NEW YORK STATE OF OPPORTUNITY. Department of Health

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Prior Approval/Authorization Requirements for Medical Supplies reinstated on July 6, 2023

As of April 1, 2023, Medicaid members enrolled in mainstream Medicaid Managed Care (MC) Plans, Health and Recovery Plans (HARPs), and HIV-Special Needs Plans (SNPs) began receiving their pharmacy benefits through NYRx, Medicaid Pharmacy Program, and some medical supplies through Fee for Service (FFS) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Providers.

This transition has included all items found in the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Procedure Code Manual in sections 4.1, 4.2, and 4.3. To ensure a smooth transition for members, the requirement for approvals were relaxed until July 5, 2023, so that claims without approvals would be paid as a part of the transition to the fee for service benefit. For more information on FFS approval and prior authorization guidelines, please see the Medicaid Update, Volume 39, Number 4.

Beginning July 6, 2023, all claims without the appropriate prior approval and/or prior authorization will be denied.

Dispensing Validation System – DVS Authorizations

For Pharmacy Providers, the NCPDP transactions using HCPCS codes will automatically check DVS for authorization and issue a number - no additional steps are necessary. The items will be approved if the claim meets dispensing criteria.

DMEPOS Providers using Claim Type S (Supply DME) will need to access ePACES as a separate transaction to obtain an authorization number. The authorization number is placed on the claim when submitting for payment. Claims without an authorization number will be denied.

For ePACES DVS reference guidance, providers should refer to the eMedNY Step-by-Step Instructions for ePACES at https://www.emedny.org/selfhelp/ePACES/ePACESRefSheets.aspx

Prior Approval – Pharmacies and DMEPOS Providers

Any item that requires a prior approval (medical necessity review or pricing review indicated by an **underline** in the procedure manuals) must be submitted via ePACES with uploaded documentation or via paper approval with documentation, prior to dispensing. All paper prior approvals must be on an original scanning form available from GDIT. NYS regulation requires determinations for approval requests be made within 21 days while in the Department's control. Time required for requests for additional information from the provider are excluded from the 21 days.

For ePACES PA guidance, providers should refer to the eMedNY Step-by-Step Instructions for ePACES at https://www.emedny.org/selfhelp/ePACES/ePACESRefSheets.aspx

PA forms (EMEDNY-361502 for paper submission) are available by contacting eMedNY by telephone at **(800) 343-9000** and by the following mailing address:

eMedNY
P.O. Box 4600
Rensselaer, NY 12144-4600

Continuous Glucose Monitoring (CGM) Supplies

Pharmacy Providers

Effective July 6, 2023, for CGM products found in the Preferred Diabetic Supply Program (PDSP), pharmacies must use claim type R (NCPDP) and NDC codes for reimbursement. HCPCS codes may only be used for products not listed (e.g., Medtronic's CGM).

DME Providers

PA requests by DME providers will be reviewed by the FFS DME program. DME provider reimbursement procedure codes and pricing for each item can be found on the table below. To align DME reimbursement with the PDSP reimbursement the following changes will be made:

Brand/Supply	Code	Fee
Freestyle Libre 14, Libre 2, or Libre 3 Sensor	A4239	$64.22
Freestyle Libre 14, Libre 2 Reader	E2103	$70.00
Dexcom G6 or G7 Sensor	A4239	$118.33
Dexcom G6 Transmitter	A4239	$237.50
Dexcom G6 Receiver	E2103	$365.00
Dexcom G7 Receiver	E2103	$299.00

Reimbursement will include pricing through the prior approval process as follows:

For **E2103, non-adjunctive, non-implanted continuous glucose monitor or receiver**, (i.e., Freestyle Libre or Dexcom) it is the ordering provider's responsibility to assure that the member meets the coverage guidelines outlined in the DME Procedure code manual and to provide documentation to the DME provider. The DME provider must keep all documentation on file to support the request. E2103 is a prior approval item and will be reviewed for the following documentation:

- To determine if the prior approval was submitted by a pharmacy or DME provider;
- avalid fiscal order from the ordering provider; and
- for correct reimbursement for each manufacturer.

The provider must supply the brand of monitor/receiver distributed so that the appropriate reimbursement can be calculated. This abbreviated review will ensure that the requests are processed timely.

For **A4239, supply allowance for non-adjunctive, non-implanted continuous glucose monitor, includes all supplies and accessories** (i.e. Freestyle Libre, Dexcom), fees will change to coincide with the PDSP in the chart above. A4239 is a prior approval item and will be reviewed for the following documentation:

- To determine if the prior approval was submitted by a pharmacy or DME provider;
- a valid fiscal order from the ordering provider; and
- for correct reimbursement for each manufacturer.

The DME provider must keep all additional documentation on file to support the medical necessity the request. When supplies and accessories are submitted for prior approval using this code, the dispensing provider **must list the estimated CGM supplies and quantities** that are anticipated to be distributed in the PA time period (up to 6 months) within the maximum allowable units on the PDSP. The individual fees will be added together, and the PA will be manually priced for the amount based on the PDSP fee schedule. For example, if 2 Dexcom sensors are used each month for a 6-month approval, the PA will be priced for 12 sensors. The provider may bill for the number of components dispensed each month up the provided estimate. If additional equipment is required, the provider must submit additional information and medical justification for the additional supplies to modify the prior approval. Prior approvals must be renewed at least every six months.

Enteral Formula – Pharmacy and DME Providers

Beginning July 6, 2023, all enteral claims must have a prior authorization through the Dirad system for reimbursement.

Enteral formula is defined benefit found in 18NYCRR 505.5 (g) or in the DMEPOS manual starting on page 35.

Enteral product prior authorization requests may be submitted via the Enteral Web Portal and/or the Interactive Voice Response (IVR) system (1-866-211-1736).

Payment for items listed in the DMEPOS procedure code manual marked with an asterisk (*) is dependent upon prior authorization through the automated system. The fiscal order, including the authorization number, is sent to the dispensing provider. The dispensing provider uses the portal or IVR to verify the information and submit the correct billing code.

Enteral formula is billed using the HCPCS B series codes on either a Pharmacy (NCPDP) or a DMEPOS supply (Professional) claim. Formula is reimbursed by caloric units; one caloric unit equals 100 calories. Worksheets are available in the DMEPOS procedure code manual to assist providers in using the automated approval systems.

NYS Medicaid Program Enteral Formula Prior Authorization Prescriber Worksheet

NYS Medicaid Program Enteral Formula Prior Authorization Dispenser Worksheet

Provider training for enteral policy and guidance on using either the IVR or web base portal are available on the DME provider manual page.

Resources

For questions related to DMEPOS supplies policy, prior approval, or DIRAD assistance or contact the Bureau of Medical Review at 1-800-342-3005, option 1 or email OHIPMEDPA@health.ny.gov

For questions regarding the Preferred Diabetic Supply Program call (518) 486-3209 or email NYRx@health.ny.gov

For questions regarding CGM coverage guidelines, contact OHIP Policy unit at (518) 473-2160 or email at pffs@health.ny.gov

For questions related to ePACES and claims processing please visit www.emedny.org for self-help information or contact GDIT at 1-800-343-9000.