New York State Department of Health

February 2023
Volume 39 | Number 5

Medicaid Update

Inside this issue:

All Providers

Pharmacy

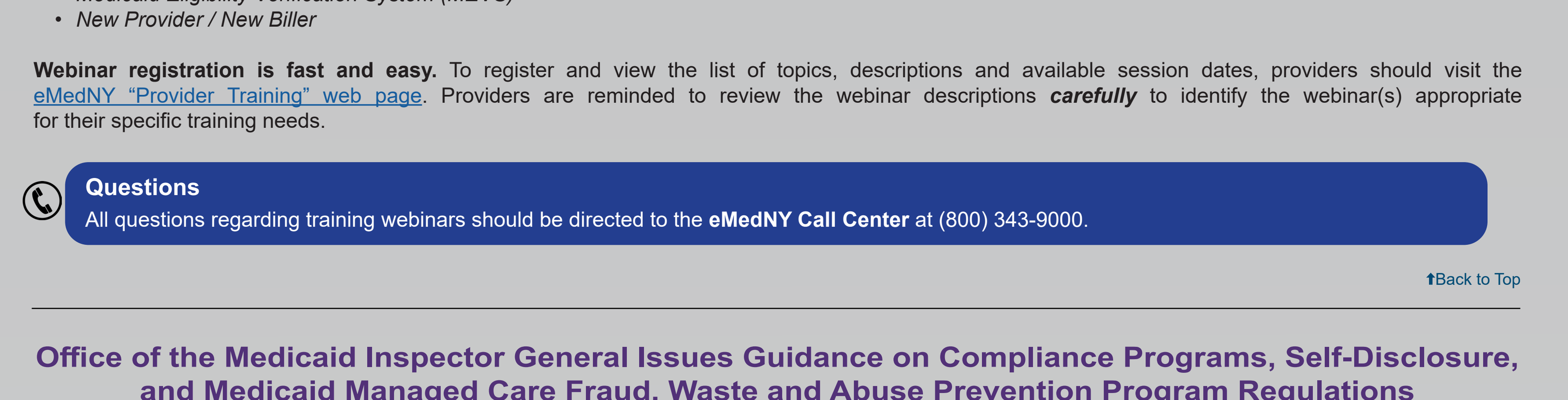
Provider Directory

Billing Guidance for Reporting Newborn Birth Weights

The New York State (NYS) Department of Health (DOH) reminds hospitals to accurately report newborn birth weights on inpatient claims. Pursuant to the inpatient billing procedures for All Patient Refined Diagnostic Related Groups (APR DRGs) shown in the *eMedNY New York State UB-04 Billing Guidelines - Inpatient Hospital* document, claims for newborns must accurately contain the birth weight in grams of the newborn. The birth weight is reported using Value Code **"54"** in the "Value Information" segment. To ensure proper payment when billing Medicaid fee-for-service (FFS), providers should follow the billing guidelines detailed in the *eMedNY New York State UB-04 Billing Guidelines - Inpatient Hospital* document (see "2.3.1.2 Acute APR DRG Payment Calculation", "Rule 3 – Newborns," located on page 9 of the document).

Questions:
- FFS coverage and policy questions should be directed to the Office of Health Insurance Programs (OHIP) Division of Program Development and Management (DPDM) by telephone at (518) 473-2160 or by email at FFSMedicaidPolicy@health.ny.gov.
- Medicaid Managed Care (MMC) reimbursement, billing, and/or documentation requirement 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.
- FFS claim questions should be directed to the eMedNY Call Center at (800) 343-9000.

↑Back to Top



Reminder: Sign Up for eMedNY Training Webinars

eMedNY offers several online training webinars to providers and their billing staff, which can be accessed via computer and telephone. Valuable provider webinars offered include:
- *Provider Enrollment Portal - Practitioner*
- *Enteral Prior Authorization Web Portal*
- ePACES for: *Dental*, *Durable Medical Equipment Supplier (DME)*, *Institutional*, *Physician*, *Private Duty Nursing*, *Professional (Real-Time)*, and *Transportation*
- *ePACES Dispensing Validation System (DVS) for DME*
- *Medicaid Eligibility Verification System (MEVS)*
- *New Provider / New Biller*

Webinar registration is fast and easy. To register and view the list of topics, descriptions and available session dates, providers should visit the eMedNY "Provider Training" web page. Providers are reminded to review the webinar descriptions ***carefully*** to identify the webinar(s) appropriate for their specific training needs.

Questions
All questions regarding training webinars should be directed to the **eMedNY Call Center** at (800) 343-9000.

↑Back to Top

Office of the Medicaid Inspector General Issues Guidance on Compliance Programs, Self-Disclosure, and Medicaid Managed Care Fraud, Waste and Abuse Prevention Program Regulations

Effective December 28, 2022, Title 18 of the New York Codes, Rules and Regulations (NYCRR) Part 521 was amended to implement statutory changes adopted in the State Fiscal Year (SFY) 2020-2021 Enacted Budget. These changes impact the requirements for establishing and operating compliance programs pursuant to Social Services Law (SOS) §363-d establish requirements for Medicaid Managed Care (MMC) Fraud, Waste and Abuse Prevention Programs pursuant to SOS §364-j(39) and update requirements that persons shall report, return, and explain overpayments pursuant to SOS §363-d(6) and (7). Providers can refer to the Office of the Medicaid Inspector General (OMIG) *Summary of Regulation* document for new regulation information. Providers should take the steps necessary to review the changes and comply.

OMIG has posted guidance on the New York State (NYS) OMIG website intended to assist providers who must adopt and implement programs designed to detect, prevent, report, and correct incidents of fraud, waste, and abuse in the Medicaid program.

Compliance Program Guidance – 18 NYCRR SubPart 521-1

18 NYCRR SubPart 521-1, located in the OMIG *Summary of Regulation* document, sets forth the requirements for establishing and operating compliance programs pursuant to SOS §363-d. Consistent with SOS §363-d(3)(c), within ninety days of the effective date of the regulation, providers are required to have in place a satisfactory compliance program that meets the new requirements. **Effective March 28, 2023**, if a provider does not have a satisfactory compliance program, it may be subject to sanction or penalty authorized by law.

Conformity with these requirements is a condition of payment from the medical assistance program. It is the responsibility of the provider to read and be familiar with the requirements of the law and regulations. Providers are advised to review the amendments made to SOS §363-d and 18 NYCRR SubPart 521-1, located in the OMIG *Summary of Regulation* document, and make changes to their compliance programs as appropriate.

Compliance program guidance is available on the NYS OMIG "Compliance Library" web page. **Please note:** The adoption of the new 521 regulation does not relieve providers of their obligations under the previous regulation for prior periods. Compliance program guidance materials are intended to assist providers in understanding and implementing the statutory and regulatory requirements; however, they are not a substitute for the regulations. In the event of a conflict between statements in the guidance and either statutory or regulatory requirements, the requirements of the statutes and regulations govern.

MMC Fraud, Waste and Abuse Prevention Programs – 18 NYCRR SubPart 521-2

18 NYCRR SubPart 521-2, located in the OMIG *Summary of Regulation* document, establishes requirements for MMC Fraud, Waste and Abuse Prevention Programs pursuant to SOS §364-j(39). Medicaid Managed Care Organizations (MMCO), including Managed Long Term Care (MLTC) Plans, must establish policies and procedures to prevent and detect fraud, waste, and abuse. These requirements include but are not limited to:
- reporting potential fraud, waste, and abuse to OMIG;
  - o MMCOs may also report cases of potential fraud by email to the Medicaid Fraud Control Unit (MFCU) at MFCUReferrals@ag.ny.gov, using the subject line "Potential Fraud Referral";
- referring reasonably suspected or confirmed criminal activity to OMIG and MFCU, respectively, by email at bmfa.mco@omig.ny.gov and MFCUReferrals@ag.ny.gov;
- establishing an effective compliance program pursuant to 18 NYCRR SubPart 521-1, located in the OMIG *Summary of Regulation* document;
- creating and publicizing on their website policies and procedures for providers to report, return, and explain overpayments;
- requiring that an MMCO establish a Special Investigation Unit (SIU) should they have 1,000 members or more; ***and***
- establishing SIU staffing requirements.

MMCOs continue to be subject to the requirements outlined in their contracts with DOH to participate as MMCOs, along with Public Health Law (PHL) §4414, 10 NYCRR 98-1.2, and 11 NYCRR 86. MMC Fraud, Waste and Abuse Prevention Programs guidance is available on the NYS OMIG "Medicaid Managed Care Fraud, Waste, and Abuse Prevention Programs Guidance and Forms" web page.

Self-Disclosure: Obligation to Report, Return and Explain – 18 NYCRR SubPart 521-3

OMIG has revised its process for receiving and processing self-disclosures of overpayments under the Medicaid program. The amendments to SOS §363-d codify in NYS law the federal requirement that providers have an obligation to report, return, and explain overpayments to the State within sixty days of identification or the date any corresponding cost report is due, whichever is later, and establish in NYS law the parameters for the Self-Disclosure Program and the requirements for participation. SOS §145-b also authorizes penalties for failure to report, return and explain overpayments required by SOS §363-d. Further information is detailed in 18 NYCRR SubPart 521-3. Providers are also encouraged to review the "Self-Disclosure Program Requirements Guidance" and "Frequently Asked Questions (FAQs)" on the NYS OMIG "Self-Disclosure" web page.

Questions and Additional Information:
- Compliance program questions should be directed to the OMIG Bureau of Compliance by email at compliance@omig.ny.gov.
- MMC fraud, waste and abuse prevention program questions should be directed to the OMIG Managed Care Organization Reporting Unit by email at bmfa.mco@omig.ny.gov.
- Self-Disclosure program questions should be directed to the OMIG Self-Disclosure Unit by email at selfdisclosures@omig.ny.gov.

↑Back to Top

NY State of Health Will Keep Enrollment Open to Ensure New Yorkers Keep Their Health Insurance

During the federal Public Health Emergency (PHE), New York State (NYS) was authorized to maintain an "Exceptional Circumstances Special Enrollment Period (SEP)" to protect New Yorkers by providing unrestricted access to health insurance offered through NY State of Health, the Official Health Plan Marketplace (Marketplace). For more information, providers can refer to the United States (U.S.) Department of Health and Human Services (HHS) Administration for Strategic Preparedness and Response (ASPR) "Declarations of a Public Health Emergency" web page.

As NYS transitions out of the PHE and eligibility reviews resume, NY State of Health will continue SEP to allow consumers, who may no longer qualify for the Essential Plan (EP) or Medicaid, to enroll in a Qualified Health Plan (QHP). This extended period of open enrollment will ensure coverage is available to consumers across all programs, as the PHE winds down.

Questions and Additional Information:
- All questions regarding the trainings should be directed to DHP@health.ny.gov.
- Additional links to studies, technical assistance, and resources can be found on the NYS DOH "Disability and Health in New York State" web page.

↑Back to Top

2023 Spousal Impoverishment Income and Resource Levels Increase

Providers of nursing facility services, certain home and community-based waiver services, and services to individuals enrolled in a Managed Long Term Care Plan are required to print and distribute the *Information Notice to Couples with an Institutionalized Spouse* at the time they begin to provide services to their patients.

Effective January 1, 2023, the federal maximum Community Spouse Resource Allowance increased to $148,620.00, while the community spouse monthly income allowance increased to $3,715.50. The maximum family member monthly allowance increased to $822.00. This information should be provided to any institutionalized spouse, community spouse, or representative acting on their behalf to avoid unnecessary depletion of the amount of assets a couple can retain under the Medicaid program spousal impoverishment eligibility provisions.

Income and Resource Amounts

Date	Allowance
January 1, 2023	**Federal Maximum Community Spouse Resource Allowance: *$148,620.00*** **Please note:** A higher amount may be established by court order or fair hearing to generate income to raise the community spouse's monthly income up to the maximum allowance. **Please note:** The State Minimum Community Spouse Resource Allowance is $74,820.00.
January 1, 2023	**Community Spouse Minimum Monthly Maintenance Needs Allowance: An amount up to *$3,715.50*** (if the community spouse has no income of their own) **Please note:** A higher amount may be established by court order or fair hearing due to exceptional circumstances that result in significant financial distress.
January 1, 2023	**Family Member Monthly Allowance (for each family member): An amount up to *$822.00*** (if the family member has no income of their own)

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

↑Back to Top

Information Notice to Couples with an Institutionalized Spouse

- "Information Notice to Couples with an Institutionalized Spouse" is available as a PDF.
- "Additionally, the *Request for Assessment – Spousal Impoverishment* form should be printed and distributed.

Medicaid is an assistance program that may help pay for the costs of your or your spouse's institutional care, home and community-based waiver services, or enrollment in a Managed Long Term Care Plan. The institutionalized spouse is considered medically needy if their resources are at or below a certain level and the monthly income after certain deductions is less than the cost of care in the facility. Federal and State laws require that spousal impoverishment rules be used to determine an institutionalized spouse's eligibility for Medicaid. These rules protect some of the income and resources of the couple for the community spouse. **Please note:** Spousal impoverishment rules do not apply to an institutionalized spouse who is eligible under the Modified Adjusted Gross Income rules.

If you or your spouse are:
1. In a medical institution or nursing facility and are likely to remain there for at least 30 consecutive days; ***or***
2. Receiving home and community-based services provided pursuant to a waiver under §1915(c) of the federal Social Security Act and are likely to receive such services for at least 30 consecutive days; ***or***
3. Receiving institutional or non-institutional services and are enrolled in a Managed Long Term Care Plan; ***and***
4. Married to a spouse who does not meet any of the criteria set forth under items 1 through 3 listed above, these income and resource eligibility rules for an institutionalized spouse may apply to you or your spouse.

If you wish to discuss these eligibility provisions, please contact your local department of social services to request an assessment of the total value of your or your spouses combined countable resources, even if you have no intention of pursuing a Medicaid application. It is to the advantage of the community spouse to request such an assessment to make certain that allowable resources are not depleted by you for your spouse's cost of care. To request such an assessment, please contact your local department of social services or complete and mail the *Request for Assessment – Spousal Impoverishment* form (DOH-5298). New York City residents may contact the Human Resources Administration Medicaid Helpline at (888) 692-6116.

Resource Information
Effective January 1, 1996, the community spouse is allowed to keep resources in an amount equal to the greater of the following amounts: 1. $74,820.00 (the NYS minimum spousal resource standard); ***or*** 2. $148,620.00 (the amount of the spousal share up to the maximum amount permitted under federal law for 2023).

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

The community spouse may be able to obtain additional amounts of resources to generate income when the otherwise available income of the community spouse, together with the income allowance from the institutionalized spouse, is less than the maximum community spouse monthly income allowance, by requesting a fair hearing or commencing a family court proceeding against the institutionalized spouse. You can contact your local department of social services or an attorney about requesting a Medicaid fair hearing. Your attorney can provide more information about commencing a family court proceeding. You may be able to get a lawyer at no cost by calling your local Legal Aid or Legal Services Office. For names of other lawyers, call your local or State Bar Association.

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

Income Information
A spouse may request an assessment/determination of: 1. The community spouse monthly income allowance (an amount of up to $3,715.50 a month for 2023); ***and*** 2. A maximum family member allowance for each minor child, dependent child, dependent parent, or dependent sibling of either spouse living with the community spouse of $822.00 for 2023 (if the family member has no income of their own).

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

If you wish to request an assessment of the total value of your or your spouse's countable resources, a determination of the community spouse resource allowance, community spouse monthly income allowance, or family member allowance(s) and the method of computing such allowances, please contact your local department of social services. New York City residents should call the Human Resources Administration Medicaid Helpline at (888) 692-6116.

Spousal Refusal and Undue Hardship Concerning a Community Spouse's Refusal to Provide Necessary Information

For purposes of determining Medicaid eligibility for the institutionalized spouse, a community spouse must cooperate by providing necessary information a bout their resources. Refusal to provide the necessary information shall be reason for denying Medicaid for the institutionalized spouse as Medicaid eligibility cannot be determined. If the applicant or recipient demonstrates that denial of Medicaid would result in undue hardship for the institutionalized spouse and an assignment of support is executed or the institutionalized spouse is unable to execute such assignment due to physical or mental impairment, Medicaid shall be authorized. However, if the community spouse refuses to make such resource information available, the New York State Department of Health or local department of social services, at its option, may refer the matter to court for recovery from the community spouse of any Medicaid expenditures for the institutionalized spouse's care.

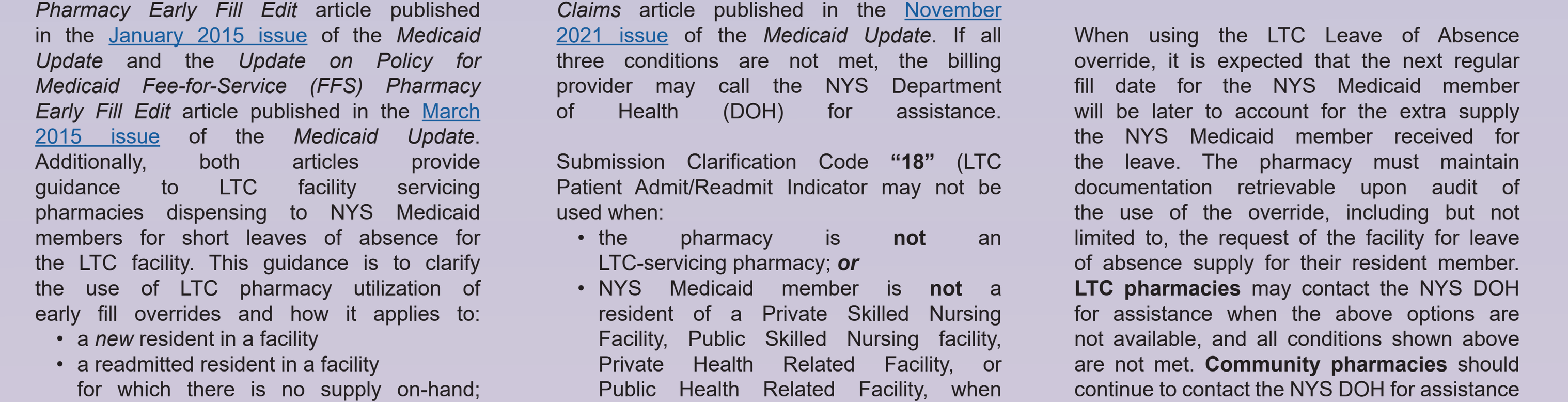
Undue hardship occurs when:
1. A community spouse fails or refuses to cooperate in providing necessary information about their resources;
2. The institutionalized spouse is otherwise eligible for Medicaid;
3. The institutionalized spouse is unable to obtain appropriate medical care without the provision of Medicaid; ***and***
   a. The community spouse's whereabouts are unknown; ***or***
   b. The community spouse is incapable of providing the required information due to illness or mental incapacity; ***or***
   c. The community spouse lived apart from the institutionalized spouse immediately prior to institutionalization; ***or***
   d. Due to the action or inaction of the community spouse, other than the failure or refusal to cooperate in providing necessary information about their resources, the institutionalized spouse will need protection from actual or threatened harm, neglect, or hazardous conditions if discharged from an appropriate medical setting.

An institutionalized spouse will not be determined ineligible for Medicaid because the community spouse refuses to make their resources in excess of the community spouse resource allowance available to the institutionalized spouse if:
1. The institutionalized spouse executes an assignment of support from the community spouse in favor of the social services district; ***or***
2. The institutionalized spouse is unable to execute such assignment due to physical or mental impairment.

Income Contribution from the Community Spouse

The amount of money that Medicaid will request as a contribution from the community spouse will be based on their income and the number of certain individuals in the community household depending on that income. Medicaid will request a contribution from a community spouse of 25 percent of the amount their otherwise available income that exceeds the minimum monthly maintenance needs allowance plus any family member allowance(s). If the community spouse feels that they cannot contribute the amount requested, the community spouse has the right to schedule a conference with the local department of social services to try to reach an agreement about the amount the community spouse is able to pay. Pursuant to Social Services Law §366(3)(a), Medicaid **must** be provided to the institutionalized spouse if the community spouse fails or refuses to contribute their income towards the institutionalized spouse's cost of care. However, if the community spouse fails or refuses to make their income available as requested, then the New York State Department of Health or the local department of social services, at its option, may refer the matter to court for a review of the community spouse's actual ability to pay.

↑Back to Top



Clarification for Long-Term Care Pharmacies New Patient and Leave of Absence

The exceptions regarding early fill edits for newly admitted New York State (NYS) Medicaid members to long term care (LTC) facilities who were admitted without supply of recently dispensed medications is outlined in previous guidance found in the *New Medicaid FFS Pharmacy Early Fill Edit* article published in the January 2015 issue of the *Medicaid Update* and the *Update on Policy for Medicaid Fee-for-Service (FFS) Pharmacy Early Fill Edit* article published in the March 2015 issue of the *Medicaid Update*. Additionally, both articles provide guidance to LTC facility servicing pharmacies dispensing to NYS Medicaid members for short leaves of absence for the LTC facility. This guidance is to clarify the use of LTC pharmacy utilization of early fill overrides and how it applies to:
- a *new* resident in a facility
- a readmitted resident in a facility for which there is no supply on-hand;
- a NYS Medicaid member with a short leave of absence from the LTC facility; ***and***
- a NYS Medicaid member who was discharged to the community without medication supply.

New Patient*

LTC pharmacies dispensing to NYS Medicaid members who were newly admitted without t heir medications may use the "New Patient Processing" (NP) override when medically necessary and *when all the following conditions are met*:
- the dispensing pharmacy is a LTC servicing pharmacy; ***and***
- the NYS Medicaid member was recently admitted to a Private Skilled Nursing Facility, Public Skilled Nursing Facility, Private Health Related Facility, or Public Health Related Facility, when "NH" returns on eligibility response; ***and***
- the claim denied for "Early Fill Overuse" edits **"01642"** or **"02242"** represents the **first** dispensing of a medication **after the recent admittance** of the NYS Medicaid member to the LTC facility (as described above).

If all conditions above are met, LTC pharmacists may override the "Early Fill Overuse" "01642" or "02242" denials by using a combination of Reason for Service Code "NP" in the National Council for Prescription Drug Programs (NCPDP) field (439-E4) and Submission Clarification Code "18" (LTC Patient Admit/Readmit Indicator).

*Applies to readmitted resident LTC pharmacy claims when the facility confirms there is no medication on hand.

This is an update to previous guidance advising use of Submission Clarification Code **"02"** (Other Override). **Please note:** Day supply will be limited to 30 days unless the medication is subject to short-cycle billing as described in the *Expansion of Guidance for Long-Term Care Pharmacy Providers on Short Cycle Billing of Pharmacy Claims* article published in the November 2021 issue of the *Medicaid Update*. If all three conditions are not met, the billing provider may call the NYS Department of Health (DOH) for assistance.

Submission Clarification Code **"18"** (LTC Patient Admit/Readmit Indicator may not be used when:
- the pharmacy is **not** an LTC-servicing pharmacy; ***or***
- NYS Medicaid member is **not** a resident of a Private Skilled Nursing Facility, Public Skilled Nursing facility, Private Health Related Facility, or Public Health Related Facility, when **"NH" does not** return on eligibility response; ***or***
- the NYS Medicaid member is **not** a **new** resident to the facility; ***or***
- the claim is not the first fill of the prescription for the same drug, strength, and directions by the LTC pharmacy.

Leave of Absence

LTC pharmacies may accommodate a LTC facility request for medication supply for a NYS Medicaid member leaving for a short absence using one of the following options:
- LTC pharmacy relabeling and repackaging dispensed medications for member use during their leave; ***or***
- LTC facility covers the cost for the additional supply of medication needed for the leave of absence; ***or***
- LTC facility prepares for the absence by ensuring the medication supply is filled for a shorter supply before the expected absence.

If the above options are not available, the LTC pharmacy may override the "Early Fill Overuse" denial *when all the following conditions are met*:
- the dispensing pharmacy is a LTC servicing pharmacy; ***and***
- the NYS Medicaid member is a current resident of a Private Skilled Nursing Facility, Public Skilled Nursing Facility, Private Health Related Facility, or Public Health Related Facility, when **"NH"** returns on eligibility response; ***and***
- the claim denied for "Early Fill Overuse" edits **"01642"** or **"02242"**; ***and***
- the claim is limited to a seven-day maximum dispensed supply.

When all conditions above are met, the LTC pharmacy may use a combination of Reason for Service Code (439-E4) "AD" (Additional Drug Needed) and a Submission Clarification Code (420-DK) of "14" (LTC Leave of Absence) to override the "Early Fill Overuse" edit.

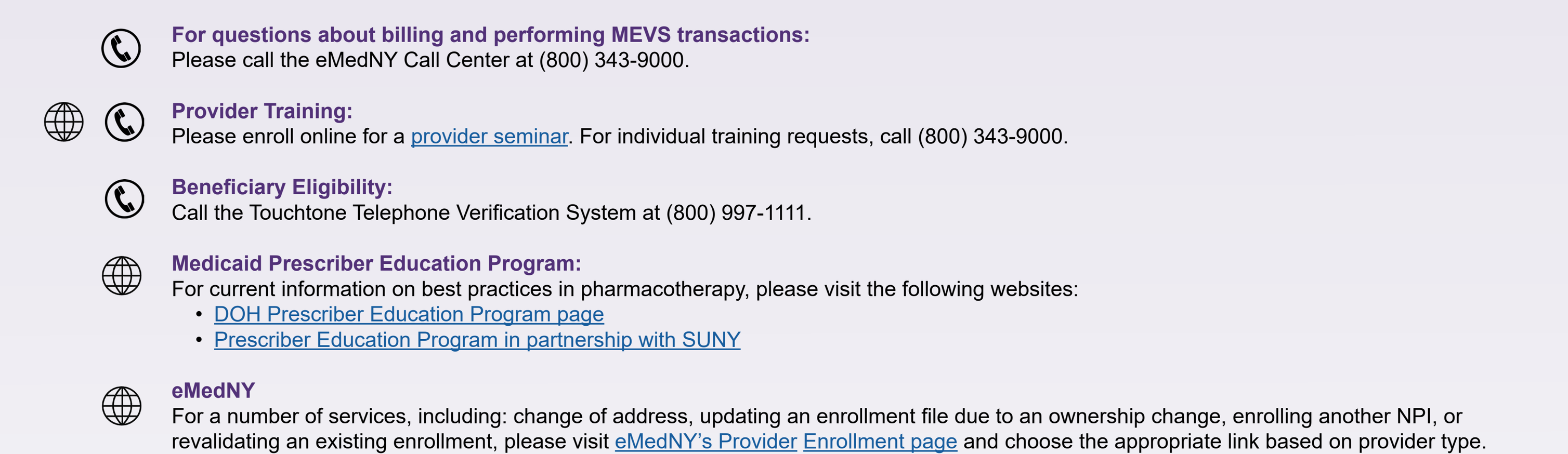
When using the LTC Leave of Absence override, it is expected that the next regular fill date for the NYS Medicaid member will be later to account for the extra supply the NYS Medicaid member received for the leave. The pharmacy must maintain documentation retrievable upon audit of the use of the override, including but not limited to, the request of the facility for leave of absence supply for their resident member. **LTC pharmacies** may contact the NYS DOH for assistance when the above options are not available, and all conditions shown above are not met. **Community pharmacies** should continue to contact the NYS DOH for assistance with "Early Fill Overuse" denials for NYS Medicaid members recently discharged from a LTC facility without their medication. **Please note: The use of the above override codes will continue to be monitored by the NYS DOH.**

All provider submitted claims must be true, accurate, medically necessary, and comply with the rules, regulations, and official directives of the NYS DOH as detailed in Title 18 New York Codes, Rules and Regulations (NYCRR) §504.3(e), (h), and (i). Unauthorized use of any override may result in audit and recovery of payment.

Reminder: When there are discontinued medications, missed doses, patient transfers or patient discharges in LTC facilities, the **"NH"** will have "unused" medications on hand. These "unused" medications should be returned to the dispensing/vendor pharmacy for credit to the NYS Medicaid program as regulated by Title 10 NYCRR §415.18 (f) and NYS Public Health Law (PHL) §2803-e, *in a timely manner*. **Medications that are not discounted should be provided whenever possible to the discharged or transferred NYS Medicaid member to minimize waste and to avoid next fill billing issues.** LTC facilities and their pharmacies are encouraged to review their protocols to ensure any waste is at a minimized and all legal and regulatory requirements are met.

Questions and Additional Information:
- For assistance with performing a permitted override, contact the eMedNY Call Center at (800) 343-9000.
- Questions regarding this policy, exceptions, or considerations, as stated above, should be directed to the NYS Medicaid Pharmacy Unit by email at (518) 486-3209 or by telephone at NYRx@health.ny.gov.

↑Back to Top



Office of the Medicaid Inspector General:
For suspected fraud, waste or abuse complaints/allegations, call 1-877-87FRAUD, (877) 873-7283, or visit Office of Medicaid Inspector General (OMIG) web site.

Provider Manuals/Companion Guides, Enrollment Information/Forms/Training Schedules:
Please visit the eMedNY website.

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).

For questions about billing and performing MEVS transactions:
Please call the eMedNY Call Center at (800) 343-9000.

Provider Training:
Please enroll online for a provider seminar. For individual training requests, call (800) 343-9000.

Beneficiary 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:
- DOH Prescriber Education Program page
- Prescriber Education Program in partnership with SUNY

eMedNY
For a number of services, including: change of address, updating an enrollment file due to an ownership change, enrolling another NPI, or revalidating an existing enrollment, please visit eMedNY's Provider Enrollment page and choose the appropriate link based on provider type.

Comments and Suggestions Regarding This Publication
Please contact the editor, Angela Lince, at medicaidupdate@health.ny.gov.

↑Back to Top

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

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