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Medicaid Update

THE OFFICIAL NEWSLETTER OF THE NEW YORK STATE MEDICAID PROGRAM

Medicaid Breast Cancer Surgery Centers Update

It is the policy of the New York State Department of Health (NYSDOH) that Medicaid beneficiaries receive mastectomy and lumpectomy procedures, associated with a breast cancer diagnosis, at high volume facilities averaging thirty or more surgeries or procedures from all payers annually over a three-year period. Low-volume facilities will not be reimbursed for breast cancer surgeries provided to Medicaid beneficiaries. This policy is part of an ongoing effort to reform New York State Medicaid and to ensure the purchase of cost-effective, high-quality health care and better outcomes for its beneficiaries. Research indicates that five-year survival increases for women having their breast cancer surgery performed at high-volume facilities and by high-volume surgeons.

NYSDOH has completed its annual review of all-payer breast cancer surgical volumes for 2008 through 2010 and identified 69 low-volume hospitals and ambulatory surgery centers throughout New York State. These facilities have been notified of this restriction. This policy does not affect a facility's ability to provide diagnostic or excisional biopsies and post-surgical care (chemotherapy, radiation, reconstruction, etc.) for Medicaid patients. Other facilities in the same region as the restricted facilities have met or exceeded the volume threshold and Medicaid patients who require breast cancer surgery should be directed to those providers.

The Department will annually re-examine all-payer surgical volumes to revise the list of low-volume hospitals and ambulatory surgery centers. This assessment is performed using the Statewide Planning and Research Cooperative System (SPARCS) database. The annual review will also allow previously restricted providers meeting the minimum three-year average all-payer volume threshold to provide breast cancer surgery services for Medicaid beneficiaries.

For more information and the list of restricted low-volume facilities, please visit: http://www.nyhealth.gov/health_care/medicaid/quality/surgery/cancer/breast/.

Please contact (518) 486-9012 with any questions.



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APRIL 2012 NEW YORK STATE MEDICAID UPDATE

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Mandatory Medicaid Managed Care Expanding To Schuyler and Steuben Counties

Effective May 1, 2012, managed care enrollment will be required for most Medicaid beneficiaries residing in **Schuyler and Steuben** counties. Once a mandatory managed care program is implemented in a county, it is expected that the enrollment of all eligible Medicaid beneficiaries will take up to twelve months to complete.



The health plan choices and the health plan's customer service phone number available in these two counties are Excellus Health Plan (800-650-4359) and Fidelis Care (888-343-3547). **Please note, as of May 1, 2012, Southern Tier Priority Health Care and Southern Tier Pediatrics will no longer be available in these two counties.**

Please note, as of May 1, 2012, Southern Tier Priority Health Care and Southern Tier Pediatrics will no longer be available in these two counties.

Providers should check the Medicaid Eligibility Verification System (MEVS) prior to rendering services to determine Medicaid eligibility and the conditions of Medicaid coverage. Providers are strongly encouraged to check eligibility at each visit as eligibility and enrollment status may change at any time. If the Medicaid beneficiary is enrolled in a Medicaid managed care plan, the first coverage message will indicate "Eligible PCP".

MEVS responses no longer include scope of benefits information so providers will need to contact the health plan to determine services covered by them. Service Type codes will be used to identify carved-out services where possible. **Medicaid will not reimburse a provider on a fee-for-service basis if a medical service is covered by the plan.**

For more information on the 5010 implementation, please see the February 2011 Special Edition Medicaid Update at:

http://health.ny.gov/health_care/medicaid/program/update/2011/2011-2_special_edition.htm.

Providers may call the eMedNY Call Center at (800) 343-9000 with any Medicaid billing issues. Medicaid beneficiaries may call NY Medicaid Choice at (800)505-5678 or contact their local department of social services (LDSS) to learn more about managed care. For additional information on managed care covered services and managed care plan types, please see the December 2010 Medicaid Update article entitled "Managed Care Covered Services" at:

http://health.ny.gov/health_care/medicaid/program/update/2010/2010-12.htm.

Roll Out of New Enrollment Plan for Mandatory Managed Long Term Care and Care Coordination Models

As a component of a fully integrated care management system for all Medicaid beneficiaries, Medicaid Redesign Team Proposal #90 and 2011 budget legislation requires the transition and enrollment of certain community-based long term care services recipients into Managed Long Term Care Plans (MLTCPs) or Care Coordination Models (CCMs). New York State operates three models of MLTCP: the Program of All-Inclusive Care for the Elderly (PACE); Medicaid Advantage Plus Plans; and partially capitated managed long term care plans (PCMLTCP). All models of MLTCPs and CCMs provide community-based long term care services, nursing home care and many ancillary services, including individualized care management.



Mandatory enrollment for certain populations will begin on July 2, 2012.

The Mandatory Population is defined as: Dual Eligible (eligible for both Medicare and Medicaid benefits), aged 21 and over, in need of community-based long term care services for over 120 days and excluding at this time the following groups:

- Nursing Home Transition and Diversion Waiver participants;
- Traumatic Brain Injury Waiver participants;
- Nursing Home residents;
- Assisted Living Program participants;
- Dual eligible individuals who do not require community-based long term care services.

Community-based long term care services include home health care, personal care, adult day health care and private duty nursing.

In addition to those individuals who must enroll in a MLTCP/CCM, the following populations may voluntarily enroll:

- Dual eligible individuals, either nursing home eligible or non-nursing home eligible, aged 18 to 21 in need of community-based long term care services for over 120 days.
- Non-dual eligible individuals, aged 18 and older, assessed as eligible for nursing home care. These individuals may opt out of Medicaid Managed Care and enroll in a MLTCP/CCM but would be required to re-enroll in Medicaid Managed Care if disenrolled from the MLTCP/CCM.

Mandatory enrollment will begin in New York City and rollout to other counties according to the following schedule.

Phase I: New York City – New Service Clients

Beginning July 2, 2012, any Dual Eligible new to service, fitting the mandatory population definition, residing in New York City (New York, Bronx, Kings, Queens and Richmond counties) will be identified for enrollment into a MLTCP/CCM and referred to the Enrollment Broker for information, assistance and enrollment activities. New to service means any first-time Medicaid recipient or any current Medicaid recipient applying to receive or deemed to require community-based long term care services at the time of the mandatory enrollment phase-in.

The Enrollment Broker can answer questions about the enrollment process and will provide the client with educational material, a list of MLTCPs/CCMs, and, if requested by the client, assistance in contacting a plan. The MLTCP/CCM will conduct an assessment to determine if the client is eligible for community based long term care. The MLTCP/CCM transmits the enrollment information to the Enrollment Broker.

The client may contact the Local Department of Social Services/Human Resources Administration, or the MLTCP/CCM may assist the client with completion and submission of the Medicaid application, if needed.

Phase I: New York City – Clients Already Receiving Service

For clients already receiving community-based long term care services, enrollment into a MLTCP/CCM will be phased-in by service type by borough and by zip code. Clients will have sixty days to choose a MLTCP/CCM or be auto-assigned to a MLTCP/CCM based on the following schedule:

- **July 2, 2012:** Enrollment of Personal Care cases in New York County begins.
- **August 1, 2012:** Enrollment of Personal Care cases in New York County continues.
- **September 2012:** Enrollment of Personal Care cases in New York County continues; enrollment of Personal Care cases in Bronx County begins; enrollment of Consumer Directed Personal Assistance Program cases in New York and Bronx Counties begins.
- **October 2012:** Enrollment of Personal Care and Consumer Directed Personal Assistance Program cases in New York and Bronx Counties continues; enrollment of Personal Care and Consumer Directed Personal Assistance Program cases in Kings County begins.
- **November 2012:** Continue enrollment of Personal Care and Consumer Directed Personal Assistance Program cases in New York, Bronx and Kings Counties.
- **December 2012:** Continue enrollment of Personal Care and Consumer Directed Personal Assistance Program cases in New York, Bronx and Kings Counties; enrollment of Personal Care and Consumer Directed Personal Assistance Program cases in Queens and Richmond Counties begins.
- **January 2013:** Initiate enrollments city-wide of Long Term Home Health Care Program, Adult Day Health Care Program, private duty nursing cases and home health over 120 days not already enrolled under Personal Care case activity. Home health over 120 days includes individuals receiving services from a CHHA who will continue to need community-based long term care.
- **February 2013 and continuing until all clients in service are enrolled in MLTCP/CCM:** Continue enrollment of Personal Care, Consumer Directed Personal Assistance Program, Long Term Home Health Care Program, home health over 120 days, Adult Day Health Care Program and private duty nursing cases in New York, Bronx, Kings, Queens and Richmond Counties.

Policy and Billing Guidance

Individuals receiving Personal Care while enrolled in a Medicaid Advantage Plan will begin MLTCP/CCM enrollment in January 2013.

As MLTCP/CCM capacity is established state-wide, enrollment of Dually Eligible community-based long term care service recipients is anticipated as follows:

- **Phase II:** Nassau, Suffolk and Westchester Counties anticipated January 2013.
- **Phase III:** Rockland and Orange Counties anticipated June 2013.
- **Phase IV:** Albany, Erie, Onondaga and Monroe Counties anticipated December 2013.
- **Phase V:** Other counties meeting capacity anticipated June 2014.

The final phase will include enrollment of previously excluded Dual Eligible groups contingent on development of appropriate programs and resources.

- Nursing Home Transition and Diversion Waiver participants;
- Traumatic Brain Injury Waiver participants;
- Nursing Home residents;
- Assisted Living Program participants;
- Dual Eligibles who do not require community-based long term care services;
- Persons in receipt of services from OPWDD.

Questions? Please contact the Bureau of Managed Long Term Care via e-mail at: MLTCWORKGROUP@health.state.ny.us.

Required Documentation for Transportation Providers

AMBULANCE SERVICE PROVIDERS

Ambulance service providers are responsible for maintaining the Pre-Hospital Care Report, a complete record of the ambulance trip that satisfies Medicaid's trip documentation requirements.

AMBULETTE, TAXI, LIVERY, AND GROUP RIDE PROVIDERS

For each leg of the trip, verification should be completed at the time of the trip and must include, at a minimum:

- The Medicaid enrollee's name and Medicaid identification number;
- The date of the transport;
- Both the origination of the trip and time of pickup;
- Both the destination of the trip and time of drop off;
- The vehicle license plate number; and
- The full printed name of the driver providing the transportation.

The documentation above is required for every leg of a trip. If any of the information above is lacking, illegible, or false, a claim will be denied.

Information on these requirements is contained in the *Policy Guidelines* section of the Transportation Provider Manual at:

<https://www.emedny.org/ProviderManuals/Transportation/index.aspx>

Questions regarding this article and general questions regarding Medicaid transportation policy can be sent to MedTrans@health.state.ny.us.

Knee Arthroscopy Coverage Guidelines

COVERAGE DECISION:

As of the effective dates indicated below, Medicaid will no longer cover Knee Arthroscopy using debridement and lavage as a treatment for osteoarthritis (OA). This policy applies to Fee-for-Service Medicaid, Medicaid Managed Care, and Family Health Plus (FHPlus).

Effective immediately, for Medicaid fee-for-service beneficiaries, and effective **June 1, 2012**, for Medicaid managed care and FHPlus enrollees, New York State (NYS) Medicaid will no longer provide coverage for arthroscopic knee surgery when the primary diagnosis is osteoarthritis (OA) of the knee (without mechanical derangement of the knee). Consistent with the recommendations of the American Academy of Orthopedic Surgeons (AAOS), there is no proven clinical benefit to arthroscopy of the knee for OA in the absence of mechanical derangement of the knee joint. The AAOS recommends against performing arthroscopy with debridement or lavage in patients with a primary diagnosis of symptomatic OA of the knee.¹

BACKGROUND:

Quality scientific evidence regarding arthroscopic lavage and arthroscopic debridement for osteoarthritis of the knee (without mechanical derangement) has shown that there is no improvement in patient outcomes, specifically reduction in knee pain or improvement of knee function, from these procedures. Arthroscopy is a surgical procedure that allows direct visualization of the interior joint space. In addition to providing visualization, arthroscopy enables the process of joint cleansing through the use of lavage or irrigation. Although generally performed to reduce pain and improve function, current practice does not recognize the benefit of lavage alone for the reduction of mechanical symptoms. Arthroscopy also permits the removal of any loose bodies from the interior joint space, a procedure termed debridement.² Debridement is intended to improve symptoms and joint function in patients with mechanical symptoms such as locking or catching of the knee.³

COVERAGE POLICY:

New York State Medicaid has determined that the following procedures performed for treatment of the osteoarthritic knee and are no longer covered by the Medicaid program:

- Arthroscopic lavage used alone for the osteoarthritic knee;
- Arthroscopic debridement for osteoarthritic patients presenting with knee pain only; or,
- Arthroscopic debridement and lavage with or without debridement for patients presenting with severe osteoarthritis as defined in the Outerbridge classification scale, grades III and IV.
 - *Outerbridge is the most commonly used clinical scale that classifies the severity of joint degeneration of the knee by compartments and grades.⁴*
 - *Grade I is defined as softening or blistering of joint cartilage.*
 - *Grade II is defined as fragmentation or fissuring in an area <1 cm.*
 - *Grade III presents clinically with cartilage fragmentation or fissuring in an area >1 cm.*
 - *Grade IV refers to cartilage erosion down to the bone.*
 - *Grades III and IV are characteristic of severe osteoarthritis.*

-continued-

¹ AAOS Arthroscopic Surgery and Osteoarthritis of the Knee. A Report to CMS-CAG, December 2002.

² Siparsky P, Ryzewicz M, Peterson B, Bartz R. Arthroscopic treatment of osteoarthritis of the knee: Are there any evidence-based indications?, 2007 Feb;455:107-12.

³ National Coverage Determination (NCD) for Arthroscopic Lavage and Arthroscopic Debridement for the Osteoarthritic Knee (150.9)

⁴ National Coverage Determination (NCD) for Arthroscopic Lavage and Arthroscopic Debridement for the Osteoarthritic Knee (150.9)

Policy and Billing Guidance

Unless there are specific indicators in addition to pain, NYS Medicaid will not cover arthroscopic debridement and lavage of the knee in the context of OA alone. Specific indicators for which NYS Medicaid will cover arthroscopic surgery of the knee include:

- Loose bodies;
- Unstable flaps of articular cartilage;
- Disruption of the meniscus;
- Impinging osteophytes.

Post payment reviews are conducted by the Office of Medicaid Inspector General (OMIG) pursuant to 18 NYCRR 504.8 on adjudicated claims. Retrospective reviews may also be conducted periodically through a Medicaid-funded utilization management contractor. Medical records must be maintained by providers for a period of not less than six years from the date of payment.⁵

Questions regarding Medicaid fee-for-service policy should be directed to the Division of Program Development and Management at (518) 473-2160.

Questions regarding MMC/FHPlus reimbursement and/or documentation requirements should be directed to the enrollee's MMC or FHPlus plan.

⁵ 18 NYCRR 540.7 (c) (8)

Low Back Pain Coverage Guidelines

COVERAGE DECISION:

As of the effective dates indicated below, New York State (NYS) Medicaid will no longer cover certain treatments for chronic low back pain. **Effective immediately**, for Medicaid fee-for-service beneficiaries, and effective **June 1, 2012**, for Medicaid managed care and Family Health Plus (FHPlus) enrollees, the following treatments are no longer eligible for reimbursement as they are considered ineffective, or experimental and investigational:

- Prolotherapy;
- Systemic corticosteroids;
- Therapeutic facet joint steroid injections in the lumbar and sacral regions with or without CT or fluoroscopic image guidance;
- Injections of steroids into intervertebral discs; and
- Continuous or intermittent traction.

Medicaid will continue to cover:

- Pharmaceuticals (prescription and non-prescription) to reduce pain; and
- Practitioner-ordered physical therapy for treatment of back pain (see August 2011 Medicaid Update for further Physical Therapy policy information, http://www.health.ny.gov/health_care/medicaid/program/update/2011/august2011mu.pdf).

BACKGROUND:

Low back pain (LBP) is the fifth most common reason for all physician visits in the United States. For the majority of patients, LBP resolves within four weeks, however, approximately one third of patients experience more long-term issues. Of the many options available for treatment, studies have shown that patients receiving different treatments experience similar outcomes, regardless of the cost of the treatment. Clinicians should use the information obtained in the history and physical examination to place patients with low back pain into one of the following three broad categories: nonspecific LBP, back pain potentially associated with radiculopathy or spinal stenosis (which may require referral for surgical intervention), or back pain potentially associated with another spinal cause (which may require referral for surgical intervention).

For those patients with nonspecific LBP, clinicians should provide patients with information regarding their expected course, and provide information about effective options for self care. Imaging should be considered carefully, to reduce exposure to unnecessary radiation. Invasive and non-invasive treatments should be limited to those treatments for which the benefit has been proven and for which the benefit will be outweighed by the risks inherent in the treatment.

Post payment reviews are conducted by the Office of the Medicaid Inspector General (OMIG) pursuant to 18 NYCRR 504.8 on adjudicated claims. Retrospective reviews may also be conducted periodically through a Medicaid-funded utilization management contractor. Medical records must be maintained by providers for a period of not less than six years from the date of payment.

Questions regarding Medicaid fee-for-service policy should be directed to the Division of Program Development and Management at (518) 473-2160. Questions regarding MMC/FHPlus reimbursement and/or documentation requirements should be directed to the enrollee's MMC or FHPlus plan.

New Medicaid Transportation Management in New York City Coming to Queens on July 1, 2012

The management of transportation services begins **May 1, 2012**, in New York City in the Borough of **Brooklyn**. For those Medicaid enrollees not enrolled in a managed care plan, facilities and practitioners in Brooklyn should order transportation services through LogistiCare by calling **(877) 564-5922** for both routine and urgent transports.

The Borough of Queens is next, to be implemented **July 1, 2012**. LogistiCare, *working closely with the Department of Health Medicaid transportation unit*, will meet with major Queens based facilities and practitioners prior to implementation during the next two months. LogistiCare will offer webinars regarding new processes at convenient times for your participation, and will mail providers information on these webinars.

To arrange a meeting with LogistiCare staff to coordinate your current processes with LogistiCare's system, please send an e-mail indicating your interest, along with your name, address, facility name and national provider identification number (NPI), and telephone number via e-mail to NYC@LogistiCare.com.

Information on this new initiative is available online at: www.NYCMedicaidRide.net

Questions regarding this article and general questions regarding Medicaid transportation policy can be sent via e-mail to: MedTrans@health.state.ny.us.

Long Term Home Health Care Program (LTHHCP) Medicaid Waiver New Rate Codes for Vehicle Modifications

The LTHHCP is a 1915(c) Home and Community Based Services (HCBS) Medicaid waiver. The waiver was renewed by the Centers for Medicare and Medicaid Services (CMS) through August 31, 2015. With this renewal, the service known as "Housing Improvements" was renamed "Environmental Modifications" (E-Mods), and broadened to include vehicle modifications.

To improve E-Mod service monitoring and ensure appropriate Medicaid expenditures, the eMedNY Data Dictionary now includes the renamed Housing Improvements listed as LTHHCP E-MODS (HOME), and established three new rate codes to be used for vehicle modifications, defined as LTHHCP E-MODS (VEHICLE). These new rate codes include:

Rate Code 9987 – LTHHCP E-MODS (VEHICLE) COMM BASED

Rate Code 9988 – LTHHCP E-MODS (VEHICLE) HOSPITAL BASED

Rate Code 9989 – LTHHCP E-MODS (VEHICLE) NURSING HOME BASED

Vehicle E-Mods may be made to a vehicle if it is in good repair, and if it is the primary means of transportation for the waiver participant. This vehicle may be owned by the waiver participant; a family member who has consistent and on-going contact with the waiver participant; or a non-relative who provides primary, long term support to the waiver participant. These modifications will be approved when the vehicle is used to improve the waiver participant's independence and inclusion in the community.

Modifications to assist with access into or out of a vehicle may include, but are not limited to, a portable ramp or swivel seat. All E-MODS must be prior authorized by the local departments of social services (LDSS).

These rate codes have been loaded to all LTHHCP agency rate files in eMedNY with an effective date of May 1, 2012. The rate code claiming structure allows the LTHHCP agency to submit one claim for the total LDSS authorized cost for the vehicle modification.

For additional guidance, please contact the Division of Long Term Care, Long Term Care Waivers, Long Term Home Health Care Program at **(518) 474-5271**. The approved HCBS waiver application for the LTHHCP is available online at:

www.health.state.ny.us/facilities/long_term_care/docs/2010-09-01_home_and_community-based_services_waiver.pdf.



Dental Services to be Included in the Medicaid Managed Care Benefit

Effective July 2, 2012, all Medicaid managed care plans will be required to cover dental services for their enrollees. Currently, health plans have the option of covering dental services for their Medicaid enrollees. Health plans will still have the option of covering dental services for Family Health Plus beneficiaries.

Medicaid managed care enrollees who are currently authorized and receiving dental care on a fee-for-service basis, and who fall under the interrupted treatment policy, will continue to have those services covered by Medicaid fee-for-service. Please refer to the eMedNY Dental Provider Manual and the June 2008 Medicaid Update article, "Policy on Interrupted Treatment for Dental Procedures", for additional information.

Dentists are encouraged to apply for participation in the networks of Medicaid managed care plans operating in their county of practice.

Orthodontic Services to be Included in the Medicaid Managed Care Benefit

Effective October 1, 2012, all Medicaid managed care plans will be required to cover orthodontic services for eligible enrollees under age 21. Orthodontic services are currently "carved out" and paid on a fee-for-service basis for Medicaid managed care enrollees.

Orthodontists are encouraged to apply for participation in the networks of Medicaid managed care plans operating in their county of practice.

Additional information will be available in future Medicaid Update newsletters.

New Cervical Cancer Screening Guidelines Announced

In March 2012, both the United States Preventive Services Task Force (USPSTF) and the American Cancer Society (ACS), in concert with the American Society for Colposcopy and Cervical pathology (ASCCP) and the American Society for Clinical Pathology (ASCP), released separate, updated cervical cancer screening guideline recommendation statements. Notable differences from previous guidelines include a recommendation against screening women less than 21 years of age for cervical cancer and the option of a lengthened five-year screening interval for those women aged 30-65 screened with a combination of Pap testing and human papillomavirus (HPV) testing. While the recommendation statements are largely in agreement, the ACS statement notes a preference for combination Pap/HPV testing for women aged 30-65. The USPSTF cervical cancer screening recommendation statement and an accompanying clinical summary chart are below for your reference.

USPSTF Current Recommendation for Cervical Cancer Screening¹ (Release Date: March 2012)

These recommendations apply to women who have a cervix, regardless of sexual history. These recommendations do not apply to women who have received a diagnosis of a high-grade precancerous cervical lesion or cervical cancer, women with in utero exposure to diethylstilbestrol, or women who are immunocompromised (such as those who are HIV positive).

- The USPSTF recommends screening women aged 21 to 65 years with cytology every 3 years or, for women aged 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and HPV testing every 5 years. **(Grade A)**
- The USPSTF recommends against screening for cervical cancer in women younger than age 21 years. **(Grade D)**
- The USPSTF recommends against screening for cervical cancer in women older than age 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer. **(Grade D)**
- The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and who do not have a history of CIN 2, CIN 3, or cervical cancer. **(Grade D)**
- The USPSTF recommends against screening for cervical cancer using HPV testing, alone or in combination with cytology, in women younger than age 30 years. **(Grade D)**

WHAT THE GRADES MEAN?

Grade	Definition
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.
B	The USPSTF recommends the service . There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.
C	<i>Note: The following statement is undergoing revision.</i> Clinicians may provide this service to selected patients depending on individual circumstances. However, for most individuals without signs or symptoms there is likely to be only a small benefit from this service.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.

Clinical Summary of U.S. Preventive Services Task Force Recommendation

Population	Women ages 21 to 65	Women ages 30 to 65	Women younger than age 21	Women older than age 65 who have had adequate prior screening and are not high risk	Women after hysterectomy with removal of the cervix and with no history of high-grade precancer or cervical cancer	Women younger than age 30
Recommendation	Screen with cytology (Pap smear) every 3 years. Grade: A	Screen with cytology every 3 years or co-testing (cytology/HPV testing) every 5 years. Grade: A	Do not screen. Grade: D	Do not screen. Grade: D	Do not screen. Grade: D	Do not screen with HPV testing (alone or with cytology). Grade: D

Risk Assessment	Human papillomavirus (HPV) infection is associated with nearly all cases of cervical cancer. Other factors that put a woman at increased risk of cervical cancer include HIV infection, a compromised immune system, in utero exposure to diethylstilbestrol, and previous treatment of a high-grade precancerous lesion or cervical cancer.					
Screening Tests	Screening women ages 21 to 65 years every 3 years with cytology provides a reasonable balance between benefits and harms. Screening with cytology more often than every 3 years confers little additional benefit, with large increases in harms. HPV testing combined with cytology (co-testing) every 5 years in women ages 30 to 65 years offers a comparable balance of benefits and harms, and is therefore a reasonable alternative for women in this age group who would prefer to extend the screening interval.					
Timing of Screening	Screening earlier than age 21 years, regardless of sexual history, leads to more harms than benefits. Clinicians and patients should base the decision to end screening on whether the patient meets the criteria for adequate prior testing and appropriate follow-up, per established guidelines.					
Interventions	Screening aims to identify high-grade precancerous cervical lesions to prevent development of cervical cancer and early-stage asymptomatic invasive cervical cancer. High-grade lesions may be treated with ablative and excisional therapies, including cryotherapy, laser ablation, loop excision, and cold knife conization. Early-stage cervical cancer may be treated with surgery (hysterectomy) or chemoradiation.					
Balance of Harms and Benefits	The benefits of screening with cytology every 3 years substantially outweigh the harms.	The benefits of screening with co-testing (cytology/HPV testing) every 5 years outweigh the harms.	The harms of screening earlier than age 21 years outweigh the benefits.	The benefits of screening after age 65 years do not outweigh the potential harms.	The harms of screening after hysterectomy outweigh the benefits.	The potential harms of screening with HPV testing (alone or with cytology) outweigh the potential benefits.

Additional resources including the evidence synthesis, decision analysis, and consumer fact sheet for patients is available on the USPSTF web site at: <http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm>). To view the ACS recommendation statement, visit <http://www.cancer.org/Cancer/news/News/new-screening-guidelines-for-cervical-cancer>.

Growth Hormone Coverage for Idiopathic Short Stature

Effective May 3, 2012, for Medicaid fee-for-service beneficiaries, and effective June 1, 2012, for Medicaid Managed Care and Family Health Plus (FHPlus) enrollees, New York State Medicaid will no longer cover Growth Hormone (GH) for patients with a diagnosis of Idiopathic Short Stature (ISS).

The Medicaid Redesign Team (MRT) Basic Benefit Review Work Group Phase II recommendations included the elimination of coverage of GH for treatment of ISS. The MRT work group determined that coverage for ISS is not medically necessary but cosmetic in purpose and does not treat a medical condition defined by growth hormone deficiency.

For additional information please visit the MRT web site at:
http://www.health.ny.gov/health_care/medicaid/redesign/

Drugs Subject to Medicaid Pharmacy Prior Authorization Programs

In order to receive payment for services rendered, all pharmacies must submit their transactions through the **online** Pro-DUR program using the NCPDP transaction format. The online system is designed to allow for capture and adjudication of the electronic submission. For drugs identified as having utilization management requirements* (prior authorization, Step Therapy, Frequency/Quantity/Duration), claims must be submitted as a real time transaction (date of adjudication/submission = date of service). Authorizations will **not** be issued retroactively.

As a reminder, all enrolled pharmacies **MUST** participate in the mandatory Prospective Drug Utilization Program (ProDUR) to receive reimbursement. Important ProDUR information can be accessed online at www.eMedNY.org. Click on Provider Manuals and select the Pharmacy Manual.

*Drugs identified on the eMedNY formulary file with a PA code = G

Medicaid Billing for Vivitrol

On September 1, 2011, dual-licensed Article 28 Hospitals became eligible to bill Medicaid for administering Vivitrol. Effective March 22, 2012, Article 32 OASAS free-standing clinics became eligible to bill for Vivitrol. Providers may bill for the drug and drug administration. If they have access to the Medicaid Ordered Ambulatory Fee Schedule (e.g., COS 0163, 0282, & 0389) using the following codes:

Code	Description	Type of Code
J2315	Naltrexone, depot form, 1 mg	HCPCS
96372	Therapeutic, prophylactic or diagnostic injection (specify drug or substance); subcutaneous or intramuscular	HCPCS

Note: In order to bill Medicaid for Vivitrol, providers must include the NDC, HCPCS, number of units (milligrams) and charges (i.e., acquisition price by invoice) on their claims. Additionally, providers must include the NDC number (i.e., 65757-0300-01) on the same line as the HCPS (Level II) drug code on the claim. **REMINDER:** Vivitrol is carved-out of the APG reimbursement methodology so providers that bill using APGs (including participating FQHCs) should submit a separate claim for administering this drug.

Reminder:

Pharmacies Must Obtain an HCS Medical Professions Account for the Upcoming AAC/COD Project

NYSDOH will utilize the Health Commerce System (HCS) to collect data for the Average Actual Acquisition Cost and Cost of Dispensing project. Data will be collected through a secure process and in a manner that ensures provider confidentiality. As a reminder, the Department is requiring Medicaid enrolled pharmacies that do not currently have accounts, to obtain a HCS Medical Professions Account.

Please Note: - An entity (pharmacy) cannot hold an account. An individual must apply to represent the entity. Chain pharmacies may apply for one account at the corporate level but the account cannot be shared by other users.

Follow the link below to request a HCS Medical Professions Account Application:

<https://hcsteamwork1.health.state.ny.us/pub/top.html>

After the submitted information is verified, the account application will be sent to you via e-mail to be signed by the practitioner and to have notarized. If you require assistance filling out the form, please contact the Commerce Accounts Management Unit (CAMU) at (866) 529-1890, option #1.

e-Prescriber Payments to be Issued By eMedNY

To encourage the use of e-Prescribing, New York State law authorizes the payment of an incentive to eligible medical practitioners for each approved ambulatory Medicaid e-prescription plus a maximum of five refills per prescription. Previous payments to prescribers for e-Prescribing were issued via checks by the Department of Health outside of the eMedNY system.

In Cycle 1807 (check dated 04/09/2012, release/mail date 04/25/2012), the e-Prescriber incentive payments for fourth quarter 2010 will be issued by eMedNY, and appear as a financial transaction (lump-sum payment) on the provider's Medicaid remittance statement. On the remittance (paper or electronic) the financial control number (FCN) will appear as LSE to indicate an e-Prescribing payment.

In Cycle 1809 (check dated 04/23/2012, release/mail date 05/09/2012), the e-Prescriber incentive payments for calendar year 2011 will be issued.

Future payments for the e-prescriber incentive will be issued **quarterly** in the form of a lump sum payment on provider's Medicaid remittance statements.

Questions can be directed to the eMedNY Call Center at (800) 343-9000.

The New York State Medicaid Prescriber Education Program Drug Information Response Center Addresses Use of Statins with HIV Protease Inhibitors

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 review was prepared by the DIRC in response to a request for information on the use of 3-hydroxy-3-methyl-glutaryl-CoA (HMG-CoA) reductase inhibitors, also known as statins, in patients receiving treatment with HIV protease inhibitors.

Several sources assert that there is a potential for drug-drug interactions between protease inhibitors (PIs) and lipid-lowering therapies, particularly statins.¹⁻³ In a recent drug safety communication, the Food and Drug Administration (FDA) states that concomitant use of PIs and certain statins may raise blood levels of the statins, increasing the risk for myopathy.⁴ There does not appear to be a clear consensus regarding a statin of choice in patients infected with human immunodeficiency virus (HIV) who are taking PIs.

The potential for drug interactions between statins and PIs may be explained by their pharmacokinetic characteristics.¹ Most of the statins undergo extensive hepatic metabolism by cytochrome P450 (CYP) 3A4.⁵ All of the PIs are metabolized by CYP enzymes, primarily CYP 3A4, and have either inducing or inhibitory effects. Additionally, however, it has been proposed that there may be multiple mechanisms of drug interactions involved, based on differences in the degree to which statin concentrations are changed when co-administered with the PIs.⁶

In February 2012, the FDA required labeling changes of all statins, including removal of routine monitoring of liver enzymes from the safety section.⁷ Healthcare providers are advised to perform liver function tests prior to initiation of statin therapy and as clinically indicated. The prescribing information for lovastatin in particular has been extensively revised to include new contraindications and dose limitations. In the revised label, the manufacturer clearly states that the combination of protease inhibitors with lovastatin is contraindicated.⁸ Notably, of all other available statins, a contraindication for concomitant use with protease inhibitors has only been specified for simvastatin.⁹

Based on the current literature, no one statin appears to be clearly superior in the management of dyslipidemia in HIV-infected patients taking PIs. There is agreement on the recommendation to avoid use of simvastatin or lovastatin based on a higher propensity to interact with the PIs. Healthcare providers should closely monitor HIV-infected patients who are taking statins and be conservative with the dosing, both at initiation and with titration. To view the complete literature review along with summary tables, please visit the NYSMPEP web site at <http://nysep.nysdoh.suny.edu/dir>.

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Medicaid to Require Electronic Funds Transfer (EFT) for Provider Payments and Electronic Remittance Advice (ERA) or PDF Version of Paper Remittances

Medicaid will soon require all billing providers to register for EFT and ERA or PDF remittances. This effort moves the Medicaid program in the direction of healthcare industry standards of practice. In addition to the cost savings associated with eliminating the production, processing and mailing of paper, this initiative is better for the environment and in line with the GO GREEN movement. The NYS Department of Health (NYSDOH) will begin phasing in this requirement effective September 2012; however, providers are urged to act now.

Electronic Funds Transfer (EFT)

Since eMedNY began offering the benefit of EFT in 2005, thousands of providers have signed up to have their Medicaid funds deposited directly to their checking or savings account. The advantages of EFT over paper checks include:

- Eliminate the possibility of lost checks;
- Eliminate delays and mail time;
- Secure funds;
- Save trips to the bank.

ERA/PDF

In addition to requiring EFT, providers will also be required to sign up for paperless remittances. There are two options:

Option 1: ERAs in the form of HIPAA compliant 835/820 formats. These will require software to interpret but have advantages for systematic posting of payments.

Option 2: PDF version of the paper remittance delivered electronically through eMedNY's secure website. PDF remittances have many advantages over paper remittances such as:

- The PDF remittance will be immediately available every week on the Monday on which your Medicaid check is dated, and will not be subject to the two-week hold of your check or EFT release.
- You will know when the PDF is available in your eXchange account.
- The remittance can be downloaded and stored electronically for ease of retrieval and you can still print a hard copy.
- The PDF will look exactly like the paper remittance.
- Remittances can be printed with Adobe Reader® (6.0 release or higher required), which is available free of charge.

The EFT and PDF remittance applications are available online at www.emedny.org and click the GO GREEN icon. Questions about either application or the process can be directed to the eMedNY Call Center at (800) 343-9000. Keep up with notifications on this initiative in future Medicaid Updates and the eMedNY Listserv at: https://www.emedny.org/Listserv/eMedNY_Email_Alert_System.aspx.

HIPAA Version 5010 Discretionary Enforcement Period Ends June 30

Providers who still submit electronic transactions to Medicaid in the HIPAA Version 4010 format are reminded that the federal government's discretionary enforcement period for Version 5010 and NCPDP D.0 will expire on **June 30, 2012**. In keeping with this federal guideline, effective 12:01AM July 1, 2012, Medicaid will no longer be able to accept or process HIPAA Version 4010 and NCPDP Version 5.1 transactions. All such transactions will be denied. We urge all our trading partners to complete their 5010 transition well in advance of the July 1, 2012 deadline in order to minimize any adverse impact on their Medicaid payments.

It is highly recommended that providers who utilize the services of a software vendor or billing service work closely with that entity to make certain that the billing system is being upgraded in a timely manner and will be able to support the 5010 format in advance of the July 1, 2012 deadline. Providers should not assume that their vendor or billing service is proceeding with completing the required upgrades, proper testing with Medicaid and timely transition. It is the provider's responsibility to ensure their transactions comply with the mandated 5010 requirements.

eMedNY offers a Provider Testing Environment (PTE) to facilitate provider transition to Version 5010 that will accept and process 5010 HIPAA X12 and NCPDP D.0 transactions from trading partners who wish to test their program changes with eMedNY. It is strongly recommended that all providers and vendors submitting electronic transactions test their submissions using the PTE. Information about testing with eMedNY is available in the Standard Companion Guide – Trading Partner Information available on the eMedNY web site at:

https://www.emedny.org/hipaa/5010/transactions/eMedNY_Trading_Partner_Information_CG.pdf

Providers experiencing difficulties transitioning their billing system to the Version 5010 format should consider converting to the Electronic Provider Assisted Claim Entry System (ePACES) software application. The ePACES application is fully Version 5010 compliant, is very simple to use and is offered free of charge by New York State Medicaid. Users only need a PC with an Internet browser with high speed access and an e-mail address. Extensive ePACES information is available at www.emedny.org under 'Self Help' or from the eMedNY Call Center at (800) 343-9000.

For additional information on Version 5010, please visit eMedNY HIPAA Support page at <http://www.emedny.org/HIPAA/5010/index.html> or e-mail any questions to: emednyproviderservices@csc.com.

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 web site at: www.emedny.org.

For providers to hear the current weeks 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.

Address Change?

Address changes should be directed to the eMedNY Call Center at (800) 343-9000.

Fee-for-Service Providers: A change of address form is available at:

<http://www.emedny.org/info/ProviderEnrollment/allforms.html>.

Rate-Based/Institutional Providers: A change of address form is available at:

<http://www.emedny.org/info/ProviderEnrollment/allforms.html>.

Does your enrollment file need to be updated because you've experienced a change in ownership?

Rate Base/Institutional and Fee-for-Service providers, please call (518) 474-3575, Option 4.

Do you have comments and/or suggestions regarding this publication?

Please contact Kelli Kudlack at: medicaidupdate@health.state.ny.us.