OCTOBER 2009 MEDICAID UPDATE
Volume 25, Number 12, www.nyhealth.gov

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SECOND NOTICE: MEDICAID TO IMPLEMENT AUTOMATED MEDICARE CROSSOVER IN DECEMBER

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VOLUME 25, NUMBER 12, WWW.NYHEALTH.GOV

Attention eMedNY eXchange Users!

It has been brought to our attention that some eMedNY eXchange users are occasionally experiencing a delay when downloading .TAR files containing large 835 Electronic Remittance Advice files. If this occurs and your screen goes "blank," please contact the eMedNY Call Center at (800) 343-9000 for assistance.

Good news!! Effective the week of October 26, cycle 1679, .TAR files exceeding 20MB will be automatically broken down into multiple .TAR files. This will improve downloading delays significantly. Each .TAR file will have a unique file name using the date/time stamp. **All of these files will need to be processed.**

Effective December 3, 2009, New York Medicaid will begin receiving Medicare crossover claims directly from Medicare's Coordination of Benefits Contractor, (COBC), Group Health Inc., (GHI), regardless of the claim's date of service. GHI, in its role as the COBC, will be sending crossover claims to New York Medicaid for all of New York State. Please note that claims submitted by pharmacies for payment of the Part B drug coinsurance and deductible are excluded from the crossover system.

What will be the process? Providers will bill claims for Medicare/Medicaid beneficiaries to Medicare. Medicare will then reimburse its portion to the provider and the provider's Medicare remittance will indicate that the claim will be crossed over to Medicaid. Medicare will send the claim data to GHI and they will submit the data to New York Medicaid for processing and payment of the deductible/coinsurance or co-pay amounts (also known as the Medicare Patient Responsibility). Medicaid will deny the claim if a claim is crossed over with no Patient Responsibility.

If the Medicare remittance does not indicate the claim has been crossed over to Medicaid, the provider should submit the claim directly to Medicaid. On the Medicare 835, the crossover indicator will be in loop 2100, NM1 segment NM101 = TT. NM103 will have a name indicating NY Medicaid. The exact name sequence is unknown at present. The paper Medicare remittance will also include a crossover indicator.

Providers are urged to review their Medicare remittances for crossover indicators beginning December 1, 2009, to determine whether their claims have been crossed over to Medicaid for processing. Any claim that was indicated by Medicare as a crossover should not be submitted to Medicaid as a separate claim. *(CONTINUED ON PAGE 2)*

Medicaid to Implement Automated Medicare Crossover in December (CONTINUED)

Important Guidelines:

- Claims submitted to Medicare must include a National Provider ID (NPI) that is also enrolled with NY Medicaid. If the NPI is not enrolled with NY Medicaid, the crossover claim will be rejected. If you have questions about a submitted enrollment application, please call DOH Provider Enrollment at (800) 342-3005, option 4.
- The COBC will only submit claims to eMedNY that have been processed and paid by Medicare. Claims denied by Medicare will not be crossed over. Claims for services not covered by Medicare should continue to be submitted directly to Medicaid for processing.
- If a separate claim is submitted directly by the provider to Medicaid for a dual eligible client and the claim is processed before the crossover claim from GHI, both the provider submitted claim and the crossover claim will be reimbursed. However, the eMedNY system will subsequently void the provider submitted claim.
- If a separate claim is submitted directly by the provider after the crossover claim from GHI is paid, the provider submitted claim will deny as a duplicate claim.
- Medicare Part C (Medicare Managed Care) and Part D claims are not part of this process.
- Providers will not be able to void a claim that was crossed over by the COBC to Medicaid. The void must be submitted to Medicare. Medicare will void the Medicare payment and the void will be crossed over to Medicaid.
- Providers may submit an adjustment directly to Medicaid for adjusting a COBC crossover claim. The provider submitted adjustment will be processed like an ordinary adjustment.

Pricing and Payment:

- Pricing of crossover claims will be the Medicare Approved Amount minus the Medicare Paid Amount reported on the claim. The amounts used by Medicaid will be as they are received from Medicare.
- The coinsurance rule for payment of practitioner and DME claims will remain the same. Medicaid will pay 20% of the Medicare coinsurance amount (20% of the 20%).
- Locator codes will default to Service Location 003 if the zip+4 does not match information in the provider's Medicaid file.
- There are no changes to the content of Medicaid remittances (paper or 835 electronic) for COBC claims. All COBC claims will be paid with a Medicaid Transaction Control Number (TCN).
- Electronic remittances from Medicaid for COBC claims will be generated to the default Electronic Transmitter Identification Number (ETIN) when a default ETIN has been selected. If there is no default ETIN, the COBC claims will be reported to the provider on a paper remittance. Providers must complete the Electronic Remittance Request form at: www.emedny.org/info/ProviderEnrollment/Provider%20Maintenance%20Forms/Electronic%20Remittance%20Request%20Form.pdf to set-up an ETIN as a default. Please make sure to check the box in item #4.

Hospital inpatient COBC claims with Medicare Part A and Part B:

Inpatient hospital claims will be priced using the approved amount minus the paid amount. The number of coinsurance days and LTR days will not be used. Medicare Part A and B claims will be crossed over to Medicaid and paid as separate claims. Medicaid will pay the Part A deductible, coinsurance and LTR on one claim and the Medicare Part B patient responsibility will be paid on a separate claim where Medicare Part A covered the claim. Therefore two separate claims will be processed. *(CONTINUED ON PAGE 3)*

Medicaid to Implement Automated Medicare Crossover in December (CONTINUED)

Enhanced Clinic Pricing:

The Enhanced Clinic Pricing that is applied to designated rate based institutional claims will still occur if a COBC crossover claim is transmitted to Medicaid with a valid rate code. DOH, OMRDD, OMH and FQHC clinics that are eligible for enhanced pricing must include the Medicaid rate code on any claims submitted to Medicare.

Medicaid will not apply enhanced clinic pricing to any COBC crossover claim that does not contain a rate code. Enhanced Clinic Pricing providers who bill Medicare via the 837 Professional transactions and cannot enter a rate code must resubmit the affected claim (s), with a valid rate code, to Medicaid as an adjustment.

If the provider submitted the claim to Medicare with a rate code and the rate code was not included on the COBC crossover claim, the provider must contact his/her Medicare payer to ensure the omission is corrected.

Enhanced pricing clinic claims will be eligible for the Medicaid retroactive rate adjustment process when the COBC claims are crossed over to Medicaid with a rate code. An enhanced pricing clinic claim submitted directly to Medicaid by the provider will also be eligible for retroactive rate adjustment processing.

Please visit www.emedny.org for updates on this project and look for upcoming articles in the Medicaid Update. Questions regarding crossover claims should be directed to the eMedNY Call Center at (800) 343-9000.

MEDICAID FEE-FOR-SERVICE REIMBURSEMENT POLICY FOR THIRTEEN SERIOUS ADVERSE (NEVER) EVENTS

This article serves as an update to the Department of Health's implementation of the Medicaid fee-for-service payment policy for 13 serious adverse (never) events. **The Department has removed one event; failure to identify and treat hyperbilirubinemia, from the original list of 14 serious events.**

Effective October 2008, the Department implemented changes in the inpatient claims processing system to reduce payment for the following three events:

- ✓ **foreign object inadvertently left in patient after surgery;**
- ✓ **air embolism; and**
- ✓ **blood incompatibility.**

Effective for discharges on or after **November 1, 2009,** hospitals will be required to bill all claims associated with one of the ten remaining adverse events. Three new rate codes have been established for use when one of 10 adverse events occur. The rate codes along with claim submission procedures are outlined in the August 10, 2009 letter to providers, and is available for download at the Website referenced below. Medicaid health plans are required to implement their own procedures to deny or reduce payment for these same events. The health plans are required to begin implementation of their programs by **January 1, 2010.**

Please visit: www.health.state.ny.us/health_care/managed_care/medicaid_neverevents.htm for a complete listing of serious adverse events, Medicaid 'Hospital Acquired Conditions' definitions, and a FAQ section covering serious adverse event payment policy.

Please contact Philip Mossman at (518) 474-1673 or Dr. Foster Gesten at (518) 486-6865 with any questions.

PROVIDERS ENROLLED IN OR ORDERING SERVICES PAYABLE BY NEW YORK MEDICAID

In a continuous effort to improve and strengthen Medicaid, the Office of Inspector General (OMIG) has compiled a comprehensive work plan (available at www.omig.state.ny.us) to address specific areas of Medicaid that are particularly vulnerable to improper payments.

Topics include:

- ✓ **Claims submitted for medical services to deceased beneficiaries;**
- ✓ **Claims submitted after third-party liability has been established, or the failure to reimburse Medicaid after third-party liability has been established;** [i] **and**
- ✓ **Bills submitted to a Medicaid beneficiary for Medicaid covered services.** [ii]

Effective January 1, 2010, the OMIG will post on its Website at www.omig.state.ny.us. the names and addresses of providers who have billed Medicaid for services rendered after the date of patient death. Providers will have the opportunity to correct any information they believe to be inaccurate prior to publication on the Website.

The OMIG will not publish the names of providers who have billed for services subsequent to the date of a patient's death if the provider has completed OMIG's Self-Disclosure Protocol Notice available for download at:

http://www.omig.state.ny.us/data/images/stories/self_disclosure/omig_provider_self_disclosure_guidance.pdf.

Providers must also take action to eliminate improper claims for payment, which includes implementation of effective compliance programs.[iii]

If you have any questions, please contact Wanda Fischer at (518) 473-3782.

i - Persons and providers participating in the Medicaid program cannot retain Medicaid payments, other than co-payments permitted by statute, when a liable third party has been ascertained (see 42 C.F.R. § 433.19 and 42 C.F.R. § 433.310-433-320, 18 § NYCRR § 540.6(e)(4)). Such payments are overpayments, and knowingly retaining such overpayments violates the Fraud Enforcement and Recovery Act (FERA) Pub. L. No. 111-21 (2009), which amends the federal False Claims Act .

ii - State regulations prohibit persons or providers participating in the Medicaid program from attempting to collect an alleged debt or an alleged balance due from a Medicaid beneficiary for Medicaid-covered services, other than a co-payment permitted by statute (see 18 § NYCRR § 515.2(b)(8) and New York *Medicaid Update*, June 2008, vol. 24, #7).

iii - Effective October 1, 2009, every New York Medicaid provider receiving, billing or ordering more than $500,000 is required to have an effective compliance program in place (see 18 NYCRR § Part 521-Provider Compliance Programs, available on the OMIG Web site). An "effective" compliance program includes identifying compliance issues and refunding overpayments.

ATTENTION: SWIPING PROVIDERS

The Office of the Medicaid Inspector General (OMIG) recently sent letters to providers notifying them of their swiping percentage in an effort to assist them with point-of-service control compliance.

New York State regulations require swiping providers to swipe 85 percent of their transactions by passing the Client Benefit Identification Card (CBIC) through a VeriFone terminal. A beneficiary must present a CBIC or a department approved equivalent to the provider before receiving medical services or supplies. To avoid interruption of service to beneficiaries, a 15 percent allowance will be made for temporary, lost, or stolen cards. OMIG will send periodic letters to swiping providers notifying them of their progress by supplying them with their four-week swiping averages**.**
****Attention Dentists —You may use either a Transaction Type 1 or Transaction Type 2 to achieve a swipe.**

If you have any questions, please contact the eMedNY Call Center at (800) 343-9000.

NEW YORK MEDICAID IMPLEMENTS PREFERRED DIABETIC SUPPLY PROGRAM (PDSP)

Effective October 1, 2009, New York Medicaid implemented a Preferred Diabetic Supply Program (PDSP) for fee-for-service Medicaid, Medicaid Managed Care, and Family Health Plus enrollees. This program does not include Medicare/Medicaid dually enrolled beneficiaries. The PDSP covers a wide variety of blood glucose monitors and test strips provided by pharmacies and durable medical equipment (DME) providers through use of a preferred supply list (PSL).

A listing of preferred supplies is available at: https://newyork.fhsc.com. To request a hard copy of the PSL, please call (518) 951-2051 or e-mail NYPDPNotices@fhsc.com.

Features of the Preferred Diabetic Supply Program

> **Access:** Enrollees will continue to obtain blood glucose monitors and strips from their pharmacy or DME provider.

> **Preferred Products:** Preferred products will not require prior approval or DVS authorization. The PSL offers a wide variety of monitors and strips providing accurate and easy to use home blood glucose testing features. Pharmacies and DME providers will bill using National Drug Codes (NDC) to identify the preferred product(s).

> **Non-Preferred Products:** Medicaid will edit claims to verify that the submitted claim is for a preferred diabetic supply product. If preferred products do not meet a beneficiary's medical needs, a non-preferred product will require prior approval. Prior approval is based on documentation of medical necessity. If approved, non-preferred products will be billed using the Healthcare Common Procedure Coding System (HCPCS) codes on the DME claim form.

> **Voice Synthesized Blood Glucose Monitors:** "Talking" blood-glucose monitors are NOT included in the PDSP. These products will continue to be covered by Medicaid through the existing prior approval process.

> **Disposable Blood Glucose Monitors:** Disposable blood glucose monitors are NOT included in the PDSP. These products will continue to be covered by Medicaid and DVS authorization will be required.

> **Reimbursement:** Reimbursement for preferred products will not exceed the lower of the customary charge or the fee for each NDC on the list of Medicaid reimbursable drugs.

PDSP RESOURCES

Questions?
PDSP Policy: (518) 486-3209
Prior Approval: (800) 342-3005
Billing: (800) 343-9000

Please visit the following Websites for more information on the PDSP:

www.nyhealth.gov/health_care/medicaid/program/pharmacy.htm

www.emedny.org/providermanuals/DME/communications.html

www.newyork.fhsc.com

PDSP Pharmacy Billing Information
www.emedny.org/ProviderManuals/Pharmacy/communications.html

www.emedny.org/ProviderManuals/Pharmacy/PDFS/Pharmacy_Billing_Guidelines.pdf

PDSP DME Billing Information
Please call (800) 343-9000 for billing assistance, or for complete DME billing guidelines please visit:

www.emedny.org/ProviderManuals/DME/PDFS/DME_Billing_Guidelines.pdf

www.emedny.org/ProviderManuals/Pharmacy/communications.html

www.emedny.org/providermanuals/DME/communications.html

By providing counseling, pharmacotherapy, and referrals, you can double your patients' chances of successfully quitting. For more information, please visit www.talktoyourpatients.org or call the NY State Smokers' Quitline at 1-866-NY-QUITS (1-866-697-8487).

Quick Reference Guide

Office of the Medicaid Inspector General: www.omig.state.ny.us. or call (518) 473-3782 with general inquiries or 1-877-87FRAUD with suspected fraud complaints or allegations. This contact information can also be used for Provider Self-Disclosures.

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 any of the following numbers:
(800) 997-1111, (800) 225-3040, (800) 394-1234.

Address Change?
Questions 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/index.html.

Rate-Based/Institutional Providers:
A change of address form is available at:
http://www.emedny.org/info/ProviderEnrollment/index.html.

Do you suspect that a Medicaid provider or an enrollee has engaged in fraudulent activities?
PLEASE CALL:
1-877-87FRAUD OR
(212) 417-4570

Your call will remain confidential. You may also complete a complaint form online at
www.omig.state.ny.us

Comments and Suggestions Regarding This Publication?
Please contact the editor, Kelli Kudlack, at: medicaidupdate@health.state.ny.us.

Does your enrollment file need to be updated because you've experienced a change in ownership?
Fee-for-Service Providers please call (518) 402-7032
Rate-Based/Institutional Providers please call (518) 474-3575