October 1, 2015, NYS Medicaid will begin accepting and processing claims using ICD-10 diagnosis and procedure codes.

What does ICD-10 mean for everyone?

- Claims for dates of service on and after October 1, 2015 require ICD-10 codes
- ICD-10 is an expanded code set and eMedNY will not publish an ICD-9 to ICD-10 crosswalk: Use the many resources available through <https://www.emedny.org/icd> to explore your options and train your office staff.
- All provider types who bill Medicaid are impacted: See the [FAQs](#) to see how your NY Medicaid claims will need to be submitted.
- ICD-9 and ICD-10 coding are not allowed within the same claim.
- Possible interruption in payment: Submitting claims with ICD-9 codes for dates of services on and after October 1 will be rejected by pre-adjudication edits.

In the meantime...

- Electronic Claims Submitters: After researching your applicable ICD-10 codes, don't hesitate to test using eMedNY's Provider Test Environment with the detailed instructions on emedny.org.
- Paper and ePACES Claims Submitters: eMedNY does not provide a method to test claims submitted with these methods. ePACES features an ICD Version radio button which you will be required to select after October 1. This field currently defaults to ICD-9 as shown in our [ePACES Claim Quick Reference Guides](#).
- Submitters using Vendors, Clearing Houses and Service Bureaus: Be sure to communicate with your vendors to understand what steps you will need to complete to be ready on October 1 and coordinate testing in eMedNY's Provider Test Environment

If you have further questions after reviewing emedny.org/icd, call the eMedNY Call Center at 1-800-343-9000.

Pharmacy Update

ATTENTION: 340B COVERED ENTITIES AND THEIR CONTRACT PHARMACIES

NYS Medicaid Fee-for-Service NCPDP D.0 Billing Changes for 340B Drug Claims

Effective July 23, 2015, NYS Medicaid Fee-for-Service (FFS) 340B claims submitted via the National Council for Prescription Drug Programs (NCPDP) D.0 format must include the following:

- Value of '20' in field **420-DK**, Submission Clarification Code; **AND**
- Value of '08' in field **423-DN**, Basis of Cost Determination.

In addition, FFS 340B claims MUST be submitted at acquisition cost.

The above guidance supersedes all previous billing guidance for NYS Medicaid FFS 340B claims submitted via the NCPDP D.0 format.

Billing questions regarding the FFS program should be directed to the eMedNY Call Center at (800) 343-9000.

ATTENTION: 340B COVERED ENTITIES AND THEIR CONTRACT PHARMACIES

Billing Instructions for 340B Drug Claims

Upon enrollment in the 340B program, covered entities must determine whether they will use 340B drugs for their Medicaid patients. In NYS, if an entity determines to use 340B drugs for their Medicaid patients, they must use them for ALL of their Medicaid patients, both Fee-for-Service (FFS) and Managed Care Organization (MCO).

Federal law (42 USC 256b(a)(5)(A)(i)) prohibits duplicate discounts – manufacturers are not required to provide a discounted 340B price and a Medicaid drug rebate for the same drug. To prevent duplicate discounts from taking place, the covered entity is required to follow the Health Resources and Services Administration's (HRSA) rules, and provide HRSA with their Medicaid provider number/NPI at the time of enrollment. HRSA then lists the covered entity and their Medicaid number/NPI on the Medicaid Exclusion File, which lets states and manufacturers know that drugs purchased under that Medicaid billing number(s) are not eligible for a Medicaid rebate. Additional

information on HRSA's Medicaid Exclusion File can be found at the following site:

<http://www.hrsa.gov/opa/programrequirements/medicaidexclusion/index.html>

The NYS Medicaid program uses HRSA's Medicaid Exclusion File to identify all 340B claims (both FFS and MCO) to be removed from the rebate stream, thereby avoiding duplicate discounts.

However, additional identifiers are required at the claim submission level for ALL 340B drug claims.

340B claim level identifiers are as follows:

- 340B claims for FFS and MCOs submitted in 837I or 837P format must include a **UD modifier**. For FFS, all 340B claims MUST be submitted at acquisition cost (by invoice when submitted via 837I or 837P format), inclusive of all discounts.
- 340B claims for FFS and MCOs submitted via the NCPDP format must include a value of '20' in field **420-DK**, Submission Clarification Code. **FFS** 340B claims submitted via the NCPDP format must also include a value of '08' in field **423-DN**, Basis of Cost Determination.

340B entities wishing to change their status on HRSA's Medicaid Exclusion File should go to HRSA's Office of Pharmacy Affairs 340B database page (<http://opanet.hrsa.gov/opa/>) and **Submit a Change/Termination Request** (link found under 'Covered Entities' on the webpage). Changes to how a covered entity uses 340B drugs for its Medicaid patients are effective with HRSA on a quarterly basis only.

FAQs on the 340B program itself, as well as information on how to ask additional questions, can be found on the HRSA website at <http://www.hrsa.gov/opa/faqs/index.html>

Medicaid 340B policy questions can be sent to PPNO@health.ny.gov

Billing questions regarding the FFS program should be directed to the eMedNY Call Center at (800) 343-9000. Billing questions regarding Managed Care plans should be directed to the plans.

Note: For NCPDP claims, this article supersedes all billing guidance published in previous issues of the Medicaid Update

Pharmacy Update

Prior Authorization Required for Medicaid Coverage of Medication

Attention Pharmacists and Prescribers:

NYS Medicaid cannot pay for prescription medications requiring Prior Authorization when dispensed before initiation of a Prior Authorization. Pharmacists must advise their Medicaid beneficiaries of this information and either assist by contacting the prescriber or recommending that the beneficiary contact the prescriber to initiate the prior approval process.

No payment will be made when the request for Prior Authorization is submitted after the prescription is dispensed. An emergency three-day Prior Authorization can be obtained by the pharmacist if the prescriber is not available. An emergency is defined as care for patients with severe, life threatening, or potentially disabling conditions that require immediate intervention. The Pharmacy Emergency Supply Worksheet can be found at https://newyork.fhsc.com/providers/PA_forms.asp. Once this process is completed and approved, the enrollee will need to obtain a new prescription from the prescriber, and obtain a new Prior Authorization, in order to acquire additional medication.

Medicaid enrollees who pay out of pocket for medications before their prescriber obtains prior authorization are considered “Private Pay” and pharmacists dispensing medications under these circumstances are urged to obtain the patient’s signed consent to be treated as a private payer prior to dispensing medication. Private pay expenses will not be reimbursed to the enrollee by Medicaid and the Medicaid program cannot be billed for services rendered under these circumstances.

Additional information on private payment arrangements can be found in the Provider General Policy manual at:

https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers-General_Policy.pdf

If you have additional questions, please contact the policy unit at (518) 486-3209 or by email at PPNO@health.ny.gov.

Policy and Billing Guidance

New Billing Instructions for Clinics that Bill Ambulatory Patient Groups (APGs) for Medicaid-only Services Provided to Dual Eligible Beneficiaries <<<Rate Codes 1126 & 1128 Activated>>>

Effective July 1, 2014, Medicaid established new Article 28 rate codes to enable free-standing and hospital based clinics licensed by the Department of Health that bill APGs for dual eligible beneficiaries to submit a separate claim for Medicaid covered services that are not covered by Medicare.

- 1126- MA CVRD NON-MEDICARE CVRD SERVICES FOR DUALS- OPD
- 1128- MA CVRD NON-MEDICARE CVRD SERVICES FOR DUALS- DTC

Providers that bill for dual eligible beneficiaries who receive Medicare and non-Medicare covered services within the same encounter or Date of Service will submit two claims:

- A Medicaid crossover APG claim (e.g., rate code 1400, 1432, or 1407) for services that are covered by both Medicare and Medicaid, AND
- A Medicaid-only APG claim (i.e., rate code 1126 or 1128) for non-Medicare covered services (e.g., dental procedures, after hours, or vision care).

<<< Note: Rate codes 1126 and 1128 do not pay a capital add-on.>>>

The Medicaid billing system will pay the first claim the Medicare coinsurance amount subject to the Medicaid cost-sharing limit and the second claim the APG fee for service amount based on procedure(s) billed, service intensity weight and provider base rate. Note, clinics or populations eligible to receive Enhanced Medicare Cost Sharing should not submit a separate claim to Medicaid for “Medicaid-only” services (See linked August 2009, Volume 25, #10 Medicaid Update).

http://www.health.ny.gov/health_care/medicaid/program/update/2009/2009-08.htm#enh

General policy questions should be directed to the Division of Program Development and Management at (518) 473-2160.

Article 28 rate code questions should be directed to the Division of Finance and Rate Setting: Hospitals – hospffsunit@health.ny.gov or Freestanding Providers – dtcffsunit@health.ny.gov

Policy and Billing Guidance

<<<Correction>>>

This is a correction to the June 2015 Medicaid Update article, titled “New York State Medicaid Updates Regulations.” **The June 2015 article references prior authorization for a number of procedures. Fee-for-service Medicaid requires prior approval for these procedures.** Information about the prior approval process, including instructions for providers, is available in the Physician Prior Approval Guidelines manual, available on eMedNY at:

https://www.emedny.org/ProviderManuals/Physician/PDFS/Physician_PA_Guidelines.pdf

NYS Medicaid Coverage of Genetic Counseling

This is a reminder that NYS Medicaid covers genetic counseling when provided by a certified or credentialed genetic counselor. Genetic counseling services may be provided in a practitioner’s office or in an Article 28 hospital outpatient department, or free-standing diagnostic and treatment center.

In order for the service to be reimbursed, NYS Medicaid requires that the genetic counselor be:

- Certified by the American Board of Genetic Counseling; or
- Certified by the American Board of Medical Genetics; or
- An Advanced Practice Nurse in Genetics who is credentialed by the Genetic Nursing Credentialing Commission.

NYS Medicaid also covers genetic counseling when provided by a physician.

NYS Medicaid does not enroll genetic counselors. Reimbursement is made to the physician, nurse practitioner, licensed midwife or Article 28 clinic that employs or contracts with the genetic counselor.

Genetic counseling is generally performed in conjunction with the following services:

- Predictive testing of asymptomatic individuals to identify future disease risks, given increased risk as determined by an assessment of family history and risk factor profiles;
- Diagnostic testing of individuals with symptoms to confirm a specific diagnosis or to rule out a suspected diagnosis;

- Testing to determine genetic risks for offspring (prenatal diagnosis), family planning, and carrier testing;
- Pharmacogenetic testing;
- Newborn screening follow-up and confirmatory testing as a result of a positive newborn screening test.

Billing:

- A written order is required.
- NYS Medicaid will pay for up to 2 hours of pre-genetic test counseling and up to 2 hours of post-genetic test counseling.
- Payment is based on units of service with one unit equaling 30 minutes of counseling. The maximum allowable session length is two hours (4 units).
- Genetic counselors should bill using CPT code 96040.
- When genetic counseling is provided by a physician, the appropriate evaluation and management (E&M) code should be billed.

Please note that a preimplantation genetic diagnosis associated with in vitro fertilization services is not covered by NYS Medicaid.

Genetic Counseling via Telemedicine:

- To increase patient access to genetic counseling services in areas of the State without qualified genetic counselors, NYS will reimburse for genetic counseling provided via telemedicine.
- Information on billing Medicaid for services provided via telemedicine can be found in the March 2015 Medicaid Update at the following link:
http://www.health.ny.gov/health_care/medicaid/program/update/2015/2015-03.htm

Questions regarding Medicaid Managed Care (MMC) reimbursement and/or documentation requirements should be directed to the enrollee's MMC plan. Medicaid Fee-for-Service policy questions may be directed to the Office of Health Insurance Programs' Division of Program Development and Management at (518) 473-2160.

Policy and Billing Guidance

Radiation Treatment Delivery Services Billing Guidelines 2015

Effective January 1, 2015, the following radiation treatment delivery coding guidance should be followed when billing for Medicaid Fee-for-Service (FFS) enrollees and dual beneficiaries who are enrolled in both Medicare and Medicaid.

BACKGROUND:

In August 2014, the American Medical Association (AMA) released the **2015 Current Procedural Technology (CPT) code sets**, which included relevant changes to the radiation treatment delivery codes (effective January 1, 2015).

The Centers for Medicare and Medicaid Services (CMS) published the Medicare fee schedules earlier this year for the new codes as part of the 2015 Medicare Physician Fee Schedule. Medicare's Physician Fee Schedule does not include the newly published 2015 AMA radiation treatment delivery codes (70000 series codes). New, temporary G codes were created by CMS to replace the 2014 radiation therapy codes and are included in Medicare's 2015 Fee Schedule.

BILLING GUIDANCE:

Medicaid FFS Enrollees (Medicaid only):

- Radiation treatment delivery services, when provided to Medicaid FFS enrollees, should be billed using the appropriate 70000 series codes. Providers should **not** bill using the G codes. Please refer to the Physician fee schedule and Physician Manual found at the following links: <https://www.emedny.org/ProviderManuals/Radiology/index.aspx> and <https://www.emedny.org/ProviderManuals/Physician/PDFS/Physician%20Procedure%20Codes%20Section4.pdf>.

FEE SCHEDULES FOR RADIOLOGY:

Medicare AND Medicaid Enrollees (Dually Eligible):

- Effective January 1, 2015, CMS released new temporary G codes for radiation oncology services. When billing for radiation treatment delivery services for Medicare/Medicaid dually eligible enrollees, providers are to follow the Medicare billing guidelines. This will allow the claims will automatically crossover to Medicaid and process appropriately.

- Crossover physician claims for radiation treatment delivery services that were previously denied, because Medicaid had not activated the G series codes, should be resubmitted with delay reason code 9. For assistance resubmitting claims that paid incorrectly (e.g. claims that paid zero), please contact the appropriate number listed below.

Questions?

- *Policy questions regarding Medicaid FFS may be directed to OHIP Division of Program Development and Management at (518) 473-2160.*
- *Questions regarding Medicaid Managed Care billing and reimbursement should be directed to the enrollee’s Medicaid Managed Care Plan.*
- *Questions on billing or claims should be directed to Computer Sciences Corporation at 1-800-343-9000.*

NYS Medicaid Coverage of Postpartum Maternal Depression Screening

Effective August 1, 2015 for Medicaid Fee-For-Service (FFS) and October 1, 2015 for Medicaid Managed Care Plans, the NYS Medicaid program will provide reimbursement, in addition to the payment for an Evaluation and Management (E&M) service, for postpartum maternal depression screening with referral for diagnosis and treatment, as appropriate. The current standard of care for pregnant women requires that all pregnant women receive depression screening as part of their routine antepartum care. Maternal depression screening that occurs antepartum is considered to be included in the payment for the E&M service.

Postpartum maternal depression screening using a validated screening tool may be reimbursed up to three times within the first year of the infant's life. Screening can be provided by the mother's health care provider and/or by the infant's health care provider following the birth of the baby. A maternal health care provider is defined as a: Physician, Midwife, Nurse Practitioner, or other health care practitioner acting within his or her lawful scope of practice. The infant's health care provider is defined as a: Physician, Nurse Practitioner, Physician Assistant, or other health care practitioner acting within his or her lawful scope of practice.

The infant's primary health care provider, by virtue of having a longitudinal relationship with families, has a unique opportunity to identify postpartum maternal depression as well, and help prevent untoward developmental and mental health outcomes for the infant and family. Screening can be integrated into the well-child care schedule.

Billing Guidance

Billing Guidance for Medicaid FFS:

NYS Medicaid will provide additional reimbursement for maternal depression screening in the postpartum period when provided by the maternal and/or infant's health care provider. Medicaid reimbursement is available for maternal depression screening up to three times within the first year of the infant's life.

If maternal depression screening is provided by the maternal health care provider, the service can be reimbursed in addition to the E&M visit. Providers should bill the service using CPT code 99420 (The Administration and Interpretation of Health Risk Assessment Instrument - Health Hazard Appraisal).

If maternal depression screening is performed on the same day as the infant's primary care visit by the infant's health care provider, the practitioner should submit two separate claims to be reimbursed for two distinct services. The infant's services are billed using the infant's Medicaid identification number, while the mother's screening services are billed by submitting her Medicaid identification number on a separate claim. Medicaid pays for maternal depression screening using the CPT code 99420 (The Administration and Interpretation of Health Risk Assessment Instrument - Health Hazard Appraisal).

If the mother screens positive for depression, then she must be further evaluated for diagnosis and treatment. Medical practices that do not have the capacity to evaluate and treat mothers who screen positive for depression must have a referral process in place for these beneficiaries. Women with current depression or a history of major depression warrant particularly close monitoring and evaluation.

Billing Guidance for Medicaid Managed Care:

If the infant's primary care provider is within the mother's Medicaid Managed Care Plan (MMCP) network, the MMCP will reimburse for maternal depression screening at the infant's primary care visit as a risk assessment for the mother. When a mother receives maternal depression screening services on the same day as the infant's primary care visit, the provider should submit two separate claims. The infant's services are billed to the health plan providing coverage for the infant, while the mother's screening services are billed separately to the mother's MMCP. However, if the infant is in a different MMCP than the mother, and the infant's provider is not in the mother's MMCP network, the screening would not be covered unless the mother's MMCP agreed to an out of network arrangement with the infant's provider. Maternal depression screening performed by the mother's primary care provider or obstetrician is also a plan-covered service. Providers will be reimbursed for maternal depression screening as a separate and distinct payment and in addition to the Evaluation and Management payment. Providers should follow the billing procedures and requirements of the mother's managed care plan, including for the use of CPT code 99420 (The Administration and Interpretation of Health Risk Assessment Instrument - Health Hazard Appraisal) for maternal depression screening. Reimbursement is available for maternal depression screening up to three times within the first year of the infant's life.

Screening and Referral Tools

There are multiple, validated depression screening tools available for use. These tools usually can be completed in less than 10 minutes. Some examples of recommended screening tools include the Edinburgh Postnatal Depression Scale and the Patient Health Questionnaire-9.

- Edinburgh Postnatal Depression Scale (EPDS) link:
http://www2.aap.org/sections/scan/practicingsafety/toolkit_resources/module2/epds.pdf
- Patient Health Questionnaire-9 (PHQ-9) link:
http://www.phqscreeners.com/pdfs/02_PHQ-9/English.pdf

Please visit the following link for additional information on validated screening tools for maternal depression:
http://www.health.ny.gov/community/pregnancy/health_care/perinatal/maternal_depression/providers/screening.htm

Please refer to the following links for helpful referral information:

- https://www.health.ny.gov/community/pregnancy/health_care/perinatal/maternal_depression/providers/additional_resources.htm
- Directory of Office of Mental Health Facilities:
http://www.omh.ny.gov/omhweb/aboutomh/omh_facility.html
- Postpartum Resource Center of New York/Emergency Resources:
http://www.postpartumny.org/resource_directory.htm

Questions regarding Medicaid Managed Care (MMC) reimbursement and/or documentation requirements should be directed to the enrollee's MMC plan. Medicaid FFS policy questions may be directed to the Office of Health Insurance Programs' Division of Program Development and Management at (518) 473-2160.

Provider Directory

Office of the Medicaid Inspector General:

For suspected fraud complaints/allegations, call 1-877-87FRAUD, (877) 873-7283, or visit www.omig.ny.gov.

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

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

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

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

Do you have questions about billing and performing MEVS transactions?

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

Provider Training:

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

Enrollee Eligibility:

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

Medicaid Prescriber Education Program:

For current information on best practices in pharmacotherapy, please visit the following websites: http://www.health.ny.gov/health_care/medicaid/program/prescriber_education/presc-educationprog
<http://nypep.nysdoh.suny.edu/home>

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

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

Medicaid Electronic Health Record Incentive Program questions?

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

Comments and Suggestions Regarding This Publication?

Please contact the editor, Amy Siegfried, at medicaidupdate@health.ny.gov