



Medicaid Update

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Continued Development of the New York State Medicaid Provider Services Portal: New Enrollment for All Provider Types Now Available

As previously shared in the *Modernization of the New York State Medicaid Provider Enrollment Process* article published in the September 2025 issue of the *Medicaid Update*, located at: https://www.health.ny.gov/health_care/medicaid/program/update/2025/docs/mu_no9_sep25_pr.pdf, the New York State (NYS) Medicaid program is modernizing the provider enrollment process with the phased roll-out of an online provider enrollment portal known as the *New York State Medicaid Provider Services Portal (PSP)*, located at: <https://www.emedny.org/PSP/#psm=step1>.

All providers who have never been enrolled in NYS Medicaid before should now use the *NYS Medicaid PSP* when applying for new enrollment, except group practices with only one NYS Medicaid-enrolled practitioner. Group practices with only one NYS Medicaid-enrolled practitioner should continue to submit paper applications until July 2026 at which time all paper applications will be discontinued. All other provider types should refer to the NYS Medicaid PSP, located at: <https://www.emedny.org/PSP/#psm=step1>. This second major release enables organizational provider types, including groups, institutions, and businesses, to enroll. Credentialing staff can also use the online portal to support new provider enrollment.

A future release will allow existing NYS Medicaid providers to use the NYS Medicaid PSP for revalidation, reporting a change of ownership, applying for reinstatement and maintaining their provider ID, all online. Details for the roll-out of upcoming phases will continue to be communicated to the provider community via *Medicaid Update*, eMedNY Listservs, and the MRT Listserv. Providers must ensure their correspondence and email addresses are current on provider files so that important information is not missed. Providers who need to update their correspondence address or email address must download the correct form on the eMedNY "Change of Address for Enrolled Providers" web page, at: <https://www.emedny.org/info/ProviderEnrollment/changeaddress.aspx>, and submit as soon as possible.

With this modernization, the paper enrollment process will be phasing out in the coming months. Providers who choose to submit a paper application, while still available, should be sure to use the most recent version of the form which is available on eMedNY.org. Applications submitted on older versions of the form will be rejected.

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All Providers

To support the complex transition from a paper application process to a web-based enrollment process, eMedNY.org has been updated to include quick reference materials and on-demand training videos. Additionally, live training webinars are offered on a recurring basis. To view the training schedule and/or register for training on the NYS Medicaid PSP, providers should refer to the eMedNY *Provider Training* web page, located at: <https://www.emedny.org/training/>. Training sessions will orient providers to the NYS Medicaid PSP and the steps necessary to apply for enrollment, including:

- creating a NY.gov Business Account to access the NYS Medicaid PSP;
- navigating NYS Medicaid PSP features and functions;
- understanding available transaction types and associated instructions within the screens; *and*
- monitoring submission status.

The eMedNY *Provider Training* calendar, also located on the eMedNY *Provider Training* web page at: <https://www.emedny.org/training/>, is updated as trainings become available. To access the NYS Medicaid PSP, providers must first spend a few minutes creating a NY.gov Business Account. Providers should visit the eMedNY *NY.GOV ID Account Overview* document, located at: https://www.emedny.org/PSP/NYGOV_ID_Account_Overview.pdf, for step-by-step instructions to create a NY.gov Business Account. Account creation only needs to be done once and can be done from a desktop, laptop, tablet or phone.

Questions

Questions related to enrollment through the NYS Medicaid PSP should be directed to the eMedNY Call Center at (800) 343-9000.

Reminder: Disenrollment Rules and Recovery Rules for Mainstream Medicaid Managed Care, Health and Recovery Plans, and Special Needs Plans

The New York State (NYS) Department of Health and NYS Office of the Medicaid Inspector General would like to remind Contractor health plans (health plans) of the retroactive recovery rules established by *The MMC Model Contract*, “Medicaid Managed Care (MMC), Family Health Plus, Human Immunodeficiency Virus-Special Needs Plans, Health and Recovery Plan Model Contract” (MMC Model Contract).

Contract Guidance on Disenrollment

The MMC Model Contract provides disenrollment rules and guidance, outlined in Appendix H, New York State Department of Health Requirements for the Processing of Enrollments and Disenrollments in the MMC. Enrollment determinations are made by NY State of Health (the Marketplace) or the local Department of Social Services (LDSS) and communicated to the health plan via 834 file or retroactive disenrollment notification. Most disenrollments are prospective; in some circumstances, retroactive disenrollment and recovery is appropriate. For those retroactive disenrollment scenarios, the contract outlines the effective date of disenrollment for each scenario.

As stated in Appendix H §7(b)(ii) “Contractor Responsibilities,” the health plan will make a good faith effort to identify cases which may be appropriate for an NY State of Health or LDSS-initiated disenrollment. Within five business days of identifying such cases and following NY State of Health or LDSS procedures, the Contractor will, in writing or electronically, refer cases which are appropriate for an NY State of Health or LDSS-initiated disenrollment and will submit supporting documentation to NY State of Health or LDSS. This includes changes in status for its enrollees that may impact eligibility for enrollment, including, but not limited to address changes, incarceration, death, exclusion from the MMC program MMC Plan, the apparent enrollment of a member in the contractor’s MMC product under more than one Client Identification Number, or the availability of Third-Party Health Insurance to the MMC enrollee.

If the health plan determines the MMC enrollee meets the requirements of a retroactive disenrollment, the health plan must refer to the case, then wait for the LDSS or NY State of Health to make a determination on the referral before taking any action to disenroll the MMC enrollee. As stated in Appendix H §7(b)(ii) of The MMC Model Contract, consistent with other health plan-initiated disenrollments, the health plan will “not consider an enrollee disenrolled without confirmation from the NY State of Health or LDSS as described in Section 5 of this Appendix.”

NYS Department of Health, NYS Office of the Medicaid Inspector General and NYS Office of the Attorney General Right to Recover

As stated in the MMC Model Contract, Appendix H (7)(a)(xiv): "Failure by the NY State of Health, Enrollment Broker, or LDSS to notify the Contractor of a disenrollment does not affect the right of the SDOH to withhold or recover capitation payment(s) as authorized by Section 3.6 of this Agreement or for the State Attorney General to bring legal action to recover any overpayment." Therefore, the right to recover capitation payments remains regardless of whether the health plan receives a notice of disenrollment from the LDSS.

Obstetric Billing Changes for Prenatal Services Related to Upcoming Global Obstetric Fee Changes

Effective immediately, New York State (NYS) Medicaid fee-for-service (FFS) directs all NYS Medicaid-enrolled providers of antepartum, postpartum, labor and delivery services to use the below for services provided to individuals that initiate prenatal care on or after June 1, 2026, and/or have an estimated due date on or after January 1, 2027:

- Evaluation and Management (E/M) Common Procedure Terminology (CPT) codes with a **TH** modifier;
- pregnancy-related **O** or **Z** International Classification of Diseases, 10th Revision (ICD-10) diagnostic codes for all prenatal visits; *and*
- initial prenatal visits must include the Category II CPT code “**0500F**”.

For services provided to NYS Medicaid members who have established prenatal care prior to June 1, 2026, current billing guidance applies through December 31, 2026.

E/M CPT codes are to be used for prenatal services in place of global/bundled obstetric CPT codes (noted in table below) in anticipation of January 1, 2027 comprehensive changes to obstetric-related services per the American Medical Association (AMA). The AMA obstetric billing guidance can be found in the *AMA/Specialty Society RVS Update Process RUC Recommendations for CPT 2027 – January 2026 Meeting* document, located at: <https://www.ama-assn.org/system/files/feb-2026-ruc-recommendations.pdf>.

Medicaid Managed Care (MMC) Plans are required to:

- prepare systems and provider agreements/contracts, as needed, to align with the use of E/M codes with a **TH** modifier as well as pregnancy-related **O** or **Z** ICD-10 diagnostic codes for all new prenatal visits that occur for the above population by June 1, 2026; *and*
- prepare systems and provider agreements/contracts to fully implement AMA billing code changes by January 1, 2027.

Bundled/Global CPT codes that will be deleted and *unavailable* when service dates include dates on or after January 1, 2027:

CPT Code	CPT Description
59400	Vaginal delivery with antepartum and postpartum care
59425	Antepartum care only; four to six visits
59426	Antepartum care only; seven or more visits
59510	Cesarean delivery with antepartum and postpartum care
59610	Vaginal birth after cesarean delivery with antepartum and postpartum care
59618	Cesarean delivery after attempted vaginal delivery with antepartum and postpartum care

CPT E/M codes available to identify routine antepartum care:

CPT Code	CPT Description	Modifier
99202	Office Or Other Outpatient Visit for New Patient	TH modifier to be used for all routine prenatal visits initiated on or after June 1, 2026.
99203	Office Or Other Outpatient Visit for New Patient	
99204	Office Or Other Outpatient Visit for New Patient	
99205	Office Or Other Outpatient Visit for New Patient	
99211	Office Or Other Outpatient Visit for Established Patient	
99212	Office Or Other Outpatient Visit for Established Patient	
99213	Office Or Other Outpatient Visit for Established Patient	
99214	Office Or Other Outpatient Visit for Established Patient	
99215	Office Or Other Outpatient Visit for Established Patient	
99341	Residence Visit For New Patient With Straightforward	
99342	Residence Visit For New Patient With Low Level	
99344	Residence Visit For New Patient With Moderate Level	
99345	Residence Visit For New Patient With High Level	
99347	Residence Visit For Established Patient With Straightforward	
99348	Residence Visit For Established Patient With Low Level	
99349	Residence Visit For Established Patient With Moderate Level	
99350	Residence Visit For Established Patient With High Level	
99417	Prolonged Outpatient Service, Each 15 Minutes	

As of January 1, 2027, additional CPT codes used for billing obstetric services will be revised and deleted. Further guidance will be released by the AMA for obstetric-related services, and the NYS Department of Health will release further *Medicaid Update* articles.

Additional Resources:

- American College of Obstetricians and Gynecologists “Payment for Obstetric Services” web page (<https://www.acog.org/practice-management/coding/coding-library/payment-for-obstetric-services>)
- AMA *A Health Plan Primer: Previewing the CPT 2027 Restructure for Maternity Care Services* recorded webinar and PowerPoint slides (<https://www.ama-assn.org/membership/events/health-plan-primer-previewing-cpt-2027-restructure-maternity-care-services>)
- American Medical Association “RUC recommendations, minutes and voting” web page (<https://www.ama-assn.org/about/rvs-update-committee-ruc/ruc-recommendations-minutes-voting>)
- *AMA/Specialty Society RVS Update Process RUC Recommendations for CPT 2027 – January 2026 Meeting* document (<https://www.ama-assn.org/system/files/feb-2026-ruc-recommendations.pdf>)

NYS Medicaid FFS Information:

- NYS Medicaid FFS claim questions should be directed to the eMedNY Call Center at (800) 343-9000.
- NYS Medicaid FFS coverage and policy questions should be directed to MaternalandChild.HealthPolicy@health.ny.gov.

MMC Information

MMC questions should be directed to the MMC Plan of the enrollee. MMC Plan contact information can be found in the eMedNY *New York State Medicaid Program Information for All Providers - Managed Care Information* document, located at: https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers_Managed_Care_Information.pdf.

Submission of Secondary Claims to New York State Medicaid and Use of Claim Adjustment Reason Codes

A recent review of secondary claims submitted to New York State (NYS) Medicaid has identified a recurring billing practice that does not comply with NYS Medicaid billing requirements or established Coordination of Benefits (COB) standards.

Prohibited Practice

COB standards for billing secondary claims require the communication of the exact Group Code returned by the primary payer. It has been identified that some claims are being submitted to NYS Medicaid with adjustment codes that differ from those returned on the Explanation of Benefits (EOB) or remittance advice issued by the primary payer. Specifically, the Group Code was altered from **CO (Contractual Obligation)** to **PR (Patient Responsibility)** prior to submission to NYS Medicaid.

Under no circumstances may adjustment codes be changed or substituted, (e.g., from **CO** to **PR**) for the purpose of altering NYS Medicaid reimbursement or liability. Any code modification constitutes a misrepresentation of the primary payers' adjudication and is prohibited. All claims submitted for NYS Medicaid members with Medicare and/or other third-party insurance must accurately reflect payments, adjustments and denials received from other insurers to allow correct calculation of NYS Medicaid reimbursement amounts.

Financial Impact

Changing adjustment codes improperly can result in NYS Medicaid overpayments. Any overpayments resulting from this practice are subject to recoupment and must be promptly reported and returned in accordance with applicable federal and state regulations. Providers should refer to the *Self-Disclosure Obligation Reminder* article published in the January 2026 issue of the *Medicaid Update*, located at: https://www.health.ny.gov/health_care/medicaid/program/update/2026/docs/mu_no01_jan26_pr.pdf, for guidance on returning overpayments.

Enforcement

Failure to follow this policy may lead to corrective action, fund recoupment, and other remedies under NYS Medicaid rules and law. Providers must maintain accurate and compliant billing practices consistent with NYS Medicaid COB requirements.

Questions and Additional Information:

- Fee-for-service coverage and policy questions should be directed to the Office of Health Insurance Programs Division of Program Development and Management by telephone at (518) 473-2160 or by email at FFSMedicaidPolicy@health.ny.gov.
- Questions regarding the NYS Office of the Medicaid Inspector General (OMIG) Self-Disclosure program should be directed to the NYS OMIG Bureau of Self-Disclosure by email at selfdisclosures@omig.ny.gov or by telephone at (518) 402-7030.
- Questions regarding billing should be directed to the eMedNY Call Center at (800) 343-9000.
- Technical assistance on ASC X12 submissions should be directed to the eMedNY HIPAA Transaction Support Team at eMedNYHIPAASupport@gdit.com.
- Additional COB compliance requirements can be found in published Medicaid Update articles:
 - *Reminder: Medicaid Requires Coordination of Benefits* article published in the November 2021 issue of the *Medicaid Update* (https://www.health.ny.gov/health_care/medicaid/program/update/2021/docs/mu_no13_nov21_pr.pdf)
 - *Submission Guidance for Fee-for-Service Claims with Third Party Liability (Medicare or Other Insurance)* article published in the December 2020 issue of the *Medicaid Update*: https://www.health.ny.gov/health_care/medicaid/program/update/2020/docs/mu_no18_dec20_pr.pdf)
 - *Reminder to Providers: New York State Medicaid Requires Coordination of Benefits* article published in the July 2020 issue of the *Medicaid Update* (https://www.health.ny.gov/health_care/medicaid/program/update/2020/docs/mu_no12_jul20.pdf)
 - *Reminder: Documentation Required for Medicare and Third-Party Insurance Primary Submissions* article published in the September 2018 issue of the *Medicaid Update* (https://www.health.ny.gov/health_care/medicaid/program/update/2018/sep18_mu.pdf)
 - *Providers Urged to Submit Correct Coordination of Benefits (COB) Information to Medicaid for Medicare Advantage (Part C) Recipients* article published in the December 2014 issue of the *Medicaid Update* (https://www.health.ny.gov/health_care/medicaid/program/update/2014/dece14_mu.pdf)
 - *Providers Urged to Submit Correct Coordination of Benefits (COB) Information to Medicaid* article published in the February 2014 issue of the *Medicaid Update* (https://www.health.ny.gov/health_care/medicaid/program/update/2014/feb14_mu.pdf)

Updates to Fee Schedules for Physician, Nurse Practitioner and Midwife Services

As part of the New York State (NYS) enacted budget for fiscal year (FY) 2026, the NYS Department of Health was authorized to benchmark NYS Medicaid fee-for-service reimbursement rates to 90 percent of Medicare reimbursement rates for select non-facility practitioner services and emergency visit codes. This investment in the physician and primary care workforce is expected to improve access to primary and preventative care for NYS Medicaid members.

Effective October 1, 2025, fees for the following procedure codes have increased:

Code	Description
99381	Evaluation and Management (E/M) Preventive Medicine: New patient initial comprehensive age (under one year of age)
99382	E/M Preventive Medicine: New patient initial comprehensive age (one to four years of age)
99383	E/M Preventive Medicine: New patient initial comprehensive age (five to 11 years of age)
99384	E/M Preventive Medicine: New patient initial comprehensive age (12 to 17 years of age)
99385	E/M Preventive Medicine: New patient initial comprehensive age (18 to 39 years of age)
99386	E/M Preventive Medicine: New patient initial comprehensive age (40 to 64 years of age)
99387	E/M Preventive Medicine: New patient initial comprehensive age (65 years of age and older)
99391	E/M Preventive Medicine: Established patient (one year of age and younger)
99392	E/M Preventive Medicine: Established patient (one to four years of age)
99393	E/M Preventive Medicine: Established patient (five to 11 years of age)
99394	E/M Preventive Medicine: Established patient (12 to 17 years of age)
99395	E/M Preventive Medicine: Established patient (18 to 39 years of age)
99396	E/M Preventive Medicine: Established patient (40 to 64 years of age)
99397	E/M Preventive Medicine: Established patient (65 years of age and older)

Effective April 1, 2026, fees for the following procedure codes have increased:

Code	Description
69210	Removal impacted cerumen requiring instrumentation, unilateral
90471	Immunization administration, one vaccine
90472	Immunization administration, each additional vaccine
90473	Immunization administration by intranasal or oral route, one vaccine
90474	Immunization administration by intranasal or oral route, each additional vaccine
90480	Immunization administration by intramuscular injection, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) vaccine, first or only component of each vaccine administered
92025	Computerized corneal topography, unilateral or bilateral, with interpretation and report
93040	Rythm electrocardiogram, one to three leads; with interpretation and report
99202	Office or other outpatient visit for the E/M of a new patient, 15 minutes or more
99203	Office or other outpatient visit for the E/M of a new patient, 30 minutes or more
99204	Office or other outpatient visit for the E/M of a new patient, 45 minutes or more
99205	Office or other outpatient visit for the E/M of a new patient, 60 minutes or more
99211	Office or other outpatient visit for the E/M of an established patient that may not require the presence of a physician or other qualified health care professional
99212	Office or other outpatient visit for the E/M of an established patient, straightforward, 10 minutes or more
99213	Office or other outpatient visit for the E/M of an established patient, low level, 20 minutes or more

Code	Description
99214	Office or other outpatient visit for the E/M of an established patient, moderate level, 30 minutes or more
99215	Office or other outpatient visit for the E/M of an established patient, high level, 40 minutes or more
99342	Home or residence visit for the E/M of a new patient, low level, at least 30 minutes
99348	Home or residence visit for the E/M of an established patient, low level, 30 minutes or more
99349	Home or residence visit for the E/M of an established patient, moderate level, 40 minutes or more
99350	Home or residence visit for the E/M of an established patient, high level, 60 minutes or more
99407	Smoking and tobacco use cessation counseling visit, intensive, greater than 10 minutes
99281	Emergency department (ED) visit for the E/M of a patient that may not require presence of a physician or other qualified health care professional
99282	ED visit for the E/M of a patient, straightforward medical decision making
99283	ED visit for the E/M of a patient, straightforward medical decision making
99284	ED visit, for the E/M of a patient, moderate level of medical decision making
99285	ED visit, for the E/M of a patient, high level of medical decision making

Please note: Procedure codes appearing on multiple fee schedules will be updated on each fee schedule.

The following impacted fee schedules include:

- *NYS Medicaid Physician Medicine Services Fee Schedule*
- *NYS Medicaid Physician Drug and Drug Administration Services Fee Schedule*
- *NYS Medicaid Physician Surgery Services Fee Schedule*
- *NYS Medicaid Nurse Practitioner Services Fee Schedule*
- *NYS Medicaid Midwife Services Fee Schedule*

Providers can refer to the eMedNY “Provider Manuals” web page, located at: <https://www.emedny.org/ProviderManuals/>, for updated fee schedules and select a category within the “Select a Provider Manual” section.

Questions

Questions regarding the updated fees should be directed to the NYS Department of Health at FFS.MedicaidPolicy@health.ny.gov.

Coverage of Healthcare Common Procedure Coding System “G2211”: Add-On Code for Complex Pediatric Care

Effective April 1, 2026, New York State (NYS) Medicaid will reimburse Healthcare Common Procedure Coding System (HCPCS) code "G2211". Medicaid Managed Care (MMC) Plans must comply with this coverage by June 1, 2026.

Add-on HCPCS code “G2211” recognizes the establishment and maintenance of an ongoing clinician-patient relationship. It provides additional reimbursement for visits with greater complexity than a typical Evaluation and Management (E/M) service. It is intended for situations where the clinician:

- serves as the focal point for all needed health care services; *and*
- provides ongoing care related to a single, serious condition or a complex condition of a patient.

Visit complexity for HCPCS code “**G2211**” is related to the additional effort of providing longitudinal care. It is not based on specific diagnoses or the level of medical decision making. HCPCS code “**G2211**” may not be reported for acute or routine care. Clinicians must document the medical complexity and ongoing care that justify the use of HCPCS code “**G2211**”, including how the visit fits within a patient centered plan of care.

Eligibility

Population

NYS Medicaid coverage of HCPCS code “**G2211**” is limited to NYS Medicaid members from birth to 20 years of age.

Billing Providers

HCPCS code “**G2211**” may be billed by physicians and nurse practitioners in pediatric primary care and pediatric subspecialties. Providers should refer to Table 1 for eligible specialty codes.

Table 1: Specialty Codes Eligible to Bill HCPCS code “G2211”

Specialty Code	Specialty Description
055	ADOLESCENT MEDICINE: FAMILY MEDICINE
056	ADOLESCENT MEDICINE: PEDIATRICS
059	PEDIATRIC RHEUMATOLOGY
061	PEDIATRIC INFECTIOUS DISEASE
073	PEDIATRIC DERMATOLOGY
076	PEDIATRIC REHABILITATION
150	PEDIATRICS
151	PEDIATRIC CARDIOLOGY
152	PEDIATRIC HEMATOLOGY – ONCOLOGY
154	PEDIATRIC NEPHROLOGY
156	PEDIATRIC ENDOCRINOLOGY
157	PEDIATRIC PULMONOLOGY
163	PEDIATRIC GASTROENTOLOGY
305	PEDIATRIC SPECIALTY – ALL EXCEPT PRIMARY CARE
936	PEDIATRIC GENERAL MEDICINE- CLINIC SPECIALTY
937	PEDIATRIC ALLERGY- CLINIC SPECIALTY
938	PEDIATRIC NEUROLOGY- CLINIC SPECIALTY

Billing Guidance and Reimbursement

HCPCS code “**G2211**” must be billed in conjunction with an E/M procedure code, which may include preventative visit codes, on the same date of service. Clinicians should not report independently. Clinicians may bill HCPCS code “**G2211**” once per week per patient.

Clinicians should report HCPCS code “**G2211**” with Place of Service code “**02**”, “**10**”, “**11**” or “**22**” on professional claims. Reimbursement for HCPCS code “**G2211**” is allowable when the service is delivered via telehealth. Clinicians should refer to the NYS Department of Health *Telehealth Policy Manual*, located at: https://www.health.ny.gov/health_care/medicaid/redesign/telehealth/docs/provider_manual.pdf, for detail on telehealth modifiers and billing instructions.

HCPCS Code	Description	NYS Medicaid Rate
G2211	Visit complexity inherent to E/M associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a single, serious condition or a complex condition of a patient. (Add-on code, list separately in addition to home or residence or office/outpatient evaluation and management service, new or established)	\$14.83

Questions and Additional Information:

- NYS Medicaid fee-for-service (FFS) billing and claims questions should be directed to the eMedNY Call Center at (800) 343-9000.
- NYS Medicaid FFS primary care coverage and policy questions should be directed to the Office of Health Insurance Programs Division of Program Development and Management by telephone at (518) 473-2160 or by email at pcmh@health.ny.gov.
- MMC enrollment, reimbursement, billing, and/or documentation requirement questions should be directed to the specific MMC Plan of the MMC enrollee.
- MMC Plan contact information and plan directory can be found in the eMedNY *New York State Medicaid Program Information for All Providers - Managed Care Information* document, located at: https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers_Managed_Care_Information.pdf.

Provider Directory

Office of the Medicaid Inspector General:

For suspected fraud, waste, or abuse complaints/allegations, please call 1-877-87 FRAUD, (877) 873-7283 or visit the Office of Medicaid Inspector General (OMIG) website, located at: www.omig.ny.gov.

Medicaid Prescriber Education Program:

For current information on best practices in pharmacotherapy, please visit the following web page and website:

- NYS Department of Health “Medicaid Prescriber Education Program” web page (https://www.health.ny.gov/health_care/medicaid/program/prescriber_education/presc-educationprog)
- New York State Medicaid Prescriber Education Program website (<http://nypep.nysdoh.suny.edu/>)

eMedNY:

For a number of services, including: change of address, updating an enrollment file due to an ownership change, enrolling another National Provider Identifier, or revalidating an existing enrollment, please visit the eMedNY “Provider Enrollment” web page, located at: <https://www.emedny.org/info/ProviderEnrollment/index.aspx>, and choose the appropriate link based on provider type.

Beneficiary Eligibility:

Please call the Touchtone Telephone Verification System at (800) 997-1111 and/or refer to the *New York State Programs Medicaid Eligibility Verification System Instructions for Completing a Telephone Transaction*, located at: https://www.emedny.org/ProviderManuals/5010/MEVS%20Quick%20Reference%20Guides/5010_MEVS_Telephone_Quick_Reference_Guide.pdf, to successfully complete an eligibility transaction.

Questions Regarding Billing and Performing Medicaid Eligibility Verification System Transactions:

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

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

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

Providers Interested in Listening to Check/EFT Amounts for the Current Week:

Please call (866) 307-5549 (available Thursday evenings, for one week, per the check/EFT amount of the current week).

Provider Training:

Please enroll online via the eMedNY “Provider Training” web page, located at: <https://www.emedny.org/training/index.aspx>, for training opportunities. For individual training requests, please call (800) 343-9000.

Comments and Suggestions Regarding the Medicaid Update:

Please contact the editor, Angela Lince, at medicaidupdate@health.ny.gov.

Providers: OMIG Self-Disclosure Obligation Reminder

Pursuant to Social Services Law §363-d and Title 18 of the New York Codes, Rules and Regulations SubPart 521-3, any person who has received an overpayment under the New York State (NYS) Medicaid program is required to report, return, and explain the overpayment through the OMIG Self-Disclosure program. Self-disclosure information and resources, including submission instructions and required forms are located on the OMIG “Self-Disclosure” web page, at: <https://omig.ny.gov/provider-resources/self-disclosure>. Contact the OMIG Self-Disclosure Unit by telephone at selfdisclosures@omig.ny.gov or by email at (518) 402-7030.