



New York State Medicaid Update

THE OFFICIAL NEWSLETTER OF THE NEW YORK STATE MEDICAID PROGRAM

Medicaid Primary Care Rate Increase

Background

The Affordable Care Act established a Medicaid Primary Care Rate Increase (PCRI) for specific primary care services furnished by certain qualified primary care providers. The increase will result in payment of primary care services at the Medicare rate to qualified Medicaid providers from January 1, 2013 through December 31, 2014. The final rule implementing the Medicaid PCRI was released in November 2012 by CMS (see 42 CFR Parts 438, 441, and 447).



Qualified Providers

The qualified providers defined as eligible to receive payment under the PCRI are:

1. Physicians holding board certification from the American Board of Medical Specialties, the American Board of Physician Specialties or the American Osteopathic Association in pediatrics, internal medicine and family medicine and associated subspecialties, **or**
2. Physicians who have furnished primary care services (see procedure on page 3) that equal at least 60 percent the Medicaid codes paid during the most recently completed calendar year, or for newly eligible providers, the prior month, **or**
3. Nurse Practitioners and Nurse Midwives practicing under the professional oversight and supervision of a qualified physician (#1 or #2 above).

Implementation

New York is pursuing CMS approval to implement the PCRI in the Medicaid fee-for-service and managed care programs. It is expected that system and procedural changes required to apply the PCRI will be in place for fee-for-service and managed care programs beginning in the second quarter of CY 2013. Qualified providers will receive retroactive reimbursement for procedure codes subject to the PCRI, effective for dates of service on and after January 1, 2013. Further details regarding payment amounts, timing and instructions for providers interested in qualifying for the PCRI will be released in the coming months. Sign up for the eMedNY listserv to obtain immediate updates for your provider type at: https://www.emedny.org/Listserv/eMedNY_Email_Alert_System.aspx.

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POLICY AND BILLING GUIDANCE

Primary Care Services & Procedure Codes

The PCRI is applicable to **evaluation and management** (99201-99499) and **vaccine administration** procedure codes (90460, 90471, 90472, 90473 & 90474) covered by Medicaid fee-for-service or managed care plans and paid to **qualified providers**.

Effective for **dates of service on and after January 1, 2013**, billing instructions for vaccine administration for **practitioner and ordered ambulatory providers** have changed as follows (**does not apply to clinic APG billing**):

- **Vaccines for Children Program (VFC) - Vaccine Administration**

For administration of vaccines supplied by VFC, including **influenza and pneumococcal administration**, providers will be required to bill **vaccine administration** code **90460**. Providers **must continue to bill the specific vaccine code with the "SL" modifier** on the claim (payment for "SL" will be \$0.00). If an administration code is billed without a vaccine code with "SL", the claim will be denied. For reimbursement purposes, the administration of the components of a combination vaccine will continue to be considered as one vaccine administration. More than one vaccine administration is reimbursable under 90460 on a single date of service.

90460	(IMMUNIZATION ADMINISTRATION THROUGH 18 YEARS OF AGE VIA ANY ROUTE OF ADMINISTRATION, WITH COUNSELING BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL; FIRST OR ONLY COMPONENT OF EACH VACCINE OR TOXOID ADMINISTERED)	\$17.85
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- **Adult and non-VFC Vaccine Administration Billing Changes**

For administration of vaccines to individuals ages 19 and over, including influenza and pneumococcal, and children's vaccines not covered by VFC, providers will be required to bill under the procedure codes below (new codes are **bold**). **Providers must continue to bill the specific vaccine code at acquisition cost, but should no longer add \$2.00 for vaccine administration to the charge for the vaccine as previously instructed.** G0008 & G0009 will no longer be reimbursed, use the appropriate codes below.

90471	IMMUNIZATION ADMINISTRATION (INCLUDES PERCUTANEOUS, INTRADERMAL, SUBCUTANEOUS, OR INTRAMUSCULAR INJECTIONS); 1 VACCINE (SINGLE OR COMBINATION VACCINE/TOXOID)	\$13.23
90472	IMMUNIZATION ADMINISTRATION (INCLUDES PERCUTANEOUS, INTRADERMAL, SUBCUTANEOUS, OR INTRAMUSCULAR INJECTIONS); EACH ADDITIONAL VACCINE (SINGLE OR COMBINATION VACCINE/TOXOID) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	\$2.00
90473	IMMUNIZATION ADMINISTRATION BY INTRANASAL OR ORAL ROUTE; ONE VACCINE (SINGLE OR COMBINATION VACCINE/TOXOID)	\$8.57
90474	IMMUNIZATION ADMINISTRATION BY INTRANASAL OR ORAL ROUTE; EACH ADDITIONAL VACCINE (SINGLE OR COMBINATION VACCINE/TOXOID) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	\$2.00

Resources

- Fee-for-service Medicaid billing assistance: CSC, (800) 343-9000.
- Fee-for-service coding, reimbursement: OHIP Operations, dprum@health.state.ny.us or (800) 342-3005, option 8.
- VFC Program: (800) 543-7468.

Update on the Health Home Consent Process

The Health Home consent process is an essential component to patient engagement and program success. The Health Homes care management service model, in which a Medicaid individual's caregivers communicate with one another to address a recipient's needs, is done mainly through a "care manager". The care manager directs and provides access to all services an individual might need to make certain they receive everything necessary to stay healthy. Health records are shared among providers so that services are not duplicated or neglected. The health home services are provided through a network of organizations – providers, health plans and community-based organizations.

The original Health Home consent process was changed in response to concerns regarding the difficulty of implementing the consent as designed. The main goal continues to remain the same – a single Health Home consent that ensures compliance with state and federal regulations on privacy and confidentiality while allowing Health Home providers to share appropriate information about their members including through the use of health information technology (HIT) through a health information exchange (HIE).

While the prior consent form required that the Health Home identify and list all of its core partners, the revised consent form allows the lead Health Home to list only the partners relevant to the individual member. Additional care partners may be added as needed to the consent form as an addendum, which the member initials and dates. The withdrawal of consent form has also been redesigned to be consistent with this format.

The new consent serves as the Regional Health Information Organization (RHIO) HIE consent for the lead Health Home. It allows the lead Health Home to collect and share information through the RHIO HIE. NYSDOH Office of Health Insurance Programs, Office of Health Information Technology Transformation and the AIDS Institute, along with the Office of Mental Health (OMH) and Office of Alcohol and Substance Abuse Services (OASAS) worked together on this redesign and each state agency has signed off on the new forms as meeting the same standards for privacy and confidentiality as the prior forms.

Health Homes are reminded that the member does not have to sign this consent for active care management to begin. While it will limit data exchange among the care providers, the care manager may begin to work with the member. Because many Health Home eligible members are disenfranchised from the healthcare system, they may not be immediately comfortable signing the consent. The goal is to work with the member so he/she understands the value of the consent, feels comfortable with the intent, and signs the consent. Updated instructions and frequently asked questions will be available on the Health Home website. The new forms will be posted upon completion of translation into the required languages. Health Homes that have successfully been able to operationalize the original consent form DO NOT need to have members sign another consent form. The original consent is still valid and can remain in effect.

For more information about the Health Home Consent Process, visit the following websites:
Health Home Consent Forms and FAQs at:

Forms and Template section at:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/forms/

Health Home Main Page at:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

Medicaid Transportation Policy

Loss of Records Due to Unforeseen Incident

Federal Law and State Regulations require Medicaid providers to maintain financial and health records necessary to fully disclose the extent of services, care, and supplies provided to Medicaid enrollees. This is stated in Title 18 New York Code of Rules and Regulation (NYCRR) 504.3:

By enrolling the provider agrees:

(a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider and to furnish such records and information, upon request.

Required records of transportation providers can be found in the policy section of the Transportation Provider Manual at:

https://www.emedny.org/ProviderManuals/Transportation/PDFS/Transportation_Manual_Policy_Section.pdf

Transportation providers whose paper and/or electronic records are damaged by fire, flood or other disaster are required to notify the New York State Department of Health (NYSDOH) of the loss of their records. This self-reporting notification should include specific details of the event causing the loss of records, the type of required record lost, the dates of service impacted by this loss, and documents/photographs which substantiate the loss. This report should be made via e-mail to: MedTrans@health.state.ny.us.

Upon the approval of NYSDOH, this notification will be forwarded to the Office of the Medicaid Inspector General (OMIG), and will be determined to meet the record-keeping requirements for Medicaid purposes.

Providers should also notify all other state or local regulatory agencies of the loss of records required by those regulatory agencies, including a taxi and limousine commission (livery, taxi and ambulette), the New York State Department of Transportation (ambulette), NYSDOH (ambulance), or the New York State Department of Motor Vehicles (ambulette).

If you have any questions, please e-mail the Medicaid Transportation group at: MedTrans@health.state.ny.us. or contact via e-mail to doh.sm.medicaid.data.exchange@health.ny.gov.

Care at Home (CAH) III, IV and VI Care Management Providers: Delayed Implementation of the OPWDD Care at Home Waiver

As previously published in the November 2012 Medicaid Update, the Office for People with Developmental Disabilities (OPWDD) and the New York State Department of Health (NYSDOH) are working with the Centers for Medicare & Medicaid Services (CMS) to combine CAH III, IV and VI into a single 1915c waiver program. **The new waiver will be known as the OPWDD Care At Home Waiver.** This consolidation will streamline and strengthen New York State's administrative oversight and reporting mechanism for these waiver programs. Due to outstanding review and approval by CMS, the effective date has changed from January 1, 2013 to April 1, 2013 (pending federal approval).

The policy and billing guidelines stated in the November 2012 publication remain unchanged except for a new implementation date of April 1, 2013. CAH III, IV and VI providers should begin billing for OPWDD Care at Home Waiver services as of April 1, 2013. Children who are currently served under CAH III, CAH IV and CAH VI, who have coverage on April 1, 2013, will be automatically enrolled in the new waiver. There should be no disruption in services and the transition should be transparent to the individuals receiving services and their families.

If you have questions about the new OPWDD Care At Home Waiver, please contact the OPWDD, Lynda Baum-Jakubiak at (518) 474-5647 or the Division of Program Development and Management at (518) 473-2160.

POLICY AND BILLING GUIDANCE

New York Medicaid Electronic Health Records Incentive Program Update

The New York State Department of Health (NYSDOH) is pleased to announce that as of December 14, 2012, the NY Medicaid Electronic Health Records (EHR) Incentive Program has now paid over \$218 million in federal incentive funds to over 3,800 New York State hospitals and healthcare practitioners.

The NY Medicaid EHR Incentive Program is now accepting attestations from eligible professionals (EPs) and eligible hospitals (EHs) for both adoption/implementation/upgrade (in providers' first year of participation) and meaningful use (for providers' second participation year).

Hospitals who are participating in both the Medicare and Medicaid EHR Incentive Programs will be required to complete their meaningful use attestation for the Medicare EHR Incentive Program using the CMS Registration & Attestation System prior to attesting in the NY Medicaid EHR Incentive Program Application Support Service (MEIPASS).

EPs have until March 31, 2013 to attest in MEIPASS for Payment Year 2012 as their first or second participation year. EHs have until January 31, 2013 to attest in MEIPASS for Payment Year 2012 as their first or second participation year. NY Medicaid encourages all providers to attend our revised Participation Year 1 and 2 webinars to view enhancements recently made in the MEIPASS application.

All providers are encouraged to make sure they have maintained all the program prerequisites and eligibility requirements prior to attesting. This includes being enrolled as a fee-for-service Medicaid provider, having an active ePACES login and calculating Medicaid eligibility requirements.

If you have not yet registered for the NY Medicaid EHR Incentive Program, we encourage you to visit the **new** and **improved** website (<https://www.emedny.org/meipass/>) or attend one of the informational webinars hosted by the NYS Department of Health throughout the month of January.

Wednesday, Jan. 2	12:00–1:00PM	Program Prerequisites
Thursday, Jan. 3	12:00–1:00PM	EP Participation Year 1 (A/I/U)
Tuesday, Jan. 8	10:00–11:00AM	EP Supporting Documentation
Thursday, Jan. 10	10:00–11:00AM	EP Participation Year 2 (MU)
Tuesday, Jan. 15	12:00–1:00PM	EP Participation Year 1 (A/I/U)
Wednesday, Jan. 16	3:00–4:00PM	Program Prerequisites
Thursday, Jan. 17	12:00–1:00PM	EH Participation Year 2 (MU)
Thursday, Jan. 24	10:00–11:00AM	EP Supporting Documentation
Wednesday, Jan. 30	12:00–1:00PM	EH Participation Year 2 (MU)

The webinar schedule is subject to change based on interest levels. To see the complete schedule or to register for one of the webinars, please view the webinar schedules posted on the eMedNY.org website:

- Current Month: <https://www.emedny.org/meipass/webinar/Webinar.pdf>
- Next Month: <https://www.emedny.org/meipass/webinar/NextMonth.pdf>

PHARMACY UPDATE

Change in Coverage of Benzodiazepines and Barbiturates for Dual Eligible Population

Medicare Part D prescription drug plans and MA-PD plans are not currently required to include barbiturates or benzodiazepines in their formularies. For prescriptions dispensed on or after January 1, 2013, these prescription Medicare drug plans will be required to cover benzodiazepines for any condition and barbiturates used for the treatment of epilepsy, cancer, or a chronic mental health disorder. Only drugs that are excluded by law from being covered by the Medicare Part D plans are covered by NYS Medicaid for dual eligibles (Medicare/Medicaid). As a result, effective January 1, 2013, NYS Medicaid will no longer provide dual eligibles with coverage of benzodiazepines for any condition and barbiturates when prescribed for Medicare Part D covered indications.

NYS Medicaid will continue to provide coverage of barbiturates for dual eligibles when prescribed for indications not covered by Medicare Part D. In addition, NYS Medicaid continues to cover benzodiazepines and barbiturates for NYS Medicaid beneficiaries who are not Medicare eligible. Barbiturates prescribed for dual-eligibles with a history of Medicare Part D covered indications will be subject to prior authorization and will require documentation of Medicare Part D denial.

Important AAC Reminder

The actual Average Acquisition Cost (AAC) drug pricing survey is in progress. All Medicaid enrolled fee-for-service pharmacy providers are required to participate.*

Section 505.3 of Title 18 of NYS Codes Rules and Regulations: "Each pharmacy enrolled in the Medicaid program shall provide the department, in such manner, for such periods, and at such times as the department may require, with the drug acquisition cost, as defined in paragraph 505.3(a)(3), of prescription drugs."

Surveys must be submitted by close of business, January 8, 2013. Extensions will not be granted for this survey. The AAC survey tool and instruction guide may be downloaded from the New York State Department of Health (NYSDOH) website:

http://www.health.ny.gov/health_care/medicaid/program/pharmacy.htm

Once the initial survey is completed, the Department will begin collecting pricing data on a monthly basis from a stratified, randomly selected subset of providers. The tentative start date for the monthly survey process is February 8, 2013. The scheduled implementation date for moving to AAC for pharmacy reimbursement with a revised dispensing fee is May 1, 2013.

Questions may be emailed to medpharmpricing@health.state.ny.us. Technical assistance is also available by calling 518-486-3209.

*Note: The pricing survey being conducted by Myers and Stauffer is not related to this survey. Submission of data for that survey does not satisfy the requirement to participate in the NYS Medicaid pharmacy fee-for-service pricing survey.

Prescriber Prevails in Medicaid Managed Care for Atypical Antipsychotics

Effective January 1, 2013, Medicaid Managed Care Plans will be required to implement “prescriber prevails” for medically necessary prescription drugs in the atypical antipsychotic therapeutic drug class. This change is the result of legislation passed in the 2012-2013 Executive Budget. Once implemented, this initiative will enable the prescriber's reasonable professional judgment to prevail in the prior authorization process for atypical antipsychotics.

Plans will continue to develop formularies and may also administer prior authorization programs for atypical antipsychotics. Prescribers will still be required to provide plans with requested information and/or clinical documentation to support prior authorization requests. As they do currently, plans may provide a temporary (3 day) supply of medication when medically necessary.

Plans are required to meet specific federal determination timeframes in response to requests for health care services. Consistent with these requirements, when the plan is unable to complete a prior authorization due to missing information or because the prescriber's reasonable professional judgment has not been adequately demonstrated, either by consistency with FDA approved labeling or use supported in at least one of the Official Compendia as defined in federal law under the Social Security Act Section 1927 (g)(1)(B)(i), the plan will issue a notice of action to the provider and member. Such notice will describe the information required to complete the authorization and the member's rights regarding appeals and fair hearings.

PHARMACY UPDATE



PROVIDER BULLETIN

BULLETIN NO. 12-03

December 2012

SUBJECT: EPIC Program Changes

Beginning January 1, 2013, many EPIC program benefits will be restored. This bulletin provides information about these changes as well as how they will affect both your EPIC customers and your pharmacy.

ALL MEMBERS MUST BE ENROLLED IN A MEDICARE PART D PLAN IN ORDER TO RECEIVE EPIC BENEFITS

Claims:

- EPIC will provide secondary coverage for EPIC and Medicare Part D covered drugs after any Part D and/or EPIC deductible is met. EPIC will also cover many Medicare Part D excluded drugs, e.g. prescription vitamins, prescription cough and cold preparations.
- Benzodiazepines will be Medicare Part D covered medications and will be covered only secondary to Medicare Part D coverage.
- Low Income Subsidy (LIS) members will be able to use EPIC during all Medicare Part D benefit stages.
- Any amount paid toward the Medicare Part D deductible cannot be applied to the EPIC deductible.
- The EPIC manufacturers' rebate program is being reinstated.

Billing:

- Submit all claims to EPIC as secondary coverage regardless of benefit stage.
- EPIC will provide secondary coverage in the initial, coverage gap, and catastrophic stages after any Medicare Part D and/or EPIC deductible is met.

EPIC Participant Eligibility:

- The Fee Plan will be reinstated. Members with full LIS will have their EPIC fees waived. EPIC co-payments will continue to range from \$3 - \$20 based on the cost of the drug.
- The Deductible Plan will be reinstated. EPIC will continue to pay Medicare Part D premiums, up to the amount of a basic plan, for members in the Fee and Deductible plans with incomes up to \$23,000 (single) or \$29,000 (married).
- Those with incomes greater than \$23,000 (single) or \$29,000 (married) are responsible to pay for their Medicare Part D premiums. The EPIC deductibles for these members will be reduced by \$519 in 2013, to help them pay their Medicare Part D premiums.

***If you have any questions or need EPIC applications, please contact the EPIC Provider Helpline at:
1-800-634-1340***

The New York State Medicaid Prescriber Education Program Drug Information Response Center Addresses the Recent Fungal Meningitis Outbreak

The New York State Medicaid Prescriber Education Program (NYSMPEP) is a collaboration between the New York State Department of Health (NYSDOH) and the State University of New York (SUNY), as approved by state legislation. This program was designed to provide prescribers with an evidence-based, non-commercial source of the latest objective information about pharmaceuticals. In conjunction, the Drug Information Response Center (DIRC) was developed to fulfill the mission of assisting clinicians in the delivery of health care to their Medicaid patients by providing timely, evidence-based information on pharmacotherapy to prescribers and serving as a resource for NYSMPEP academic educators in their outreach to prescribers. A recent article was prepared by the DIRC regarding the recent fungal meningitis outbreak.

Meningitis is a serious condition associated with significant morbidity and mortality. Recently, an outbreak in the United States was identified, linked to contaminated injections of methylprednisolone acetate (MPA) solution originating from a compounding pharmacy, the New England Compounding Center (NECC), in Framingham, MA.¹ The identification of the recent outbreak began on September 18, 2012, when the Tennessee Department of Health was notified of a culture-confirmed case of *Aspergillus fumigatus* meningitis. As of December 3, 2012, a total of 524 cases of fungal meningitis, stroke secondary to presumed fungal meningitis, or paraspinal/spinal infection had been confirmed by the Centers for Disease Control and Prevention (CDC), with 36 deaths.² Cases have been reported in 19 states, though only a single case of paraspinal/spinal infection has been reported in NY. A total of 23 states received injections from the contaminated lots, which were recalled by the NECC on September 26, 2012, followed by a recall of all compounded products from the NECC on October 6. Though the index case of fungal meningitis was laboratory confirmed to be *Aspergillus fumigatus*, further testing by the CDC revealed the major causative pathogen to be *Exserohilum rostratum* with 75 culture-confirmed cases as of November 2.² *Exserohilum rostratum*, a brown-black mold, has been known to cause human disease. Several case reports and series have been published highlighting *Exserohilum*'s ability to infect both healthy and immunocompromised individuals.³⁻⁹

Since the outbreak, the CDC has issued a definition for probable fungal meningitis.² Patients must have received an epidural or paraspinal preservative free MPA injection and subsequently contracted: 1) meningitis of unknown etiology after May 21, 2012; or 2) had a posterior circulation stroke without documentation of a normal cerebrospinal fluid (CSF) profile. Associated signs and symptoms should include at least one of the following: fever, headache, stiff neck, or photophobia, in addition to an abnormal CSF profile (>5 white blood cells, regardless of glucose or protein). Other symptoms include weakness or numbness in any part of the body, slurred speech, and increased pain, tenderness or swelling at the injection site. Cases should be confirmed by the presence of a fungal pathogen in a culture of the blood or CSF.

In response to the outbreak, the CDC issued interim treatment guidance for CNS infections associated with the injection of tainted MPA.² The recommended therapy for fungal meningitis is voriconazole, possibly with the addition of liposomal amphotericin B depending on severity and patient response. This recommendation coincides with the Infectious Diseases Society of America (IDSA) guidelines for

the treatment of aspergillosis of the CNS.¹⁰ Itraconazole or posaconazole may be used in patients unable to tolerate or refractory to voriconazole. There are few data supporting echinocandins (caspofungin, micafungin, anidulafungin) as single agents or in combination with voriconazole for aspergillosis infections of the CNS. Voriconazole is preferred because it is active against brown-black molds, *Aspergillus*, and has good penetration across the blood-brain-barrier, with concentrations approximately 50% of those found in plasma. In order to ensure adequate concentrations are reached, voriconazole should be administered at a dosage of 6 mg/kg every 12 hours, preferably by intravenous (IV) route.² Because voriconazole is metabolized through the liver, and there is significant interpatient variability, a trough level should be drawn 5 days after initiation of therapy and weekly thereafter, targeting a level of 2-5mcg/mL. Voriconazole is also available in a tablet formulation, and patients may be transitioned to this once they are clinically stable or improving. In patients who exhibit severe cases of fungal meningitis or are deteriorating despite antifungal therapy, providers should consider adding liposomal amphotericin B. The preferred formulation is AmBisome®, given at 5-6 mg/kg IV daily. Doses as high as 7.5 mg/kg daily may be considered in patients who are not improving. Intrathecal amphotericin B should be avoided. Prolonged therapy is likely necessary to fully cure the infection. A minimum of three months of therapy is recommended, and possibly longer in patients with underlying immunosuppression, more severe disease, or disease involving the bone.

The current outbreak of fungal meningitis associated with contaminated MPA injections from the NECC indicates the importance of maintaining sterility when compounding injectable medications.¹¹ Patients who received injections from the three identified lots should continue to be vigilant for symptoms. It is imperative that providers begin antifungal treatment empirically in patients with probable fungal meningitis, and can optionally perform a lumbar puncture in patients without symptoms. Voriconazole is the treatment of choice, and liposomal amphotericin B may be added if needed. Though the compounded products have been recalled, cases may continue to appear.

To view the complete article, please visit: <http://nysep.nysdoh.suny.edu/>.

To contact a NYSEMPEP academic educator in your area, please visit <http://nysep.nysdoh.suny.edu/contactus/contactus>.

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eMedNY Website To Get Facelift

During January 2013 the New York State Department of Health (NYSDOH) and Computer Sciences Corporation (CSC) will implement changes to the eMedNY website (www.emedny.org). These enhancements will make the site more user-friendly and easier to navigate. Very little of the content will be moved so as not to adversely impact providers' navigation of the site. One area which will improve will be the 'Self Help' section that is currently located as one of the main tabs at the top of the site. 'Self Help' will be able to be accessed from a 'Self Help' button in the upper right hand corner of the site.

The changes, mostly cosmetic, will be to fonts, spacing, color and the size of certain buttons. Providers who access ePACES, eXchange and other applications on the right hand section of the site will see the application buttons in a new right side column entitled 'eMedNY Tool Center'. NYSDOH and CSC welcome feedback on the new format and suggestions for additional enhancements to the eMedNY website. Please use the contact form located at: <https://www.emedny.org/contacts/emedny.aspx>.

ALL PROVIDERS

Most Common Reasons for Claim Denials

Listed below are some of the most common reasons for claims being denied. Providers who are experiencing a significant number of claim denials should consult with their vendor or submitter to ensure they are complying with Medicaid billing requirements. The following information can assist providers with claim denial resolution:

DENIAL REASON 00152 – CLIENT’S FILE INDICATES MEDICARE COVERAGE – NO MEDICARE INFORMATION PRESENT ON CLAIM:

Medicaid is the payer of last resort. Providers need to bill any other insurance a client has before submitting a claim to Medicaid for any outstanding balance. If a claim is submitted to Medicaid with no other insurance information, Medicaid will deny the claim for this reason. **Electronic Remittance Claim Adjustment Reason Code: 22 with Remark Code: N479 Claim Status code: 85 with Entity Identifier Code: MR**

DENIAL REASON 01172 – CLIENT IS IN A MEDICAID MANAGED CARE PLAN/THIS SERVICE IS THE RESPONSIBILITY OF THE MANAGED CARE PLAN:

Clients enrolled in Managed Care plans receive most services through the plan and those services are not paid by Medicaid. When MEVS indicates a Prepaid Capitation Plan (PCP) message – the provider should not submit the claim to Medicaid unless, in limited circumstances, the service is carved-out and therefore payable by Medicaid. Consult with the plan for covered services.

Electronic Remittance Claim Adjustment Reason Code: 24 Claim Status Code: 97 with Entity Identifier Code: PR

DENIAL REASON 00162 – CLIENT IS NOT MEDICAID ELIGIBLE:

This is the error reason that will appear on the provider’s remittance for clients who have no eligibility for the date of service billed.

Electronic Remittance Claim Adjustment Reason Code: 27 Claim Status Code: 88 with Entity Identifier Code: QC

NOTE:

Providers who do not verify eligibility run the risk of receiving claim denials such as the ones detailed above. Please take a minute to review your remittance statements. If you are seeing claims denials for error codes 00152, 01172, or 00162, you are most likely not consistently verifying Medicaid eligibility.

In addition to the denial reasons above, the following reasons are impacting a large number of providers’ remittances:

DENIAL REASON 00068 – CLAIM SUBMISSION DATE NOT WITHIN REQUIRED TIME LIMITS:

Claims must be submitted within 90 days of the date of service to be valid and enforceable, unless delay is due to circumstances outside provider’s control. If appropriate, delayed claim submissions must include an acceptable delay reason code. More information can be found in the March 2012 Medicaid Update and your provider manual at: https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers-General_Billing.pdf

Electronic Remittance Claim Adjustment Reason Code: 29 Claim Status Code: 187

00705 - DUPLICATE CLAIM IN HISTORY:

A duplicate claim is triggered when there is a previously paid claim for the same service (procedure/rate code) on the same date of service for the same client and paid to the same billing provider.

Electronic Remittance Claim Adjustment Reason Code: 18 Claim Status Code: 54

02113 – DUPLICATE OF EXISTING CROSSOVER IN HISTORY:

In late 2009 NY Medicaid instituted the automated Medicare Crossover project. Since that time claims are automatically crossed to Medicaid for payment of patient responsibility amounts without the provider having to submit a claim directly to Medicaid. A substantial number of these claims are still being directly submitted by the provider which is causing denials for this Edit.

Electronic Remittance Claim Adjustment Reason Code: 18 with Remark Code N111 Claim Status Code: 454

(These codes are subject to future changes).

Questions related to billing, claim denials and MEVS should be directed to the eMedNY Call Center at (800) 343-9000.

New Training Schedule and Registration

- Do you have billing questions?
- Are you new to Medicaid billing?
- Would you like to learn more about ePACES?

If you answered YES to any of these questions, you should consider registering for a Medicaid training session. Computer Sciences Corporation (CSC) offers various types of educational opportunities to providers and their staff. Training sessions are available at no cost to providers and include information for claim submission, Medicaid Eligibility Verification, and the eMedNY Website.

WEB TRAINING NOW AVAILABLE

You can also register for a webinar in which training would be conducted online and you can join the meeting from your computer and telephone. After registration is completed, just log in at the announced time. No travel involved.

Many of the sessions planned for the upcoming months offer detailed instruction about Medicaid's free web-based program-ePACES which is the electronic Provider Assisted Claim Entry System that allows enrolled providers to submit the following type of transactions:

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

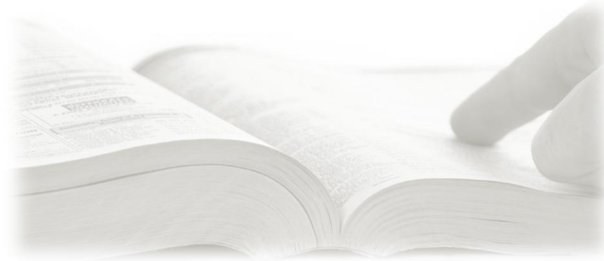
Physician, Nurse Practitioner, DME and Private Duty Nursing claims can even be submitted in "REAL-TIME" via **ePACES**. Real-time means that the claim is processed within seconds and professional providers can get the status of a real-time claim, including the paid amount without waiting for the remittance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

Fast and easy registration, locations, and dates are available on the eMedNY Website at: <http://www.emedny.org/training/index.aspx>

CSC Regional Representatives look forward to having you join them at upcoming meetings!

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

PROVIDER DIRECTORY



Office of the Medicaid Inspector General: For general inquiries or provider self-disclosures, please call (518) 473-3782. For suspected fraud complaints/allegations, call 1-877-87FRAUD (1-877-873-7283), or visit www.omig.ny.gov.

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

Providers wishing to hear 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.