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New York State Medicaid Update

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THE OFFICIAL NEWSLETTER OF THE NEW YORK STATE MEDICAID PROGRAM

Medicaid to Require Electronic Funds Transfer (EFT) for Provider Payments and Electronic Remittance Advice (ERA) or PDF Version of Paper Remittances

New York State Medicaid will soon require all billing providers to register for EFT and ERA or PDF remittances. This effort moves the New York State Medicaid program in the direction of health care industry standards of practice. In addition to the cost savings associated with eliminating the production, processing and mailing of paper, this initiative is better for the environment and in line with the GO GREEN movement. The Department of Health will begin phasing in this requirement beginning in September 2012; however, providers are urged to act now.

EFT

Since eMedNY began offering the benefit of EFT in 2005, thousands of providers have enrolled to have their Medicaid funds deposited directly to their checking or savings account.

The advantages of EFT over paper checks include:

- **Eliminate the possibility of lost checks.**
- **Eliminate delays that would be caused by misdirected checks.**
- **Eliminate mail time.**
- **Enjoy knowing your funds are secure.**
- **Save trips to the bank to deposit your Medicaid checks.**

ERA/PDF

In addition to requiring EFT, providers will also be required to enroll for paperless remittances. There are two options:

Option 1: ERAs in the form of HIPAA compliant 835/820 formats. These will require software to interpret but have advantages for systematic posting of payments.

Option 2: PDF version of the paper remittance delivered electronically through eMedNY's secure web site. PDF remittances have many advantages over paper remittances such as:

- **The PDF remittance will be immediately available every week on the Monday on which your Medicaid check is dated, and will not be subject to the two-week hold of your check or EFT release.**
- **You will know when the PDF is available in your eXchange account and not have to wait for the mail.**
- **The remittance can be downloaded and stored electronically for easy retrieval.**
- **The remittance can be word-searched to help locate specific claims.**
- **The PDF will look exactly like the paper remittance.**
- **Remittances can be printed with Adobe Reader® (6.0 release or higher required), available free of charge.**

Both the EFT and PDF remittance applications are available online at www.emedny.org. Questions about either application or the process can be directed to the eMedNY Call Center at (800) 343-9000. Keep up with notifications on this initiative in future Medicaid Updates and the eMedNY Listerv at https://www.emedny.org/Listserv/eMedNY_Email_Alert_System.aspx.

MARCH 2012 NEW YORK STATE MEDICAID UPDATE

POLICY AND BILLING GUIDANCE

PHARMACY UPDATES

ALL PROVIDERS

All Rehabilitation Providers

New Benefit Year Begins April 1, 2012 for Medicaid Fee-for-Service (FFS) Enrollees

The August 2011 Medicaid Update notified providers that the Social Services Laws of 2011 changed the rehabilitation benefit for Medicaid enrollees (Medicaid Redesign Team Proposal #34). Effective October 1, 2011, physical therapy, occupational therapy, and speech therapy visits are limited to 20 visits each per twelve-month benefit year.

For Medicaid fee-for-service (FFS) enrollees, the twelve-month benefit year is a state fiscal year, beginning April 1 of each year, and ending March 31 of the following year. For Medicaid Managed Care (MMC), and Family Health Plus (FHPlus) enrollees, the twelve-month benefit year is a calendar year, beginning January 1 and ending December 31 of the same year.

For Medicaid FFS enrollees, the current benefit year ends March 31, 2012. **A new benefit year begins April 1, 2012. Unused prior authorizations, dated in the previous benefit year (up to and including March 31, 2012) will not carry over into the new benefit year.**

For claiming questions, DVS technical assistance, enrollment, and POS purchase information, please call the eMedNY Call Center at (800) 343-9000.

For Medicaid policy questions, please call the Office of Health Insurance Programs at (518) 473-2160.

For questions about Medicaid managed care or Family Health Plus enrollees, please call the enrollee's health plan.

Unused Prior Authorizations

The December 2011 Medicaid Update notified providers of the prior authorization requirement, which became **effective February 23, 2012,** for Medicaid FFS enrollees.

A prior authorization (PA) is valid from the date it is requested through the end of the current benefit year. The current benefit year ends March 31, 2012. A new benefit year begins April 1, 2012. **Unused prior authorizations will not carry forward into the next benefit year.** Prior authorizations are anchored in the benefit year in which they are ordered.

Rehabilitation Policy Highlights

- For Medicaid FFS enrollees, the benefit year begins April 1 of each year and ends March 31 of the following year. A new benefit year begins April 1, 2012.
- Some enrollees, settings, and circumstances are exempt from the 20-visit limitation. Please see the August 2011 Medicaid Update**.**
- All claims for rehabilitation services must have a modifier, including exempt categories. Claims without modifiers will be denied.
- Prior authorizations are generated through eMedNY's "Dispensing Validation System" (DVS). The DVS system can be accessed using one of the following methods: ePACES, PC-to-Host Link, or Verifone POS Device. Refer to the December 2011 Medicaid Update. DVS operates on "real time" and will give an immediate response to a request for a prior authorization.
- Prior authorizations cannot be requested retroactively.
- Cancellations must be performed within 90 days of the request.
- **Prior authorizations are anchored in the benefit year in which they are ordered. PAs will not carry forward into the next benefit year.**

New York Medicaid Transportation Management for Fee-For-Service Enrollees in New York City

The management of transportation services begins May 1, 2012, in New York City beginning in the Brooklyn borough. For Medicaid recipients not enrolled in a managed care plan, orders for transportation will be phased-in by borough throughout 2012. Medicaid managed care enrollees will continue to receive transportation services through their health plan until further notice. Medical facilities or practitioners whose place of business is in the respective borough and request transportation will contact the Department's contractor, LogistiCare, to schedule transportation according to the timeline below.

When the Practitioner/Facility is Located in …	LogistiCare Will Begin Accepting Reservations ...	For All Trips Which Will Occur On or After …
Brooklyn	April 9, 2012	May 1, 2012
Queens	June 18, 2012	July 1, 2012
Manhattan and Bronx	August 13, 2012	September 1, 2012
Staten Island	September 17, 2012	October 1, 2012

LogistiCare will meet with facilities and practitioners prior to the implementation date of each borough. LogistiCare also offers webinars regarding new processes. If you would like information regarding upcoming webinars, or would like to arrange a meeting with LogistiCare staff to coordinate your current processes with LogistiCare's system, please send an e-mail indicating your interest, along with your name, address, facility name, national provider identification number (NPI), and telephone number to NYC@LogistiCare.com.

Ordering Proper Mode of Transportation

Medical practitioners are responsible for ordering appropriate modes of transportation for enrollees. Guidelines are listed at: www.emedny.org/ProviderManuals/Transportation/index.aspx. Click on "Prior Authorization Guidelines". These guidelines are also available online at www.NYCMedicaidRide.net.

- Requests are required at least three days before the date of transport, Monday through Friday, 7 AM to 6 PM.
- Urgent medical care needed less than three days? Hospital discharge? Request these trips anytime, 24 hours/7 days.
- Requests are accepted via telephone, fax or online.
- Currently, in order to request authorization of transportation, you telephone your request to Computer Sciences Corporation (CSC), or fill out Form 3897 Transportation Prior Approval (pilot form) and mail to CSC. You should continue this process for trips which occur up to the date of transition to the LogistiCare system. **After the date of implementation, you should contact LogistiCare directly; Form 3897 is no longer needed**.

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LogistiCare Call Center:

Medical Facility and Practitioner Contact Information

	Number or Link
Telephone	(877) 564-5922
Internet	www.NYCMedicaidRide.net
Fax Numbers	
Brooklyn	(877) 585-8758
Queens	(877) 585-8759
Manhattan	(877) 585-8760
Bronx	(877) 585-8779
Staten Island	(877) 585-8780

Enrollees can also call LogistiCare:

Medicaid Enrollee Transportation Contact Information

	Number or Link	Type of Requests Handled
Telephone	(877) 564-5922	Routine and urgent trips
Telephone	(877) 564-5923	"Where's My Ride" number, to call when ready to be picked up or when pick up is late; lodge a complaint
Internet	http://member.logisticare.com	Routine trips

Justification for Mode of Transport

An updated "Medicaid Transportation Justification Request "(Form 2015) or "Medicaid Transportation Standing Order Request for Appointments Occurring 3 Days or More Per Week" (Form 2015-SO) are available on both web sites listed above, or upon request. **These forms are the primary method of documenting an enrollee's need for a certain transportation mode, and should be maintained as part of the patient record.**

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Complaints Regarding Transportation Service Delivery or LogistiCare Handling of Requests

If you have a complaint, please call the toll-free number listed above or use the web site www.NYCMedicaidRide.net to lodge the complaint. LogistiCare is required to report to the Department on all complaints, and their resolution. Also, Department policy stipulates that Medicaid enrollees are entitled to make their own complaints.

Transportation Providers

Enrolled Medicaid transportation providers will continue to participate, and will be used for those facilities and practitioners who request their service. Further, reimbursement of rendered transports will continue to be made via eMedNY, at the Department of Health established fees. If you have not participated in recent presentations, please e-mail LogistiCare at NYC@LogistiCare.com to request information and discuss the new transportation management process.

Transportation Provider Contact Information

	Number or Link	Type of Requests Handled
Telephone	(877) 564-5924	Trip assignment, trip re-route, prior authorization issues, change in transportation provider's contact information
Fax	(877) 714-6882	Re-route or cancel trips
Internet	http://transportationco.logisticare.com	All of the above

Questions regarding this article and general questions regarding Medicaid transportation policy can be sent via e-mail to: MedTrans@health.state.ny.us.

New Edits for Original and Adjusted Delayed Claims

New York State Medicaid has been working to increase provider compliance with delay reason reporting on claims. As part of this effort, the following new edits will be phased-in beginning in May 2012 to verify the validity of Delay Reason Codes reported on both original and adjustments to paid claims. These edits will translate to Claim Adjustment Reason/Group Code CO 29 (Time Limit for Filing has Expired) and Claim Status Code 718 (Claim/Service Not Submitted within Required Timeframe) or, for Pharmacy, NCPDP Reject Code - 70 (NDC/APC Not Covered).

Edit 02157 - Delay Reason Code 1 (Proof of Eligibility Unknown) Invalid
Edit 02160 - Delay Reason Code 4 (Delay in Certifying Provider) Invalid
Edit 02161 - Delay Reason Code 5 (Delay in Supplying Billing Forms) Invalid
Edit 02162 - Delay Reason Code 7 (Third Party Processing Delay) Invalid
Edit 02163 - Delay Reason Code 8 (Delay in Eligibility Determination) Invalid
Edit 02164 - Delay Reason Code 9 (Original Claim Denied Unrelated to Timeliness Edits) Invalid
Edit 02165 - Delay Reason Code 10 (Administrative Delay in Prior Approval Process) Invalid
Edit 02166 - Delay Reason Code 11 (Other Delay) Invalid

In addition, both original and **adjustments to paid claims** will now be subject to the following existing edits.

Edit 00068 - Claim Submission Date not within required time limits (CO 29, Claim Status Code 187, NCPDP Reject 70).

Edit 00658 - Inpatient claim not submitted within required time limits (CO 29, HIPAA Claim Status Code 188).

Edit 01007 - Institutional claim not submitted within required time limits (CO 29, HIPAA Claim Status Code 187).

TIMELY SUBMISSION OF CLAIMS TO MEDICAID

New York State Medicaid regulations (18NYCRR 540.6) require that claims for payment of medical care, services, or supplies to eligible beneficiaries be initially submitted within **90 days of the date of service** to be valid and enforceable, unless the claim is delayed due to circumstances outside the control of the provider. All such claims submitted after 90 days must be **submitted within 30 days** from the time submission came within control of the provider. Providers must maintain, and upon request, provide documentation of the reason for such delay. Below are the HIPAA delay reasons which may be used, when appropriate, for all claims aged over 90 days from the date of service, **including adjustments to paid claims.**

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Code Delay Reason

1) Proof of eligibility unknown or unavailable
This delay reason is valid when the beneficiary's eligibility status is unknown or unavailable on the date of service due to the beneficiary not informing the provider of their eligibility. The claim must be submitted within 30 days from the date of notification of eligibility. This delay reason is invalid for adjusted or resubmitted claims.

2) Litigation
This means there was some type of litigation involved and there was a possibility that payment for the claim may come from another source, such as a lawsuit. The claim must be submitted within 30 days from the time submission came within the control of the provider.

3) Authorization Delays
This applies when there is a State administrative delay. Specifically, state authorized and directed delayed claim submissions due to retroactive reimbursement changes or system processing resolution. The claim must be submitted within 30 days from the date of notification. Documentation from the applicable state rate setting or policy office must be maintained on file.

4) Delay in Certifying Provider
This delay reason is valid when a change in a provider's enrollment status causes the delay. The claim must be submitted within 30 days from the date of notification.

5) Delay in Supplying Billing Forms
This delay reason is valid for paper claims only, submitted using eMedNY proprietary forms (eMedNY 150003, Claim Form A, Pharmacy Claim Form). The claim must be submitted within 30 days from the time submission came within the provider's control. This delay reason is invalid for electronic/POS claims and for rate-based claims submitted on NUBC standard form UB-04.

7) Third Party Processing Delay
This delay reason is valid when Medicare and other Third Party insurer processing caused the delay. The claim must be submitted within 30 days from the date submission came within the control of the provider and, with paper claims, include an Explanation of Medical Benefits or claims will be denied.

8) Delay in Eligibility Determination
This delay reason is valid when the beneficiary's eligibility date and/or coverage was changed or backdated due to eligibility determination administrative delays, appeals, fair hearings or litigation. The claim must be submitted within 30 days from the date of notification of eligibility.

9) Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
This delay reason is valid for resubmitted claims when the original claim was submitted within 90 days of the date of service and the claim was denied or rejected for a reason unrelated to timeliness edits. The corrected claim must be submitted within 60 days of the date of notification. This delay reason is invalid for adjustments.

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10) Administrative Delay in the Prior Approval Process
This delay reason is valid only for services that require prior approval and when prior approval is granted after the date of service due to administrative appeals, fair hearings or litigation. The claim must be submitted within 30 days from the time of notification.

11) Other

This delay reason is valid only in the following limited situations:

a) *Paid claim requiring correction or resubmission through adjustment of original claim for a delay reason not listed above. Adjusted claim must be submitted within 60 days of date of notification.*

b) *An audit agency directed the provider to void an original claim and to resubmit a new replacement claim for the same beneficiary and related service. The replacement claim must be submitted within 60 days from the time of notification by the audit agency.*

c) *The provider, as part of their internal control and compliance plan, discovers an original claim which was submitted within 90 days of the date of service that has to be voided due to an incorrect beneficiary or provider identification (ID) number. The replacement claim with the corrected ID must be submitted within 60 days from the time of discovery of the incorrect ID.*

d) *Interrupted maternity care – valid for prenatal care claims delayed over 90 days because delivery performed by a different practitioner.*

e) *IPRO (Island Peer Review Organization) previously denied the claim, but the denial was reversed on appeal.*

If a claim is returned to a provider due to data insufficiency or claiming errors (rejected or denied), it must be corrected and resubmitted within **60 days of the date of notification** to the provider.

In addition, **paid claims requiring correction or resubmission must be submitted as adjustments to the paid claim within 60 days of the date of notification.** In most cases, adjustments, rather than voids, must be billed to correct a paid claim. Both adjustments and replacements of voided claims are subject to these timely submission rules.

All claims must be **finally** submitted to the fiscal agent and be payable within two years from the date the care, services or supplies were furnished in order to be valid and enforceable against the Department or a social service district.

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It is the provider's responsibility to determine and report the appropriate delay reason code. Refer to your provider manual's **Information for All Providers General Billing Section** for more details about delayed claim submission including claims over two years old at:

https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers-General_Billing.pdf.

New York State Medicaid and its Fiscal Agent will not accept requests for exceptions to these rules.

NEW EMEDNY DELAY REASON CODE FORM FOR PAPER CLAIMS

Effective May 1, 2012, paper claims submitted over 90 days from the date of service must include the scannable **eMedNY Delay Reason Code Form** available online at: https://www.emedny.org/HIPAA/QuickRefDocs/index.aspx.

Each paper claim, including **adjustments** to paid claims, must have its **own eMedNY Delay Reason Code Form** attached. Delayed paper claims with provider generated delay forms or letters will be denied after April 30, 2012.

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

The New York State Medicaid Prescriber Education Program Drug Information Response Center Addresses Use of Metformin in Patients with Kidney Disease

The New York State Medicaid Prescriber Education Program (NYSMPEP) is a collaboration between the New York State Department of Health (NYSDOH) and the State University of New York (SUNY), as approved by state legislation. This program was designed to provide prescribers with an evidence-based, non-commercial source of the latest objective information about pharmaceuticals. In conjunction, the Drug Information Response Center (DIRC) was developed to fulfill the mission of assisting clinicians in the delivery of health care to their Medicaid patients by providing timely, evidence-based information on pharmacotherapy to prescribers and serving as a resource for NYSMPEP academic educators in their outreach to prescribers.

The NYSMPEP has implemented an educational module on the management of type 2 diabetes, accessible online at http://nypep.nysdoh.suny.edu/diabetes/km. Recently, information was requested on the usage of metformin in patients with mild renal impairment. It has been proposed that usage of metformin in patients with renal impairment may lead to an increased risk of lactic acidosis due to decreased renal clearance of the drug. Lactic acidosis is a rare metabolic adverse event with a documented incidence of 0.03 cases per 1000 patient-years, but it is potentially fatal in up to 50% of cases. Per the manufacturer, the risk of lactic acidosis increases with degree of renal function impairment and patient age, and the risk may be significantly reduced through regular monitoring of renal function and use of the minimum effective dose. Based on a review of the literature, it may be recommended that prescribers consider the individual patient's renal function in concert with other factors that may predispose the patient to the development of lactic acidosis, rather than renal function alone, when choosing to initiate or continue metformin therapy. Consideration of the nature of renal dysfunction is also warranted, as the development of lactic acidosis has been shown to occur more often in acute rather than chronic renal failure.

The full literature review and recommendations prepared by the DIRC concerning the use of metformin in patients with kidney disease may be accessed at http://nypep.nysdoh.suny.edu/dirc. Contact information for NYSMPEP academic educators in your area may be accessed at http://nypep.nysdoh.suny.edu/contactus.

Family Planning Benefits for Fidelis Care New York Members should be billed as Medicaid Fee-for-Service Claims

Medicaid Managed Care and Family Health Plus members that are enrolled in **Fidelis Care New York** continue to obtain **family planning drugs** as a fee-for-service (FFS) benefit from Medicaid.

How can a pharmacy identify members affected by this change?

Pharmacy claims that are submitted to Fidelis Care New York for family planning drugs will receive a denial message from Fidelis stating to "Bill Medicaid FFS". If a pharmacy receives this message, they should bill Medicaid FFS using the recipient's alpha-numeric Client Identification (CIN) as shown on their health plan identification card.

What family planning services and items will remain billable to Medicaid FFS for Fidelis Medicaid Managed Care and Fidelis Family Health Plus members?

Pharmacy benefits include the following: birth control pills; other kinds of birth control (such as patches, shots, etc.); and emergency contraception.

Family Health Plus covers over-the-counter (OTC) emergency contraception but does not cover OTC birth control such as condoms, foam, etc.

How will the pharmacy be reimbursed for these services?

Pharmacies should bill Medicaid directly by submitting an electronic claim for the family planning item. Reimbursement will be made at the Medicaid rates and fees.

Pharmacists can access the list of Medicaid reimbursable drugs to determine coverage of family planning drugs at: http://www.eMedNY.org/info/formfile.html.

For billing questions or problems submitting claims, please contact the eMedNY Call Center at (800) 343-9000.

NOTE: Family Health Plus members will not have a Medicaid card issued to them.

Updated Billing Guidelines for 17 Alpha-Hydroxyprogesterone Caproate (17P)

The following article outlines changes to Medicaid's coverage and billing guidelines for 17 Alpha-Hydroxyprogesterone Caproate beginning January 1, 2012.

17P is an injectable long-acting synthetic derivative of progesterone. It is available as both a compounded sterile product and commercially as a product under the brand name Makena™. Both forms, the compounded 17P and Makena™, are used for the prevention of preterm delivery in patients with a documented history of spontaneous preterm birth. Both the compounded 17P and Makena™, are covered under the Medicaid program and will be reimbursed based on the provider's acquisition cost.

General coverage and billing guidelines for 17 Alpha-Hydroxyprogesterone Caproate (17P) for dates of service prior to January 1, 2012 were provided in the August 2011 Medicaid Update and can be accessed at the following link: http://www.health.ny.gov/health_care/medicaid/program/update/2011/2011-08.htm

Effective for dates of service ***on or after*** **January 1, 2012**.

- Physicians, nurse practitioners, licensed midwives and Article 28 clinics should use the newly established HCPCS procedure code, J1725, when billing for compounded 17P and Makena. ***Please Note****: As of January 1, 2012, J1725 replaces Q2042.*
- As a practitioner administered drug, it is the responsibility of the practitioner or clinic provider to obtain the drug to administer to the patient and bill Medicaid or the patient's Medicaid managed care or Family Health Plus (FHPlus) plan. Patients should not be given a prescription to obtain these drugs from a pharmacy. Doing so will result in a pharmacy claim denial and may cause an unnecessary delay in treatment.
- Article 28 clinics should bill compounded 17P and Makena as an ordered ambulatory service (Category of Service 0282 or 0163) using procedure code J1725.
- ***Please Note:*** *Do NOT code J1725 on your APG claim. Doing so may result in a lower reimbursement amount than if billed as an ordered ambulatory service.*
- Medicaid fee-for-service claims for compounded 17P, billed with the new procedure code J1725, may be submitted electronically. A copy of the invoice does not need to accompany claims for compounded 17P.
- Medicaid fee-for-service claims for Makena, using the new procedure code J1725, must be submitted on paper. A copy of the invoice, showing the acquisition cost of the drug, must accompany the claim.
- The claim should reflect the actual drug dose that was administered to the patient. Do not bill for the entire multi-dose vial of medication on one claim.
- Medicaid managed care (MMC) and FHPlus providers should also use the new procedure code, J1725, when billing for compounded 17P and Makena. Claims submission should be in accordance with the respective health plan's claiming requirements.

Questions regarding MMC/FHPlus reimbursement and/or documentation requirements should be directed to the enrollee's MMC or FHPlus plan. Questions regarding Medicaid fee-for-service policy and claiming should be directed to the Bureau of Policy Development and Coverage at (518) 473-2160.

Important Information Concerning the Preferred Drug Program and Frequency/Quantity/Duration (F/Q/D) Edits

The Medicaid Fee-for-Service (FFS) program recently implemented Frequency, Quantity, and Duration (F/Q/D) recommendations made by the Drug Utilization Review (DUR) Board. Some of the drugs/drug classes affected by F/Q/D editing are also included in the Preferred Drug Program (PDP). Therefore, drugs/drug classes that have a preferred status can also be subject to F/Q/D editing.

System messaging has been developed to help guide the pharmacists to appropriately submit the claim or to refer to the prescriber. For claims that do not meet clinical criteria, the eMedNY POS will return a rejected response (NCPDP field 511-FB) "85- Claim Not Processed", along with additional detailed "75" messages (NCPDP field 526-FQ):

- **75AT** - Step Therapy or Preferred Product Required
- **75ST** - Stable Therapy Criteria Failure
- **75RD** - Required Diagnosis Criteria Failure
- **75MV and 75SY** - Prior Authorization Required
- **75AC** - Age Criteria Failure
- **75UD** - Units Per Day or Days Supply Criteria Failure
- **75MQ** - Quantity Criteria Failure
- **75CC** - Maximum Claim Count Exceeded
- 75UF - Units Per Fill or Units Per 30 Days Criteria Failure
- 75MD - Duration Criteria Failure

The following links have been provided as helpful resources for information on the PDP, F/Q/D and Step Therapy Programs:

https://newyork.fhsc.com/ and http://www.health.ny.gov/health_care/medicaid/program/dur/index.htm.

Clarifying Information for Medicaid Fee-for-Service (FFS) and Managed Care Pharmacy Providers

The NYS Department of Health (NYSDOH) has received a number of questions from stakeholders related to differences between the policies and rules that apply to the Medicaid fee-for-service pharmacy benefit as compared to those that apply to the pharmacy benefits provided through Medicaid Managed Care plans. The intent of this article is to provide clarification regarding these questions.

Important Reminder:
All NYS federal rules and regulations, NY State Education Department pharmacy rules, requirements, and regulations, as well as the Bureau of Narcotic Enforcement (BNE) rules, requirements and regulations continue to apply to all prescriptions regardless of whether a member receives pharmacy benefits through the fee-for-service program or a managed care plan.

FREQUENTLY ASKED QUESTIONS

Q1. Do managed care prescribers have to use official NYS prescription forms? Yes. Section 21 of Public Health Law requires that all NYS written prescriptions, no matter who the insurer is, must be on official NYS prescription forms.

Q2. Are the requirements for "Dispense as Written" the same for Medicaid managed care prescribers and Medicaid fee-for-service prescribers? Yes. Pursuant to Section 6810 of State Education Law, regardless of who the insurer is, unless the prescriber writes "DAW" on a prescription in the prescriber's own handwriting or, in the case of electronic prescriptions, inserts an electronic direction to dispense the drug as written, the prescriber's signature or electronic signature shall designate approval of substitution by a pharmacist.

Q3. Are the requirements for "Brand Medically Necessary" the same for Medicaid managed care prescribers and Medicaid fee-for-service prescribers? The federal requirement to write "Brand Medically Necessary" for brand name drugs on the Federal Upper Limit (FUL) list only applies to the fee-for-service pharmacy program. *NOTE: When dispensing a brand name drug that is included in the fee-for-service "Dispense Brand Drugs When Less Expensive" initiative, it is not necessary to write "Brand Medically Necessary" on the prescription.*

Q4. If a Medicaid client (FFS, Managed Care or Family Health Plus) states that he/she is unable to pay a co-payment can a pharmacy provider refuse to dispense the medication? No. 42 U.S.C. § 1396o(e) requires that no Medicaid enrolled provider deny care or services to an individual eligible for such care or services on account of such individual's inability to pay a deduction, cost sharing, or similar charge. This applies to all Medicaid providers, both fee-for-service and managed care. Providers may attempt to collect outstanding copayments through methods such as requesting the co-payment each time the member is provided services or goods, sending bills or any other legal means.

Q5. Do pharmacies contracting with the Medicaid managed care plans have to adhere to the terms and conditions of the individual managed care contracts or do we still have to adhere to the NY Medicaid guidelines or both? As indicated above, all pharmacies must continue to adhere to all SED and BNE rules, requirements and regulations, regardless of the insurer. Managed care plans do have the authority to operationalize the pharmacy benefit differently than the Medicaid fee-for-service program. As examples, managed care plans and/or their Pharmacy Benefit Managers are permitted to:

- Establish formularies and reimbursement rates.
- Create specific prior authorization processes.
- Administer the enrollment and credentialing of their network providers.
- Establish their own utilization management controls such as quantity limits, step therapy and limitations on days supply.
- Determine policies for their members, such as establishing the period of time from the date written in which a prescription can be filled, the number of refills allowed, or the requirements for medical supplies.
- Determine "proof of delivery" signature requirements. Note- All managed care plans require that a signature be obtained as "proof of delivery" of a prescription.
- Establish the time period for which prescription records related to claims paid by the plan must be retrievable.
- Determine whether to provide extended supplies (>30 days) of medications.

Q6. Is the NYS prescription serial number required on managed care plan prescription claims? Currently, managed care plans are not required to report the NYS prescription serial number to the Medicaid program. *In September 2012*, the pharmacy claim data submitted by the managed care plans to the state must include the NYS prescription serial number. Managed care plans and/or their Pharmacy Benefit Managers will be working with their network pharmacy providers to alert them regarding these changes and the timeline for managed care plan implementation.

Q7. Is the OMIG aware that the card swipe requirement does not apply to managed care beneficiaries? Yes. OMIG is aware that the card swipe requirement will not apply to managed care beneficiaries. OMIG is also aware of DOH's strategy to move all recipients into managed care and/or care management over the next three years. The pharmacy card swipe program for fee-for-service beneficiaries will continue during the course of the transition to managed care, as there will continue to be fee-for-service pharmacy expenditures until the transition is complete. During that time, the initiative will be evaluated and its continuation determined accordingly.

Q8. What roles do both the managed care plans and the OMIG have in auditing pharmacies? Managed care plans are responsible for managing and auditing their pharmacy networks. If there is a suspicion of fraud or abuse, plans are required to report such cases to the DOH and OMIG. OMIG will review and work with the plan and/or provider to determine if further action is needed. OMIG has a statutory responsibility under NYS Public Health law to examine documents or records of any kind related to the Medicaid program or necessary for the OMIG to perform its duties and responsibilities. As a result, OMIG may also conduct audit and investigation activities relating to program integrity of the provision of pharmacy services as needed.

Additional questions may be sent via e-mail to: ppno@health.state.ny.us.

Medicaid Pharmacy Drug Utilization Review (DUR) Program Update

Effective April 12, 2012, the fee-for-service pharmacy program will implement the following parameters which include step therapy and frequency/quantity/duration (F/Q/D) requirements. These changes are the result of recommendations made by the Drug Utilization Review Board (DURB) at the March 8, 2012, DURB meeting.

Angiotensin Converting Enzyme Inhibitors (ACEI)/Angiotension Receptor Blockers (ARB)/Direct Renin Inhibitors (DRI) and Related Combination Products:

- Require trial with a product containing an ACEI prior to initiating a preferred ARB
- Require trial with a product containing either an ACEI or an ARB prior to initiating a preferred DRI

Amitiza:

- Require trials of both a bulking-agent and an osmotic laxative prior (defined as within 89 days) to lubiprostone
- Duration limit of 30 days with 2 refills per prescription

Selective Serotonin Reuptake Inhibitors/Serotonin-Norepinephrine Reuptake Inhibitors:

- Require trial with an SSRI prior to an SNRI (exception for specific indications: Chronic musculoskeletal pain (CMP), Diabetic peripheral neuropathy (DPN) and Fibromyalgia (FM)

Human Growth Hormone (HGH)

- Require diagnosis for all HGH products regardless of patient age

With the implementation of new system enhancements, prescribers can prevent the need to obtain certain prior authorizations (PA) by properly coding all medical claims with the appropriate diagnoses and following clinical recommendations.

DURB recommendations for step therapy and FQD are based on best practice, as established by FDA approved manufacturer labeling, official compendia, and major treatment guidelines. Recommendations are instituted to ensure clinically appropriate and cost effective use of these drugs and drug classes. To view all DURB recommendations visit the DUR program web site at:

http://www.health.ny.gov/health_care/medicaid/program/dur/index.htm

The Preferred Drug List also includes links to the DUR program web site for drugs/drug classes within the Preferred Drug Program that are affected by step therapy and F/Q/D requirements. The most recent PDL can be found at: https://newyork.fhsc.com/

ATTENTION: PROVIDERS

Please assist us in notifying EPIC members of recent program changes by displaying this poster, the Frequently Asked Questions (FAQs), and the List of Resources for Those Who Need Help With Prescription Costs in your practice. Feel free to copy and distribute.

Effective January 1, 2012

EPIC MEMBERS

This notice provides information regarding the recent changes to your EPIC coverage

- EPIC is a free program, with no fees or deductibles.
- You **must** be enrolled in a Medicare drug plan in order to receive benefits.
- EPIC **only** provides coverage for Medicare Part D covered drugs or Part D excluded drugs purchased during the Part D coverage gap (donut hole).
- Your EPIC copayment for drugs purchased during the Part D coverage gap (donut hole) will be $3-$20, depending on the cost of the drug.

For more information call the toll-free EPIC Helpline at (**800) 332-3742,** or write to:

EPIC
P.O. Box 15018
Albany, New York 12212

EPIC Members

Effective January 1, 2012 your EPIC coverage changed

Frequently Asked Questions (FAQ)

Q1. How has the EPIC program changed?
ANSWER: Effective January 1, 2012, EPIC is a free program, with no fees or deductibles. All members must be enrolled in a Medicare Part D drug plan in order to receive EPIC benefits. EPIC only provides drug coverage in the Medicare Part D coverage gap (donut hole).

Q2. What drug coverage does the EPIC program provide?
ANSWER: EPIC only provides secondary drug coverage for Medicare Part D covered drugs or Part D excluded drugs purchased during the coverage gap (donut hole).

Q3.What is a Medicare Part D excluded drug?
ANSWER: Part D excluded drugs are medications that are not required to be covered by a Part D plan. (e.g., some anti-anxiety drugs such as benzodiazepines or some anti-seizure drugs such as barbiturates).

Q4. My Medicare Part D drug plan has a deductible. Will EPIC provide secondary coverage during this time?
ANSWER: No, EPIC coverage is limited to drugs purchased during the Part D coverage gap. You will need to pay any deductible required by your Part D drug plan.

Q5. Will EPIC provide secondary coverage of my drugs after I pay my Part D deductible and enter the initial coverage phase (prior to the coverage gap)?
ANSWER: No. EPIC drug coverage is limited to drugs purchased during the Part D coverage gap. You will need to pay the co-payment charged by your Part D plan (approximately 25 percent of the drug cost) during the initial coverage phase.

Q6. How much will I have to pay before EPIC helps me pay for drugs?
ANSWER: You will have to pay approximately $970 out of pocket before you reach the Medicare Part D coverage gap. Your total cost of drugs prior to the coverage gap (what you pay and what Medicare Part D pays is $2,930).

Q7. What are the EPIC co-payments for drugs purchased in the Part D coverage gap?
ANSWER: EPIC's co-payment structure has not changed. Members pay EPIC copayments of $3-$20 based on the cost of a covered drug.

Q8. Will EPIC provide secondary coverage during the Part D catastrophic coverage phase?
ANSWER: No. You will use your Part D plan for covered drugs and your co-insurance will be approximately 5 percent of the cost of the drug.

Q9. Will EPIC help pay my monthly Part D drug premium?
ANSWER: EPIC will pay the monthly Part D drug premium up to $39.79 in 2012 for members with income up to $23,000 if single or $29,000 if married. Those with higher incomes must pay their Part D drug premium each month.

Q10. How can I reduce my drug costs?
ANSWER: You should work with your doctor and pharmacist to use drugs covered by your Part D plan. You should ask your doctor if you can take a generic drug or a lower cost brand drug that is covered by your Part D plan, if appropriate for you.

Q11. I need additional help in paying for my prescriptions. What can I do?
ANSWER: The Patient Assistance Resources sheet (attached) lists various organizations that may offer financial assistance in paying for your drugs.

Q12. Am I eligible for Extra Help from Medicare?
ANSWER: If your current annual income is up to $16,755 if single or $22,695 if married and your total assets are up to $13,070 if single or $26,120 if married, you may be eligible for Extra Help from Medicare. If approved in 2012, you will pay copayments as low as $2.60 for generics and $6.50 for brand drugs covered by your Part D plan. Please call the EPIC Helpline at (800) 332-3742 and ask for a Request for Additional Information form to be mailed to you. You must complete, sign and return the form to EPIC and we will apply for the benefit for you.

Q13. Am I eligible for a Medicare Savings Program?
ANSWER: If your current annual income is up to $15,324 if single or $20,676 if married, you may be eligible for a Medicare Savings Program. There is no asset limit to apply for the benefit. If approved in 2012, you will receive Extra Help from Medicare and you will pay copayments as low as $2.60 for generics and $6.50 for brand drugs covered by your Part D plan. Please call the EPIC Helpline at (**800) 332-3742** and request a **Medicare Savings Program** application to be mailed to you. You must complete, sign and return the form to EPIC, along with required income documentation, and we will apply for the benefit for you.

Patient Assistance Resources for Members who Need Help with Prescription Costs

- Contact the manufacturer of the drug needed to see if they can help with the cost
- Many counties have discount cards available (e.g. BIG APPLE RX NYC http://www.bigapplerx.com)
- Contact your local County Office for the Aging

Resource	Program Summary	Contact
Cancer Care Foundation **www.cancercarecopay.org**	○ Specifically for covering the cost of breast, lung, pancreatic, or colon cancer medications ○ Medication must be covered by foundation ○ Individual must be covered by private insurance OR have Medicare Part B, Medicare Part D, Medicare Advantage (MA), or Medigap plan ○ Assistance for Individual or family with income of up to 4 times federal poverty level	(866) 55-COPAY
Chronic Disease Fund **www.cdfund.org**	○ Income levels by geographic area, number of household dependents and current out-of-pocket medical expenses are considered ○ Individual must have one of the fund listed diseases. There are separate 'Disease Trusts' with separate funds ○ *Pulmonary Arterial Hypertension* (PAH), Psoriasis, Rheumatoid Arthritis (RA) and Asthma are examples on the list	(877) 968-7233
Healthwell Foundation **www.healthwellfoundation.org**	○ Household Adjusted Gross Income (AGI) must be below 400% of poverty level with cost of living also taken into account ○ Psoriasis, Rheumatoid Arthritis (RA) and Asthma are examples of diseases on the list ○ Foundation suggests contacting manufacturer first since assistance level from manufacturer may be greater than foundation assistance	(800) 675-8416
Leukemia and Lymphoma Society **www.leukemia-lymphoma.org**	○ Household income at/within 500% above US poverty guidelines ○ Must have prescription insurance ○ Must have a blood cancer (Chronic Lymphocytic Leukemia - CLL, Hodgkin Lymphoma, non-Hodgkin Lymphoma, Myelodysplastic Syndromes, Myeloma, or Waldenstrom Macroglobulinemia) diagnosis confirmed by MD	(877) 557-2672
National Organization for Rare Disorders **www.rarediseases.org/patients-and-families/patient-assistance**	○ Web site contains a list of medication-specific assistance programs, disorder-specific programs and clinical trial programs ○ Assistance level varies depending upon the program ○ Upon receipt of a completed application, National Organization for Rare Disorders (NORD) reviews and responds with an award decision within 2 business days	(800) 999-6673

Needy Meds – Discount Card www.needymeds.org	○ Needy Meds drug discount card can only be used by those without insurance or as an alternative to their insurance ○ Web site also has a list of brand names for individual to click on drug to see if manufacturer assistance program/coupon is available http://www.needymeds.org/drug_list.taf	Refer to Website
Patient Access Network Foundation **www.panfoundation.org**	○ Individual should be insured ○ Individual's insurance must cover the medication ○ Medication must fight the disease directly ○ Income must be below a designated percentage of federal poverty level depending upon individual fund requirements ○ Specific disease funds; including Crohn's, Diabetic Foot Ulcers, Macular diseases, Multiple Sclerosis (MS), Kidney Transplant Immunosuppression, Rheumatoid Arthritis (RA)	(866) 316-7263
Patient Advocate Foundation **www.copays.org**	○ Assists insured patients who are financially and medically qualified ○ Breast, Lung, Lymphoma and Cutaneous T-Cell Lymphoma, Prostate, Kidney, Colon, Pancreatic, Head/Neck Cancers, Malignant Brain Tumor, Sarcoma, Diabetes, Multiple Myeloma, Myelodysplastic Syndrome (and other Pre-Leukemia diseases), Osteoporosis, Pain, Hepatitis C, Rheumatoid Arthritis, selected Autoimmune Disorders and *Chemo Induced Anemia* (CIA)/Chemo Induced Neutropenia (CIN)	(866) 512-3861
PatientAssistance.com **www.patientassistance.com**	○ This is a resource for finding various assistance programs ○ Contains a searchable database of thousands of patient assistance programs	Refer to Website
Patient Services Incorporated **www.patientservicesinc.org**	○ Based on financial need ○ Disease must be on list - Acromegaly, Advanced Idiopathic Parkinson' s Disease, Alpha1 Antitrypsin Deficiency, Bone Metastases, Breast Cancer Screening, Chronic Myelogenous Leukemia, Chronic Inflammatory Demyelinating Polyneuropathy (CIPD), Complement Mediated Diseases (CMD), Clostridium Difficile, Cutaneous T-Cell Lymphoma (CTCL), Cystic Fibrosis (with Pseudomonas), Fabry Disease, Gastrointestinal Stromal Tumors (GIST), Hemophilia, Hereditary Angioedema (C1 Inhibitor Deficiencies), Inhibitors in Hemophilia, Insulin like Growth Factor 1 Deficiency (IGF1), Malignant Ascites, Mucopolysaccharidosis Type I (MPS 1 – Hurlers Syndrome), Patient Services Items Program (PSIp), Pleural Effusion, Pompe Disease, Primary Immune Deficiency, Severe Congenital Protein C Deficiency), von Willebrand Disease	(800) 366-7741
Partnership for Prescription Assistance **www.pparx.org**	○ Different funds offering co-payment assistance are listed	(888) 477-2669
RxAssist **www.rxassist.org**	○ Database search by drug name to locate various assistance programs. Click on patients to get to the search window	Refer to Website

All Providers

New York Medicaid Electronic Health Records Incentive Program Update

As of March 21, 2012, the New York Medicaid Electronic Health Records (EHR) Incentive Program has paid over $44 million in federal incentive funds to New York State hospitals and healthcare practitioners.

If you have not yet registered for the New York Medicaid EHR Incentive Program, we encourage you to visit https://www.emedny.org/meipass/ or attend one of the informational webinars hosted by the New York State Department of Health throughout the month of April.

Wednesday, April 4	12:00–1:00 PM	Eligible Professional Registration & Attestation
Tuesday, April 10	12:00–1:00 PM	Eligible Hospital Questions & Answers
Thursday, April 12	12:00–1:00 PM	MEIPASS Prerequisites
Tuesday, April 17	12:00–1:00 PM	Eligible Hospital Registration & Attestation
Wednesday, April 18	3:00–4:00 PM	Meaningful Use, Stage 1
Monday, April 23	3:00–4:00 PM	Eligible Professional Registration & Attestation
Tuesday, April 24	12:00–1:00 PM	MEIPASS Prerequisites
Thursday, April 26	10:00–11:00 AM	Meaningful Use, Stage 1

To see the complete schedule or to register for one of the webinars, please view the webinar schedule on the eMedNY.org web site at https://www.emedny.org/meipass/webinar/Webinar.pdf.

All Providers

Colorectal Cancer Prevention Update

All patients ages 50 and older should be screened for colorectal cancer. Research indicates that the willingness of adults to utilize colorectal cancer screening tests depends on multiple factors, including individual disease risk, personal preference, and physician recommendation[1]. Discussing the importance of colorectal cancer screening tests with your patients is critically important to their use of these preventive services.

Most health plans, including Medicaid and Medicaid Managed Care Plans, reimburse for age- and risk-appropriate colorectal cancer screening tests. The United States Preventive Services Task Force recommends that average-risk men and women ages 50-75 get regular colorectal cancer screening with any of three tests: a high-sensitivity, multi-slide fecal occult blood test (FOBT) every year using either guaiac (gFOBT) or immunochemical (iFOBT - also known as fecal immunochemical test or FIT); a flexible sigmoidoscopy every 5 years; or a colonoscopy every 10 years.[2,3] Screening patients ages 76-85 should be performed on an individual basis, as deemed necessary. Fecal testing is not recommended for those at high-risk of developing colorectal cancer and these individuals may need to start screening at a younger age.

The use of a single-slide, in-office fecal occult blood test (FOBT) completed after a digital rectal examination is NOT an approved modality for colorectal cancer screening and should NOT be coded as such for reimbursement through Medicaid.

What is FOBT?

FOBT (fecal occult blood test) is a fecal-based colorectal cancer screening option that allows patients to procure samples in the comfort of their own homes, at their convenience.

What is FIT?

FIT (fecal immunochemical test), sometimes identified as iFOBT (immunochemical fecal occult blood test), is an improved FOBT with higher sensitivity and specificity when compared to guaiac FOBT (or gFOBT). When used yearly, FIT has accuracy rates near those of colonoscopy.[4]

How does FIT compare to Guaiac FOBT?

- FIT has superior sensitivity and specificity as compared to guaiac FOBT.
- FIT uses antibodies specific for human globin and are specific for colorectal bleeding and are not affected by diet or medications, unlike the guaiac test.
- Automated development is available for some FITs which aids in the management of large numbers of tests and improves quality assurance.
- There is evidence that FIT use improves patient participation in screening by giving patients another choice for colorectal cancer screening.
- FIT has a variety of improved stool collection methods such as a brush or probe.
- New technology for FITs allows them to quantify fecal hemoglobin so that sensitivity, specificity, and positivity rates can be adjusted in screening for colorectal neoplasia.[4]

How can FIT help me?

FIT can help increase colorectal cancer screening rates in your practice. It is easy-to-use, non-invasive, effective, low-risk and inexpensive. Use of FIT for colorectal cancer screening can help patients overcome many of these common barriers to screening with colonoscopy:

- Time constraints
- Child or elder care issues
- Lack of transportation/inaccessibility to specialists and/or facilities
- Unwillingness or inability to complete bowel prep for colonoscopy [4]

How do I code FIT, guaiac FOBT and in-office tests for reimbursement through Medicaid?

- The CPT code for testing for occult blood by fecal hemoglobin determination by immunoassay (FIT or iFOBT), qualitative is **82274**
- The CPT code for multi-slide take-home FOBT by peroxidase activity (e.g., guaiac) for colorectal neoplasm screening **82270**
- The CPT code for an in-office test performed after a digital rectal exam to confirm the presence or absence of blood on examination by peroxidase activity (e.g., guaiac) is **82272**. ***Remember, this is NOT a modality for colorectal cancer screening.***

New York State Department of Health Cancer Services Program

The NYSDOH Cancer Services Program (CSP) has a 15-year history of screening average-risk clients with FIT through its cancer screening program and can provide you with colorectal cancer risk assessment guidance for your practice. For more information, call (518) 474-1222 or e-mail canserv@health.state.ny.gov.

The CSP also offers a number of patient education materials about colorectal cancer and FIT use free of charge; to access a list of available materials, please visit: http://www.health.ny.gov/diseases/cancer/docs/cancer_serv_prog_resource_guide.pdf.

The CSP facilitates access to and provides funding for colorectal, breast and cervical cancer screening and diagnostic services for uninsured and underinsured New Yorkers and assists those diagnosed with cancer to obtain prompt treatment through the New York State Medicaid Cancer Treatment Program (NYS MCTP). The NYS MCTP is a Medicaid program for eligible uninsured persons who are found to be in need of treatment for breast, cervical, colorectal or prostate cancer and in some cases, pre-cancerous conditions of these cancers. The CSP works to improve cancer screening services with the ultimate goal of increasing age appropriate, guideline-concordant cancer screening and decreasing cancer mortality in NYS.

Uninsured NYS residents can call the CSP toll-free referral line (1-866-442-CANCER), 24 hours a day, 7 days a week, to be directly connected to cancer screening services in the county in which they live or work. For more information about the NYS Cancer Services Program visit http://www.nyhealth.gov/cancerservicesprogram.

References

1) Subramanian S, Klosterman M, Amonkar MM, Hunt TL. *Adherence with colorectal cancer screening guidelines: a review*. Preventive Medicine. 2004;38:536-50.
2) Whitlock EP, Lin JS, Liles E, Beil TL, Fu R. *Screening for colorectal cancer: a targeted, updated systematic review for the U.S. Preventive Services Task Force*. Ann Intern Med 2008;149:638-58.
3) United States Preventive Services Task Force. *Screening for colorectal cancer: U.S. Preventive Services Task Force recommendation statement*. Ann Intern Med 2008;149:627-37.
4) Adapted from Florida Department of Health *Get the FIT Facts* web site http://www.getthefitfacts.com accessed 2/6/2012.

Sign Up for Medicaid Training Schedule and Registration

- **Do you have billing questions?**
- **Are you new to Medicaid billing?**
- **Would you like to learn more about ePACES?**

If you answered YES to any of these questions, you should consider registering for a Medicaid seminar or webinar. Computer Sciences Corporation (CSC) offers various types of educational opportunities to providers and their billing staff. Training sessions are available for new providers, specific provider types, Managed Care and the Medicaid Eligibility Verification System. Many of the sessions planned for the upcoming months offer detailed information and instruction about Medicaid's web-based billing and transaction program - **ePACES.** The schedule will be posted to the web site early in the Month of April.

You can also register for a webinar in which training would be conducted online and you can join the meeting from your computer and telephone. After registration is completed, just log in at the announced time. No travel time or expenses involved.

ePACES is the electronic Provider Assisted Claim Entry System which allows enrolled providers to submit the following type of transactions:

- **Claims**
- **Eligibility Verifications**
- **Claim Status Requests**
- **Prior Approval/DVS Requests**

Physician, Nurse Practitioner, DME and Private Duty Nursing claims can even be submitted in "REAL-TIME" via **ePACES.** Real-time means that the claim is processed within seconds and professional providers can get the status of a real-time claim, including the paid amount without waiting for the remittance advice.

Fast and easy seminar/webinar registration, locations, and dates are available on the eMedNY web site at: **http://www.emedny.org/training/index.aspx**.

CSC Regional Representatives look forward to having you join them at upcoming meetings!

If you are unable to access the Internet to register or have questions about registration, please contact the eMedNY Call Center at (800) 343-9000.

PROVIDER DIRECTORY

Office of the Medicaid Inspector General:
For general inquiries or provider self-disclosures, please call (518) 473-3782.
For suspected fraud complaints/allegations, call 1-877-87FRAUD (1-877-873-7283), or visit www.omig.ny.gov.

Provider Manuals/Companion Guides, Enrollment Information/Forms/Training Schedules:
Please visit the eMedNY web site at: www.emedny.org.

For providers to hear the current weeks 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.

Address Change?
Address changes should be directed to the eMedNY Call Center at (800) 343-9000.

Fee-for-Service Providers: A change of address form is available at: http://www.emedny.org/info/ProviderEnrollment/allforms.html.

Rate-Based/Institutional Providers: A change of address form is available at: http://www.emedny.org/info/ProviderEnrollment/allforms.html.

Does your enrollment file need to be updated because you've experienced a change in ownership?

Fee-for-service providers please call (518) 402-7032.
Rate-Based/Institutional providers please call (518) 474-3575.

Do you have comments and/or suggestions regarding this publication?

Please contact Kelli Kudlack at: medicaidupdate@health.state.ny.us.