



Department
of Health

Medicaid Update

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All Providers: Medicaid Recipients May Not be Billed for COVID-19 Related Provider Expenses

This is a reminder that the Medicaid program prohibits enrolled providers from billing recipients for charges for COVID-19 protective measures, including sanitizing exam rooms and using personal protective equipment, such as masks, gowns, and gloves (collectively, “PPE”). Cost sharing for Medicaid fee-for-service and managed care members is limited to applicable copays based on federal rules, including New York’s Medicaid State Plan and 1115 Medicaid Redesign Team Waiver.

Billing Medicaid recipients for PPE is considered an “Unacceptable Practice” under Medicaid rules, which may result in provider sanctions up to and including termination from the Medicaid program.

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All Providers

August is National Immunization Awareness Month

Vaccinations are one of the best ways health care providers can protect patients of all ages from vaccine-preventable diseases. Each year, thousands of children and adults become seriously ill and are hospitalized because of diseases that vaccines can help prevent. Providers have the power to ensure their patients are protected from serious diseases like measles, cancers caused by HPV, and seasonal flu! By ensuring patients get recommended vaccines, providers can help protect them from much of this unnecessary suffering. The Centers for Disease Control and Prevention (CDC) and the New York State Department of Health (NYS DOH) have resources available for providers and their patients about vaccines. Information for children, adolescents and adults can be found at: <https://www.health.ny.gov/prevention/immunization/>.

Many children need to receive vaccines during the summer to stay up-to-date and comply with school vaccination requirements. The 2020-21 School Year New York State Immunization Requirements for School Entrance/Attendance can be found at: <https://www.health.ny.gov/publications/2370.pdf>.

The current COVID-19 pandemic has brought unique challenges to the healthcare system. SARS-CoV-2 is expected to continue to circulate in the fall. Increasing influenza coverage this season will decrease stress on the healthcare system by decreasing doctor visits and hospitalizations. Healthcare providers are encouraged to focus on reaching adults at higher risk of complications from COVID-19, such as those with underlying illnesses and African Americans.

The NYS Vaccine Program participates in federally funded programs that supply vaccines to providers who treat underinsured or uninsured patients. Additional information on how to enroll in the Vaccines for Children (VFC) Program, can be found at: https://www.health.ny.gov/prevention/immunization/vaccines_for_children/. Additional information on enrollment in the Vaccines for Adults (VFA) Program can be found at: https://www.health.ny.gov/prevention/immunization/providers/state_vaccines_for_adults_program.htm.

Questions should be directed to the NYS Vaccine Program at (800) 543-7468.

2020 New York State Vaccine Program Re-Enrollment

All providers who participate in the New York State (NYS) Vaccine Program are required to complete an annual re-enrollment application. Beginning this year, re-enrollment is being done electronically using the New York State Immunization Information System (NYSIIS). Each participating provider organization is responsible for reviewing and updating the Provider Agreement, Provider Profile, and Storage and Handling forms. Information will be pre-populated with existing information on record for the practice.

The re-enrollment feature in NYSIIS is only available to providers actively enrolled in the NYS Vaccine Program. To re-enroll, providers must login to NYSIIS and navigate to the Vaccine Program Re-Enrollment menu on the blue banner on the left of the page. There are tools available throughout the process to assist providers with any questions they may have. Providers can also utilize the help “lightbulb” at the end of the blue banner on the top of each screen for clarification of each element of the application. Providers who need assistance, or would like more information on eligibility, program requirements, and enrollment in the NYS Vaccine Program to provide free public vaccine to eligible children and adults, should contact the Vaccine Program at (800) 543-7468 or via email at: nyvfc@health.ny.gov.

New York Medicaid EHR Incentive Program

Distribution to Eligible Professionals & Eligible Hospitals Since the Start of the Program in 2011*

Number of Payments:	Distributed Funds:
44,271	\$1,016,625,783

*As of 7/7/2020

Through the NY Medicaid Electronic Health Record (EHR) Incentive Program, eligible professionals (EPs) and eligible hospitals (EHs) in New York who adopt, implement, or upgrade certified EHR technology (CEHRT) and subsequently become meaningful users of CEHRT, can qualify for financial incentives. The Centers for Medicare and Medicaid Services (CMS) is dedicated to improving interoperability and patient access to health information. The NY Medicaid EHR Incentive Program is a part of the CMS Promoting Interoperability Program but will continue to operate under the current name of NY Medicaid EHR Incentive Program.

Payment Year (PY) 2020 Pre-Validation Period

If EPs or a group of EPs have already selected their reporting period and calculated their patient volume prior to the Medicaid EHR Incentive Program Administrative Support Service (MEIPASS) attestation system being opened for the payment year, the EPs are able to complete a pre-validation. This allows practices to submit their patient volume data for review and approval ahead of attestation and can help the EP advance through the review process more quickly once MEIPASS begins accepting attestations.

Pre-Validations for PY 2020 will be accepted from September 14, 2020 to December 14, 2020. If providers would like to take advantage of this service to avoid patient volume remediation during the official or soft opening attestation periods, they need to begin the process of finding a suitable Medicaid patient volume reporting period. More information on how to submit a Pre-Validation will be made available as the acceptance period draws closer.

Check Participation Status

At minimum*, a provider must have completed and received an incentive payment for one payment year in PY 2016 or earlier to participate for future years. Providers uncertain about their participation status are encouraged to reach out to the NY Medicaid EHR Incentive Program support team for assistance. Program participation status can be verified and reviewed using the provider's National Provider Identifier (NPI) and may assist in determining a provider's ability to attest in PY 2019-2021. Providers who wish to check their participation status should contact the support team at **(877) 646-5410 (Option 2)** or via email at: hit@health.ny.gov.

**Providers must also meet all other relevant program requirements and metrics to be eligible to participate in the NY Medicaid EHR Incentive Program.*

LISTSERV Communications

Additional information and program changes are announced periodically, especially as the program begins its final years. The NY Medicaid EHR Incentive Program uses a LISTSERV messaging system to quickly communicate any changes or updates and recommends that providers and administrators subscribe in order to best be kept up to date. Information and instructions on how to subscribe can be found on the NY Medicaid EHR Incentive Program LISTSERV webpage at: https://www.health.ny.gov/health_care/medicaid/redesign/ehr/listserv/index.htm. Providers who experience any difficulty when attempting to subscribe should contact the support team for assistance.

Webinars

The NY Medicaid EHR Incentive Program will host quarterly Program Discussion Webinars on a variety of topics identified by support staff and the provider community. Providers who would like to have a particular topic discussed should submit requests by completing the Program Satisfaction Survey at: https://www.surveymonkey.com/r/NY_EHR. Schedule and registration information for all webinars, including Program Discussions, Stage 3, Security Risk Analysis, Public Health Reporting, Patient Engagement, and Health Information Exchange can be found at: https://www.health.ny.gov/health_care/medicaid/redesign/ehr/calendar/.

New York State (NYS) Regional Extension Centers (RECs)

NYS RECs offer free support to help providers achieve Meaningful Use of CEHRT. Support provided by NYS RECs includes, but is not limited to, the following:

- Answers to questions regarding the program and requirements
- Assistance on selecting and using CEHRT
- Help on meeting program objectives

NYS RECs offer **free** assistance for all practices and providers located within New York.

For Providers Located:	
Inside the five boroughs of NYC	Outside the five boroughs of NYC
Contact: NYC REACH Phone: (347) 396-4888 Website: https://www.nycreach.org MU Direct: https://www.nycreach.org/qi-services/#meaningful-use Email: nycreach@health.nyc.gov	Contact: New York eHealth Collaborative (NYeC) Phone: (646) 817-4101 Website: http://www.nyehealth.org MU Direct: https://www.nyehealth.org/services/meaningful-use Email: ep2info@nyehealth.org

Questions

The EHR Incentive Program has a dedicated support team ready to assist. Please contact the program at: **(877) 646-5410 (Option 2)** or via email at: hit@health.ny.gov.

Please Complete the New York Medicaid EHR Incentive Program Customer Satisfaction Survey
The NY Medicaid EHR Incentive Program values provider insight. The survey can be found at: https://www.surveymonkey.com/r/NY_EHR .

Reminder: Sign Up for eMedNY Training Webinars

eMedNY offers various types of training webinars for providers and their billing staff. Webinars are conducted online, so that providers may join the meeting via a computer and telephone. **No travel is necessary.**

Webinar registration is fast and easy. Providers may register for webinars, as well as view a list of webinar topics, descriptions, and available sessions, at: <https://www.emedny.org/training/index.aspx>. Providers are reminded to review the webinar descriptions **carefully** to identify the webinar appropriate for their specific training needs.

Questions regarding training webinars should be directed to the **eMedNY Call Center** at (800) 343-9000.

ePACES Self-Help Guides Available

Electronic Provider Assisted Claim Entry System (ePACES) self-help guides are available on the eMedNY website at: <https://www.emedny.org>. These documents have been created to assist ePACES users with a wide variety of topics including claim entry, eligibility determination, prior approval and claim status inquiry.

ePACES Claim Quick Reference Guides are available in Professional, Professional Real-Time, Dental, and Institutional formats. The guides include claim specific screen captures, descriptions of the individual claim entry fields, and instructions on how to batch and submit completed claims. ePACES Claim Quick Reference Guides can be found at: <https://www.emedny.org/selfhelp/ePACES/ClaimQuickRefDocs.aspx>.

ePACES Reference Sheets assist users with important features and functions of ePACES. Reference sheets currently available include the topics listed below and can be found at: <https://www.emedny.org/selfhelp/ePACES/ePACESRefSheets.aspx>:

- Building and Submitting Claim Batches
- Claim Balancing
- Claim Status Inquiry and Response
- PA/DVS Request*
- PA/DVS Response
- PA/DVS Revise Cancel Quick Reference Guide
- Obtaining a DVS for DME*
- Obtaining a DVS for Occupational, Physical, and Speech Therapy in ePACES
- Edit a Claim Function
- Electronic Attachments for Dental Prior Approvals
- MEVS Eligibility Request*
- MEVS Eligibility Response
- Enhanced ePACES PA Inquiry
- Enrollment
- Enrollment Removing and Adding an ETIN (Submitter)*
- Finding, Editing, and Deleting Claims
- Replicating a Claim for a New Client
- Support Files Provider, Other Payer, and Submitter
- Setting Up User Accounts
- Voiding and Replacing Claims
- Eligibility Request for SSHSP Providers*

Questions and Additional Information:

- Additional self-help documents can be found at: <https://www.emedny.org/selfhelp/index.aspx>.
- ePACES enrollment questions should be directed to the eMedNY Call Center at (800) 343-9000.

*Acronyms defined in order of first use: PA – Prior Authorization, DVS – Dispensing Validation System, DME – Durable Medical Equipment, MEVS – Medicaid Eligibility Verification System, ETIN – Electronic/Paper Transmitter Identification Number, SSHSP – School Supportive Health Services Program.

Policy and Billing

Pharmacy Fee-for-Service Billing Guidance: Long Term Care and Foster Care (Child Care) Facilities

This guidance pertains to Long Term Care (LTC) and Foster Care (FC) facility servicing pharmacies. **All pharmacy claims included in the rate must be billed to the facility.** Practitioner administered drugs (also known as physician administered drugs) are not a covered benefit for LTC and FC residing members, these drugs should be billed to the facility. Information on LTC pharmacy claims can be found in the [June 2011 Special Edition Medicaid Update](#); information regarding Foster Care claims can be found at: https://www.health.ny.gov/health_care/medicaid/program/carveout.htm.

The following process is necessary to successfully bill pharmacy claims that are not covered in the rate by identifying and billing the appropriate coverage. Additionally, this guidance must be followed **prior to** sending New York State (NYS) Medicaid requests for retroactive claim overrides.

Determine Third-Party Liability (TPL) and Medicaid Eligibility Coverage

Providers must use **any and all** resources available to determine eligibility coverage including:

- the facility billing office,
- Medicaid Eligibility Verifying Eligibility & Third-Party Liability System (MEVS) (<https://www.emedny.org/ProviderManuals/AllProviders/supplemental.aspx>),
- Electronic Provider Assisted Claim Entry System (ePACES) (<https://www.emedny.org/epaces/>),
- the local district office.

Providers should check for TPL and eligibility coverage updates **at least twice monthly** following the first Date of Service (DOS). **NY State Medicaid is always the payor of last resort, every effort must be taken to obtain correct billing information.** Inaccurate billing that causes an overpayment is recoverable by audit and puts the pharmacy at risk to the loss of their enrollment, [18 New York Consolidated Rules and Regulations (NYCRR) 348.1, 360-7.7, 504.3].

When TPL is applicable, providers must bill TPL first, including commercial plans or Medicare, billing Medicaid if appropriate as secondary. Any claim issues must be resolved with the third party, including prior authorization (PA) requirements, prior to submitting the claim to Medicaid. **Note:** If the primary insurer does not cover a medication, Medicaid will not cover the claim. Failure to submit the claim to the third party will result in denial of the claim by Medicaid.

When a member has Medicare, providers will bill:

- **Medicare Part B for Part B covered drugs** (Part B coverage information can be found at: <https://www.medicare.gov/what-medicare-covers/what-part-b-covers>), or
- **Medicare Part D or a Medicare Advantage Prescription Drug (MAPD) contracting plan (Part C) for other prescription drugs** (Part D coverage information can be found at: <https://www.medicare.gov/drug-coverage-part-d>).

When a member has Medicare Parts A or B or both and is not enrolled in Medicare Part D, providers will bill Part D covered claims to the Limited Income Newly Eligible Transition (LINET) program per: <https://www.cms.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/MedicareLimitedIncomeNET.html> to initiate Medicare Part D enrollment and also facilitate payment of claim.

When a member has Medicare Part C, it is imperative the pharmacy bill correctly: bill Part B covered drugs to the Part B portion of their coverage and, likewise, bill Part D covered drugs to the Part D portion of their coverage.

Billing Claims That Require Medicaid PA

For members whose active eligibility status began after the date the pharmacy service was provided (retroactive billing):

- If date of notification of eligibility is within 90 days of DOS, call Magellan for PA at (877) 309-9493.
- If date of notification of eligibility is after 90 days of DOS, and the bypass explained in this Medicaid Update article titled *Updated Pharmacy Guidance for Long term (LTC) Providers and Prior Authorization Requirements* is inappropriate to the claim, LTC/FC Facility servicing pharmacies may send the claim information for retro-PA consideration to the Medicaid Pharmacy unit at PPNO@health.ny.gov. Additional information on submitting claims after 90 days from DOS can be found at: https://www.emedny.org/HIPAA/QuickRefDocs/FOD-7001_Sub_Claims_Over_90_days_Old.pdf. This applies to members who reside in a Private Skilled Nursing Facility, Public Skilled Nursing facility, Private Health Related Facility, or Public Health Related Facility, (when "NH" returns on eligibility response) **within 30 days from the date of notification of eligibility**. Pharmacies will need to confirm with the local district for NH or Foster Care Facility placement if pharmacy is unsure. **All claims submitted for PA after 30 days of eligibility determination, or members not residing in a NH (as defined above), or FC Facility will be denied.**
- Any claim submitted with a DOS **after** the date of notification of eligibility will be denied. These claims should have been billed on DOS.

Reminders:

- It is the responsibility of the providers, both the facility and the pharmacy, to actively and regularly seek TPL enrollment and Medicaid eligibility for their patients.
- It is the pharmacy's responsibility to bill timely and to the appropriate party, i.e., the facility, commercial plan, Medicare, or Medicaid. Information regarding timely billing can be found at: https://www.emedny.org/ProviderManuals/AllProviders/Guide_to_Timely_Billing.pdf.
- All pharmacies that are not required to bill the facility (pharmacy benefit not included in the rate) must submit their transactions through the online Prospective Drug Utilization Review (Pro-DUR) program (https://www.emedny.org/ProviderManuals/Pharmacy/ProDUR-ECCA_Provider_Manual/index.aspx) using the National Council for Prescription Drug Programs (NCPDP) transaction format. NCPDP format specifications can be found in the *ProDUR ECCA Standards Manual* at: https://www.emedny.org/HIPAA/5010/transactions/NCPDP_D.0_Companion_Guide.pdf.
- If upon claims submission the member is determined ineligible, the Pro-DUR transaction will adjudicate. **If a PA message is received that states: "UNABLE TO PROCESS A PHARMACY PA PLEASE CALL MAGELLAN" the pharmacy should alert the prescriber at first and every occurrence** to align medication therapy with the Preferred Drug Program when appropriate, found at: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf. This is the opportune time to explore non-PA alternatives and facilitate payment. A PA will not be issued by the clinical call center for a member who is ineligible.
- Original prescriptions must be filled within 60 days (30 days for controlled substances) of prescriber written/order date; a system edit will deny claims beyond this limitation. The same drug/strength/quantity, i.e., prescription, cannot have more than one prescription number per same written date. **Bypassing the edit by giving a refill a new prescription number and new written date is considered fraudulent billing, and subject to audit and recovery.**

Data Definitions:

- *Eligibility Date* – the date that begins active eligibility status.
- *Date of Notification of Eligibility* – the date eligibility was updated or activated in the Medicaid system.

Questions regarding this policy may be referred to phone (518) 486-3209 or email ppno@health.ny.gov.

Updated Pharmacy Guidance for Long Term Care Providers and Prior Authorization Requirements

Effective June 25, 2020, system changes have been made to allow for providers to initiate a bypass from prior authorization (PA) when:

- a member is a resident of a Long Term Care (LTC) facility which is either a Private Skilled Nursing Facility, Public Skilled Nursing Facility, Private Health Related Facility, or Public Health Related Facility (identified as “NH” on an eligibility response), **and**
- a member first obtains Medicaid eligibility *after* 90 days from the prescription date of service/fill date for claims not included in the rate. Please see in this Medicaid Update, article titled *Pharmacy Fee-For-Service Billing Guidance: Long Term Care and Foster Care (Child Care) Facilities* for the full guidance for LTC facilities.

If the billing provider has determined that the member is a resident of a LTC facility as described above and that the member has first obtained eligibility *after* 90 days from the prescription date of service/fill date, the provider can enter a “2” - (Override) in the Eligibility Clarification Code field (309-C9) to bypass the PA requirement. Billing providers are required to actively check for eligibility every two weeks after first service date and to submit claims in a timely manner. **Claims in which this override has been used are subject to audit and recovery.**

Questions:

- Billing questions should be directed to the eMedNY call center at (800) 343-9000.
- Questions regarding this policy may be referred to (518) 486-3209 or ppno@health.ny.gov.

Reminder: Long Term Care Pharmacy Providers Will Identify Fee-for-Service Short Cycle Pharmacy Claims

As previously communicated, effective February 22, 2018, the Department of Health had implemented system enhancements, to improve the submission of Medicaid FFS pharmacy claims for Long Term Care (LTC) pharmacy providers by the addition of supplementary Submission Clarification Codes in field 420-DK.

Short cycle dispensing is used by LTC facility pharmacies as required by federal law for certain Medicare claims or by LTC contract to reduce wasteful dispensing of outpatient prescription drugs. This guidance applies to any Medicaid claim dispensed to an LTC member who resides in a Private Skilled Nursing Facility, Public Skilled Nursing facility, Private Health Related Facility, or Public Health Related Facility, (when “NH” returns on eligibility response) where the member is stabilized on the drug and is taking it on a consistent basis.

The Department requires the submission of the following appropriate code when dispensing an LTC pharmacy claim for a maintenance drug in less than a 30-day supply. A maintenance drug is one where the member is taking on a consistent basis. **Note:** Use of the short cycle code allows for the full dispensing of the prescription beyond five refills and removes the need for a new prescription after five refills (for example, after seven day supply dispensed each time) up until the end of the prescribed amount or six months.

LTC pharmacy providers should indicate, via an appropriate submission clarification code from the following table in field 420-DK, when they are submitting claims for maintenance medications with short days' supply:

Valid Values	Short Name Description	Long Name Description
21	LTC14DAYLS	14 DAYS OR LESS [is not applicable due to Centers for Medicare and Medicaid Services (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	LTCDAILY3D	DAILY AND 3 DAY WEEKEND (pharmacy or remote dispensed daily during the week and combines multiple days dispensing for weekends)
30	LTC SHIFT	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 reviews claims to ensure compliance to this policy.

Questions:

- Questions regarding claim submission for 340B or short cycle billing, or any billing issues should be directed to the eMedNY Call Center at (800) 343-9000.
- Policy related questions should be directed to the Medicaid Pharmacy Policy Department at (518) 486-3209, or ppno@health.ny.gov.

Prescriber Dispensing Medication Policy

The New York (NY) Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC) Pharmacy Benefit may not be used to dispense drugs directly from a physician, physician group, nurse practitioner, etc. This is referred to as prescriber dispensing. Where prescriber dispensing is allowed by NY State Education Law Article 137 section 6807(1)(b) and (2)(a), drugs if separately billable from visit service claim are billed as a medical benefit claim.

Questions:

- Questions regarding the law should be referred to the New York State Education Department at (518) 474-3817, Ext. 130 or via email at pharmbd@nysesd.gov.
- Questions regarding Medicaid Pharmacy Policy should be directed to (518) 486-3209 or via email at ppno@health.ny.gov.

Expansion of Smoking Cessation Counseling

Effective August 1, 2020, for Medicaid fee-for-service (FFS) and November 1, 2020, for Medicaid Managed Care (MMC), New York State Medicaid is expanding smoking cessation counseling (SCC) sessions to allow for as many sessions as medically necessary for all Medicaid members. Current coverage of smoking cessation counseling services will be modified to eliminate the limit of eight (8) SCC sessions per year.

For additional information regarding the smoking cessation counseling benefit, please refer to the following index of Medicaid Update topics: https://www.health.ny.gov/health_care/medicaid/program/update/medup-q-s.htm#smokingcess.

Questions:

- Medicaid FFS policy questions should be directed to the Office of Health Insurance Programs (OHIP), Division of Program Development and Management at (518) 473-2160.
- FFS billing questions should be directed to the eMedNY Call Center at (800) 343-9000.
- MMC reimbursement questions should be directed to the member's MMC plan.
- MMC policy questions should be directed to the specific MMC plan in question. A directory by plan can be found on the Department of Health's website at: https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers_Managed_Care_Information.pdf.
- Dental policy questions should be directed to OHIP's Dental Policy Unit at: dentalpolicy@health.ny.gov.

Non-Dental Practitioner Application of Fluoride Varnish in a Primary Care Setting

This is a reminder that fluoride varnish is currently reimbursable to physicians and nurse practitioners with Common Procedural Technology (CPT) code “**99188**”. A maximum of four (4) annual fluoride varnish applications will be covered for children from birth until seven years of age.

Effective August 1, 2020 for fee-for-service (FFS) and October 1, 2020 for Medicaid Managed Care (MMC), fluoride varnish can be applied by multiple primary provider types including Registered Nurses and Physician Assistants, based on scope of practice, to optimize treatment. This policy applies to mainstream MMC plans and HIV Special Needs Plans (HIV SNPs).

The primary care setting is the ideal location to address Early Childhood Caries (ECC), the most preventable, **chronic**, childhood disease, since young children tend to see their primary care providers far more often than dentists.

- Providers should be trained and competent in fluoride varnish application.
- Training resources can be accessed through the New York State Department of Health's website at: https://www.health.ny.gov/prevention/dental/child_oral_health_fluoride_varnish_for_hcp.htm.

Questions:

- Questions regarding Medicaid FFS policy should be directed to the Office of Health Insurance Programs (OHIP), Division of Program Development and Management, at (518) 473-2160 or dentalpolicy@health.ny.gov.
- Questions regarding MMC reimbursement and/or documentation requirements should be directed to the enrollee's MMC plan.

Transgender Related Care and Services Pharmacy Coverage Update

This article updates the *Medicaid Coverage of Pubertal Suppressants and Cross-sex Hormones* section of the [January 2017 Medicaid Update](#) article titled *Transgender Related Care and Services Update*.

Effective June 19, 2020, testosterone topical gel 1.62 percent (Androgel) has been added to the list of cross-sex hormones covered for the treatment of gender dysphoria consistent with the guidance provided in the January 2017 Medicaid Update mentioned above. Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC) members are eligible for coverage of medically necessary cross-sex hormones that are Federal Drug Administration (FDA) approved or Compendia *supported* for the treatment of gender dysphoria. The official Compendia sources would include American Hospital Formulary Service (AHFS) and Micromedex DrugDex. In Medicaid FFS, **testosterone topical gel** can be found within the Anabolic Steroids-Topical section of the Medicaid Preferred Drug List (PDL) (https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf). For MMC, please refer to the plan specific formularies which can be accessed through the Medicaid Managed Care Pharmacy Benefit Information Center. (<https://mmcdruginformation.nysdoh.suny.edu/>).

Questions:

- Questions regarding Medicaid FFS pharmacy policy should be directed to the Medicaid Pharmacy Policy department at (518) 486-3209, or ppno@health.ny.gov.
- Questions regarding MMC should be directed to the enrollee's MMC plan. A directory by plan can be found on the Department of Health's web site at: <https://mmcdruginformation.nysdoh.suny.edu/>.

Reminder to Providers: New York State Medicaid Requires Coordination of Benefits

The New York State (NYS) Department of Health (DOH) wants to remind NYS Medicaid providers that the NYS Medicaid program is designed to provide payment for medical care and services **only after** all other resources available for payment have been reviewed and utilized. Medicaid requires providers to exhaust all existing benefits prior to billing the Medicaid program. If a Medicaid member has third-party insurance coverage, the benefits of that coverage must fully be utilized before billing the NYS Medicaid program. Providers should always ask Medicaid members if they have other third-party coverage to ensure the proper coordination of benefits. **Medicaid is always the payor of last resort; federal regulations require that all other available resources be used before Medicaid considers payment.** If there is a responsible third-party that should be paying for the members' health benefits, such as a health insurance provider, the responsible third-party should pay first.

All claims submitted for members with Medicare and/or other third-party insurance must accurately reflect payments and denials received from other insurers to allow correct calculation of Medicaid reimbursement amounts. The Explanation of Benefits (EOB) and other documentation supporting Medicare and third-party reimbursement amounts must be kept and made available for audit or inspection by the DOH, Office of the Medicaid Inspector General (OMIG), the Office of the State Comptroller (OSC) or other state or federal agencies responsible for audit functions.

Additionally, for any claim submitted to Medicaid with a zero-fill reimbursement from Medicare or a third-party insurer, the provider must retain evidence that the claim was initially billed to Medicare and/or the third-party insurer and was denied **before** seeking reimbursement from Medicaid. The exception to this policy, in which providers may bill Medicaid directly without first receiving a denial, is for items that are statutorily not covered by the Medicare program. Providers are responsible for retaining the statutory exemption from Medicare for audit or inspection.

Fee-for-service (FFS) claim questions should be directed to the eMedNY call center at (800) 343-9000.

Addition to the Medicaid Dental Program D1354 - Interim Caries Arresting Medicament

Effective August 1, 2020 for fee-for-service (FFS) and October 1, 2020, for Medicaid Managed Care (MMC) plans, the New York State (NYS) Medicaid program will begin coverage of silver diamine fluoride (SDF). This applies to MMC plans, including mainstream MMC plans and HIV Special Needs Plans (HIV SNPs).

Clinical criteria for the use of SDF:

- Stabilize ***non-symptomatic*** teeth with active carious lesion and no pulpal exposure
- High caries risk (e.g. xerostomia, severe early childhood caries)
- Treatment challenged by behavioral or medical management
- Difficult to treat carious lesions

Criteria for reimbursement:

- Covers individuals 0-20 years of age, inclusive.
- For individuals 21 years of age and older, “D1354” is only approvable for those individuals identified with a recipient exception code of “RE 81” (TBI Eligible) or “RE 95” (Office for Persons With Developmental Disabilities/Managed Care Exemption).
- Covers two (2) times per tooth within a 12-month period with a total of four (4) times per lifetime of the tooth.
- Covers with topical application of fluoride (“D1206” or “D1208”) when they are performed on the same date of service if “D1354” is being used to treat caries and “D1206” or “D1208” is being used to prevent caries.
- Covers the application of SDF to five (5) teeth on the same date of service with more teeth considered in exceptional circumstances. Documentation supporting necessity must be submitted with the claim.

Providers are required to:

- Fully disclose the risks and benefits of SDF use.
- Discuss treatment alternatives where appropriate.
- Obtain written consent.

The most common risks with the use of SDF should be highlighted to include:

- Staining to treated lesion.
- Staining to tooth-colored restorations and crowns if SDF is applied to them (this color change is temporary and can be polished off).
- Potential staining of clothes, skin, or gums if accidentally applied (staining of skin and gums will disappear in one to three weeks).
- Metallic taste that may occur (this will go away rapidly).
- That if tooth decay is not arrested, the decay will progress, requiring reapplication of SDF, a filling, crown, possible root canal treatment, or extraction.

“D1354” interim caries arresting medicament application – per tooth \$15.00

Conservative treatment of an active, ***non-symptomatic*** carious lesion by topical application of a caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure.

Questions:

- Questions regarding Medicaid FFS policy should be directed to the Office of Health Insurance Programs (OHIP), Division of Program Development and Management at (518) 473-2160 or dentalpolicy@health.ny.gov.
- Questions regarding MMC reimbursement and/or documentation requirements should be directed to the enrollee’s MMC plan.

Medicaid Fee-for Service Coverage Policy and Billing Guidance for Vaccinations

This article provides New York State (NYS) Medicaid fee-for-service's (FFS) vaccine coverage policy and consolidates existing NYS FFS billing policies for vaccinations provided by NYS Medicaid enrolled office-based practitioners, ordered ambulatory providers, Article 28 outpatient facilities [including hospital outpatient departments, Federally Qualified Health Centers (FQHC), Diagnostic & Treatment Centers (D&TC), and Local County Health Departments (LCHD)] and School Based Health Centers (SBHC). This article provides billing instructions for vaccines:

- available via the Vaccines for Children (VFC) Program, not available via the VFC Program for children under 19 years of age,
- for adults 19 years of age and older, and for Medicaid FFS and Medicaid Managed Care (MMC) members in SBHC.

Vaccine Coverage Policy

NYS FFS covers medically necessary adult and child vaccinations administered as recommended by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP). Once ACIP has voted in favor of a change in vaccine recommendations, NYS FFS will adopt the new recommendation. Additional information on ACIP Vaccine Recommendations and Guidelines can be found at: <https://www.cdc.gov/vaccines/hcp/acip-recs/index.html>.

The Vaccines for Children Program (VFC)

The VFC Program is a federally funded program that provides vaccines at no cost to eligible children under 19 years of age. VFC vaccines are distributed to enrolled VFC providers to administer to VFC-eligible children. VFC providers may also obtain other publicly funded vaccines to serve children eligible under other criteria. Medicaid will reimburse \$17.85 for the **administration** of VFC-available vaccines to Medicaid members under 19 years of age. Medicaid **will not** reimburse providers for the **cost** of vaccines available through the VFC program.

Vaccines available through the VFC Program are subject to change. The CDC maintains a current list of VFC-available vaccines. A current list of vaccines available through the VFC Program can be found at the following link: <https://www.cdc.gov/vaccines/programs/vfc/awardees/vaccine-management/price-list/index.html>.

Publicly purchased vaccines for Adult Medicaid members

The Vaccines for Adults (VFA) program is intended for adults without access to vaccines and for the control of vaccine-preventable disease outbreaks. Vaccines for routine immunization of Medicaid members 19 years of age and older must be purchased by the provider. Medicaid members 19 years of age and older are only eligible for publicly purchased vaccines from select providers under specific conditions, such as for outbreak-response measures.

Practitioners and Ordered Ambulatory

The following is vaccine billing guidance for office-based practitioners and providers billing vaccinations as an Ordered Ambulatory service. Ordered Ambulatory services are those services provided in a clinic setting on the order and/or referral of a qualified health care provider not affiliated with the clinic providing the Ordered Ambulatory service.

VFC Vaccine Administration for Children under 19 years of age

To be reimbursed for the administration of vaccines supplied by or available through the VFC Program, providers will be required to bill using the current procedural terminology (CPT) code of the vaccine/toxoid administered, along with the “**SL**” modifier (indicating the administration of a vaccine supplied by or available

through the VFC Program or a vaccine supplied at no cost) and the vaccine administration CPT code “**90460**”. Providers will be reimbursed **\$17.85** for the administration of the vaccine.

“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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Vaccine Administration for Adults and Non-VFC Vaccines for Children under 19 years of age

For the administration of vaccines (*except for vaccines supplied at no cost*) for adults 19 years of age and over, and for the administration of vaccines not provided by or available through the VFC program (e.g. travel-related vaccines) for children under 19 years of age, providers will be required to bill the specific CPT code of the vaccine/toxoid administered at the actual acquisition cost with the appropriate vaccine administration CPT code listed 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

For the administration of any vaccines supplied at no cost to Medicaid members 19 years of age and older, providers must use the “**FB**” modifier (indicating a vaccine supplied at no cost) with the CPT code of the vaccine/toxoid administered on the service line. Providers will be reimbursed **\$13.23** for the administration of the vaccine. No separate or additional vaccine administration CPT code is required.

Article 28 Facilities

The following is vaccine billing guidance for Article 28 hospital outpatient departments, FQHCs, D&TCS, and LCHDs that bill using the Ambulatory Patient Group (APG) reimbursement methodology.

Vaccine Administration for Children under 19 years of age

Vaccines supplied by or available through the VFC Program for children under 19 years of age are reimbursed via APGs. Providers will be required to bill the CPT code of the vaccine/toxoid administered with the “**SL**” modifier (indicating the administration of a vaccine supplied by or available through the VFC Program or a vaccine supplied at no cost). Providers will be reimbursed **\$17.85** for the administration of the vaccine. No separate or additional vaccine administration CPT code is needed.

Vaccine Administration for Adults and Non-VFC Vaccines for Children under 19 years of age

Vaccinations for Medicaid members 19 years of age and older are reimbursed via APGs. Providers are to bill the vaccine/toxoid CPT code administered to receive the APG line item reimbursement. A separate reimbursement of **\$13.23** will be made for the administration of the influenza and/or pneumococcal vaccine for adults 19 years of age and older when the following vaccine administration codes are added to the claim:

- Influenza – “**G0008**”
- Pneumococcal – “**G0009**”

All other vaccinations administered to Medicaid members 19 years of age and older, and vaccines for members under the age of 19 years not covered by the VFC program (e.g. travel-related vaccines), are also

reimbursed via APGs using the CPT code of the vaccine/toxoid administered. No separate vaccine administration CPT code is required. Reimbursement for vaccine administration is included within the APG reimbursement made to the facility.

Providers that administer any vaccines supplied at no cost, including influenza and pneumococcal, to Medicaid members 19 years of age and older must use the “**FB**” modifier (indicating a vaccine supplied at no cost) with the CPT code of the vaccine/toxoid administered. Providers will be reimbursed **\$13.23** for the administration of the vaccine. No separate or additional vaccine administration CPT code is required.

Federally Qualified Health Centers (FQHCs)

FQHCs that opt out of the APG classification and reimbursement methodology receive the Federal Prospective Payment System (PPS) rate for all services provided to a Medicaid member for the entire visit. FQHCs may submit a PPS threshold clinic claim if the vaccine is administered as part of an encounter in which a significant procedure and/or medical visit accompanies the vaccination.

FQHCs that bill under the PPS rate should not submit a claim for reimbursement seeking the PPS threshold clinic visit rate when the **only** service provided to a member is a vaccine administration. Instead, FQHCs should seek reimbursement for the vaccine and vaccine administration as an ordered ambulatory service by using the guidance provided in the above *Practitioner and Ordered Ambulatory* section and the NYS Medicaid Freestanding or Hospital Based Ordered Ambulatory fee schedule found at: <https://www.emedny.org/ProviderManuals/OrderedAmbulatory/index.aspx>.

School Based Health Centers (SBHC)

Influenza and pneumococcal vaccinations provided at SBHCs for either Medicaid FFS members or MMC enrollees are billable using the following, non-APG rate codes:

- Influenza – Rate code “**1381**”
- Pneumococcal – Rate code “**1383**”

Providers are to use the CPT code of the vaccine/toxoid administered with the appropriate rate code (listed above) to be reimbursed **\$17.85** for the administration of influenza and/or pneumococcal vaccines supplied by or available through the VFC program. No separate or additional vaccine administration CPT code is required.

SBHCs should bill all other vaccinations utilizing one of the APG rate codes listed below. The provider must append the “**SL**” modifier to the CPT code of the influenza vaccine/toxoid administered (indicating the administration of a vaccine supplied by or available through the VFC Program or a vaccine supplied at no cost) to be reimbursed **\$17.85**. No separate or additional vaccine administration CPT code is required.

- Hospital Outpatient Department SBHC Rate codes – Visit “**1444**”; Episode “**1450**”
- Diagnostic & Treatment Center SBHC Rate codes – Visit “**1447**”; Episode “**1453**”

Non-Patient Specific Standing Orders - All Providers

When provided within their scope of practice, licensed health care practitioners may administer vaccines under non-patient specific or standing orders. The list of vaccines that can currently be administered under non-patient specific orders and the NYS Education Department’s (NYSED) Protocol Requirements can be accessed at the following link: <http://www.op.nysed.gov/prof/nurse/immunguide.htm>.

Questions and Additional Information:

- Additional information on the NYS VFC program and child eligibility requirements can be found at: https://www.health.ny.gov/prevention/immunization/vaccines_for_children/.
- Questions regarding the VFC and/or the VFA program can be directed to: nyvfc@health.ny.gov.
- Medicaid FFS coverage and policy questions should be directed to the Office of Health Insurance Programs (OHIP), Division of Program Development and Management at (518) 473-2160.
- MMC reimbursement, billing, and/or documentation requirement questions should be directed to the enrollee's MMC plan.

- FFS claim questions should be directed to the eMedNY call center at (800) 343-9000.

Pharmacy Questions and Additional Information:

- Guidance on Medicaid pharmacy billing for vaccines can be found in the *NYS Medicaid Program Pharmacists as Immunizers Fact Sheet* available at: https://www.health.ny.gov/health_care/medicaid/program/docs/phar_immun_fact.pdf.
- Questions regarding MMC pharmacy reimbursement and/or billing requirements should be directed to the enrollee's MMC plan. Information for the individual plans can be found here: <http://mmcdruginformation.nysdoh.suny.edu/>.
- Questions regarding FFS pharmacy claims should be directed to the eMedNY Call Center at (800) 343-9000.

Pharmacy

Matching Origin Codes to Correct Prescription Serial Number in Medicaid Fee-for-Service

Reminder. Prescriptions billed to Medicaid fee-for-service (FFS) require the appropriate origin code and corresponding serial number; the information describes the format the prescription was received. Serial numbers are a unique alphanumeric number on the bottom right of an Official New York Prescription Form (ONYSRx). The table below describes all the different circumstances a prescription may be obtained at various pharmacy types; and will assist in choosing the correct match. **Note:** Prescriptions received from a 'care coordinator' or other party other than the prescribing practitioner are not valid.

It has been noticed that many pharmacies are billing with **incorrect information**; there have been and will continue to be audits on these fields submitted by pharmacies. Providers should utilize the following chart to make the serial number determination:

Origin Code	Corresponding Serial Number Determination	Description
1	Unique ONYSRx #	Written - Prescriptions prescribed in New York will be on official New York prescription forms with a designated serial number to use.
1	ZZZZZZZZ	Written - Prescriptions prescribed from out-of-state providers or by prescribers within a federal institution (e.g., United States Department of Veterans Affairs) or Indian Reservation.
2	99999999	Telephone - Prescriptions obtained via oral instructions or interactive voice response using a telephone.
2	SSSSSSSS	Telephone – Fiscal orders obtained via oral instructions using a telephone.*
3	EEEEEEEEE	Electronic - Prescriptions obtained via SCRIPT or Health Level 7 (HL7) standard transactions, or electronically within closed systems.**
4	Unique ONYSRx #	Facsimile – non-controlled ONYSRx prescriptions and fiscal orders obtained via fax machine transmission.*
4	SSSSSSSS	Facsimile – Fiscal Orders not on a ONYSRx obtained via fax machine transmission.*
4	NNNNNNNN	Facsimile – non-controlled prescriptions obtained via fax machine transmission for nursing home patients *** (a.k.a "roster billing") in accordance with written procedures approved by the medical or other authorized board of the facility.
5	TTTTTTTT	Pharmacy - this value is used to cover any situation where a new Rx number needs to be created from an existing valid prescription such as traditional transfers, intra-chain transfers, file buys, software upgrades/migration, and any reason necessary to give it a new number.****
5	99999999	Pharmacy - this value is appropriate for "Pharmacy dispensing" when applicable such as non-patient specific orders (immunizations), BTC (behind the counter), Plan B, established protocols, lab specimen collection, Clinical Laboratory Improvement Amendments (CLIA)-waived testing, pharmacist's authority to prescribe, etc.
5	DDDDDDDD	Pharmacy - this value is used to cover prescriptions dispensed as "Medically Necessary during a Declared State of Emergency" (excluding controlled substances).

**Oral or facsimile Fiscals not on ONYSRx are not considered an original order. The dispensing provider is required to obtain the original signed Fiscal order from the ordering provider within 30 days. An original order is defined as: A prescription or fiscal order, received in written or electronic format, that is executed in accordance with all applicable State and federal law or regulation; also can be known as a hard copy or follow up if written in response to an oral or faxed order. Facsimile prescriptions are not valid without a unique ONYSRx#.*

***Fail-over electronically transmitted prescriptions that come to the pharmacy as a facsimile are invalid. Reference: <http://www.op.nysesd.gov/prof/pharm/pharmelectrans.htm>.*

****As per NYS Education Department Law (SED) Article 137 §6810(7)(b) and Regents Rules Section 29.7(a)(1).*

*****Remember to use original date prescribed as “written date” when processing prescription transfers. Transfers are not allowed for controlled substances in New York State.*

Questions

Questions regarding this billing requirement should be directed to the eMedNY Call Center at (800) 343-9000.

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 <https://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).

For 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, please enroll online at <https://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>

eMedNY

For a number of services, including: change of address, updating an enrollment file due to an ownership change, enrolling another NPI, or revalidating an existing enrollment, please visit: <https://www.emedny.org/info/ProviderEnrollment/index.aspx> and choose the appropriate link based on provider type.

NY Medicaid Electronic Health Record (EHR) Incentive Program

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

Comments and Suggestions Regarding This Publication

Please contact the editor, Georgia Wohnsen, at medicaidupdate@health.ny.gov.