



Medicaid Update

The Official Newsletter of the New York State Medicaid Program

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Continued Medicaid Enrollment for Hospitals, Portable X-Ray Providers, Chiropractors, Nurse Practitioners, Physician Assistants, Nurse Midwives and Nurses

Federal regulation 42 CFR, Part 455.414 requires New York State Medicaid to revalidate your enrollment every five years. Revalidation involves completion of the enrollment form for Hospitals, Portable X-Ray Providers, Chiropractors, Nurse Practitioners, Physician Assistants, Nurses and Midwives. Additionally, Portable X-Ray providers will require a site visit.

You can save time and money by coordinating your New York State Medicaid revalidation with Medicare, another state's Medicaid program or CHIP Program. If you revalidate with New York within 12 months of your Medicare/state/CHIP enrollment, the New York application fee will be waived.

The Revalidation process for these providers **has begun**. Revalidation letters have been mailed to providers actively submitting claims to Medicaid. Find out more about Revalidation by clicking on the links below.

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

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

Click [here](#) for the Portable X-Ray Provider Enrollment Form and Instructions

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

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

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

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

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

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The Medicaid Update is a monthly publication of the New York State Department of Health.

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All Providers

New York Medicaid EHR Incentive Program Update

The NY Medicaid Electronic Health Record (EHR) Incentive Program provides financial incentives to eligible practitioners and hospitals to promote the transition to EHRs. Providers who practice using EHRs are in the forefront of improving quality, reducing costs and addressing health disparities. Since December 2011 **over \$655.5 million** in incentive funds have been distributed *within 16,927* payments to New York State Medicaid providers.

The NY Medicaid EHR Incentive Program Support Team takes great pride in offering providers free high quality program support and services. Don't take our word for it, call us at 1-877-646-5410 to speak with a program analyst for one-on-one support or navigate to the [NY Medicaid EHR Incentive Program Website](#) to view our online services.

16,927+ Payments.	\$655.5 Million Paid.	Are YOU eligible?
NY Medicaid EHR	Incentive Program	emedny.org/meipass/

Taking a closer look: **NEW NY Medicaid EHR Incentive EP Program Updates**

CMS Flexibility Rule MEIPASS Capabilities

Capabilities in the Medicaid EHR Incentive Payment Administrative Support System (MEIPASS) supporting the CMS Flexibility Rule have been implemented and are now available for providers attesting for Payment Year 2014. For more information, please access the [EP FAQs](#) and search “flexibility”.

Reminder: March 31, 2015 – Payment Year 2014 EP Attestation Deadline

Please be aware that Eligible Professionals (EP) intending to attest for Payment Year 2014 must submit an attestation by March 31, 2015.

- April webinar dates on our [Upcoming Event Calendar](#)
- NEW EP Audit [FAQs](#)

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

All Providers

New York State Medicaid Prenatal Care Standards Update

The New York State Medicaid Prenatal Care Standards (Standards) were recently updated to be consistent with the most recent recommendations for prenatal risk assessment and immunizations. The prenatal risk assessment now includes an evaluation of prior preterm birth, risk for recurrent preterm birth and eligibility for progesterone supplementation as per ACOG recommendations. In addition, the Prenatal Care Services, Immunizations Section contains updated ACOG and CDC recommendations for influenza vaccination and Tdap vaccination during pregnancy.

To review the Standards, please visit:

http://www.health.ny.gov/health_care/medicaid/standards/prenatal_care/

For questions, please send an email to: qi@health.ny.gov

The Medicaid Update Moves to Electronic Distribution

Reminder: In an effort to reduce costs and be more environmentally minded, beginning April 1, 2015 the Office of Health Insurance Programs will no longer produce a printed version of the Medicaid Update.

The Medicaid Update will ONLY be available electronically. This delivery system allows our providers to receive policy sensitive bulletins faster. The newsletter will be delivered monthly to your designated e-mail address in a Portable Document Format (PDF).

If you do not presently receive the Medicaid Update electronically, please send your request to the following e-mail: MedicaidUpdate@health.ny.gov.

Providers who are unsure about receiving an electronic-only version of the newsletter should bear in mind that the PDF newsletter can always be printed and read in hard copy. Additionally, the current and archived newsletters are posted on the DOH Website at the following address:

http://www.nyhealth.gov/health_care/medicaid/program/update/main.htm

ICD-10 Reminder for Providers and Vendors

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

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

Pharmacy Update

Update on Policy for Medicaid Fee-for-Service (FFS) Pharmacy Early Fill Edit

On January 22, 2015, a new pharmacy early fill edit was implemented that tightens early fill parameters based on days' supply on hand in an effort to further reduce overutilization, stockpiling and/or diversion of drugs. This new enhanced edit denies a claim if more than a 10 day supply of medication is remaining in the cumulative amount that has been dispensed over the previous 90 days, and augments current editing where claims are denied when less than 75% of the previously dispensed amount has been used (the more stringent rule applies). Beneficiaries still have the ability to refill their prescription(s) early, allowing for ample supply of their medication(s) on hand.

The determination of an early fill will be applied to all claims for the same drug product and strength, regardless of prescribing provider, billing provider, or prescription number.

The ability of Long Term Care (LTC) providers to override early fill edits for residents newly admitted to a LTC facility will continue. When medically necessary, LTC pharmacists can override edit 01642 "Early Fill Overuse" or edit 02242 "Early Fill Overuse" denials at the point of sale, by using a combination of the NCPDP Reason for Service Code (439-E4) 'NP', and a Submission Clarification Code (420-DK) of '02'. The use of the '02' Submission Clarification Code is limited to only LTC providers.

Use of this override code will be monitored by the Department of Health.

Exceptions/Considerations:

- If the LTC provider needs to perform an override for an existing patient or if a patient has been discharged from a LTC facility without a supply of their medications, a non-LTC pharmacy provider may contact the Department of Health for approval to utilize the above override process for their patient.
- Requests for replacement of damaged medications can be reviewed by the Department of Health for approval. *These requests will utilize a different override process.*

10 NYCRR 415.18 (f) states the parameters for the return of *unused medication* and *medication for leaves* as it pertains to facilities:

<http://w3.health.state.ny.us/dbspace/NYCRR10.nsf/56cf2e25d626f9f785256538006c3ed7/8525652c00680c3e8525652c004979e0?OpenDocument&Highlight=0,Section,415>

The Department of Health expects that all facilities are in compliance with this regulation.

For help performing a permitted override please contact Computer Sciences Corporation at 1-800-343-9000.

For questions regarding **Exceptions/Considerations** above the provider may contact the Pharmacy Department at 518-486-3209 or ppno@health.ny.gov.

The original article on this topic was published in the January 2015 Medicaid Update:

http://www.health.ny.gov/health_care/medicaid/program/update/2015/jan15_mu.pdf

Pharmacy Update

Attention 340B Hospitals and Freestanding Clinics Billing Instructions for 340B Drug Claims

Reminder: The NYS Medicaid program uses the Federal agency Health Resources and Services Administration's (HRSA) Medicaid Exclusion File to identify 340B claims from 340B providers that must be removed from the rebate stream, thereby avoiding duplicate discounts.

Additional identifiers are required at the claim submission level for ALL 340B drug claims, both Fee-for-Service and Managed Care.

340B claims submitted in 837I or 837P format **must** include a **UD modifier**. Inclusion of the UD modifier helps to avoid duplicate discounts on 340B Medicaid claims.

Medicaid 340B policy questions should be sent via e-mail to PPNO@health.ny.gov

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

Policy and Billing Guidance

Revised Physician Payment Policy for PET Scan Procedures and Tracers Effective April 1, 2015 Radiology Fee Schedule

The Medicaid Program is revising payment methodology for positron emission tomography (PET) scans.

Presently, physicians are paid a global fee for a PET scan. The global fee includes the cost of the radioactive tracer administered to the patient. Effective April 1, 2015, Medicaid is carving out the cost of the tracer from the global fee. Physicians will now receive payment for the professional/technical component for the PET scan and will bill the radioactive tracer on a separate claim line (in addition to the professional/technical PET scan component). The physician must report actual acquisition cost for the tracer and/or tracer components along with the invoice(s) net of any rebates, discounts or other cost considerations.

Please note, that Medicaid payment for the professional/technical component of the PET scan has been reduced to reflect that the tracer cost has been carved out of the global fee. This change in policy is aligned with Medicare’s policy, which pays for the procedures and tracers separately. The table below lists the current PET scan professional/technical fee, the new PET scan fees effective April 1, and the CPT billing codes for tracers:

CODE	DESCRIPTION	PHYSICIAN RADIOLOGY FEES, (JANUARY 1- MARCH 31, 2015)	PHYSICIAN RADIOLOGY FEE SCHEDULE, (EFFECTIVE APRIL 1, 2015)
PET Scan Procedures			
78459	MYOCARDIAL IMAGING, PET, METABOLIC EVALUATION	\$ 1,154	\$ 480
78491	MYOCARDIAL IMAGING, PET, PERFUSION; SINGLE STUDY AT REST OR STRESS	\$ 579	\$ 483
78492	MYOCARDIAL IMAGING, PET, PERFUSION; MULTIPLE STUDY REST AND/OR STRESS	\$ 1,154	\$ 793
78608	BRAIN IMAGING, PET; METABOLIC EVALUATION	\$ 903	\$ 594
78609	BRAIN IMAGING, PET; PERFUSION EVALUATION	\$ 903	\$ 594
78811	PET IMAGING; LIMITED AREA (EG, CHEST, HEAD/NECK)	\$ 907	\$ 569
78812	PET IMAGING; SKULL BASE TO MID-THIGH	\$ 921	\$ 255
78813	PET IMAGING; WHOLE BODY	\$ 923	\$ 847
78814	PET WITH CONCURRENTLY ACQUIRED COMPUTED TOMOGRAPH; (EG, CHEST, HEAD/NECK)	\$ 930	\$ 310
78815	PET WITH CONCURRENTLY ACQUIRED COMPUTED TOMOGRAPH; (SKULL BASE TO MIDTHIGH)	\$ 939	\$ 541
78816	PET WITH CONCURRENTLY ACQUIRED COMPUTED TOMOGRAPH; (WHOLE BODY)	\$ 941	\$ 696
Radioactive Tracers			
A9526	NITROGEN N-13 AMMONIA, DIAGNOSTIC, PER STUDY DOSE, UP TO 40 MILLICURIES		BY REPORT
A9552	FLUORODEOXYGLUCOSE F-18 FDG, DIAGNOSTIC, PER STUDY DOSE, UP TO 45 MILLICURIES		BY REPORT
A9555	RUBIDIUM RB-82, DIAGNOSTIC, PER STUDY DOSE, UP TO 60 MILLICURIES		BY REPORT
A9580	SODIUM FLUORIDE F-18, DIAGNOSTIC, PER STUDY DOSE, UP TO 30 MILLICURIES		BY REPORT

Note: Federal National Correct Coding Initiative (NCCI) edits apply.

Questions regarding Medicaid FFS policy should be directed to the Division of Program Development and Management at (518) 473-2160. General questions regarding the fee schedule should be directed to the Division of OHIP Operations at (518) 474-8161.

Policy and Billing Guidance

Medicaid Breast Cancer Surgery Centers

Research shows that five-year survival increases for women who have their breast cancer surgery performed at high-volume facilities and by high-volume surgeons. Therefore, it is the policy of New York State Department of Health that Medicaid recipients receive mastectomy and lumpectomy procedures associated with a breast cancer diagnosis, at high-volume facilities defined as averaging 30 or more all-payer surgeries annually over a three-year period. Low-volume facilities will not be reimbursed for breast cancer surgeries provided to Medicaid recipients. 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 recipients.

The Department has completed its seventh annual review of all-payer breast cancer surgical volumes for 2011 through 2013 using the Statewide Planning and Research Cooperative System (SPARCS) database. Sixty-seven low-volume hospitals and ambulatory surgery centers throughout New York State were identified. These facilities have been notified of the restriction effective April 1, 2015. The policy does not restrict 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 SPARCS surgical volumes to revise the list of low-volume hospitals and ambulatory surgery centers. 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 recipients.

For more information and the list of restricted low-volume facilities, please see:
http://www.nyhealth.gov/health_care/medicaid/quality/surgery/cancer/breast/.
If you have any questions, please contact the Department at (518) 486-9012.

The Billing of Hearing Aids and Repairs for Assisted Living Program (ALP) Participants

The *Durable Medical Equipment Provided to Assisted Living Program Participants* article in the DOH Medicaid Update [March 2007 Vol. 22, No. 3](#), provided clarification regarding the provision of Durable Medical Equipment (DME) and medical supplies that are included in the daily Medicaid Assisted Living Program (ALP) rate. As outlined in the article, the ALP operates in adult homes and enriched housing programs and provides a combination of residential services and home care services to Medicaid and private pay residents.

The Medicaid Update article explains that a daily rate is paid to the ALP for Medicaid-eligible residents for the provision of nine services, including the provision of DME and medical supplies not requiring prior approval. Hearing aid batteries (V5266) are an example of medical supplies that are included in the ALP's rate.

This notice is to clarify that hearing aids and their repairs are not considered DME or medical supplies. Therefore, such items are not captured within the services paid for within the ALP Medicaid rate, and should be billed to the ALP participant's individual Medicaid benefit.

For questions related to hearing aid policy and coverage guidelines, please send an email to: ohipmedpa@health.ny.gov or contact the Division of OHIP Operations at 1-800-342-3005, option 1.

For questions related to Assisted Living policy and coverage, please contact the Division of Long Term Care at 1-518-474-5888.

Policy and Billing Guidance

ATTENTION: PROVIDERS OF NURSING FACILITY SERVICES, CERTAIN HOME AND COMMUNITY BASED WAIVER SERVICES AND SERVICES TO INDIVIDUALS ENROLLED IN A MANAGED LONG TERM CARE PLAN

2015 Spousal Impoverishment Income and Resource Levels Increase

Providers of nursing facility services, home and community based waiver services and services to individuals enrolled in a managed long term care plan, are required to PRINT and DISTRIBUTE the *“Information Notice to Couples with an Institutionalized Spouse”* (pages 11-14 of this newsletter) at the time they begin to provide services to their patients.

Effective January 1, 2015, the federal maximum community spouse resource allowance increases to **\$119,220** while the community spouse income allowance increases to **\$2,980.50**. The maximum family member monthly allowance increases to **\$664**.

This information should be provided to any institutionalized spouse, community spouse, or representative acting on their behalf so as to avoid unnecessary depletion of the amount of assets a couple can retain under the spousal impoverishment eligibility provisions.

INCOME AND RESOURCE AMOUNTS

January 1, 2015

Federal Maximum Community Spouse Resource Allowance: \$119,220

NOTE: A higher amount may be established by court order or fair hearing to generate income to raise the community spouse’s monthly income up to the maximum allowance. **NOTE:** The State Minimum Community Spouse Resource Allowance is \$74,820.

January 1, 2015

Community Spouse Minimum Monthly Maintenance Needs Allowance

is an amount up to: \$2,980.50 (if the community spouse has no income of his/her own)

NOTE: A higher amount may be established by court order or fair hearing due to exceptional circumstances that result in significant financial distress.

January 1, 2015

Family Member Monthly Allowance for each family member is an amount up to: \$664
(if the family member has no income of his/her own)

NOTE: If the institutionalized spouse is receiving Medicaid, any change in income of the institutionalized spouse, the community spouse, and/or the family member may affect the community spouse income allowance and/or the family member allowance. Therefore, the social services district should be promptly notified of any income variations.

Information Notice to Couples with an Institutionalized Spouse:

Medicaid is an assistance program that may help pay for the costs of your or your spouse's institutional care, home and community based waiver services, or enrollment in a managed long term care plan. The institutionalized spouse is considered medically needy if his/her resources are at or below a certain level and the monthly income after certain deductions is less than the cost of care in the facility.

Federal and State laws require that spousal impoverishment rules be used to determine an institutionalized spouse's eligibility for Medicaid. These rules protect some of the income and resources of the couple for the community spouse.

NOTE: Spousal impoverishment rules do not apply to an institutionalized spouse who is eligible under the Modified Adjusted Gross Income (MAGI) rules.

If you or your spouse are:

- | |
|---|
| (1) In a medical institution or nursing facility and are likely to remain there for at least 30 consecutive days; or |
| (2) Receiving home and community based services provided pursuant to a waiver under section 1915(c) of the federal Social Security Act and are likely to receive such services for at least 30 consecutive days; or |
| (3) Receiving institutional or non-institutional services and are enrolled in a managed long term care plan; AND |
| (4) Married to a spouse who does <u>not</u> meet any of the criteria set forth under (1) through (3), these income and resource eligibility rules for an institutionalized spouse may apply to you or your spouse. |

If you wish to discuss these eligibility provisions, please contact your local department of social services. Even if you have no intention of pursuing a Medicaid application, you are urged to contact your local department of social services to request an assessment of the total value of your and your spouse's combined countable resources. It is to the advantage of the community spouse to request such an assessment to make certain that allowable resources are not depleted by you for your spouse's cost of care. To request such an assessment, please contact your local department of social services or mail the attached completed "Request for Assessment Form." New York City residents may contact the Human Resources Administration (HRA) Infoline at (718) 557-1399.

Information about resources:

Effective January 1, 1996, the community spouse is allowed to keep resources in an amount equal to the greater of the following amounts:

- | |
|--|
| (1) \$74,820 (the State minimum spousal resource standard); or |
| (2) The amount of the spousal share up to the maximum amount permitted under federal law (\$119,220 for 2015). |

For purposes of this calculation, "spousal share" is the amount equal to one-half of the total value of the countable resources of you and your spouse at the beginning of the most recent continuous period of institutionalization of the institutionalized spouse. The most recent continuous period of institutionalization is defined as the most recent period you or your spouse met the criteria listed in items 1 through 4 (under "If you or your spouse are."). In determining the total value of the countable resources, we will not count the value of your home, household items, personal property, your car, or certain funds established for burial expenses.

The community spouse may be able to obtain additional amounts of resources to generate income when the otherwise available income of the community spouse, together with the income allowance from the institutionalized spouse, is less than the maximum community spouse monthly income allowance, by

requesting a fair hearing or commencing a family court proceeding against the institutionalized spouse. Your attorney or local Office for the Aging can provide you with more information.

Either spouse or a representative acting on their behalf may request an assessment of the couple's countable resources, at the beginning, or any time after the beginning of a continuous period of institutionalization. Upon receipt of such request and all relevant documentation, the local district will assess and document the total value of the couple's countable resources and provide each spouse with a copy of the assessment and the documentation upon which it is based. If the request is not filed with a Medicaid application, the local department of social services may charge up to \$25.00 for the cost of preparing and copying the assessment and documentation.

Information about income:

You may request an assessment/determination of:

- (1) The community spouse monthly income allowance (an amount of up to \$2,980.50 a month for 2015); and
- (2) A maximum family member allowance for each minor child, dependent child, dependent parent or dependent sibling of either spouse living with the community spouse of \$664 for 2015 (if the family member has no income of his/her own).

The community spouse may be able to obtain additional amounts of the institutionalized spouse's income, due to exceptional circumstances resulting in significant financial distress, than would otherwise be allowed under the Medicaid program, by requesting a fair hearing or commencing a family court proceeding against the institutionalized spouse. Significant financial distress means exceptional expenses which the community spouse cannot be expected to meet from the monthly maintenance needs allowance or from amounts held in resources. These expenses may include, but are not limited to: recurring or extraordinary non-covered medical expenses (of the community spouse or dependent family members who live with the community spouse); amounts to preserve, maintain, or make major repairs to the home; and amounts necessary to preserve an income-producing asset. Social Services Law 366-c.2(g) and 366-c.4(b) require that the amount of such support orders be deducted from the institutionalized spouse's income for eligibility purposes. Such court orders are only effective back to the filing date of the petition. Please contact your attorney or local Office for the Aging for additional information.

If you wish to request an assessment of the total value of your and your spouse's countable resources, a determination of the community spouse resource allowance, community spouse monthly income allowance, or family member allowance(s) and the method of computing such allowances, please contact your local department of social services. New York City residents should call the Human Resources Administration (HRA) Infoline at (718) 557-1399.

Additional Information

For purposes of determining Medicaid eligibility for the institutionalized spouse, a community spouse must cooperate by providing necessary information about his/her resources. Refusal to provide the necessary information shall be reason for denying Medicaid for the institutionalized spouse because Medicaid eligibility cannot be determined. If denial of Medicaid would result in undue hardship for the institutionalized spouse and an assignment of support is executed or the institutionalized spouse is unable to execute such assignment due to physical or mental impairment, Medicaid shall be authorized. However, if the community spouse refuses to make such resource information available, then the Department, at its option, may refer the matter to court.

Undue Hardship Occurs When:

- (1) A community spouse fails or refuses to cooperate in providing necessary information about his/her resources;**
- (2) The institutionalized spouse is otherwise eligible for Medicaid;**
- (3) The institutionalized spouse is unable to obtain appropriate medical care without the provision of Medicaid; and**

(a) The community spouse's whereabouts are unknown; or

(b) The community spouse is incapable of providing the required information due to illness or mental incapacity; or

(c) The community spouse lived apart from the institutionalized spouse immediately prior to institutionalization; or

(d) Due to the action or inaction of the community spouse, other than the failure or refusal to cooperate in providing necessary information about his/her resources, the institutionalized spouse will be in need of protection from actual or threatened harm, neglect, or hazardous conditions if discharged from appropriate medical setting.

An institutionalized spouse will not be determined ineligible for Medicaid because the community spouse refuses to make his or her resources in excess of the community spouse resource allowance available to the institutionalized spouse if:

(1) The institutionalized spouse executes an assignment of support from the community spouse in favor of the social services district; or

(2) The institutionalized spouse is unable to execute such assignment due to physical or mental impairment.

Contribution from Community Spouse

The amount of money that we will request as a contribution from the community spouse will be based on his/her income and the number of certain individuals in the community depending on that income. We will request a contribution from a community spouse of 25% of the amount his/her otherwise available income that exceeds the minimum monthly maintenance needs allowance plus any family member allowance(s). If the community spouse feels that he/she cannot contribute the amount requested, he/she has the right to schedule a conference with the local department of social services to try to reach an agreement about the amount he/she is able to pay.

Pursuant to Section 366(3)(a) of the Social Services Law, Medicaid MUST be provided to the institutionalized spouse, if the community spouse fails or refuses to contribute his/her income towards the institutionalized spouse's cost of care. However, if the community spouse fails or refuses to make his/her income available as requested, then the Department, at its option, may refer the matter to court for a review of the spouse's actual ability to pay.



Date: _____

Request for Assessment Form

Institutionalized Spouse's Name:
Address:
Telephone Number:
Community Spouse's Name:
Current Address:
Telephone Number:

/we request an assessment of the items checked below:

- Couple's countable resources and the community spouse resource allowance
- Community spouse monthly income allowance
- Family member allowance(s)

Check if you are a representative acting on behalf of either spouse. Please call your local department of social services if we do not contact you within 10 days of this request.

NOTE: If an assessment is requested without a Medicaid application, the local department of social services may charge up to \$25 for the cost of preparing and copying the assessment and documentation.

Signature of Requesting Individual

Address and telephone # if different from above

New York State Medicaid Updates Regulations

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

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

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

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

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

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

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

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

Payment will not be made for the following services:

- Cryopreservation, storage, and thawing of reproductive tissue, and all related services and charges;
- Reversal of genital and/or breast surgery;
- Reversal of surgery to revise secondary sex characteristics;
- Reversal of any procedure resulting in sterilization;
- Cosmetic surgery, services, and procedures, including but not limited to:
 - Abdominoplasty, blephoroplasty, neck tightening, or removal of redundant skin;
 - Breast augmentation*;
 - Breast, brow, face, or forehead lifts;
 - Calf, cheek, chin, nose, or pectoral implants;
 - Collagen injections;
 - Drugs to promote hair growth or loss;
 - Electrolysis, unless clinically indicated for vaginoplasty or phalloplasty;
 - Facial bone reconstruction, reduction, or sculpturing, including jaw shortening and rhinoplasty;
 - Hair transplantation;
 - Lip reduction;
 - Liposuction;
 - Thyroid chondroplasty;
 - Voice therapy, voice lessons, or voice modification surgery.

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

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

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

Post-Transition Care

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

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

Fee-for-Service Billing Instructions for Gender Reassignment Surgery

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

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

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

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

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

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

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

Telemedicine Coverage to be Further Expanded

Telemedicine involves the use of interactive audio and video telecommunications technology to support “real time” interactive patient care and consultations between healthcare practitioners and patients at a distance. It is viewed as a cost-effective alternative to the more traditional face-to-face way of providing medical care between providers and patients. The medical specialist providing the consultation or service is located at a distant site or “hub.” The referring healthcare practitioner and patient are located at the originating site or “spoke.”

The following policy guidelines apply to Medicaid fee-for-service (FFS). Medicaid managed care (MMC) plans may cover telemedicine at their option and establish their own payment guidelines and structure.

In October 2011, Medicaid expanded coverage of telemedicine to include the following settings as distant “hub” sites and originating “spoke” sites:

- Article 28 hospitals;
- Article 28 Diagnostic and Treatment Centers (DTCs);
- Federally Qualified Health Centers (FQHCs) that had “opted into” APGs; and
- Non-FQHC School Based Health Centers (SBHCs) as originating “spoke” sites.

The list of distant “hub” site practitioner types, reimbursed for furnishing services via telemedicine, was also expanded at that time. In addition to physician specialists, Certified Diabetes Educators (CDEs) and Certified Asthma Educators (CAEs) were reimbursed by Medicaid for providing services via telemedicine.

Effective immediately, Medicaid will further expand its coverage of telemedicine services.

Distant “hub” (location of consulting practitioner) sites will be expanded to include the following:

- Article 28 facilities providing dental services
- Practitioner offices

Originating “spoke” (location of patient) sites will be expanded to include the following:

- Practitioner offices
- Article 28 facilities providing dental services
- FQHCs that have “opted out” of APGs

Distant “hub” site practitioners will now include all of the following:

- Physician Specialists
- Psychiatric Nurse Practitioners

- Clinical Psychologists
- Dentists
- Certified Diabetes Educators (CDEs)
- Certified Asthma Educators (CAEs)
- Genetic Counselors
- Licensed Clinical Social Workers (LCSWs) and Licensed Master Social Workers (LMSWs) only when employed by an Article 28 clinic. Based on statute, LCSWs and LMSWs can only provide services to Medicaid enrollees under age 21 and pregnant women up to 60 days post-partum.

Coverage Requirements:

Telemedicine consultations are covered when medically necessary and when the following requirements are met:

- The patient must be physically present at the originating "spoke" site; the consulting practitioner is located at the "hub" site.
- The practitioner at the "hub" site, who is performing the consultation, must be licensed in New York State, enrolled in New York State Medicaid and credentialed and privileged at both the "hub" and "spoke" sites according to the applicable setting-specific standards.
- The request for the telemedicine consultation, the medical necessity for the telemedicine consultation and the findings of the distant "hub site" practitioner must be documented in the patient's medical record.
- The telemedicine consultation must be "real time," and provided via a fully interactive, secure two-way audio visual telecommunication system ("store and forward" is not covered by Medicaid).

Credentialing and Privileging Requirements:

New York State regulations require that Article 28 hospitals, acting as originating telemedicine "spoke" sites, are ultimately responsible for ensuring that consulting physicians located at distant "hub" sites are appropriately credentialed and privileged.

Changes in 2012 to Public Health law, Section 2805-u, require that Article 28 originating telemedicine "spoke" site hospitals, pursuant to a written agreement with a distant "hub" site hospital, may rely on the credentialing and privileging decisions of the distant "hub" site hospital when granting or renewing privileges to a health care practitioner who is a member of the clinical staff at the distant "hub" site hospital provided that:

- The distant "hub" site hospital participates in Medicare and Medicaid;
- Each health care practitioner providing telemedicine services is licensed to practice in New York State;
- The distant "hub" site hospital, in accordance with the requirements otherwise applicable to that hospital, collects and evaluates all credentialing information concerning each health care practitioner providing telemedicine services, performs all required verification activities, and acts on behalf of the originating "spoke" site hospital for such credentialing purposes;
- The distant "hub" site hospital reviews periodically, at least every two years, and as otherwise warranted based on outcomes, complaints or other circumstances, the credentials, privileges, physical

and mental capacity, and competence in delivering health care services of each health care practitioner providing telemedicine services, consistent with requirements otherwise applicable to that hospital; reports the results of such review to the originating “spoke” hospital; and notifies the originating “spoke” hospital immediately upon any suspension, revocation, or limitation of such privileges; and

- With respect to each distant “hub” site health care practitioner who holds privileges at the originating “spoke” hospital, the originating “spoke” hospital conducts a periodic internal review, at least every two years, of the distant “hub” site practitioner’s performance of these privileges and provides the distant “hub” site hospital with such performance information for use in the distant “hub” hospital’s periodic appraisal of the distant “hub” site physician or health care practitioner.

The entire regulation can be viewed at the following link: <http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO>
(Select LAWS; select PBH; select Article 28; select 2805u)

Facility/Physician Reimbursement:

The following rules apply when billing for telemedicine services:

Only one payment will be made when both the “hub” site and “spoke” site are part of the same provider network/billing entity. **In such cases, the “spoke” site should bill Medicaid for the telemedicine visit. The “spoke” site will be responsible for reimbursing the in-network “hub” site facility and/or practitioner.**

Distant “Hub” Sites:

The distant Article 28 “hub” site should bill Medicaid under APGs for the telemedicine consultation using the appropriate CPT code for the consultation services provided. The CPT code should be appended with the "GT" modifier (*via interactive audio and video telecommunication system*).

When the distant “hub” site is an **Article 28 hospital outpatient department/clinic and telemedicine services are provided by a physician**, the physician should bill Medicaid using the appropriate CPT consultation code appended with the "GT" modifier. *The professional component for all other practitioners providing telemedicine services in a hospital outpatient department/clinic is included in the APG payment to the facility.*

In all institutional settings, other than hospitals, the professional component for all practitioners (including physicians) is included in the APG payment to the facility.

If the consulting practitioner is providing telemedicine services from his/her private office, the practitioner should bill the appropriate CPT code for the consultation services provided. The CPT code should be appended with the "GT" modifier (*via interactive audio and video telecommunication system*).

Originating "Spoke" Sites:

When the originating “spoke” site is an **Article 28 hospital (outpatient department/clinic, emergency room, inpatient) and a physician** is present with the patient, the physician should bill the appropriate E&M. *The professional component for all other practitioners, who are present with the patient at the time of the consultation, is included in the APG payment to the facility.*

In all institutional settings (e.g., DTCs), other than hospitals, the professional component for all practitioners (including physicians) is included in the APG payment to the facility.

When a qualified practitioner is present with the patient during the telemedicine encounter, the Article 28 facility should bill the appropriate E&M code.

If medical services are not being provided by a qualified practitioner at the “spoke” site and only a telemedicine link to the “hub” site is being provided, the “spoke” site should bill CPT code Q3014* through APGs to recoup administrative expenses associated with the telemedicine patient encounter.

If a consultation via telemedicine is being provided to a patient in a private physician’s office and the physician is present in the room with the patient during the consult, the physician should bill the appropriate CPT code(s) for the services provided.

* Under APG reimbursement, Q3014 will only be paid to “spoke” facilities when billed as a stand-alone service. If the “spoke” site is providing and billing for medical services that take place at the time of the telemedicine encounter, Q3014 will not be reimbursed.

FQHCs That Have “Opted Out” of APGs:

Medicaid will reimburse the “spoke” site the Federal Prospective Payment System (PPS) rate. The “spoke” site will be responsible for paying the consulting practitioner, who is located at the “hub” site. If only a telemedicine connection is being provided and a qualified practitioner is not present with the patient at the time of the telemedicine encounter, the “spoke” site should include CPT code Q3014 on the claim.

FQHCs Providing Tele-dentistry Services:

FQHCs that have “opted out” of APGs - When services (e.g., dental cleaning procedures, etc.) are performed by a dental hygienist at the “spoke” site and the dentist is located at a “hub” site, Medicaid will reimburse the “spoke” site the PPS rate. The “spoke” site will be responsible for paying the dentist.

FQHCs that have “opted into” APGs - When services (e.g., teeth cleaning, etc.) are performed by a dental hygienist at the “spoke” site and the dentist is located at a “hub” site, Medicaid will reimburse both sites through APGs. The “hub” should append the CDT procedure code with the “GT” modifier. The professional component is included in the APG payment to the facilities.

Managed Care Coverage:

Coverage of telemedicine services by Medicaid managed care (MMC) plans is optional. Providers should check with the enrollee’s MMC plan to determine whether telemedicine services are covered and, if so, for medical necessity criteria and plan-specific billing instructions. Although optional, if telemedicine services are covered by a MMC plan, the credentialing and privileging requirements described in this article must be met.

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

Questions regarding Medicaid managed care coverage should be directed to the enrollee's MMC plan.

ALL Claim Types Pending Review for Edits 00127 & 01283

Effective **April 1, 2015**, claims setting eMedNY **edits 00127** (Medicare Paid Amount Reported Less Than Reasonable) and **01283** (Upper Dollar Limit Exceeded) **will pend to New York State Department of Health (NYSDOH) for review.**

The corresponding **HIPAA codes** that will be reported on the 835 remittance are:

- 00127:** Adjustment Reason Code 23 with no Remittance Remark Code
- 01283:** Adjustment Reason Code 16 and Remittance Remark Code M54

If the claim(s) is pended, the corresponding claim status **response** codes will be:

- 00127:** Claim status code 182
- 01283:** Claim status code 585

For claims submitted on paper with the Explanation of Medicare Benefits (EOMB) attached, once it pends for one of these edits NYSDOH will compare the EOMB to the information on the paper claim. If the information matches, the claim will be approved. If it doesn't match, the claim will be denied for the edit.

For claims submitted on paper without an EOMB or submitted electronically, send the Medicare EOMB, indicating the corresponding 16 digit Medicaid Transaction Control Number (TCN) found on your Medicaid remittance to:

New York State Department of Health
Attn: Medical Pended Claims
150 Broadway
Albany, NY 12204-2736

Failure to submit the EOMB within 60 days will result in the claim being denied for the edit.

NYSDOH staff will review the documentation and adjudicate the claim(s) accordingly through the regular claim processing system. The adjudicated claims will appear on the provider remittance statement.

Reminder:

When billing Medicaid for a service reimbursed by Medicare, the provider NPI, procedure code, all modifiers and dates of service should appear exactly the same on the claim to Medicaid as on the Medicare claim. The NPI submitted on your claim to Medicare must be enrolled with New York State Medicaid.

In addition, providers must reduce the Medicare Allowed Amount by any sequestration payment reduction (CO 253) amount to obtain the correct coinsurance payment.

Questions should be directed to Medical Pended Claims staff at 1-800-342-3005, option 3.

Patient Centered Medical Home Statewide Program Incentive Payments

UPDATE: DELAYED IMPLEMENTATION DATE

In order to allow providers additional time to achieve Patient Centered Medical Home (PCMH) recognition from the National Committee for Quality Assurance (NCQA) under the 2014 standards, New York State Medicaid is extending the implementation date of the Statewide PCMH Incentive Payment Program changes affecting payments to providers recognized under 2011 or 2014 standards, which was announced in the February 2015 Medicaid Update. The implementation date related to payment changes for recognition under 2011 and 2014 standards years will be delayed from April 1, 2015 to January 1, 2016. This extension only applies to providers recognized under the 2011 standards and all incentive payments for PCMH-recognized providers under NCQA's 2008 standards will still be discontinued as of April 1, 2015.

This revised policy is applicable to both Medicaid Managed Care (MMC) and Medicaid Fee-for-Service (FFS). Postponing the reduction of payments for 2011 recognition allows for the continuation of support to PCMH providers while they further transform their practices to NCQA's newest 2014 standards. The January 1, 2016 implementation date for these changes give primary care practices and providers a financial incentive to achieve level 2 or 3 NCQA PCMH recognition under the 2014 standards by the end of 2015, and remains consistent with the Medicaid Redesign Team's (MRT) and State Health Innovation Plan's (SHIP) Triple Aim to improve care, health, and reduce per capita costs.

Table 1 summarizes the MMC Per Member Per Month (PMPM) payment and the Medicaid FFS 'add-on' amounts by provider type and recognition status as of April 1, 2015, and will remain in effect through December 31, 2015. Level 2 providers, who have achieved recognition under either the 2011 or 2014 standards, will receive an incentive payment of \$4 PMPM for MMC and \$11.25 or \$14.25 for institutional and professional Medicaid FFS claims, respectively. Level 3 providers, who have achieved recognition under either the 2011 or 2014 standards, will receive an incentive payment of \$6 PMPM for MMC and \$16.75 or \$21.25 for institutional and professional Medicaid FFS claims, respectively.

Table 1: Statewide PCMH Incentive Payment Program PMPM and 'Add-on' Amounts			
<i>April 1, 2015 through December 31, 2015</i>			
	NCQA Level 1, 2, or 3 2008 Standards	NCQA Level 2 2011 or 2014 Standards	NCQA Level 3 2011 or 2014 Standards
MMC-PMPM	\$0.00 PMPM	\$4.00 PMPM	\$6.00 PMPM
FFS Per Visit			
Institutional	\$0.00	\$11.25	\$16.75
Professional	\$0.00	\$14.25	\$21.25

- NCQA Level 1 payments for all standard years were discontinued on January 1, 2013.
- NCQA Level 2 payments for 2008-recognized providers were discontinued on July 1, 2013.

On January 1, 2016, the reimbursement for PCMH incentive payments will be updated to reflect the program changes that were originally published in the February 2015 Medicaid Update (http://www.health.ny.gov/health_care/medicaid/program/update/2015/feb15_mu.pdf).

Effective January 1, 2016, all incentives for providers recognized at any level under NCQA’s 2008 standards incentives will remain discontinued. Incentives for providers recognized at level 2 or level 3 under NCQA’s 2011 standards will be reduced and incentives for providers recognized at level 2 or level 3 under NCQA’s 2014 standards will be increased. Table 2 summarizes the MMC PMPM payment and the Medicaid FFS ‘add-on’ amounts by provider type and recognition status, which will begin on January 1, 2016.

Table 2: PCMH Statewide Payment Incentive Payment Program PMPM and ‘Add-on’ Amounts		
<i>Effective January 1, 2016</i>		
	NCQA Level 2 2011/2014 Standards	NCQA Level 3 2011/2014 Standards
MMC – PMPM	\$2.00 / \$6.00	\$4.00 / \$8.00
FFS Per Visit		
Institutional	\$7.75 / \$23.25	\$12.50 / \$25.25
Professional	\$6.75 / \$20.50	\$14.50 / \$29.00

For more information on FFS claim eligibility, please see page 13 of the February 2015 Medicaid Update article.

New York Medicaid providers participating in the Adirondack Medical Home Demonstration Project are not eligible for enhanced payment through the Statewide Patient-Centered Medical Home Program.

Questions/Information:

For more information on how to achieve NCQA PCMH recognition, providers may contact NCQA at (888) 275-7585 or visit NCQA’s website at www.ncqa.org.

MMC PCMH questions may be directed to the Division of Health Plan Contracting and Oversight at (518) 474-5050, or the eMedNY Call Center at (800) 343-9000 or pcmh@health.ny.gov regarding Medicaid FFS questions.

For more information on claim eligibility please contact eMedNY at (800) 343-9000

Provider Directory

Office of the Medicaid Inspector General:

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

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

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

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

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

Do you have questions about billing and performing MEVS transactions?

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

Provider Training:

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

Enrollee Eligibility:

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

Medicaid Prescriber Education Program:

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

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

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

Medicaid Electronic Health Record Incentive Program questions?

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