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# New York State Medicaid Update

THE OFFICIAL NEWSLETTER OF THE NEW YORK MEDICAID PROGRAM

## Colorectal Cancer Screening Importance

All adults aged 50 and older should be screened for colorectal cancer. Research indicates that the willingness of patients to utilize colorectal cancer screening tests depends on multiple factors, including individual disease risk, personal preference, and physician recommendation.<sup>(1)</sup> Physicians are encouraged to discuss the importance of colorectal cancer screening tests with their patients so they are made aware of these preventive services.



Colorectal cancer is the third most common cancer diagnosed in men and women in the United States, excluding skin cancers, and the third leading cause of cancer-related deaths in New York State. Approximately 10,000 new cases of colorectal cancer are diagnosed each year in New York State, and 3,500 men and women annually die from the disease.

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 (USPSTF) recommends that average-risk men and women begin regular colorectal cancer screening at age 50 with any of three tests: a high sensitivity, multi-slide fecal occult blood test (FOBT) every year; a flexible sigmoidoscopy every five years; or a colonoscopy every 10 years.<sup>(2,3)</sup> Patients with a personal or family history of colorectal cancer, history of intestinal polyps or inflammatory bowel disease, and people with a history of certain inherited diseases such as familial adenomatous polyposis and hereditary nonpolyposis colon cancer are at increased risk and may need to begin regular screening earlier. – continued on page 3 –



## APRIL 2011 MEDICAID UPDATE

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### **Sign up today and join the eMedNY LISTSERV®**

New York State Medicaid has developed and implemented a LISTSERV® system that allows providers, vendors and other partners to instantly receive eMedNY related information and notifications. The LISTSERV® email system runs on a free, wide-open platform and enrolling is as simple as visiting [www.emedny.org](http://www.emedny.org). Any number of individuals in your office may sign up for this free service. Questions? Please contact the eMedNY Call Center at (800) 343-9000.



## Colorectal Cancer Screening Importance (continued)

The five-year survival rate for persons who received a diagnosis of localized colorectal cancer is 91 percent, compared with 70 percent for regional-stage cancer and 11 percent for distant-stage cancer.<sup>(4)</sup> Colorectal cancer screening tests have been proven to reduce mortality through detection of early-stage cancer and detection of adenomatous polyps before they progress into cancer.<sup>(2,5)</sup>

The New York State Department of Health Cancer Services Program (CSP) oversees the delivery of guideline-concordant, comprehensive breast, cervical, and colorectal cancer screening services to eligible New Yorkers in every county and borough in the state. Men and women who are uninsured or underinsured for these screening services may contact their local CSP to find out how to get free colorectal, breast and cervical cancer screening. Screening tests are also often covered by Medicare and most health insurance plans.

Please contact 1-866-442-CANCER (2262) to locate a Cancer Services Program in your community.

Information about the CSP can be found online at: <http://www.health.ny.gov/diseases/cancer/services/> and information about colorectal cancer can be found at: [www.cdc.gov/cancer/colorectal/](http://www.cdc.gov/cancer/colorectal/).

### References:

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3. U.S. Preventive Services Task Force. Screening for colorectal cancer: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med* 2008;149:627--37.
4. Horner MJ, Ries LAG, Krapcho M, et al. SEER cancer statistics review 1975--2006. Bethesda, MD: National Cancer Institute; 2009. Available at [http://seer.cancer.gov/csr/1975\\_2006](http://seer.cancer.gov/csr/1975_2006).
5. Smith RA, Cokkinides V, Brooks D, Saslow D, Brawley OW. Cancer screening in the United States, 2010: a review of current American Cancer Society guidelines and issues in cancer screening. *CA Cancer J Clin* 2010;60:99--119.



# Mandatory Medicaid Managed Care Expanding To Delaware and Franklin Counties

**Effective May 1, 2011**, managed care enrollment will be required for most Medicaid beneficiaries residing in **Delaware and Franklin** counties. Once a mandatory managed care program is implemented in a county, it is expected that the enrollment of all eligible Medicaid beneficiaries will take up to 18 months to complete.

Providers should check the Medicaid Eligibility Verification System (MEVS) prior to rendering services to determine Medicaid eligibility and the conditions of Medicaid coverage. Providers are strongly encouraged to check eligibility at each visit as eligibility and enrollment status may change at any time. If the Medicaid beneficiary is enrolled in a Medicaid managed care plan, the first coverage message will indicate "Managed Care Coordinator" or "Eligible PCP" (depending on the device used).



MEVS will identify the scope of benefits a Medicaid beneficiary's Medicaid managed care organization provides through specific coverage codes. When using a touch-tone telephone, you will hear the "Description" of each covered service. When using either the Point of Service (POS) or ePACES, the "coverage codes" will be displayed. If the message "All" appears, all services will be covered. ***Medicaid will not reimburse a provider on a fee-for-service basis if MEVS indicates that the service is covered by the plan.***

The Department will implement substantial changes to Medicaid processes effective July 21, 2011, that will change the messages that providers will receive when checking eligibility, including messages concerning covered services. For more information, please see the February 2011 Special Edition Medicaid Update article at: [http://health.ny.gov/health\\_care/medicaid/program/update/2011/2011-2\\_special\\_edition.htm](http://health.ny.gov/health_care/medicaid/program/update/2011/2011-2_special_edition.htm).

Providers may call the eMedNY Call Center at (800) 343-9000 with any Medicaid billing issues. Medicaid beneficiaries may contact their local department of social services to learn more about managed care. For additional information on managed care covered services and managed care plan types, please see the December 2010 Medicaid Update article entitled "Managed Care Covered Services" at: [http://health.ny.gov/health\\_care/medicaid/program/update/2010/2010-12.htm](http://health.ny.gov/health_care/medicaid/program/update/2010/2010-12.htm).

Questions? Please contact the Division of Managed Care, Bureau of Program Planning and Implementation at (518) 473-1134.



# **Genetic Counselors Must Submit National Provider Identifier (NPI) on Medicaid Claims**

Effective January 1, 2011, Medicaid began coverage for genetic counseling when provided by a certified or credentialed genetic counselor. Genetic counselors must be certified by the American Board of Genetic Counseling (ABGC), the American Board of Medical Genetics (ABMG), or be an advanced practice nurse in genetics (APNG), who is credentialed by the Genetic Nursing Credentialing Commission (GNCC).

***Note: The individual genetic counselor's NPI must be provided on the Medicaid claim in the servicing provider field for the claim to be reimbursed.***

Genetic counselors can obtain information on the NPI application process from the Centers for Medicare and Medicaid Services (CMS) website at: [https://www.cms.gov/NationalProvIdentStand/03\\_apply.asp](https://www.cms.gov/NationalProvIdentStand/03_apply.asp).

For specific policy guidelines regarding Medicaid coverage for genetic counseling services, please refer to the December 2010 Medicaid Update, available at:

[http://www.health.state.ny.us/health\\_care/medicaid/program/update/2010/dec10mu.pdf](http://www.health.state.ny.us/health_care/medicaid/program/update/2010/dec10mu.pdf)

If you have questions regarding billing and claims submission, please contact the eMedNY Call Center at (800) 343-9000.

Questions regarding Medicaid Policy for genetic counseling? Contact the Division of Financial Planning and Policy at (518) 473-2160.



## **POLICY & BILLING GUIDANCE**

# **Physician Enrollment Update**

**Effective May 2, 2011**, eMedNY Form 4084 will no longer be accepted for physicians enrolling in New York State Medicaid fee-for-service. Physicians must use eMedNY Form 4086 after May 1, 2011.

Also, physicians must complete the standardized CAQH UPD® application on the CAQH website at: [www.upd.caqh.org/oas/](http://www.upd.caqh.org/oas/).

For additional practitioner enrollment information (i.e., dentist, nurse practitioner, etc.) or changes to existing enrolled physician information, please continue to use the enrollment applications and forms available at: [www.eMedNY.org](http://www.eMedNY.org).

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

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# **New Provider Enrollment and Screening Regulations**

On March 25, 2011, new Federal Rules and Regulations surrounding provider screening and enrollment took effect. For additional information regarding the changes to the enrollment process, please visit the Provider Enrollment section at [www.eMedNY.org](http://www.eMedNY.org) or reference the Federal Register 42 CFR Parts 405, 424, 447 et al. for the complete set of rules and regulations. Outlined below are some of the changes:

- *All ordering or referring physicians or other professionals providing services under the state plan or under a waiver of the plan must be enrolled as participating providers.*
- *Additional screening may be required for your provider type. To ensure compliance with the new Federal Rules and Regulations, please complete the most current version of the enrollment application. If your enrollment form is not available at: [www.eMedNY.org](http://www.eMedNY.org), please contact the Rate Based Provider Bureau at (518) 474-3575, Option #8.*
- *Some provider types may require an application fee. This information will be contained in the specific enrollment applications. To ensure compliance with the new Federal Rules and Regulations, please complete the most current version of the enrollment application.*
- *Revalidation of enrollment of all providers will occur at least every five years.*
- *Medicare award letters will be required for enrolling Physical Therapists and Physical Therapy Groups.*

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



# **Managed Care Program Provider Access and Availability**

Providers who contract with Medicaid managed care and Family Health Plus (FHPlus) plans must meet specific appointment and availability standards to ensure that enrolled members have appropriate access to necessary health care. New York State annually conducts surveys of managed care providers to evaluate compliance with the following appointment availability standards:

- *Emergency care immediately upon presentation at a service delivery site;*
- *Routine appointments within four weeks of a request;*
- *Urgent care within twenty-four hours of a request;*
- *Non-urgent "sick" visits within forty-eight to seventy-two hours of a request, as clinically indicated;*
- *Prenatal care:*
  - *an initial prenatal visit within three weeks during the first trimester;*
  - *within two weeks during the second trimester and within one (1) week during the third trimester;*
- *Initial office visit for newborns within two weeks of hospital discharge;*
- *Specialist referrals (not urgent) within four to six weeks of a request;*
- *Adult baseline and routine physicals within twelve weeks from enrollment (adults >21 years);*
- *Well child care within four weeks of a request;*
- *Initial family planning visit within two weeks of a request; and,*
- *Members must have after hour access to a live voice.*

Providers should not require that members submit a copy of their medical record, complete a health screening questionnaire or meet with a social worker as a prerequisite to scheduling an appointment. These requirements may serve as barriers to accessing health care services. To facilitate access to care, providers are strongly encouraged to schedule the appointment and use that opportunity to work with the member to obtain the medical record or to complete the health screening.

The Department values the participation of all providers in the managed care program and encourages providers to work closely with their staff and contracted health plans in an attempt to meet the above appointment and availability standards.





► *This article serves as an update to the NYS Department of Health's (NYSDOH) implementation of the SPARCS Expanded Outpatient Data Collection program.*

# **SPARCS Expanded Outpatient Data Collection Program Update**

On April 12, 2006, Section 2816(2)(a)(iv) of the Public Health Law was amended to authorize the collection of outpatient clinic data from all licensed Article 28 general hospitals and diagnostic and treatment centers (D&TCs) operating in New York State.

The Department expanded the collection of SPARCS outpatient clinic visit data to support the accuracy of Medicaid claims data, capture pertinent data needed to determine compliance with federal requirements for Disproportionate Share Hospital (DSH) payments, provide benchmarking capabilities for the state's ambulatory care reimbursement system (APG), and ensure that the Department is using the most complete data available for calculating the Upper Payment Limit (UPL) demonstrations for the Centers for Medicare and Medicaid Services (CMS). Incomplete and inaccurate data in UPL calculations may result in the inability to meet this critical test and a possible reduction of federal financial participation for all Medicaid outpatient services.

To take advantage of existing data submission capabilities and since there are a large number of providers that perform outpatient services, the collection of the new data will gradually be phased-in. Since hospitals have mature data reporting systems in place, the first phase, beginning in July 2011, will focus on data collected from hospital outpatient departments.

The second phase, likely to begin in January 2013, will include those providers of outpatient services that are affiliated with a hospital that already report data to SPARCS. In light of this affiliation, the Department wants to make certain that affected hospitals are aware they are responsible for ensuring that clinic sites under their umbrella have the necessary technologies to provide the required expanded outpatient data to SPARCS.

The third phase, currently with no established implementation time frame, will include those non-hospital affiliated sites (D&TCs) not currently required to report to SPARCS. These facilities must become equipped with the necessary technologies to provide the required expanded outpatient data to SPARCS. The phase-in should allow sufficient time to develop an appropriate data reporting methodology and infrastructure.

In addition to this update, facilities may be notified of this requirement by SPARCS personnel, webinars, and their respective trade associations.

Please visit the Department of Health website at: <http://www.health.ny.gov/statistics/sparcs/> for information concerning implementation time frames, system requirements and information on downloading the SPARCS-837 Software and User Guide.

**Questions?** Contact Charles Fontenot at (518) 473-8822 or Laura Dellehunt at (518) 473-8144.





# Final Cycle for 1.1% Reduction and Delayed Remittance Check

The final 2010-11 State Budget required across the board reductions to Medicaid reimbursements with dates of service on and after September 16, 2010, and was scheduled to end for payments made by March 31, 2011. Billing cycle 1750 (check dated March 7, 2011, released March 23, 2011) is the final cycle in which the FMAP 1.1% contingency reduction was applied.

Additionally, remittance checks originally slated to be released on March 30, 2011, were held and released on April 1, 2011, and should not reflect the FMAP 1.1% reduction. However, if any portion of this cycle was inadvertently processed with the reduction applied, restoration will be made to all affected providers.

Please email your questions to: [b1191@health.state.ny.us](mailto:b1191@health.state.ny.us). Please include your provider name and National Provider Identifier (NPI) in your email.



# Expansion of Smoking Cessation Counseling to ALL Medicaid Beneficiaries

Effective April 1, 2011, Medicaid expanded coverage of smoking cessation counseling (SCC) to ALL Medicaid beneficiaries. Each Medicaid beneficiary will be allowed six counseling sessions during any 12 continuous months which must be provided on a face-to-face basis. Smoking cessation counseling complements the use of prescription and non-prescription smoking cessation products. These products are also covered by Medicaid.



**Smoking cessation counseling services is reimbursable when provided by the following provider types:**

- *Office-based practitioners (physicians, registered nurse practitioners [RNP], and licensed midwives [LM]); and*
- *Article 28 hospital outpatient departments (OPD), free-standing diagnostic and treatment centers (D&TC) and federally qualified health centers (FQHC) including FQHC school based health centers (SBHC) that bill using Ambulatory Patient Groups (APGs).*

**Reimbursement for smoking cessation counseling (SCC) must meet the following criteria:**

- *SCC must be provided face-to-face by a physician, registered physician assistant, registered nurse practitioner (RNP), or licensed midwife (LM) either with or without an Evaluation and Management procedure code.*
- *SCC may take place during individual or group counseling sessions. Group sessions will be reimbursable effective June 1, 2011, for office-based practitioners and July 1, 2011, for Article 28 clinics.*
- *Each Medicaid beneficiary will be allowed six counseling sessions during any 12 continuous months; including any combination of individual or group counseling sessions.*
- *Claims for SCC must include the appropriate SCC CPT Procedure Code. Only one procedure code per day may be billed.*
- **99406** – *Intermediate SCC, 3 to 10 minutes (billable ONLY as an individual session) OR*
- **99407** – *Intensive SCC, greater than 10 minutes (billable as an individual or group session; using the 'HQ' modifier to indicate a group SCC session, up to eight patients in a group).*
- *Claims must include ICD-9-CM diagnosis code, 305.1 tobacco use disorder.*

-continued on next page-



# POLICY & BILLING GUIDANCE

## Expansion of Smoking Cessation Counseling to ALL Medicaid Beneficiaries *(continued)*

Providers should be aware of the following guidelines for smoking cessation counseling:

The Clinical Practice Guideline, “*Treating Tobacco Use and Dependence: 2008 Update*” demonstrated that efficacious treatments for tobacco users exist and should become a part of standard care giving. The guideline recommends that a practitioner should follow the “**5 A’s**” of treating tobacco dependence, which include: **Ask, Advise, Assess, Assist, and Arrange** follow-up. For patients not ready to make a quit attempt, clinicians should use a brief intervention designed to promote the motivation to quit. Content areas that should be addressed can be captured by the “**5 R’s**”: **Relevance, Risks, Rewards, Roadblocks, and Repetition**. Research suggests that the “**5 R’s**” enhance future quit attempts. (Chapter 3 - Clinical Interventions for Tobacco Use and Dependence).

The following links provide further information regarding evidence-based clinical approaches to SCC and pharmacotherapy:

**AHRQ’s Treating Tobacco Use and Dependence Pathfinder--Resources for Clinicians and Consumers** – This site provides the DHHS Public Health Service Clinical Practice Guideline for *Treating Tobacco Use and Dependence: 2008 Update*. (PHSG) and includes evidence-based treatment, provider and patient educational materials. <http://www.ahrq.gov/path/tobacco.htm>.

**Quick Reference Guide for Clinicians** – Here you’ll find the abbreviated version of the PHSG. <http://www.ahrq.gov/clinic/tobacco/tobaqrg.htm>.

**NYS Smokers’ Quitline** – Refer your patients to the NYS Smokers’ Quitline where they can receive free counseling and a two week starter kit of nicotine replacement therapy. Patient and provider education materials and fact sheets are also available. [www.nysmokefree.com](http://www.nysmokefree.com).

**Cessation Centers** – New York State’s 19 Tobacco Cessation Centers provide free training and technical assistance for providers on evidence-based cessation treatment. These free services include, on-site staff training, patient educational materials, information on local cessation programs and assistance with the NYS Smokers’ Quitline – “Fax-to-Quit” program. [http://www.health.state.ny.us/prevention/tobacco\\_control/community\\_partners/tobacco\\_cessation\\_centers.htm](http://www.health.state.ny.us/prevention/tobacco_control/community_partners/tobacco_cessation_centers.htm).

**Smokefree.gov website sponsored by NCI, CDC, and the American Cancer Society** – Provides tobacco users with online cessation support and links to other resources. <http://www.smokefree.gov/>.

Questions? Please call the Division of Financial Planning and Policy at (518) 473-2160.

This article updates information that was previously provided in the December 2009 Medicaid Update.



## ► **ATTENTION PRESCRIBERS AND PHARMACISTS**

# Lost/Stolen Edit Update

**Effective June 1, 2011**, the Medicaid “04” (Lost/Stolen) Submission Clarification Code Field 420-DK **will be denied** when submitting a pharmacy claim. If a Medicaid beneficiary has experienced a loss or theft of medication, pharmacy providers should instruct beneficiaries to contact their prescriber. The decision to honor a beneficiary’s request should be based on the professional judgment of the prescriber.

**In no event will approval be granted for lost or stolen controlled substances.**

Prescribers or their authorized agents may initiate a prior authorization request for a loss or theft of medication by contacting the Bureau of Pharmacy Policy and Operations at (518) 486-3209 for replacement. Approval will **ONLY** be granted for the balance of the medication reported lost or stolen.

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## ► **ATTENTION LONG-TERM CARE PHARMACY PROVIDERS ONLY**

**A newly admitted resident to a long-term care facility is eligible for an early fill on their medication.** When medically necessary, a pharmacist can override edit 01642 “Early Fill Overuse” denial at the point of sale, by using a combination of the NCPDP Reason for Service Code (439-E4) ‘NP’, and a Submission Clarification Code (420-DK) of ‘02’. **Only long term care providers are allowed to use the “02” Submission Clarification Code.** Use of this override code will be monitored by the Department of Health.



## New York State Medicaid Guidelines for Palivizumab (Synagis®) Effective 10/16/11

Palivizumab is an intramuscular injection used as prophylaxis for respiratory syncytial virus (RSV). It is used in certain high-risk infants and children with histories of prematurity (35 weeks or less), chronic lung disease (CLD), or congenital heart disease. RSV is a leading cause of bronchiolitis and pneumonia in infants. Palivizumab is usually administered in five monthly doses throughout the RSV season, typically beginning in November or December. Palivizumab should not be used for the treatment of established RSV disease.

The following guidelines include the major points used to identify infants and children who should be considered for RSV prophylaxis. These guidelines have been adapted from the evidence-based recommendations for the prevention of RSV with palivizumab in children less than two years of age published by the American Academy of Pediatrics (AAP).

<b>GROUP AT RISK</b>	<b>CHRONOLOGICAL AGE LIMITS AND ADDITIONAL CRITERIA</b>	<b>SEASONAL DOSE LIMITS</b>
Chronic Lung Disease of Prematurity requiring treatment within 6 months before start of RSV season	Under 24 months of age at RSV season onset	5 doses per season limit
Hemodynamically significant cyanotic or acyanotic Congenital Heart Disease	24 months of age or younger at RSV season onset	5 doses per season limit
GA ≤ 28 weeks 6 days	Under 12 months of age at RSV season onset	5 doses per season limit
GA 29 weeks 0 days through 31 weeks 6 days	Under 6 months of age at RSV season onset	5 doses per season limit
GA 32 weeks 0 days through 35 weeks 6 days	Under 6 months of age at RSV season onset and meets at least 1 of 2 risk factors: 1. Infant attends childcare/daycare 2. At least one sibling or other child under age 5 years lives permanently in subject’s household	5 doses per season limit
Infants born before 35 weeks of gestation with significant congenital airway abnormalities or neuromuscular condition that compromises handling of respiratory tract secretions	Under 12 months of age at RSV season onset	5 doses per season limit

**References:**

Committee on Infectious Diseases. Modified recommendations for use of Palivizumab for prevention of respiratory syncytial virus infections. *Pediatrics*. 2009 Dec; 124 (6): 1694-1701. Krilov LR, Weiner LB, Yogev R, Fergie J, Katz BZ, Henrickson KJ, and Welliver Sr, RC. The 2009 COID recommendations for RSV Prophylaxis: Issues of efficacy, cost and evidence-based medicine. *Pediatrics*. 2009 Dec; 124 (6):1682-1684. Law BJ, MacDonald N, Langley J, Mitchell I, Stephens D, Wang EEL, Robinson J, Boucher F., McDonald J, Dobson S. Severe respiratory syncytial virus infection among otherwise healthy prematurely born infants: What are we trying to prevent? *Paediatrics and Child Health*. 1998 Nov/Dec; 3(6): 402-404.

# ALL PROVIDERS

## ePACES Training Schedule and Registration

With the July 21, 2011 implementation of changes for HIPAA-compliant electronic submissions, including ePACES, CSC Regional Representatives will be scheduling educational sessions to demonstrate the ePACES changes. These sessions will be scheduled statewide and will begin in June 2011 and continue throughout the summer.

The general format of ePACES will not change. However, the following items represent some of the changes that will occur in ePACES:

- ***Addition of some new fields and the deletion of some current fields;***
- ***Changes in the location of some fields within the claim section as well as in other ePACES functions ( Prior Approval, Eligibility, DVS, etc);***
- ***Rules for completing the Other Payer screen and Service Line Claim Adjustment section (Coordination of Benefits);***
- ***Service Authorization function will be removed;***
- ***Significant changes will be made to eligibility inquiry response messages.***



**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***

Fast and easy seminar registration, locations, and dates will soon be available on the eMedNY website at: <http://www.emedny.org/training/index.aspx>.

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.

For providers who can't attend an instructor-led session, CSC will offer web meetings and will be posting demonstrations of the ePACES changes on [www.emedny.org](http://www.emedny.org) prior to the July 21 implementation date.

***CSC Regional Representatives look forward to meeting with you at upcoming seminars!***

# 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](http://www.omig.ny.gov).

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

Please visit the eMedNY Web site at: [www.emedny.org](http://www.emedny.org).

## 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 email: [emednyproviderrelations@csc.com](mailto:emednyproviderrelations@csc.com).

## Enrollee Eligibility:

Call the Touchtone Telephone Verification System at any of the following numbers:  
(800) 997-1111, (800) 225-3040, (800) 394-1234.

## 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.

## Comments and Suggestions Regarding This Publication?

Please contact the editor, Kelli Kudlack, at: [medicaidupdate@health.state.ny.us](mailto:medicaidupdate@health.state.ny.us).

Do you suspect that a Medicaid provider or beneficiary has engaged in fraudulent activities?

PLEASE CALL: 1-877-87FRAUD

Your call will remain confidential. You may also complete a complaint form online at: [www.omig.ny.gov](http://www.omig.ny.gov).

