



Medicaid Update

The Official Newsletter of the New York State Medicaid Program

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NY Medicaid EHR Incentive Program Update

The NY Medicaid Electronic Health Record (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 **over \$681 million** in incentive funds have been distributed **within 18,737** payments to New York State Medicaid providers.

18,737

Payments

\$681+

Million Paid

Are you
eligible?

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

Taking a closer look: NY Medicaid EHR Incentive Program Updates

- July webinar dates on our [Upcoming Event Calendar](#)
- **NEW** [Frequently Asked Questions \(FAQs\)](#) about audit documentation
- **NEW** Reference page for FAQs published by the Centers for Medicare and Medicaid Services (CMS) about the [public health objectives](#)

Did you know?

New York State has two Regional Extension Centers (RECs) that provide support services to healthcare providers as they navigate the EHR adoption process and achievement of meaningful use.

NYC Regional Electronic Adoption Center for Health (NYC REACH) aims to help providers adopt health information technology and new methods of patient-centered care that measurably improve the health of New Yorkers. It is the vision of NYC REACH to catalyze a fundamental reorientation of the NYC health care system towards prevention and health outcomes through the meaningful use of EHRs and EHR-derived data by physicians and health plans.

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NYC REACH offers support services to providers located in the five boroughs of New York City.

Website: www.nycreach.org Email: pcip@health.nyc.gov Phone: 347-396-4888

New York eHealth Collaborative (NYeC) is a not-for-profit organization, working to improve healthcare for all New Yorkers through innovative health information technology. In support of the grant by the Office of the National Coordinator (ONC) to create a REC in New York State, NYeC's Healthcare Advisory Professional Services (HAPS) team delivers services that help providers choose the right software and learn how to use it effectively.

NYeC offers support services to providers located outside of New York City, including the upstate region and Long Island.

Website: www.nyehealth.org Email: hapsinfo@nyehealth.org Phone: 646-619-6400

NYC REACH and NYeC operate the **Medicaid Eligible Professional Expansion Program (EP2)**, which is an extension of NYS DOH Medicaid Specialist REC initiative that provides outreach, technical, and support services for EHR adoption and achieving Meaningful Use (MU). Eligible professionals previously ineligible to receive support from the RECs are encouraged to enroll in this MU extension program. The EP2 program has been extended until September 30, 2016 and has added direct assistance for eligible professionals to achieve Meaningful Use Stage 2.

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

Revised Reimbursement Methodology for Practitioners Providing Services to Medicare/Medicaid Dually Eligible Individuals

Effective July 1, 2015 a change to New York State Social Services Law adjusts Medicare Part B coinsurances reimbursement methodology for practitioner claims: Medicaid presently pays practitioners the full Medicare Part B annual deductible and partial Medicare Part B coinsurance amounts (20 percent of the Part B coinsurance) for Medicaid covered services provided to Medicare/Medicaid dually eligible recipients. Pursuant to recent changes to Social Services Law, New York State Medicaid has revised the reimbursement methodology for practitioner claims effective July 1, 2015. **Beginning July 1, 2015,** Medicaid is no longer reimbursing partial Medicare Part B coinsurance amounts. The total Medicare/Medicaid payment to the provider will not exceed the amount that the provider would have received for a Medicaid-only patient. If the Medicare payment is greater than the Medicaid fee, no additional payment will be made.

Note: The Medicare and Medicaid payment (if any) must be accepted as payment in full. Per State regulation 18 NYCRR Section 360-7.7, a provider of a Medicare Part B benefit cannot seek to recover any Medicare Part B deductible or coinsurance amounts from Medicare/Medicaid Dually Eligible Individuals.

There is no change to the current reimbursement methodology of Medicare Part B coinsurance for the following: Ambulance providers; Psychologists; Article 16 clinics; Article 31 clinics; and Article 32 clinics. Medicaid will continue to reimburse these providers the full Medicare Part B coinsurance.

Reminder: If a patient is dually eligible, private practitioners must bill Medicare prior to billing Medicaid for the Part B co-insurance. Most claims are submitted to Medicare and are automatically crossed over to Medicaid for processing.

New Fee Schedule for Air Ambulance Trips

Attention Air Ambulance Providers:

Air Ambulance includes both rotary wing (i.e., helicopter) and fixed wing (i.e., airplane) services, and is often used to transport the most critical patients in both emergency and non-emergency situations.

The enacted 2015-16 New York State Budget authorizes the Medicaid program to increase the Medicaid pickup and mileage fees for Air Ambulance Trips statewide effective **May 15, 2015 as depicted in the table below:**

Service	Procedure Code	Fee Effective May 15, 2015
Rotary Wing - Pickup	A0431	\$5017.74
Rotary Wing - Mileage	A0436	\$33.65
Fixed Wing – Pickup	A0430	\$4315.78
Fixed Wing – Mileage	A0435	\$12.60

Questions? Please contact the Medicaid Transportation Unit via email at MedTrans@health.ny.gov.

Add-on Mileage for Certain Trips Now Available

Attention New York City Ambulance Providers:

Historically, add-on mileage has not been paid to New York City ambulance providers. However, the enacted 2015-16 State Budget authorizes the Department to reimburse New York City ambulance vendors for add-on loaded mileage at a fee of \$2.75 per mile, when performing **NON-EMERGENCY Basic Life Support (BLS)** trips (i.e., those coded under A0428). This change was effective **May 15, 2015**.

The Department’s transportation manager, LogistiCare Solutions, will apply the applicable mileage code and units to prior authorizations according to the parameters of this new policy.

If you have questions concerning retroactive prior authorization adjustments, please contact LogistiCare at 1-877-564-5924.

Questions concerning Medicaid transportation policy? Please contact the Medicaid Transportation Unit at MedTrans@health.ny.gov.

New York State Medicaid Updates Regulations

This article supersedes the one published in the March 2015 Medicaid Update

In response to litigation filed in federal court by several organizations, the Department of Health revised its regulations to repeal the existing prohibition on Medicaid coverage for transition-related transgender care and services. These revisions were the result of a comprehensive analysis of evidence-based practices, scientific literature, and stakeholder comments.

Effective March 11, 2015, the regulations outline the specific requirements, under both New York State fee-for-service Medicaid and Medicaid Managed Care, for coverage of transition-related care and services for persons diagnosed with gender dysphoria. Gender dysphoria is the diagnosis given to persons whose gender assigned at birth does not match the gender with which they identify and who experience clinically significant distress as a result. This condition may be manifested by a strong desire to be treated as the other gender, or to be rid of one's sex characteristics, or by a strong conviction that one has feelings and reactions typical of the other gender. Treatments for gender dysphoria may include counseling, hormone therapy, and/or gender reassignment surgery, depending on the gender goals of the patient. The Medicaid program has covered and will continue to cover counseling services for individuals with gender dysphoria.

Effective March 11, 2015, the Medicaid program will now cover medically necessary cross-sex hormone therapy and gender reassignment surgery for individuals with a diagnosis of gender dysphoria (ICD-9 code 302.85). Medically necessary cross-sex hormone therapy is covered for individuals 18 years of age and older. Medicaid reimbursement is only available for conjugated estrogens, estradiol, and testosterone cypionate at this time.

Gender reassignment surgery is covered for individuals who are 18 years of age or older, or 21 years of age or older if that surgery will result in sterilization. If the surgery will result in sterilization, the sterilization consent form must be completed at least 30 days, but not more than 180 days, prior to surgery: [Sterilization Consent Form](#).

Physicians performing gender reassignment surgery must also obtain, and retain in their records, letters from two New York State licensed health professionals recommending surgery for the patient. One letter must be written by a New York State licensed psychiatrist or psychologist who has an ongoing relationship with the patient. The second letter may be written by a New York State licensed psychiatrist, psychologist, physician, or clinical social worker working within their scope of practice. The recommendation for surgery in each letter must be based on an independent assessment/evaluation of the individual.

At a minimum, these letters must establish that the individual:

1. Has a persistent and well-documented case of gender dysphoria;

2. Has received hormone therapy appropriate to the individual's gender goals, which shall be for a minimum of 12 months in the case of an individual seeking genital surgery, unless hormone therapy is medically contraindicated or the individual is otherwise unable to take hormones;
3. Has lived for 12 months in a gender role congruent with the individual's gender identity, and has received mental health counseling, as deemed medically necessary, during that time;
4. Has no other significant medical or mental health conditions that would contraindicate gender reassignment surgery, or if so, that those conditions are reasonably well-controlled prior to surgery;
5. Has the capacity to make a fully informed decision and to consent to treatment.

Payment will not be made for the following services:

- Cryopreservation, storage, and thawing of reproductive tissue, and all related services and charges;
- Reversal of genital and/or breast surgery;
- Reversal of surgery to revise secondary sex characteristics;
- Reversal of any procedure resulting in sterilization.

Payment will not be made for any procedures that are performed solely for the purpose of improving an individual's appearance. The following procedures will be presumed to be performed solely for the purpose of improving appearance and will not be covered, unless justification of medical necessity is provided and prior authorization is received:

- Abdominoplasty, blephoroplasty, neck tightening, or removal of redundant skin;
- Breast augmentation*;
- Breast, brow, face, or forehead lifts;
- Calf, cheek, chin, nose, or pectoral implants;
- Collagen injections;
- Drugs to promote hair growth or loss;
- Electrolysis, unless clinically indicated for vaginoplasty or phalloplasty;
- Facial bone reconstruction, reduction, or sculpturing, including jaw shortening and rhinoplasty;
- Hair transplantation;
- Lip reduction;
- Liposuction;
- Thyroid chondroplasty;
- Voice therapy, voice lessons, or voice modification surgery.

*For male-to-female transgender individuals, augmentation mammoplasty will be considered medically necessary, regardless of whether the individual plans to pursue genital surgery, when both of the following criteria are met:

- 1.) The patient meets all the pre-requisites for gender reassignment surgery set forth in the regulation; and
- 2.) The patient has completed a minimum of 24 months of hormone therapy during which time no breast growth has occurred, or hormone therapy is medically contraindicated or the patient is otherwise unable to take hormones.

For female-to-male transgender individuals, mastectomy is a covered service, provided that the pre-requisites for surgery have been met.

Post-Transition Care

New York State Medicaid recognizes that transgender individuals may require a unique set of gender-based services once they begin or complete their transition (e.g., prostate-related care may be needed by a transgender individual whose assigned gender at birth was male but whose gender marker has been changed to female). System edits will be implemented to ensure access to critical services for individuals who are in the process of transitioning or have completed their transition.

Individuals who have undergone gender reassignment may no longer meet the definition of gender dysphoria as laid out in the DSM-V. For these individuals only, where a dysphoria diagnosis is no longer appropriate, the following ICD-9 diagnosis codes may be included on claims for maintenance hormones and post-transition care: 302.50; 302.51; 302.52; 302.53.

Fee-for-Service Billing Instructions for Gender Reassignment Surgery

When billing for gender reassignment surgery, providers will submit a paper claim using procedure code 55970 or 55980. Providers are required to include copies of the two letters recommending surgery with their paper claim. It is the responsibility of the provider to verify that all pre-requisites have been met prior to surgery. Gender reassignment surgery will only be reimbursed when it is billed with ICD-9 diagnosis code 302.85.

New York State Medicaid considers both phalloplasty and metoidioplasty to be medically necessary procedures for female to male transitions. When reporting procedure code 55980 for New York State Medicaid recipients, the surgeon will have to identify if a phalloplasty or metoidioplasty was performed.

When clinically indicated, hair removal is included as part of the above surgery codes.

For standalone procedures (e.g., orchiectomy, hysterectomy, etc.), providers should bill the distinct CPT, HCPCS, or ICD-9 codes that correctly identify the procedure.

Transgender related care and services are not covered services for individuals with Emergency Services Only Medicaid coverage.

Specific billing guidance for use of procedure codes 55970 and 55980 is available in the Physician Manual at: <https://www.emedny.org/ProviderManuals/Physician/PDFS/Physician%20Procedure%20Codes%20Sect5.pdf>.

In a future Medicaid Update, additional information will be provided regarding billing Medicaid fee-for-service using procedure codes 55970 and 55980. Medicaid fee-for-service policy questions may be directed to OHIP Division of Program Development and Management at (518) 473-2160. For Medicaid Managed Care (MMC) enrollees, providers should contact the enrollee's MMC plan for implementation details.

The New York Medicaid Management Information System Project Website

The New York State Department of Health and Xerox State Healthcare, LLC are working diligently on the design and development of the new Medicaid Management Information System, called NYMMIS.

NYMMIS has an interim website on-line that was created to serve as an 'information billboard'. It will be used as a main source for communicating information by providing updates and email bulletins regarding the implementation of the new system. Updates will be provided on a regular basis in an effort to share relevant NYMMIS information that may potentially impact providers' business processes.

The interim website hosts a ListServ signup section. Those who sign up for the ListServ are able to receive timely emails that contain updates on the projects that might affect them.

The interim NYMMIS website will have no impact on eMedNY nor will it be used for provider billing or other transactions.

Please visit: www.interimnymmis.com

Continued Medicaid Enrollment for Therapists, Dentists, Clinical Psychologists and Podiatrists

Federal regulation 42 CFR, Part 455.414 requires New York State Medicaid to revalidate your enrollment every five years. Revalidation involves completion of the enrollment form for Therapists (Occupational, Physical, and Speech-Language), Dentists, Clinical Psychologists and Podiatrists. Additionally, Physical Therapists may require a site visit.

The Revalidation process for Therapists, Dentists, Clinical Psychologists and Podiatrists **has begun**. Revalidation letters have been mailed to providers actively submitting claims to Medicaid. Find out more about Revalidation by clicking on the links below.

Click [here](#) for more information on Revalidation

Click [here](#) for the Occupational Therapist Enrollment Form and Instructions

Click [here](#) for the Physical Therapist Form and Instructions

Click [here](#) for the Speech-Language Therapist Enrollment Form and Instructions

Click [here](#) for the Dentist Enrollment Form and Instructions

Click [here](#) for the Podiatrist Enrollment Form and Instructions

Click [here](#) for the Clinical Psychologist Enrollment Form and Instructions

All Providers

ICD-10 Reminder for Providers and Vendors

- The eMedNY Provider Testing Environment (PTE) is available for end-to-end testing of Medicaid claims with ICD-10 diagnosis codes (procedure codes for inpatient hospitals). The PTE mirrors the eMedNY production environment, in both content and functionality. Submitters and providers can be assured that successful testing through the PTE will minimize potential issues with submission of their production files come October 1, 2015. All Medicaid partners are urged to test at their earliest convenience.
- The <https://www.emedny.org/icd/index.aspx> website provides an extensive amount of eMedNY related ICD-10 information including FAQs and eMedNY end-to-end testing. The area should be visited regularly to ensure submitters have the most up to date ICD-10 information.
- Providers and vendors are encouraged to regularly access the federal Centers for Medicare and Medicaid Services ICD-10 website www.cms.gov/Medicare/Coding/ICD10/index.html for the most comprehensive and detailed compilation of ICD-10 resources including Intro Guide to ICD-10, ICD-10 and Clinical Documentation, ICD-10 Official Coding Guidelines, General Equivalence Mappings (GEMs), and many other documents focusing on all aspects of ICD-10 implementation.
- Medicaid providers are reminded that they are ultimately responsible for ensuring that the data submitted to New York Medicaid by them, or a third party on their behalf, is correct and compliant with mandated standards and regulations. As such it is of utmost importance that providers take a proactive role and work diligently with their staff, clearinghouse, billing service or software vendor to ensure their practice will be able to successfully submit ICD-10 compliant transactions for services rendered on or after October 1, 2015.
- Effective October 1, 2015 New York Medicaid will only accept, recognize and process ICD-10 codes for services rendered on or after October 1, 2015. ICD-9 codes will only be accepted for services rendered prior to October 1, 2015. **Transactions which contain ICD-9 codes, with a date of service of October 1, 2015 or after will be rejected.**

October 1, 2015 is only three months away. Transition to ICD-10 will take time and resources. If you are not yet preparing for transitioning to ICD-10 the time to start is now. Do not put your Medicaid payments at risk by delaying your compliance efforts.

Pharmacy Update

Medicaid Fee for Service Pharmacy Billing Instructions for Coordination of Benefits (COB) Submission

Coordinating benefits ensures the correct party pays first. Medicaid is the payer of last resort. This means when a patient has other insurance or Medicare, federal regulations require that all available resources be used before Medicaid considers payment. If there is a responsible third party who should be paying for the patients' health benefits, for example a health insurance provider, that responsible third party should be paying first.

Medicaid pays the lesser of Patient Responsibility (PR) or the Medicaid fee regardless of the PR amount. For pharmacy this rule applies to all PR, which includes deductible, co-insurance, copay and other patient responsibility.

The following list of values reported in field 308-C8 (Other Coverage Code) are considered acceptable. This field is used by the pharmacy to indicate whether or not the patient has other insurance coverage or is enrolled in a Medicare Managed Care organization. Valid entries for field 308-C8 are:

- 0 = Not Specified by patient, "0" is the default value.
- 1 = No Other Coverage, Code used in coordination of benefits transactions to convey that no coverage is available. This value must **only** be submitted **AFTER** the provider has exhausted all means of determining pharmacy benefit coverage and no other coverage was identified. Coordination of Benefits/Other Payments Segment must not be sent. **This value must not be used as a default.**
- 2 = Other Coverage Exists, Payment Collected. Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment received. Used when Total Amount Paid (509-F9) from a prior payer is greater than zero. Coordination of Benefits/Other Payments Segments is required.
- 3 = Other Coverage Exists, This Claim Not Covered. Code used in coordination of benefits transactions to convey that coverage is available, the payer has been billed and payment denied because the service is not covered.
- 4 = Other Coverage Exists, Payment Not Collected- If the Total Amount Paid (509-F9) <=0. **Code used in coordination of benefits transactions to convey that other coverage is available, the payer has been billed and payment has not been received.**

The following failed edit was implemented on the specified value submitted in field 308-C8 effective June 18, 2015:

- **Submission of Other Coverage Code "8"- (Billing for Co-pay). This value will no longer be allowed, as full disclosure is required.**
- **Edit 02227 (Claims Other Insurance Payment Collection Code is Equal to "8") will be failed when the value of "8" is sent in field 308-C8. The NCPDP Reject code "13" (M/I Other Coverage Code) will be returned on the rejected response**

A previous article on this subject was released in the May 2014 Medicaid Update and can be found at: http://www.health.ny.gov/health_care/medicaid/program/update/2014/may14_mu.pdf

Contact the eMedNY Call Center at (800) 343-9000 for questions regarding COB billing.

Provider Directory

Office of the Medicaid Inspector General:

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

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

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

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

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

Do you have questions about billing and performing MEVS transactions?

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

Provider Training:

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

Enrollee Eligibility:

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

Medicaid Prescriber Education Program:

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

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

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

Medicaid Electronic Health Record Incentive Program questions?

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

Comments and Suggestions Regarding This Publication?

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