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Medicaid Update

THE OFFICIAL NEWSLETTER OF THE NEW YORK MEDICAID PROGRAM

Governor Cuomo Announces Medicaid Redesign Web Site to Track Progress and Invite Public Participation

The Medicaid Redesign Team has been tasked by Governor Cuomo to identify ways to reduce costs and increase quality and efficiency in the New York State Medicaid program for the upcoming 2011-12 Fiscal Year. As part of its work, the Team is seeking ideas from the public at large, as well as experts in health care delivery and insurance, the health care workforce, economics, business, consumer rights and other relevant areas.

New York State Medicaid spends more than $53 billion annually to provide health care to more than 4.7 million people in need. In effect, Medicaid is the largest health insurance program in New York State. The costs are borne by state, county and federal taxpayers. The Team will undertake the most comprehensive examination of New York Medicaid since its inception. The Team must submit its first report with findings and recommendations to the Governor by March 1 for consideration in the budget process, and shall submit quarterly reports thereafter until the end of Fiscal Year 2011-12, when it will disband.

As part of its collaborative approach, the Team wants to hear reform ideas, big and small, from health care professionals, administrators, stakeholders, and the general public through regional public hearings and an online survey. As ideas are collected, the Medicaid Redesign Team will evaluate the feedback and approve a final package to be reviewed and approved by the Governor and the Legislature.

Please visit http://www.health.ny.gov/health_care/medicaid/redesign/ to participate and learn more about this important initiative.

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DEPARTMENT OF HEALTH

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JANUARY 2011 MEDICAID UPDATE

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New York State Medicaid offers a new solution for enrolling physicians

Effective January 1, 2011, New York State Medicaid will utilize the Council for Affordable Quality Healthcare (CAQH) Universal Provider Datasource® (UPD) to electronically collect data to enroll physicians. The UPD utilizes an online credentialing application process that supports administrative simplification efforts by eliminating the need to fill out multiple, redundant and time-consuming forms, saves money by reducing administrative costs, minimizes paperwork through online updates, and ensures that provider credentialing data stays current and accurate.

Currently 64,000 New York State physicians are enrolled with CAQH. Many providers in New York are already familiar with UPD; the credentialing application is accepted by health plans, hospitals, and other healthcare organizations operating throughout New York State.

Physicians interested in enrolling with New York State Medicaid must complete the standardized UPD application available on the CAQH Web site at: www.upd.caqh.org/oas/. Physicians must also complete the Physician Request for Enrollment form available at: www.emedny.org.

For additional practitioner enrollment information (i.e., dentist, nurse practitioner, etc.) or changes to existing enrolled physician information, please continue to use the enrollment applications and forms available online at: www.emedny.org.

Questions? Please contact the eMedNY Call Center at (800) 343-9000.

POLICY & BILLING GUIDANCE

EDITOR'S NOTE: The date listed in the December 2010 Medicaid Update for the following article was incorrect. The proper effective date is listed below. We regret any inconvenience this may have caused.

Hospice Care for Children in Medicaid, Family Health Plus and Child Health Plus

Effective March 23, 2010, New York State Medicaid including Medicaid managed care, Family Health Plus (FHPlus), and Child Health Plus (CHPlus) covers all medically necessary curative services, in addition to palliative care, for children under age 21 who receive hospice care. This change in coverage policy complies with recent changes to Section 2302 of the federal Affordable Care Act, entitled "Concurrent Care for Children."

This new provision applies ONLY to Medicaid, Medicaid managed care, FHPlus and CHPlus recipients under age 21 and allows hospice care to be available without forgoing any other medically necessary curative services to which the child is entitled under Medicaid, or under the enrollee's FHPlus or CHPlus benefit package, for treatment of the terminal illness.

There is no change in the eligibility criteria for electing hospice care. The child must be certified by a physician as terminally ill, defined as a medical prognosis for a life expectancy of six months or less if the illness runs its normal course. Hospice provides palliative and supportive care that focuses on pain and symptom management related to the terminal illness and related conditions.

Prior to enactment of the new law, curative treatment of the terminal illness ceased upon election of the hospice benefit. Curative care refers to treatment with intent to cure the child's terminal illness. Palliative care does not aim to cure but rather is focused on relieving pain and symptoms related to the terminal illness with the goal of improving quality of life. The goal of this change in coverage is to provide a blended package of curative, palliative and support services for children, as needed.

FHPlus and CHPlus enrollees receive both hospice and covered curative services through their managed care plan. Hospice services are carved-out of the Medicaid managed care benefit package and billed directly to eMedNY, while covered curative services are billed to the health plan. Individuals receiving hospice services may not be newly enrolled in Medicaid managed care, but individuals already enrolled in Medicaid managed care may remain enrolled after they begin receiving hospice services.

General questions? Please call the Office of Long Term Care, Division of Home and Community Based Services at (518) 408-1638 or e-mail: homecare@health.state.ny.us.

Medicaid program questions? Please call the Office of Health Insurance Programs, Division of Financial Planning and Policy at (518) 473-2160.

Medicaid Managed Care and FHPlus questions? Please call the Office of Health Insurance Programs, Division of Managed Care at (518) 473-0122.

Child Health Plus (CHPlus) questions? Please call the Bureau of Child Health Plus Enrollment at (518) 473-0566.

Medicaid billing questions? Please call the eMedNY Call Center at (800) 343-9000.

Bariatric Surgery Procedure Change

Effective January 1, 2011, Partial Gastrectomy (sleeve resection of the stomach, ICD-9-CM procedure code 43.89) procedures, when accompanied by a primary diagnosis of obesity, unspecified (278.00), morbid obesity (278.01) or overweight (278.02), will be included as part of APR-DRG 403 "Procedures for Obesity." Version 28.0 of the APR-DRG classification system now includes this procedure as a procedure for obesity and this classification system will be used for payment beginning January 1, 2011, (for a complete list of procedures included in APR-DRG 403, please refer to Volume 1 of the APR-DRG Classification System Definitions Manual, page 349).

The October 2010 Medicaid Update provided guidance on approved hospitals at which bariatric surgery will be reimbursed for fee-for-service Medicaid beneficiaries. The change described below has the following implications:

Fee-for-service Medicaid:

> *Only five Bariatric Specialty Centers in New York City designated by the NYS Department of Health will be reimbursed for the procedures grouped to APR-DRG 403, including sleeve resection of the stomach.*

> *Only non New York City hospitals that meet the Centers for Medicare & Medicaid Services (CMS) minimum facility standards and are designated as a Medicare Approved Facility for Bariatric Surgery will be reimbursed for the procedures grouped to APR-DRG 403, including sleeve resection of the stomach.*

Effective January 1, 2010, reimbursement for Medicaid managed care recipients receiving bariatric surgery was restricted to any CMS approved facility for Bariatric Surgery. Effective January 1, 2011, only these approved facilities will be reimbursed for the procedures grouped to APR-DRG 403, including sleeve resection of the stomach.

Questions? Please contact the Office of Health Insurance Programs at (518) 486-9012.

Medicaid Managed Care now available in Jefferson and St. Lawrence Counties

Most Medicaid beneficiaries residing in Jefferson and St. Lawrence counties now have the option to enroll in Medicaid Managed Care. Excellus Health Plan is now available in these counties for both Medicaid Managed Care and Family Health Plus (FHPlus).

Providers are encouraged to 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 "Managed Care Coordinator" or “Eligible PCP” (depending on the device used). If they are enrolled in a FHPlus plan, the first coverage message will indicate “Family Health Plus”.

MEVS will identify the scope of benefits a Medicaid beneficiary's Medicaid Managed Care Organization provides through specific coverage codes. When using a touch-tone telephone you will hear the "Description" of each covered service. When using either the Point of Service (POS) or ePACES the "Coverage Codes" will be displayed. If the message "All" appears, all services will be covered.

Note: Medicaid will *not* reimburse a provider on a fee-for-service basis if MEVS indicates that the service is covered by the plan.

Providers may call the eMedNY Call Center at (800) 343-9000 with any Medicaid billing issues. Medicaid beneficiaries should contact their local department of social services to learn more about managed care.

Questions? Please contact the Bureau of Program Planning & Implementation at (518) 473-1134.

Providers are responsible for all submitted claims

The eMedNY system allows enrolled New York State Medicaid providers to submit claims and receive reimbursements for Medicaid-covered services provided to eligible beneficiaries by direct billing or by using a service bureau or clearinghouse (Section 18 NYCRR 360-7.5 (c)).

Regardless of the claim submission method, the provider bears full responsibility for all phases of the claim process. This includes the accurate, timely, and compliant submission of Medicaid claims and the monitoring of reimbursements, including timely disclosure and repayment of overpayments obtained from Medicaid.

The use of a billing service or clearinghouse does not absolve the provider of these responsibilities. Providers agree to these responsibilities by signing and filing an annual notarized claim certification statement, as required, for participation in the eMedNY system.

Included in the attestations of the claim certification statement is the acknowledgement that the provider will keep, for a period of six years from date of payment, records and information regarding a submitted claim and the related payment (if any), and the provider must furnish this documentation upon request. Additionally, the provider certifies an understanding and an agreement to be "bound by all rules, regulations, policies, standards, fee codes and procedures of the DOH as set forth in Title 18 of the Official Compilation of Codes, Rules and Regulations of New York State and other Department publications."

Questions? Please contact the eMedNY Call Center at (800) 343-9000.

Radiology Management Program for Fee-for-Service Medicaid

New York State Medicaid will soon implement a radiology management program to ensure that beneficiaries receive the most clinically appropriate imaging studies. The program will be applied to outpatient non-emergency advanced imaging procedures, for fee-for-service beneficiaries. Beneficiaries who are eligible for both Medicaid and Medicare (dual eligible) or beneficiaries who are enrolled in a managed care plan are not included.

RadConsult,™ administered by HealthHelp, is a consultative, educational program that improves quality and reduces the cost of care by providing expert peer consultation and the latest evidence-based medical criteria for diagnostic imaging. It provides access to consultations with subspecialists affiliated with academic radiology departments.

Once the program is implemented, practitioners who order CT, CTA, MRI, MRA, cardiac, nuclear and PET procedures will be required to obtain prior authorization.

Educational materials and program implementation information will be featured in future issues of the Medicaid Update and will also be posted on www.eMedNY.org.

New York City Medical Practitioners, Programs and Facilities That Order Transportation Services

New Non-Emergency Transportation Procedure Codes Must Be Used by New York City Medical Practitioners

Effective for dates of transportation **on or after April 27, 2011**, the following procedure Healthcare Common Procedure Coding System (HCPCS) codes will be required by the federal government to be used for ordering non-emergency transportation for Medicaid enrollees who are not enrolled in a managed care organization (please note that ambulance procedure codes have not changed, only ambulette, livery and group ride):

	HCPCS Codes And Modifiers to Use for Transports That Occur On or After April 27, 2011		
Current Transportation Procedure Code	**HCPCS Transportation Code to Be Used**	**HCPCS Modifier (to be only used where indicated below)**	**Type of Service**
Ambulance	*(no change from current codes)*		
A0425	A0425	-	Ambulance: Mileage Outside City Only
A0426	A0426	-	Ambulance: Advanced Life Support
A0428	A0428	-	Ambulance: Basic Life Support
Ambulette			
NY100	A0130	-	Ambulette: One-way trip under 5 miles
NY102	A0130	TN	Ambulette: One-way trip over 5 miles
NY165	A0130	HC	Ambulette: One-way trip to/from adult day health care
Livery			
NY200	A0100	-	Livery: One-way trip under 5 miles
NY202	A0100	TN	Livery: One-way trip over 5 miles
Group Ride			
NY217	A0110	-	One-way Group ride: Ambulatory
NY218	A0110	HE	One-way Group ride: Wheelchair

-continued-

For transports that occur on or before April 26, 2011, the current procedure codes should be ordered.

Beginning March 27, 2011, providers will have the opportunity to order either the current procedure codes, or the new HCPCS procedure codes, depending on the date of the transport(s). For example, if on March 30, 2011, a provider orders three months of transportation for a Medicaid beneficiary (who is not enrolled in a Medicaid managed care plan) to a dialysis center, providers should use the old codes for transports on or before April 26, and use the new codes for transports on and after April 27.

Prior authorization request forms are being revised to allow providers to use the modifier code, when applicable to the transport. If you currently use these forms, you will automatically receive a supply of the revised prior authorization request forms in March 2011.

Annual or Semi-Annual Prior Authorizations:

Some programs, such as adult day health care or mental health day treatment, request prior authorizations on an annual (12-month) or semi-annual (6-month) basis. If you have already ordered transportation for dates after April 26, 2011, you must submit a new order using the new HCPCS procedure codes at some time on or after March 27, 2011.

Which prior authorization request form should be used?

Providers should only use the new federal code set on the new prior authorization form eMedNY-389703. A supply of these forms will be mailed to providers in early March 2011. Note: The new eMedNY-389703 form can be used for trips that occur up to April 26; these forms must be used for trips that occur on or after April 27.

Prior Authorization Guidelines Manual:

The Prior Authorization Guidelines Manual has been updated with this new information, and is available online at http://www.emedny.org/ProviderManuals/Transportation/index.html. This manual provides step-by-step processing instructions for medical professionals who request Medicaid funded transportation on behalf of their patients.

Questions?

Questions regarding this article or Medicaid Transportation policy can be referred to the Medicaid Transportation Policy staff at (518) 473-2160, or via email to MedTrans@health.state.ny.us.

Questions regarding the process for requesting Medicaid-funded transportation services can be addressed through the Prior Authorization Guidelines Manual, online at: http://www.emedny.org/ProviderManuals/Transportation/index.html.

Questions regarding forms? Please call the eMedNY Call Center at (800) 343-9000.

Policy & Billing Guidance from *EPIC* - Secondary Coverage for Medicare Part D

Paper Remittance Advice Discontinued:

Effective January 1, 2011, EPIC will cease providing paper remittance advices to participating providers. To request a detailed explanation of claims transactions electronically, please contact the EPIC Provider Helpline at (800) 634-1340 to obtain the guidelines and forms needed to receive ANSI X 12N 835 Electronic Remittance Advice.

Steps to take if receiving claim denials from Part D and EPIC:

- *Check for billing errors.*
- *Identify the correct Part D plan by submitting a Medicare Eligibility transaction (E1) to confirm current plan information and to bill the correct Part D plan primary and EPIC secondary.*
- *Call the prescriber if a Prior Authorization (PA) is needed.*
- *If the drug is not covered because it is not on the Part D formulary, ask the prescriber if an alternative covered drug can be substituted. If the prescriber does not want to change the drug, notify them that if the Temporary Coverage Request (TCR) line is called (800-634-1340) EPIC will allow up to a 90-day temporary supply of the drug while the Part D plan is contacted to discuss an appeal. Explain that EPIC will cover the drug if coverage determination and two levels of Part D appeal are denied.*
- *If providers are unable to reach the prescriber and the beneficiary has an immediate need for the drug, providers should call the TCR line directly and get authorization for a three–day emergency supply.*

Reminder: If you receive a denial from EPIC, please inform the EPIC member of the reason for the denial.

Questions? Please contact the EPIC Provider Helpline at (800) 634-1340.

Attention: New York State Medicaid and Family Health Plus Prescribers

Growth Hormones for Beneficiaries 21 and Older

Growth Hormones (Genotropin, Nutropin, Nutropin AQ®, Saizen®, Humatrope®, Norditropin®, Omnitrope®, Tev-Tropin®, and Zorbtive®) **for beneficiaries 21 years of age and older** are currently subject to the prior authorization (PA) requirements of the Clinical Drug Review Program (CDRP).

Prior authorization for beneficiaries 21 years of age and older must be initiated by the prescriber calling (877) 309-9493 and speaking to a clinical call center representative. A CDRP growth hormone worksheet is available to assist providers with the PA process. Please visit: https://newyork.fhsc.com/downloads/providers/NYRx_CDRP_PAworksheet_Prescribers_Growth_Hormones.pdf.

After you obtain a PA number ending in W please complete the following process:

- *Provide the pharmacy with the prior authorization number;*
- *Provide the pharmacy with the following phone number (518) 473-0912;*
- *Inform the pharmacy that they must call (518) 473-0912 after they submit the claim and it is denied, and Medicaid staff will process the prior authorization.*

For additional information regarding the CDRP, please visit www.nyhealth.gov and http://newyork.fhsc.com or contact the clinical call center at (877) 309-9493.

Important Notice to Pharmacies

New York Medicaid Pharmacy Home Delivery Policy

The Department has received numerous requests from providers for additional clarification regarding Medicaid's policy on pharmacy home delivery.

Prescription drugs, over-the-counter products, medical/surgical supplies, and durable medical equipment (DME) can be delivered to the homes of Medicaid beneficiaries (non-institutional residences), provided pharmacies implement and operate a distribution and delivery system that reflects "best practices".

If a pharmacy chooses to provide this optional service to their customers, the following criteria will apply to home delivery provided to Medicaid beneficiaries:

1. All shipping and delivery costs are the responsibility of the pharmacy.
2. Medicaid beneficiaries can not be charged for delivery if Medicaid reimburses for all or any portion of the item being delivered.
3. The pharmacy should inform the beneficiary or their designee of the pharmacy's delivery schedule, verify the date and location for the delivery, and notify the beneficiary that a signature will be required at the time of delivery. The number of times a pharmacy attempts to deliver is left to the discretion of the pharmacy.
4. The pharmacy must advise the beneficiary or their designee, either verbally or in writing (e.g., a patient information leaflet) of the correct handling and storage of the delivered prescriptions.
5. The pharmacy is accountable for proper delivery and will obtain a signature from the beneficiary or their designee confirming the delivery. A waiver signature form is not an acceptable practice, and such forms will not serve as confirmation of delivery. Delivery confirmation must be maintained by the pharmacy for six years from the date of payment and must be retrievable upon audit. Delivery industry tracking receipts that contain a signature qualify as a signature for receipt of delivery. Electronic signatures for receipt are permitted only if retrievable and kept on file by the pharmacy.
6. The pharmacy is liable for the cost of any prescription damaged or lost through distribution and delivery.

Questions? Please contact the Office of Health Insurance Programs at (518) 486-3209.

Upcoming Changes

New York State Medicaid Preferred Diabetic Supply Program

Effective March 1, 2011, modifications will be made to the New York State Medicaid Preferred Diabetic Supply Program (PDSP). The Department of Health has selected Abbott, Bayer and LifeScan as preferred manufacturers.

Preferred blood glucose monitors and corresponding test strips from the preferred manufacturers will be available without prior approval. Beneficiaries currently using non-preferred products will require a new fiscal order to obtain preferred monitors and strips. 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 are billed using HCPCS codes on the DME claim form.

Note: In order to facilitate a smooth transition, the implementation of the new Preferred Supply List (PSL), will be phased-in as follows:

- *As of February 1, 2011, only Abbott, Bayer and LifeScan blood glucose monitors will be available through the PDSP. Therefore, providers are strongly encouraged to dispense monitors manufactured by Abbott, Bayer or LifeScan effective immediately. This will ensure that beneficiaries will not have to switch monitors on March 1, 2011.*
- *Test strips for non-preferred meters will remain on the PSL through February 28, 2011.*

The current PSL is available at https://newyork.fhsc.com/providers/diabeticsupplies.asp. Providers are encouraged to frequently visit the PDSP Web site for updates to the program.

Additional information is available on the following Web sites:

www.nyhealth.gov or http://newyork.fhsc.com or www.eMedNY.org

Questions?

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

Did You Know?

Medicaid Covers Smoking Cessation Pharmacotherapies

Smoking cessation therapy consists of prescription and non-prescription agents. Covered agents include nasal sprays, inhalers, Zyban (bupropion), Chantix (varenicline), over-the-counter nicotine patches and gum.

Two courses of smoking cessation therapy per recipient, per year are allowed. A course of therapy is defined as no more than a 90-day supply (an original order and two refills, even if less than a 30-day supply is dispensed in any fill). If a course of smoking cessation therapy is interrupted, it will be considered one complete course of therapy. Any subsequent prescriptions would then be considered the second course of therapy.

Some smoking cessation therapies may be used together. Professional judgment should be exercised when dispensing multiple smoking cessation products. Duplicative use of any one agent is not allowed (i.e., same drug and same dosage form and same strength).

Help your patients' kick this deadly habit!

NYS SMOKERS' QUITLINE:
(866) NY-QUITS (866-697-8487)

For all smoking cessation products, the recipient must have an order. A prescription is the terminology for an order of a prescription product. A fiscal order refers to an order, which looks just like a prescription—written on a prescription blank, for an over-the-counter product.

Prescription nicotine patches will no longer be reimbursed. New York State Medicaid will only reimburse for over-the counter nicotine patches. For more information on the New York State Medicaid Smoking Cessation policy, please call (518) 486-3209.

Attention eMedNY Gateway Users:

eMedNY Gateway To Be Eliminated

The eMedNY Gateway will be eliminated on **April 1, 2011.** In order to be prepared for this implementation, eMedNY Gateway submitters are strongly encouraged to consider the alternative options available now.

eMedNY eXchange

- *Internet accessible*
- *Easy to use – works just like an e-mail mailbox*
- *No special scripting or software necessary to upload or download files*
- *Files retained for 28 days after submission*
- *ePACES user ID is used to access your eMedNY eXchange mailbox*
- *All HIPAA x12 Batch and NCPDP Batch files supported*
- *Can receive 835 Electronic Remits, PDF remits, PA Rosters*
- *Provider Test Environment can be accessed*

FTP (Dial-up)

- *For those without high speed internet access who wish to continue to use a dial-up method*
- *Login and file transmission is fully scriptable.*
- *All HIPAA x12 Batch and NCPDP Batch files supported*
- *Can receive 835 Electronic Remits*
- *Provider Test Environment can be accessed*

eMedNY Simple Object Access Protocol (SOAP) – Batch, Real-Time

- *Trading Partners may use SOAP, and the underlining Service Oriented Architecture (SOA) for exchange of batch files with eMedNY.*
- *eMedNY SOAP is an XML based protocol which enables applications to exchange information over Hyper Text Transfer Protocol (HTTP).*
- *The interface for this access method is completely user defined. Trading partners should discuss this option with their software vendor/programmer to see if this is a good fit.*
- *Uses an existing FTP or ePACES user ID.*
- *All HIPAA x12 Batch and NCPDP batch files are supported with Batch submission.*
- *270 Eligibility and Meds History (NCPDP) are supported with Real-Time submission.*

All technical guides for each of these methods are posted in the Companion Guide section of NYHIPAA Desk Support pages on **www.emedny.org**. Software vendor listings are also available on the NYHIPAA Desk Support pages.

Questions? Please visit **www.emedny.org** or contact the Call Center at (800) 343-9000. You may also e-mail your questions to emednyproviderservices@csc.com.

ALL PROVIDERS

Important Information about the 1099 Form

Computer Sciences Corporation (CSC), the eMedNY contractor for the NYS Department of Health (NYSDOH), annually issues the Internal Revenue Service (IRS) Form 1099 to providers for the previous year's Medicaid payments. 1099 forms are issued with the individual provider's Social Security Number, or if a business, with the Federal Employer Identification Number (FEIN) registered with New York State Medicaid. As with previous years, the IRS 1099 amount is not based on the date of the checks/EFTs; rather, it is based on the date the checks/EFTs were released to providers.

Since there is a two-week payment lag between the date of the checks/EFTs and the date the check/EFT is issued, the IRS 1099 amount will not correspond to the sum of all checks/EFTs issued for your provider identification number during the calendar year.

The IRS 1099 issued for 2010 will include the following:

- *Check/EFT dated 12/21/09 (Cycle 1687) released on 01/06/2010 through,*
- *Check/EFT dated 12/13/10 (Cycle 1738) released 12/29/10.*

Each year, CSC receives calls from individual providers who are issued 1099s for funds the practitioner is unaware of. This generally occurs because in order for group practice providers to direct Medicaid payments to a group NPI and corresponding IRS 1099 for the group, group practices must submit the group NPI in the appropriate field on the claim (paper or electronic). When claims are submitted without the group NPI listed it causes payment to go to the *individual* provider and his/her IRS 1099. Regardless of who deposits the funds, the 1099 will be issued to the individual provider when the funds had been paid to the individual provider's NPI.

NOTE: 1099s are not issued to providers whose yearly payments are less than $600.00. IRS 1099s for the year 2010 will be mailed no later than January 31, 2011.

Questions? Please contact the eMedNY Call Center at (800) 343-9000.

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 Website at: www.emedny.org.

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?
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?
Fee-for-Service Providers please call (518) 402-7032.
Rate-Based/Institutional Providers please call (518) 474-3575.

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

Do you suspect that a Medicaid provider or beneficiary has engaged in fraudulent activities?

PLEASE CALL: 1-877-87FRAUD

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