EPIC Income Levels Expanded to Provide Drug Coverage for More New York State Seniors

GOOD NEWS! Effective April 1, 2014, The NYS 2014-15 budget included the expansion of the Elderly Pharmaceutical Insurance Coverage Program (EPIC) to cover the prescription needs of more seniors. Eligible income brackets were expanded from $35,000 to **$75,000** for singles and from $50,000 to **$100,000** for married couples.

The new income brackets will be added to existing ones and current EPIC members will not be impacted. EPIC income is based on the previous income year and does continue to include the reporting of net Social Security Income. Seniors must also be a NYS resident, 65 or older and be enrolled or eligible to enroll in a Medicare Part D drug plan and not be receiving full Medicaid benefits.
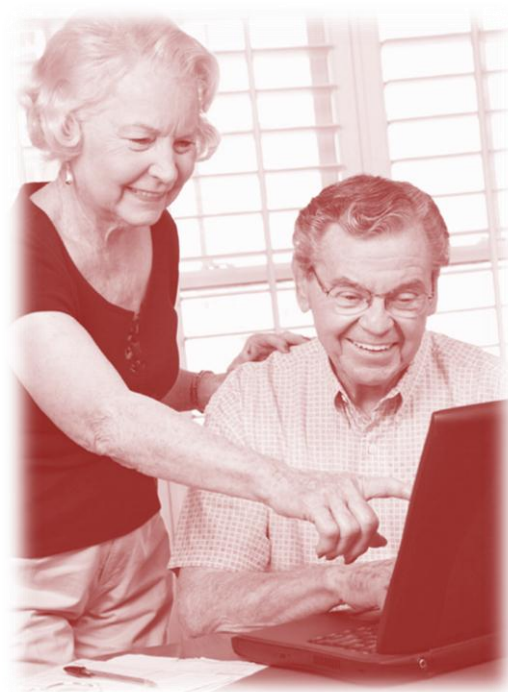
EPIC provides secondary prescription coverage for Medicare Part D and EPIC covered drugs after any Medicare Part D deductible is met. By using EPIC together with Medicare Part D, members save more money on the cost of their prescription drugs.

For many seniors, it is less expensive to enroll in EPIC and Medicare Part D than just Medicare Part D alone. EPIC pays the Part D drug plan premiums up to $37.23 per month in 2014 for members with income up to $23,000 single or $29,000 married. Higher income members are responsible for paying their Medicare Part D premiums but will receive Part D assistance in the form of reduced EPIC deductibles.

Seniors may apply for EPIC at any time during the year even if they do not already have a Medicare Part D Plan. Enrolling in EPIC will provide eligible seniors a Special Enrollment Period from Medicare allowing them to join a Medicare Part D drug plan or switch to another Medicare Part D plan outside of their Open Enrollment Period.

Join EPIC today for additional savings on your Medicare Part D prescription drugs.

For an application or more information, please call the toll-free EPIC Helpline at (800) 332-3742 Monday through Friday from 8:30 AM to 5:00 PM or visit the EPIC website at www.health.ny.gov and click on *EPIC for Seniors* on the left side of the page.

IN THIS
ISSUE …

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JULY 2014 NEW YORK STATE MEDICAID UPDATE

Update on the Fully Integrated Duals Advantage (FIDA) Demonstration

The New York State Department of Health (NYSDOH) Division of Long Term Care, in partnership with the Centers for Medicaid and Medicare Services (CMS), is implementing the Fully Integrated Duals Advantage (FIDA) demonstration project. NYSDOH is entering into a three-way contract agreement with CMS and health plans to implement this three-year demonstration program. Through this demonstration, certain dual eligible individuals will be enrolled into fully-integrated managed care products. FIDA eligible individuals enrolled in a Managed Long Term Care (MLTC) plan will "convert" to their Plan's FIDA product.

FIDA will be become effective January 2015 for dual eligibles residing in Region I, which consists of the following counties: Bronx, Brooklyn, Kings, Queens, Richmond, and Nassau. Opt-in enrollment will begin in January 2015 and passive enrollment will begin April 2015. In Region II, which consists of Suffolk and Westchester counties, opt-in enrollment will begin on April 1, 2015, and passive enrollment on July 1, 2015. In FIDA, participants can get all of their Medicaid and Medicare benefits through one managed care plan.

Highlights of the FIDA Demonstration include:

- *FIDA participants will not have to pay plan premiums, co-pays, or deductibles.*
- *FIDA will provide patient centered service planning through an interdisciplinary team (IDT) approach. The IDT will be a care team in which the FIDA member can choose family members, doctors, nurses or personal attendants to join his or her IDT to help make care decisions and access to services.*
- *FIDA offers an expanded package of covered items and services which includes traditional Medicaid and Medicare benefits as well as behavioral health, home and community based waiver services and community and facility long term care services. Providing fully integrated care will improve health outcomes for dual eligible individuals.*
- *In addition to having an integrated package of covered items and services, FIDA will offer an integrated appeals process whereby the most consumer-favorable elements of the Medicare and Medicaid grievance and appeals systems are incorporated into a consolidated, integrated grievance and appeals system for FIDA Participants.*
- *Participants will also have access to the services provided by the State Ombudsman which will provide direct assistance to individuals and their families in navigating their coverage, and in understanding and exercising their rights and responsibilities.*

For more details about the FIDA program please see:
http://www.health.ny.gov/health_care/medicaid/redesign/mrt_101.htm

Attention Family Planning Providers:

Clarification of Medicaid Family Planning Services for Beneficiaries Enrolled in the Family Planning Benefit Program (FPBP) and the Family Planning Extension Program (FPEP)

During February 2008, the New York State Department of Health (NYSDOH) announced changes to Medicaid coverage for **additional procedures and services** performed during a family planning visit as well as **follow-up procedures and treatment** for "limited medical conditions" diagnosed during a family planning visit for FPBP and FPEP enrollees. Additionally, New York State authorized coverage of the follow-up treatment of **specific sexually transmitted infections** (STIs) when provided during a family planning visit. The Centers for Medicare and Medicaid Services (CMS) recently issued State Medicaid Director Letter #14-003, dated April 16, 2014, clarifying the coverage of family planning-related services, specifically the diagnosis and treatment of STIs.

The United States Preventive Services Task Force recommends "high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs" (where increased risk includes patients with an active STI).[1] In addressing the needs of a patient with an active sexually transmitted infection (STI), providers will, as a matter of course, provide behavioral counseling on contraceptives. Contraceptive counseling is always a covered family planning service.

Prior to this clarification, under FPBP and FPEP, Medicaid reimbursement was only available when the diagnosis and treatment of an STI were provided as part of, or as a follow up to, a family planning visit (primary purpose of the medical visit was contraceptive management and the diagnosis and treatment of an STI, or other related condition was secondary). STI counseling and treatment was always covered for enrollees with full Medicaid coverage. This clarification applies to services provided to both men and women with FPBP and FPEP coverage on and after April 16, 2014.

To meet program requirements and receive Medicaid reimbursement, all claims processed for FPBP and FPEP recipients must contain a family planning, or family planning related) procedure code from the list provided below. In addition one of the diagnosis codes must be in the V25 contraceptive management series.   Please see billing instructions
http://www.uspreventiveservicestaskforce.org/uspstf/uspsstds.htm

Policy & Billing Guidance

Required Medicaid Claim Information

Family Planning Visit (Family Planning Service(s) with or without Treatment for Limited Medical Conditions and/or STIs)

To bill for these services, claims **must contain:**
- A "Y" in the Family Planning Box.
- A primary ICD-9CM diagnosis code in the V25 series.
- The appropriate CPT evaluation and management visit code, initial visit **(Table D),** or follow-up visit **(Table E).**
- The appropriate CPT code for the procedure(s) or medical supply **(Table A) or (Table B).**
- Clinic claims must also include the clinic rate code.

Follow-up Visit for Treatment for Limited Medical Conditions Diagnosed During a Previous Family Planning Visit

To bill for these services, claims **must contain:**

- A primary or secondary ICD-9CM diagnosis code in the V25 series.
- A "Y" in the Family Planning Box when primary diagnosis is in the V25 series.
- The appropriate CPT-4 procedure code(s) performed from the approved follow-up procedures **(Table B)**
- The appropriate CPT-4 evaluation and management follow-up visit code **(Table E).**
- Clinic claims must also include a clinic rate code.

Visit for Diagnosis and Treatment of Sexually Transmitted Infections "pursuant to" family planning Services

To bill for these services, claims **must contain:**

- If the primary reason for the follow-up visit is for treatment of a STI, the primary ICD-9 CM diagnosis code must be the STI **(Table C) and the secondary diagnosis code must be in the V25 series.**
- If the primary reason for the follow-up visit is for family planning and STI treatment is secondary, the primary ICD-9CM diagnosis code must be in the V25 series and the secondary diagnosis code must be the specific STI **(Table C).**
- A "Y" in the Family Planning Box when primary diagnosis is in the V25 series.
- A CPT-4 procedure code for an evaluation and management visit **(Tables D and E).**
- The appropriate CPT code for the procedure(s) or medical supply **(Table A) or (Table B).**
- Clinic claims must also include a clinic rate code.

Policy & Billing Guidance

FPBP Transportation Benefits

Transportation is a Medicaid covered service available through the FPBP. Medicaid will reimburse the most appropriate mode of transportation required to transport an eligible enrollee to a FPBP covered service. Providers should consult the Transportation manual to obtain information regarding transportation policy guidelines, procedures and the county contact list. The manual can be viewed at: http://www.emedny.org/ProviderManuals/Transportation/index.html.

Questions? Please call the **Bureau of Policy Development and Coverage** at (518) 473-2160.

Table A: Approved Family Planning Procedure Codes (items and procedures must clearly be provided or performed for family planning purposes)

00851	11982	58565	71010	77081	93307	A4268	J7301	J7307
00921	55250	58600	71015	89321	96372	A4931	J7302	S4993*
00952	55450	58615	71020	93000	A4264	J1050	J7303	
11976	58300	58670	77078	93010	A4266	J1056	J7304	
11981	58301	58671	77080	93040	A4267	J7300	J7306	

*Please see the February Medicaid Update article Reimbursement Available to Family Planning Clinics Dispensing Oral Contraceptives to Medicaid recipients at:
http://www.health.ny.gov/health_care/medicaid/program/update/2013/2013-02_pharmsped_edition.htm#rei

Table B: Procedure Codes for Treatment of Limited Medical Conditions (conditions diagnosed during a family planning visit)

10060	56501	74000	82247	84144	85378	86780	87207	87590	88154
10140	56700	76830	82270	84146	85576	86781	87210	87591	88155
11420	56820	76856	82465	84443	85610	86900	87252	87620	88160
11421	56821	76857	82550	84703	85651	86901	87254	87621	88161
17110	57061	80048	82553	85002	85652	87015	87255	87797	88162
17111	57420	80053	82565	85004	85730	87040	87270	87798	88164
46900	57421	80061	82570	85007	86580	87070	87273	87800	88165
46922	57452	80076	82575	85013	86592	87075	87274	87801	88173
46924	57454	81000	82670	85014	86593	87077	87320	87808	88174
54050	57455	81001	82677	85018	86631	87081	87340	87899	88175
54055	57456	81002	82947	85025	86632	87086	87390	88141	88302
54056	57460	81003	82948	85027	86687	87088	87486	88142	88305
54057	57461	81007	82950	85032	86689	87102	87490	88143	88307
54060	57505	81015	82951	85045	86696	87110	87491	88147	99070
54065	57510	81025	83001	85048	86701	87164	87495	88148	J0696
56405	57511	82040	83002	85049	86702	87166	87510	88150	
56420	58100	82043	83690	85210	86703	87205	87535	88152	
56440	58340	82150	84075	85300	86762	87206	87536	88153	

Policy & Billing Guidance

Table C: ICD-9 CM Diagnosis Codes for Sexually Transmitted Infections

054.10-054.12	054.40-054.1	054.71-054.74	054.8-054.9	078.19	079.4
054.13	054.43-054.44	054.79	077.0	078.88	131.0-131.9
054.19	054.49	090-099.9	077.98	079.88	
054.2-054.3	054.6	078.1	078.11	079.98	

Table D: Procedure Codes for Evaluation and Management Services (new patient)

99050	99201	99203	99205	99242	99244	99384	99386
99051	99202	99204	99241	99243	99245	99385	

Table E: Procedure Codes for Evaluation and Management Services (established patient)

99050	99211	99213	99215	99242	99244	99394	99396
99051	99212	99214	99241	99243	99245	99395	

Smoking Cessation Counseling Includes Smokeless Tobacco Products

This notice is to clarify that Medicaid coverage of smoking cessation counseling (SCC) for all Medicaid beneficiaries includes cessation services for smokeless tobacco use. Smokeless tobacco products include: dip, chew, snuff, snus (a moist powder tobacco product) and dissolvable tobacco products such as pellets, strips and toothpick-like sticks.

Smokeless tobacco products contain nicotine and are just as addictive as cigarettes. They can cause cancers of the mouth, tongue, cheek, gum, pharynx, larynx, esophagus, stomach and pancreas and precancerous mouth lesions, receding gums, gingivitis, abrasion of teeth, cavities, bone loss around the roots of teeth and tooth loss. In addition, use of smokeless tobacco increases the risk of cardiovascular disease, including heart attacks.

Despite the risks and harms, a growing number of teens are using smokeless tobacco as an alternative to or concurrently with combustible tobacco. In 2013, 7% of New York State high school students used smokeless tobacco, up 60% from a decade earlier, while the percentage of youth who smoked cigarettes dropped almost in half from 20.2% to 10.6%.

Among New York State adults (ages 18 and older), 2.3% used smokeless tobacco in 2012, up from 1.4% the year before, while the cigarette smoking rate was 16.2%, the fifth lowest adult smoking rate in the nation.

For more information about smokeless tobacco products, please refer to the July 2001 Medicaid Update or see the National Cancer Institute's fact sheet on Smokeless Tobacco and Cancer.

For a comprehensive summary of Medicaid SCC policy and billing guidelines, please refer to the April 2011, December 2013 and May 2014 Medicaid Updates.

Questions regarding Medicaid Managed Care or Family Health Plus should be directed to the enrollee's Medicaid Managed Care or Family Health Plus plan. Questions regarding FFS coverage or SCC billing may be directed to the eMedNY Call Center at (800) 343-9000 and policy questions to the Division of Program Development and Management at (518) 473-2160.

Policy & Billing Guidance

Attention Operators of OPWDD Services, Facilities or Programs
Supervised Individualized Residential Alternatives (IRAs) and Supervised Community Residences (CRs)

Effective July 1, 2014, **Supervised** IRAs and CRs, certified by OPWDD under the Home and Community Based Services (HCBS) waiver, will transition from a monthly to a daily unit for the purposes of service recording and billing. **Supportive model IRAs and CRs will continue to use the existing monthly service unit.** A Supervised IRA/CR has staff onsite or proximately available 24 hours a day. A Supportive IRA/CR provides variable amounts of oversight depending on the individual's need for supervision. The chart below identifies three new rate codes established to accommodate the new daily service unit for **supervised** model facilities operated by voluntary agencies:

Rate Code	Defined Use
4437	**Service Day:** Submitted when qualifying residential habilitation services were delivered and were appropriately documented.
4438	**Retainer Day:** Submitted when a resident was absent from the facility due to a **temporary** stay (i.e., expected to return to the IRA or CR) in a hospital, skilled nursing facility, or any other institutional, inpatient, or residential facility **reimbursed by Medicaid.**[1]
4439	**Therapy Leave Day:** Submitted when an individual is **temporarily** absent (i.e., expected to return) from the facility for the purpose of visiting with family or friends **and** receives no residential habilitation services from agency staff that day.

A similar series of three rate codes (4428-4430) exists for state operated supervised IRAs. **For any single date of service, one and only one supervised IRA/CR rate code may be billed for a resident.** When a particular day could potentially be recorded under multiple rate codes, the conflict may be resolved by observing resident's status at 11:59pm. For example, if a residential habilitation service is rendered to a resident in the morning, but the same resident is later admitted to the hospital for an overnight stay, the correct rate code to bill is 4438. Likewise, in the case of an individual transferring to an IRA operated by another agency, it is the receiving agency that will bill the service day. **Effective July 1, 2014,** providers must also select the proper **location code** based on the resident's eligibility for "enhanced" (also known as "template") funding. The following chart identifies the four location codes established to support **supervised IRA/CR** billing as of 7/1/14:

Policy & Billing Guidance

Location Code	Defined Use
005	Regular funding. This includes the vast majority of supervised IRA/CR residents.
006	Approved for enhanced funding - Specialized Level
007	Approved for enhanced funding - Highly Complex Level
008	Approved for enhanced funding - Auspice Change or SNF Transfer.

OPWDD provides specific written authorization when an individual is approved for enhanced funding. When such written authorization does not exist, location 005 must be used. Questions regarding a particular resident's eligibility for enhanced funding should be directed to the appropriate OPWDD Regional Office.

Administrative Memorandum (ADM) # 2014-01 outlines the service documentation requirements associated with the new daily service unit. The ADM is available at the following link: http://www.opwdd.ny.gov/opwdd_regulations_guidance/adm_memoranda.

Questions regarding service documentation requirements can be directed to OPWDD's Waiver Management Bureau at (518) 486-6466. Questions regarding the billing changes can be directed to OPWDD's Central Operations Bureau at (518) 402-4333.

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[1] For the first year of per diem billing for supervised IRA services, July 1, 2014 to June 30, 2015, retainer day services will be paid at $0. Providers are expected to record and submit claims for these days even though paid at $0. Commencing July 1, 2015, the first 14 retainer days (4438) billed for an individual during an annual July to June period will pay at the provider's payment rate for rate code 4438. The 15th day, and all retainer days thereafter, will pay at $0. **Although retainer days after the initial 14 for an individual will pay at $0, it is still important for providers to record and submit claims for these days.** Failure to do so will result in an assumed absence or vacancy. This could negatively impact future rate calculations. Note, during the July 1, 2014-July 30, 2015 period, retainer day reimbursement will be provided by revision of the Service Day and Therapy Leave Day rate when reconciliation occurs at the mid-point and end of this period.

Requests for Livery Transportation of New York City Enrollees

Enrollees travelling to medical care and services are expected to use public transit if they already use public transit for normal activities of daily living. Further, enrollees who use public transit for normal activities of daily living and live no more than ½ mile from their medical destination are not eligible to receive reimbursement of any subway or bus travel with Medicaid funded MetroCards. Medicaid funded MetroCard reimbursement is reserved only for those enrollees who use public transit traveling to a medical destination and reside more than ½ mile from the medical destination.

There are enrollees who require a livery service to access medical services due to some disabling condition. For these enrollees, medical practitioners will be asked by the Department's transportation manager, LogistiCare, to submit a new and updated Medicaid Transportation Justification Request (Form 2015) with compelling medical justification for livery transportation. Submission of this form will be necessary to ensure uninterrupted livery travel to future medical care and services.

Currently, there are some enrollees who now use a livery service to their medical care, but can use public transportation. These enrollees who have no disabling condition limiting their ability to use public transit will be moved to public transit by September 30, 2014.

If you have any questions regarding this policy, please contact LogistiCare at (866) 564-5911.

Medicaid Electronic Health Records (EHR) Incentive Program Update

The New York Medicaid 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 $590.4 million** in incentive funds have been distributed *within* **14,306** payments to New York State Medicaid providers.

● ●

Taking a closer look: Program hits "10,000 unique providers paid" milestone!

Over 10,000 unique eligible practitioners and hospitals have received incentive payments from the NY Medicaid EHR Incentive Program. Become a paid provider and don't delay your Centers for Medicare & Medicaid Services (CMS) registration to the NY Medicaid EHR Incentive Program.

The NY Medicaid EHR Incentive Program Support Team recommends that new providers looking to participate in the Program use the "3-Step Approach".

Step 1 Educate	→	**Step 2** Register	→	**Step 3** Attest
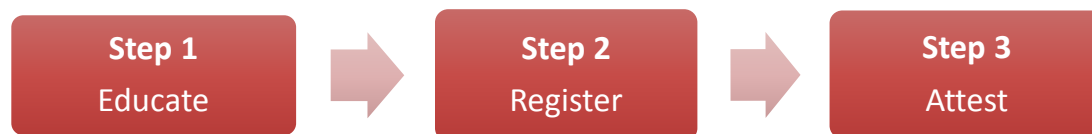
Figure 1, 3-Step Approach

Step 1: Become informed on the NY Medicaid EHR Incentive Program.

- ✓ Review our program website and educational resources.
- ✓ Attend our re-occurring monthly webinars.
- ✓ Sign up for our e-mailing list.
- ✓ **Need Help?** Contact our Support Team at 877-646-5410 or by email.

Step 2: Register in the CMS Registration and Attestation System.

- ✓ Review the CMS EHR Incentive Program Website
- ✓ Register in the CMS Registration and Attestation System.
- ✓ **Need Help?** Contact CMS Support Team at 888-734-6433.

Step 3: Attest in the Medicaid EHR Incentive Payment Administrative Support Service

- ✓ Review the EP Participation Year 1 Medicaid EHR Incentive Payment Administrative Support Service (MEIPASS) Walkthrough
- ✓ Review the EP Participation Year 1 webpage.
- ✓ Attest in MEIPASS

Need Help? Contact our Support Team at 877-646-5410 or by email

Pharmacy Update

Requirements for Telephoned Prescription Drug Orders

Prescribers may telephone prescriptions and fiscal orders for drugs directly to a pharmacy unless otherwise prohibited by State or federal law or regulations. The pharmacist is responsible to make a good faith effort to verify the prescriber's identity and validity of the prescription if the prescriber is unknown to the pharmacist.

➢ A telephone order must be reduced to writing in conformance with the format described in 18 NYCRR 505.3(b)(5) and NYS Education Law [subdivision (4) of Section 6810 either through written documentation or electronic record, indicating the time of the call, the name of the prescriber, and initials of the pharmacist (See the NYS Medicaid Program Pharmacy Manual Policy Guidelines version 2013-1 and all editions between 2006 -1 and 2010-2 as well as the Medicaid Updates: April 2005, Vol. 20, No.5 and May 2007, Vol. 23, No.5)

➢ The date of the call of the telephone order must also be memorialized as noted in the Rules of the Board of Regents 8 NYCRR 29.7(a)(1) and 8 NYCRR 29.7 (a)(2).

➢ If a prescriber's employee provides the telephone order the retained written documentation of the call should identify the name of the prescriber's employee who provided the telephone order.

➢ Prescriptions for multi-source brand drugs requiring "dispense as written" and "brand necessary" may be ordered over the telephone.

➢ When an ordering prescriber **conveys** a prescription over the telephone, it is the responsibility of the ordering prescriber to notate in the Medicaid beneficiary's medical record in their own handwriting that the drug is "brand medically necessary," and the reason that a brand name multi-source drug is required.

➢ A follow-up hardcopy of a **controlled prescription drug** telephone order is required by State and Federal law. (See Public Health Law Art. 33 § 3334; § 3337)

➢ A follow-up hardcopy of a non-controlled prescription drug telephone order is not required.

➢ Pharmacists must assure the accuracy of information contained on Medicaid pharmacy claims, particularly prescriber information.

➢ When billing for these claims, the pharmacist must submit all 9's in place of the official prescription serial number to identify oral prescriptions.

Automatic refills are not allowed. Relevant guidance can be found at https://www.emedny.org/ProviderManuals/Pharmacy/PDFS/Pharmacy_Policy_Guidelines.pdf.

Questions? Please contact the Medicaid Policy Unit at (518) 486-3209 or via e-mail to: PPNO@health.state.ny.us.

eMedNY ICD-10 Testing Opens

On July 28, 2014 eMedNY opened the Provider Testing Environment (PTE) for submitters to begin testing Medicaid claims with ICD-10 diagnosis codes. In addition inpatient hospital claims that utilize ICD-10 procedure codes may be tested beginning on this date.

Date of Service Requirement: When submitting test claims with ICD-10 codes submitters must use a date of service of July 1, 2014 or any date of service up to the date of the test submission. Future dates are not allowed. Submitters who may be testing claims with ICD-9 codes must use a date of service prior to July 1, 2014.

What is PTE?: The eMedNY Provider Testing Environment is designed to enable NYS Medicaid trading partners to test batch and real-time Electronic Data Interchange (EDI) transactions using the same validation, adjudication logic, and methods as the eMedNY production environment. Test transactions submitted to the eMedNY PTE undergo processes that verify and report on data structure and content to the same degree of stringency as live transactions sent to the eMedNY production environment, and receive, in most cases, the same system responses at each step. For similar inquiries, the response in the PTE may not be identical to the response in the production environment. For example, edits involving duplicate and near-duplicate claims, or prior authorization submissions, are not applied in PTE, so as to allow for iterative testing. Also no claim, or authorization, requests are pended in PTE.

PTE Access Methods: eMedNY PTE can be accessed using any of your existing eMedNY Access Methods with a few exceptions (see below).

Test Indicator

Since existing access methods are being used for PTE access, it is critical the test indicator is valued in the inbound/outbound transactions.

For ASC X12 transactions: "Test Indicator" in *ISA15* is set to *"T"*

For NCPDP Batch 1.2/D.0 transactions: File Type *(702-MC)* field in the NCPDP Batch Header is set to *"T"*

All Providers

No "Test" indicator has been defined for NCPDP Real-time transactions, therefore, a separate phone number has been established. Connect using (800) 433-1747.

Important Note: *If the appropriate indicator for a transaction is not set to Test, the transactions will be processed through the production environment.*

PTE Access Exceptions (not supported):

ePACES; VeriFone POS; Audio Response Unit (ARU); and Paper

PTE Reminders

- PTE has a strictly enforced limit of 2 files per day/per user and a limit of 50 claims per file submission
- PTE is available to current trading partners (ETIN required)
- Test remittances are produced according to the submitter's/provider's production method of delivery
- PTE weekly cycle ends on Fridays and remittances are delivered the following week

For more information about ICD-10 implementation see the FAQs published at: https://www.emedny.org/icd/index.aspx.

Questions may be directed to the eMedNY Call Center at (800) 343-9000 or via e-mail to:emednyHIPAAsupport@csc.com.

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, (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.