



Department
of Health

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Governor Cuomo Signs Executive Order to Combat Widespread Flu Epidemic In New York

On January 25, 2018, Governor Andrew M. Cuomo signed an [executive order](#) to allow pharmacists to administer flu vaccines to children ages 2 to 18 - increasing access and convenience for New Yorkers seeking the flu vaccination as the number of reported cases across the state continues to rise. Over the previous week, 7,779 laboratory confirmed influenza cases were reported to the state and 1,759 New Yorkers were hospitalized with confirmed influenza, the highest weekly numbers in both categories since reporting began in 2004.

The Executive Order suspends the section of state education law that limits the authority of pharmacists to administer immunizing agents to anyone under age 18 to allow vaccines to be administered to anyone age 2 and up. Parents and guardians are encouraged to call pharmacies ahead of their visit, to ensure they are ready to receive patients in this age group. Parents and guardians with children between the ages of 6 months and 24 months are still encouraged to see their primary care provider for the vaccination.

According to the Center for Disease Control and Prevention (CDC), vaccination should continue throughout flu season, as long as influenza viruses are circulating. The CDC also recommends that people who are very sick or people who are at a high risk of serious influenza complications be treated early with flu antiviral drugs. Antiviral drugs work best when started within two days of symptoms first appearing. There are no current shortages of vaccines or antiviral drugs, and manufacturers report they expect to meet projected seasonal demands.

For more information about the flu, visit: www.health.ny.gov/diseases/communicable/influenza/seasonal.

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Policy & Billing Guidance

Change in Medicaid Fee for Service Billing for Flu Vaccine Administration for Children Between the Ages Of 2 Years And 18 Years

On January 25, 2018, Governor Andrew M. Cuomo declared a Public Health Emergency for all of New York State in response to this year's increasingly severe flu season. The Governor issued an Executive Order which allows NYS certified pharmacists to administer flu vaccinations to patients between 2 years and 18 years of age. This Order suspends, during the period that the disaster emergency remains in effect, the section of State Education Law that limits the authority of NYS certified pharmacists to administer immunizing agents only to individuals 18 years of age or older.

Based on the above, administration of flu vaccines to Medicaid enrolled children between the ages of 2 years and 18 years by qualified pharmacists employed by, or under contract with, Medicaid enrolled pharmacies is reimbursable under NYS Medicaid for the duration of the Executive Order. Specialized instructions have been issued to Medicaid Managed Care plans to assure access to the flu vaccine by removing any prior authorization. Further, plans have been instructed to approve and pay for brand-name medication when the generic is not available.

NYS certified pharmacists may secure flu vaccine to administer to Medicaid enrolled and uninsured children through the Vaccine for Children Program (VFC). Pharmacies not already enrolled in VFC are strongly encouraged to enroll to enable access to flu vaccine for both Medicaid and uninsured children. For VFC enrollment information, go to: https://www.health.ny.gov/prevention/immunization/vaccines_for_children/. The flu vaccine is provided free of charge by Centers for Disease Control and Prevention (CDC) to the VFC and in turn to enrolled pharmacies. Pharmacies may bill for the administration. Pharmacies enrolled in the VFC program **must** use procedure code 90460 for administration of a VFC vaccine, and reimbursement for such is \$17.85. The cost of the flu vaccine should **not** be billed to Medicaid when it is obtained through the VFC program.

During the period the Executive Order remains in effect, pharmacies not enrolled in the VFC program may bill the acquisition cost of the vaccine and its administration. The procedure code for **administration of a non-VFC vaccine is 90471** and reimbursement for such is \$13.23. Procedure codes for flu vaccines obtained outside the VFC program can be found on eMedNY at: <https://www.emedny.org/ProviderManuals/Pharmacy/index.aspx> (click on "OTC and Supply Fee Schedule").

Services must be provided and documented in accordance to NYS Department of Education laws and regulations. Visit <http://www.op.nysed.gov/prof/pharm/pharmimmunizations.htm> for links to additional information, including the reporting of all immunizations administered to persons less than 19 years of age to the New York State Department of Health using the New York State Immunization Information System (NYSIIS).

Please note that **NDCs are not to be used** for billing the vaccine product. Reimbursement for the product will be made at no more than the **actual** acquisition cost to the pharmacy. No dispensing fee or enrollee co-payment applies. Pharmacies will bill with a quantity of "1" and a day supply of "1".

Billing Instructions

Providers must submit via NCPDP D.0, in the Claim Segment field 436-E1 (Product/Service ID Qualifier), a value of "09" (HCPCS), which qualifies the code submitted in field 407-D7 (Product/Service ID) as a Procedure code. In field 407-D7 (Product/Service ID), enter the Procedure code.

Patient Centered Medical Home Statewide Incentive Payment Program: Revised Incentive Payments and Updated Billing Guidance

Effective May 1, 2018, in accordance with the 2018-2019 proposed State budget, New York State (NYS) Medicaid is proposing to change the reimbursement amounts for providers working at practices that are recognized as a Patient Centered Medical Home (PCMH) by the National Committee for Quality Assurance (NCQA). The following is early notice of changes necessary if the proposed budget is adopted as proposed. The revised policy applies to both Medicaid Managed Care (MMC) and Medicaid Fee-For-Service (FFS). Since its inception, this program has significantly grown, and NYS Medicaid continues to make every effort to reward primary care providers (PCPs) who achieve PCMH recognition and provide high quality of care to New York Medicaid members.

This revised policy is in response to the fiscal constraints of the current Medicaid Global Spending Cap on the PCMH incentive payments and State efforts to increase participation in the PCMH program.

The table below summarizes, by provider type and recognition status, the MMC per member per month (PMPM) amounts and the FFS 'add-on' amounts for visits with qualified evaluation and management codes for the period **May 1, 2018 - June 30, 2018**. Practices recognized under the NCQA 2014 Level 3 or NCQA 2017 standards will receive a temporarily reduced MMC incentive payment of \$2.00 PMPM for two (2) months. The PCMH FFS incentive add-on amounts will remain unchanged, and will be \$29.00 and \$25.25 for professional and institutional claims, respectively. All incentive payments for PCMH-recognized providers under NCQA's 2014 Level 2 standards will be permanently eliminated for both MMC and FFS.

PCMH Statewide Incentive Payment Program MMC-PMPM and FFS 'Add-on' Amounts <i>Effective May 1, 2018 – June 30, 2018</i>			
	2014 Standards NCQA Level 2	2014 Standards NCQA Level 3*	2017 NCQA/NYS PCMH Standards*
MMC-PMPM	\$0.00	\$2.00	\$2.00
Professional FFS claim add-on	\$0.00	\$29.00	\$29.00
Institutional FFS claim add-on	\$0.00	\$25.25	\$25.25

*NYS Medicaid is planning to add APC providers, who are Gates 2 and 3 certified, into the PCMH incentive program once federal approval is obtained. They will be paid at the 2014 PCMH Level 3 rates.

Beginning July 1, 2018, the PCMH incentive payments will be modified (increased from the temporary two-month reduction) to align with the principles of Value Based Payments (VBP). NYS Medicaid will engage key stakeholders to focus on making sustainable fiscal recommendations that are in line with the Medicaid global spending cap for the PCMH program, and to explore options to tie the incentive to VBP participation, and quality. The Department anticipates that later this year, the incentive will be tied to whether providers have a VBP contract (Level 1 or higher). Projected rates for the MMC PMPM range from \$5.00-\$6.00 for providers with a VBP contract, and around \$2 for those without. Additional guidance and educational materials will be published in the coming months outlining the new PCMH incentive payment amounts effective July 1, 2018.

Please refer to the [April 2017](#) issue of the *Medicaid Update* for additional information on FFS policy and billing guidance relative to the NYS PCMH program. Please refer to the [June 2016](#) issue of the *Medicaid Update* for additional information on FFS plan types that are eligible for PCMH/APC incentive payments.

Questions/Information

- Questions regarding MMC PCMH payments should be directed to the Division of Health Plan Contracting and Oversight at 518-474-5050 or bmcfhelp@health.ny.gov.
- Medicaid FFS questions may be directed to the eMedNY Call Center at 800-343-9000. Inquires on FFS claim eligibility can also be directed to the eMedNY Call Center.
- Policy questions or any additional questions related to the New York State Medicaid PCMH Incentive Payment Program may be directed to the Office of Health Insurance Programs at 518-473-2160 or to pcmh@health.ny.gov.

New York State Medicaid Will Begin Covering Axicabtagene Ciloleucel (YESCARTA™)

New York State (NYS) Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC) will begin covering axicabtagene ciloleucel (brand name YESCARTA™) for members who have a diagnosis of B-cell lymphoma, when the member meets the criteria outlined in this policy. This coverage policy is effective February 1, 2018 for FFS and April 1, 2018 for MMC.

Axicabtagene ciloleucel is a CD19-directed genetically modified autologous T cell immunotherapy indicated for the treatment of adult patients with relapsed or refractory large B-cell lymphoma after two or more types of systemic therapy. This includes types of diffuse large B-cell lymphoma (DLBCL) not otherwise specified, primary mediastinal large B-cell lymphoma, high grade B-cell lymphoma, and DLBCL arising from follicular lymphoma. Axicabtagene ciloleucel was approved by the U.S. Food and Drug Administration (FDA) for use on October 18, 2017.

NYS Medicaid Coverage Policy

In accordance with FDA indications, Medicaid reimburses for axicabtagene ciloleucel when the following criteria are met:

- The patient must be an adult (18 years, 0 months and above);
- The patient must have a confirmed diagnosis of large B-cell lymphoma, including DLBCL not otherwise specified, primary mediastinal large B-cell lymphoma, high grade B-cell lymphoma, and DLBCL arising from follicular lymphoma; and
- The large B-cell lymphoma must be relapsed or refractory after two or more types of systemic therapy.

Note: Axicabtagene ciloleucel is not indicated for the treatment of patients with primary central nervous system lymphoma.

Hospitals administering axicabtagene ciloleucel must be appropriately authorized to do so. You can view the list of currently authorized treatment centers here: <https://www.yescarta.com/authorized-treatment-centers/>.

Medicaid Managed Care (MMC) Billing

Providers participating in MMC should check with the individual health plans to determine how each MMC plan will apply this policy.

Fee-For-Service (FFS) Billing

- Hospitals which are appropriately certified to administer axicabtagene ciloleucel will be reimbursed for using the ordered ambulatory fee schedule. Payment for axicabtagene ciloleucel will be made in addition to the inpatient All Patients Refined Diagnosis Related Groups (APR-DRG) payment or, if administered on an outpatient basis, in addition to the outpatient Ambulatory Patient Groups (APG) payment.
- Hospitals are to submit a separate ordered ambulatory claim for axicabtagene ciloleucel. The ordered ambulatory claim should be submitted on paper (using the eMedNY 150003 claim form) and should include the hospital's actual acquisition cost by invoice. Documentation of medical necessity that includes the criteria listed above must accompany the claim. Ordered ambulatory billing guidelines can be found at: https://www.emedny.org/ProviderManuals/OrderedAmbulatory/PDFS/OrderedAmbulatory_Billing_Guidelines.pdf.
- Providers are reminded that any off-invoice discounts or rebates received from the manufacturer must be passed back to Medicaid. Additionally, consistent with any performance guarantee conveyed by the manufacturer of YESCARTA™ (e.g. providers will only pay if the patient goes into remission), Medicaid should not be billed if no payment has been made by the provider to the manufacturer.
- Healthcare Common Procedure Coding System (HCPCS) code J3590 (*unlisted biologic*) should be used to bill for axicabtagene ciloleucel until an official HCPCS code is assigned. The associated National Drug Code (NDC) must be included on the claim.
- Storage and handling charges are included in the APR-DRG inpatient payment and the APG outpatient payment and will not be reimbursed separately.

Questions

- Questions regarding Medicaid FFS billing, should be directed to eMedNY Provider Services at (800) 343-9000.
- Policy questions regarding Medicaid FFS may be directed to the Office of Health Insurance Programs, Division of Program Development and Management at (518) 473-2160.
- Questions regarding MMC reimbursement and/or documentation requirements should be directed to the enrollee’s MMC plan.

Reminder: Payment Policy for Global Surgery Periods

This is a reminder to providers of fee-for-service (FFS) Medicaid payment rules for global surgery periods, also known as follow-up days or post-operative periods. New York State Medicaid follows Medicare rules on billing and payment during global surgery periods. Medicare’s March 2015 guidance on global surgery periods is available on the Centers for Medicare and Medicaid Services website here: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GlobalSurgery-ICN907166.pdf>.

Global surgery includes all necessary services normally furnished by a surgeon before, during, and after a procedure. New York State Medicaid payment for the surgical procedure includes the pre-operative, intra-operative, and post-operative services normally performed by the practitioner. Global surgery days, or follow-up days, are identified on each practitioner's fee schedule. For procedures with 10- and 90-day follow-up periods, all routine services related to the surgery are included in payment for the procedure. There may be instances when evaluation and management services, unrelated to the original procedure, may occur during the post-operative period. **In these instances, providers may select the appropriate modifier to include on the claim; however, this should not be routine practice.**

Minor procedures and endoscopies may not have a follow-up period (indicated by a "0" in the follow-up days column on the practitioner fee schedule). When the evaluation and management service that leads to the decision to provide the minor procedure occurs on the same day as the procedure, providers should bill Medicaid **only** for the procedure. There may be instances when the patient's condition requires a significant, separately identifiable evaluation and management service, above and beyond the usual care. **In these instances, providers may select the appropriate modifier to include on the claim; however, this should not be routine practice.**

For questions related to Medicaid FFS policy, please contact the Office of Health Insurance Programs, Division of Operations and Systems at (518) 474–8161. Billing questions for individuals enrolled in Medicaid managed care plans should be directed to the individual enrollee’s Medicaid managed care plan.

Pharmacy Update

Medicaid FFS Pharmacy Change in Early Fill Edit for Controlled Substances

Effective February 22, 2018, per the 2017-18 enacted budget, the pharmacy early fill edit will be adjusted for controlled substances and will decrease early fill parameters based on days' supply on hand in an effort to further reduce overutilization, stockpiling and/or diversion of drugs.

This more stringent edit will deny a claim for a controlled substance, if more than a 7-day supply of the medication is remaining of the cumulative amount that has been dispensed over the previous 90 days. This supersedes previous guidance in the [March 2015 Medicaid Update](#), for early fills of controlled substances only.

Section 365-a (2)(g-1) of Social Services law was amended to create this new 7-day supply limit for controlled substances. In addition, this further aligns with Section 3339 of New York State Public Health Law relating to early refill limits on controlled substances

Members will still have the ability to refill their prescription(s) early, allowing for ample supply of their medication(s) on hand. The determination of an early fill will be applied to all claims for the same drug product and strength, regardless of prescribing provider, billing provider, or prescription number.

Like the current eMedNY claim denial messaging, eMedNY will indicate the reason for denial and specify the date that is the earliest the claim will be accepted for payment in the Response DUR/PPS Segment field 544-FY- (DUR Free Text Message). This can be found in the ProDUR/ECCA Provider manual and is shown below:

New edit 02242 (Early Fill Overuse, 7 or 10-day Supply Threshold)

NCPDP Reject Code- "88"- (DUR Error) and "ER"- (Overuse) will be returned in the rejected Response Status Segment field 511-FB- (Reject Code). The Response DUR/PPS Segment field 544-FY- FY REJECT- DRUG OVERUSE (**DYS**) XX/XX/XX

Existing edit 01642 (Early Fill Overuse, 75% Threshold)

NCPDP Reject Code- "88"- (DUR Error) and "ER"- (Overuse) will be returned in the rejected Response Status Segment field 511-FB- (Reject Code). The Response DUR/PPS Segment field 544-FY- FY REJECT- DRUG OVERUSE XX/XX/XX

Changes to Medicaid FFS Pharmacy Reimbursement To Be Implemented February 22, 2018

Changes to FFS ingredient cost and professional dispensing fee per the enacted budget

As previously mentioned in the [March 2016](#) and [July 2017 Medicaid Update](#), once these changes have been implemented, a determination will be made on how to process the retroactive adjustments back to April 1, 2017. Retroactive adjustments will be handled at a future date, which will be communicated to providers ahead of time. Such adjustments will be spread out over a period of time (to be determined) and will show on the remittance with claim level detail.

Starting February 22, 2018, the pricing methodology will be systematically determined as follows:

Drug Type	If NADAC is available, reimburse at:	If NADAC is unavailable, reimburse at:	Professional Dispensing Fee (applies if not paid at U&C)
Generics	Lower of NADAC, FUL, SMAC or U&C	Lower of WAC – 17.5%, FUL, SMAC, or U&C	\$10.00
Brands	Lower of NADAC or U&C	Lower of WAC – 3.3%, or U&C	\$10.00
OTCs (<i>Covered Outpatient Drugs</i>)	Lower of NADAC, FUL, SMAC or U&C	Lower of WAC, FUL, SMAC, or U&C	\$10.00

Note: Claims will pay at the pharmacy's Usual and Customary Pricing if lower than drug ingredient cost plus dispensing fee. Over-the-counter (OTCs) drugs that do not meet the definition of a covered outpatient drug will continue to pay at current methodology.

Provider Pricing Inquiries:

- National Average Drug Acquisition Cost (NADAC) is determined by a federal survey, and is an average of the drug acquisition costs submitted by retail community pharmacies.
 - The NADAC Help Desk will investigate provider inquiries, and will evaluate them based upon invoice data collected from the pharmacy initiating the review, additional pharmacies contacted by the help desk, and other market factors, such as compendia price changes. Additional details on this can be found here: <https://www.medicaid.gov/medicaid/prescription-drugs/retail-price-survey/index.html>.
- State Maximum Acquisition Cost (SMAC) is developed by Magellan Medicaid Administration for NYS Medicaid and is applied on multiple source generic drugs. It represents an upper limit that NYS Medicaid will pay for these drugs.
 - Magellan Medicaid Administration will investigate provider inquiries and evaluate them based upon invoice data collected from the pharmacy initiating the review, additional pharmacies contacted by the help desk, and other market factors, such as compendia price changes. Information on this can be found here: <https://newyork.fhsc.com/providers/smacinfo.asp>.

Covered Outpatient Drugs (COD) are defined in section 1927(k)(2) and (3) of the Social Security Act. The following link provides information on the Covered Outpatient Drug Policy & FAQ per CMS: <https://www.medicaid.gov/medicaid/prescription-drugs/covered-outpatient-drug-policy/index.html>.

OTC drugs in the Medicaid FFS Program that meet the definition of CODs can be identified at the following website: <https://www.emedny.org/info/formfile.aspx>.

- When performing a search, select field “OTC Indicator” and then select a value of “Y”

For NADAC inquiries please use the following contact methods, phone: (855) 457-5264; email: info@mslcrps.com; or fax: (844) 860-0236.

For SMAC inquiries, please use the following contact methods, email: StateMACProgram@MagellanHealth.com; fax: (888)-656-1951; or visit the webpage: <https://newyork.fhsc.com/providers/smacinfo.asp>.

System editing on Medicaid FFS NCPDP D.0 340B drug claims

340B drug claims submitted via the National Council for Prescription Drug Programs (NCPDP) D.0 format need to be properly identified as 340B and submitted at the 340B acquisition cost.

The following fields are required on Medicaid 340B drug claims submitted in the NCPDP format:

Field	Medicaid Primary Claim	Medicaid Secondary Claim (Medicare; Commercial)
420-DK, Submission Clarification Code (SCC)	20	20
423-DN, Basis of Cost Determination (BCD)	08	
409-D9 Ingredient Cost Submitted	340B Acquisition Cost	
426-DQ Usual and Customary Cost (U&C)	Lowest Net Charge to Cash Customers	Lowest Net Charge to Cash Customers

Effective February 22, 2018, editing will be put in place that will require a pharmacy to submit all three fields when identifying an NCPDP pharmacy drug claim as 340B. Additionally, editing will check the ingredient cost submitted against the drug's 340B ceiling price as defined by the Health Resources and Services Administration (HRSA).

Pharmacies are still expected to submit field **426-DQ**, Usual and Customary Cost, as the lowest net charge to cash customers for the same prescription.

The above guidance clarifies previous billing guidance for NYS Medicaid FFS 340B claims submitted via the NCPDP D.0 format by specifying that 340B acquisition cost **must** be reported in field 409-D9, Ingredient Cost Submitted.

Please note that Medicaid takes a rebate on every claim it pays on; therefore, the value of '20' in field 420-DK, Submission Clarification Code **must** be included on a 340B claim even when Medicaid is paying as secondary. This will enable Medicaid to remove the claim from rebate invoicing.

System enhancements to improve the submission of Medicaid FFS pharmacy claims for Long Term Care pharmacy providers when reporting Short Cycle Billing

Effective February 22, 2018, the Department of Health will be implementing system enhancements to improve the submission of Medicaid FFS pharmacy claims for Long Term Care (LTC) pharmacy providers with the addition of supplementary Submission Clarification Codes in field 420-DK. The intent of short cycle dispensing is to reduce wasteful dispensing of outpatient prescription drugs in LTC facilities.

LTC pharmacy providers should indicate via an appropriate submission clarification code, when they are submitting claims for medications with short days' supply. Additionally, values 22-35 will have a prorated dispensing fee applied.

The following list of values reported in field 420-DK will now be available for claim submission for LTC pharmacy providers:

Valid Values	Short Name Description	Long Name Description
21	LTC14DAYLS	14 DAYS OR LESS (is not applicable due to CMS exclusion and/or manufacturer packaging may not be broken or special dispensing methodology (i.e. leave of absence, ebox, splitter dose). Medication quantities are dispensed as billed.
22	LTC7DAY	7 DAY SUPPLY
23	LTC4DAY	4 DAY SUPPLY
24	LTC3DAY	3 DAY SUPPLY
25	LTC2DAY	2 DAY SUPPLY
26	LTC1DAY	1 DAY SUPPLY (pharmacy or remote (multiple shifts) dispenses medication in 1-day supplies
27	LTC43DAY	4 THEN 3 DAY SUPPLY
28	LTC223DAY	2 THEN 2 THEN 3 DAY SUPPLY
29	LTCDAAILY3D	DAILY AND 3 DAY WEEK END (pharmacy or remote dispensed daily during the week and combines multiple days dispensing for weekends)
30	LTCSHIFT	PER SHIFT DISPENSING
31	LTCMED	PER MED PASS DISPENSING
32	LTCPRN	PRN ON DEMAND
33	LTC7ORLES	7 DAYS OR LESS (cycle not otherwise represented)
34	LTC14DAY	14 DAY DISPENSING
35	LTC814DAY	8-14 DAYS DISPENSING (cycle not otherwise represented)
36	LTCOUT	OUTSIDE SHORT CYCLE (Claim was originally submitted to a payer other than Medicare Part D and was subsequently determined to be Part D)

The Department will review claims post “go-live” to ensure compliance to our policy. Contact the eMedNY Call Center at (800) 343–9000 for questions regarding claim submission for 340B or short cycle billing, or any billing issue.

Reminder: Emergency Contraceptive Coverage

Both prescription and over-the-counter (OTC) Emergency Contraception is a Covered Benefit for all Medicaid Fee-for-Service and Managed Care enrollees without age restrictions. This includes individuals enrolled in the Family Planning Benefit Program. In accordance with Title 18 of NY Codes, Rules and Regulations section 505.3(b)(1)(i), OTC emergency contraceptive drugs can be obtained without a written order from a practitioner.

Prescription-only contraceptive drugs continue to require a practitioner order. For Medicaid-eligible females, a fiscal order or prescription is **not** required for OTC emergency contraception. Both prescription only and OTC emergency contraception is limited to six courses of therapy in a 12-month period.

Medicaid Fee-for-Service Billing

When dispensing these products without a written/electronic/oral order, the prescriber identification field for pharmacy claims may be left blank and the claim will still be processed.

Managed Care Plan Billing

For information, please check with the individual managed care plan. Contact information is available at: <http://mmcdruginformation.nysdoh.suny.edu/>. Select a plan card for their specific contact information.

All Providers

Medicaid Managed Care and Children’s Health Insurance Program Network Providers Must Enroll in the New York State Medicaid Program

Federal Requirement

As previously mentioned in the [May 2017 Medicaid Update](#), Section 5005(b)(2) of the 21st Century Cures Act and Section 1932(d) of the Social Security Act requires all Medicaid Managed Care (MMC) and Children’s Health Insurance Program (CHIP) network providers to be enrolled with State Medicaid programs no later than January 1, 2018. The requirement applies to all provider types who can be enrolled in the NYS Medicaid program.

Provider Outreach

NYS DOH has been actively working with Managed Care Organizations (MCOs) to implement this requirement. Throughout the fall of 2017, MCOs informed all required network providers not yet enrolled to submit an enrollment application to NYS DOH by December 1, 2017. A significant number of providers have complied with this requirement. It is expected that applications submitted to NYS DOH by the December 1, 2017 deadline will be processed by April 1, 2018.

Enrollment in NYS Medicaid does not require a provider to provide services to Medicaid fee-for-service recipients. Providers may choose to either enroll in Medicaid as a billing provider or non-billing provider. Practitioners may also choose to enroll under the non-billing category of Ordering/Prescribing/Referring/Attending (OPRA).

Compliance

Providers who have not submitted their enrollment applications must do so immediately. Non-compliant providers will be subject to claims payment delay, rejection, denial and/or termination from MCO networks.

Resources

The following resources are available through NYS DOH’s provider enrollment website at: <https://www.emedny.org/info/ProviderEnrollment/ManagedCareNetwork/index.aspx>:

- Provider enrollment forms and instructions
- Medicaid fee-for-service (FFS) active provider listing (updated monthly)
- List of NYS Enrollable Provider Types
- Frequently Asked Questions (FAQs)
- PowerPoint presentations

Identity Theft and “Medicaid Mills”

The “Medicaid Mill” of the past has evolved into a modern identity theft and money laundering machine. The proliferation of new forms of non-traditional professional relationships exposes good faith healthcare providers to identity theft in support of “medical mills” or “Medicaid mills”. Medical mills are purported medical clinics which use patients, usually Medicaid fee-for-service and Medicaid Managed Care beneficiaries, as pawns in schemes to collect on fraudulently submitted claims. Typically, the “mill” is operated by a former healthcare provider excluded by the New York State Office of the Medicaid Inspector General or federal Department of Health and Human Services due to a conviction of fraud or other healthcare offense, or some other bad-faith operator.

The mill typically has set up an operation that resembles a low-budget medical office which uses recruiters who solicit patients on the street or in settings such as shelters and soup kitchens with promises of a cash payment. After getting patients in the door and obtaining their unique Medicaid Client Identification Numbers, the mills submit as many fraudulent claims to Medicaid or MCOs for services as will be paid for each patient. These services are typically never rendered or not medically necessary. Often, the facility has untrained laypersons engaging in quasi-medical practices, such as running diagnostic equipment. The “patient’s” healthcare needs are irrelevant to a medical mill.

Equally key to the scheme is the obtained identity of a licensed healthcare provider who was purportedly the service provider or referring provider. A specialist is asked by a stranger with no verifiable professional standing to order tests or to read results without any knowledge of the patient. Sometimes, new practitioners who have not learned professional norms are exploited to obtain their billing credentials or are directed to perform activity beyond the scope of their licensing. Once a “mill” has a physician’s license number, it will look like they are submitting the fraudulent claims. Some bad-faith licensed persons have been complicit in giving the mills the use of their medical licenses and Medicaid credentials, but often never even saw a patient.

Providers are advised to be alert for these signs of a “medical mill”. Review your ordered services frequently and do not allow persons who are not licensed and qualified professionals to direct your practice. The consequences of being involved in such a scheme can have a devastating impact on your career, including exclusion from healthcare programs, substantial financial and malpractice liability, and even criminal conviction.

Protect yourself and your reputation. If you are solicited to participate in, or become aware of such activity, please contact the Office of the Medicaid Inspector General at 1-877-873-7283, or visit www.omig.ny.gov. Alternately, you can report it to the New York State Attorney General’s Medicaid Fraud Control Unit hotline at 800-771-7755 or online at: AG.NY.Gov.

NY Medicaid EHR Incentive Program Update

The NY Medicaid Electronic Health Records (EHR) Incentive Program provides financial incentives to eligible professionals 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, **more than \$881 million** in incentive funds have been distributed through **30,981** payments to New York State Medicaid providers.

Eligible Professionals and Eligible Hospitals Total	
Payments Made: 30,981	Amount Paid: \$881,889,340

Resources Available for Eligible Professionals Preparing to Attest

To receive incentive payments, an eligible professional must be a meaningful user of certified EHR technology. Providers must show that they are using certified EHR technology in ways that can be measured significantly in quality and quantity. The NY Medicaid EHR Incentive Program offers several resources to assist in preparing for the meaningful use attestation process.

Tutorials

The NY Medicaid EHR Incentive Program website has recorded video tutorials available for on-demand assistance. The interactive tutorials are instructor-led with step-by-step guidance to assist with completing your MU attestation. To access these videos, visit the Tutorials page here: http://www.health.ny.gov/health_care/medicaid/redesign/ehr/tutorials.htm.

Webinars

The NY Medicaid EHR Incentive Program has instructor-led webinars available to assist in the meaningful use attestation process. To register for a session, visit the Webinar Calendar here: http://www.health.ny.gov/health_care/medicaid/redesign/ehr/calendar/. Past sessions can be viewed in the Document Repository here: https://www.health.ny.gov/health_care/medicaid/redesign/ehr/repository/index.htm.



Contact us at 877-646-5410, option 2 or hit@health.ny.gov. Questions? We have a dedicated support team ready to assist.

Provider Directory

Office of the Medicaid Inspector General:

For suspected fraud or abuse 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.

Beneficiary 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 <https://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 (EHR) 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, Chelsea Cox, at medicaidupdate@health.ny.gov.