



# Medicaid Update

The Official Newsletter of the New York State Medicaid Program

February 2019  
Volume 35 | Number 2

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## Special Edition

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### Expansion of Telehealth

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#### A. General Information

Pursuant to New York State (NYS) Public Health Law (PHL) Article 29-G, as recently amended, and Social Services Law (SSL) Section 367-u, NYS Medicaid has expanded coverage of telehealth services to include:

1. additional originating and distant sites;
2. additional telehealth applications (store-and-forward technology, and remote patient monitoring); and
3. additional practitioner types.

This article outlines NYS Medicaid's updated telehealth coverage and reimbursement policy. The following information applies to Article 28 facilities and private practitioners. The Office of Mental Health (OMH), the Office for People with Developmental Disabilities (OPWDD), and the Office of Alcoholism and Substance Abuse Services (OASAS) are publishing separate guidance on telehealth and regulations that will align with state law and Medicaid payment policy for Medicaid enrollees being served under their authority. Additional guidance on specialty consultations for OMH, OPWDD, and OASAS members will be forthcoming. This policy is effective January 1, 2019 for Medicaid Fee-for-Service (FFS) and March 1, 2019 for Medicaid Managed Care (MMC) plans. Nothing precludes implementation by the MMC Plans prior to January 1, 2019.

#### Definition of Telehealth

**Telehealth** is defined as the use of electronic information and communication technologies to deliver health care to patients at a distance. Medicaid covered services provided via telehealth include assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a Medicaid member. Telephone conversations, e-mail or text messages, and facsimile transmissions between a practitioner and a Medicaid member or between two practitioners are not considered telehealth services and are not covered by Medicaid when provided as standalone services. Remote consultations between practitioners, without a Medicaid member present, including for the purposes of teaching or skill building, are not considered telehealth and are not reimbursable. The acquisition, installation and maintenance of telecommunication devices or systems is not reimbursable.

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

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## A. General Information (continued)

While NYS Medicaid has expanded coverage of telehealth services, such telehealth services should not be used by a provider if they may result in any reduction to the quality of care required to be provided to a Medicaid member or if such service could adversely impact the member. Telehealth is designed to improve access to needed services and to improve member health. Telehealth is not available solely for the convenience of the practitioner when a face-to-face visit is more appropriate and/or preferred by the member.

### Originating Site

The **originating site** is where the member is located at the time health care services are delivered to him/her by means of telehealth. The originating site must be located within the fifty United States or United States' territories. Originating sites previously included facilities licensed under Article 28 (general hospitals, nursing homes, and diagnostic and treatment centers) and private physician's or dentist's offices located within the state of New York.

Since the last article on telehealth was published in the [March 2015 Medicaid Update](#), several originating sites have been added. The list now reads as follows:

1. Facilities licensed under Article 28 of the PHL (general hospitals, nursing homes, and diagnostic and treatment centers);
2. Facilities licensed under Article 40 of the PHL (hospice programs);
3. Facilities as defined in Subdivision 6 of Section 1.03 of the Mental Hygiene Law (MHL) (includes clinics certified under Articles 16, 31 and 32);
4. Certified and non-certified day and residential programs funded or operated by OPWDD;
5. Private physician's or dentist's offices located within the state of New York;
6. Any type of adult care facility licensed under Title 2 of Article 7 of the SSL;
7. Public, private and charter elementary and secondary schools located within the state of New York;
8. School-age child care programs located within the state of New York;
9. Child daycare centers located within the state of New York; and
10. The member's place of residence located within the state of New York or other temporary location within or outside the state of New York.

### Distant Site

The **distant site** is any secure location within the fifty United States or United States' territories where the telehealth provider is located while delivering health care services by means of telehealth. Services provided by means of telehealth must be in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and all other relevant laws and regulations governing confidentiality, privacy, and consent (including, but not limited to 45 CFR Parts 160 and 164 [HIPAA Security Rules]; 42 CFR Part 2; PHL Article 27-F; and MHL Section 33.13).

## **B. Telehealth Applications (Telemedicine, Store-and-Forward, Remote Patient Monitoring)**

NYS Medicaid has covered both remote patient monitoring provided by Certified Home Health Agencies (CHHAs) for their patients and telemedicine for a number of years. At this time, NYS Medicaid is expanding coverage of telehealth to include store-and-forward technology, additional originating sites, and additional practitioners.

### **Telemedicine**

**Telemedicine** uses two-way electronic audio-visual communications to deliver clinical health care services to a patient at an originating site by a telehealth provider located at a distant site. The totality of the communication of information exchanged between the physician or other qualified health care practitioner and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via face-to-face interaction.

### **Store-and-Forward Technology**

**Store-and-forward technology** involves the asynchronous, electronic transmission of a member's health information in the form of patient-specific pre-recorded videos and/or digital images from a provider at an originating site to a telehealth provider at a distant site.

1. Store-and-forward technology aids in diagnoses when live video or face-to-face contact is not readily available or not necessary.
2. Pre-recorded videos and/or static digital images (e.g., pictures), excluding radiology, must be specific to the member's condition as well as be adequate for rendering or confirming a diagnosis or a plan of treatment.

### **Remote Patient Monitoring**

**Remote patient monitoring (RPM)** uses digital technologies to collect medical data and other personal health information from members in one location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations. Monitoring programs can collect a wide range of health data from the point of care, such as vital signs, blood pressure, heart rate, weight, blood sugar, blood oxygen levels and electrocardiogram readings. RPM may include follow-up on previously transmitted data conducted through communication technologies or by telephone. Follow-up is included in the monthly time component (see Application-Specific Telehealth Billing Rules).

The following considerations apply to RPM:

1. Medical conditions that may be treated/monitored by means of RPM include, but are not limited to, congestive heart failure, diabetes, chronic obstructive pulmonary disease, wound care, polypharmacy, mental or behavioral problems, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding.
2. RPM must be ordered and billed by a physician, nurse practitioner or midwife, with whom the member has or has entered into a substantial and ongoing relationship. RPM can also be provided and billed by an Article-28 clinic, when ordered by one of the previously mentioned qualified practitioners.
3. Members must be seen in-person by their practitioner, as needed, for follow-up care.

4. RPM must be medically necessary and shall be discontinued when the member's condition is determined to be stable/controlled.
5. Payment for RPM while a member is receiving home health services through a Certified Home Health Agency (CHHA) is pursuant to PHL Section 3614 (3-c)(a) – (d) and will only be made to that same CHHA.

## **C. Telehealth Providers**

**This Medicaid Update article addresses the telehealth payment policy for the following provider types:**

1. Physicians;
2. Physician assistants;
3. Dentists;
4. Nurse practitioners;
5. Registered professional nurses (only when such nurse is receiving patient- specific health information or medical data at a distant site by means of RPM);
6. Podiatrists;
7. Optometrists;
8. Psychologists;
9. Social workers;
10. Speech language pathologists;
11. Audiologists;
12. Midwives;
13. Physical therapists;
14. Occupational therapists;
15. Certified diabetes educators;
16. Certified asthma educators;
17. Genetic counselors;
18. Credentialed alcoholism and substance abuse counselors (CASAC) credentialed by OASAS or by a credentialing entity approved by such office pursuant to Section 19.07 of the MHL;
19. Providers authorized to provide services and service coordination under the Early Intervention (EI) Program pursuant to Article 25 of PHL (Note: The EI Program will issue program-specific guidance regarding the use of and reimbursement for EI services delivered via telehealth.)
20. Hospitals licensed under Article 28 of PHL, including residential health care facilities serving special needs populations;
21. Home care services agencies licensed under Article 36 of PHL;
22. Hospices licensed under Article 40 of PHL;

**Regulations will be forthcoming and will address telehealth payment policy for the following provider types:**

23. Clinics licensed or certified under Article 16 of the MHL;
24. Certified and non-certified day and residential programs funded or operated by the OPWDD; and
25. Any other provider as determined by the Commissioner of Health pursuant to regulation or in consultation with the Commissioner, by the Commissioner of OMH, the Commissioner of OASAS, or the Commissioner of OPWDD pursuant to regulation.

**The following applies to practitioners providing services via telehealth:**

1. Practitioners providing services via telehealth must be licensed or certified, currently registered in accordance with NYS Education Law or other applicable law, and enrolled in NYS Medicaid.
2. Telehealth services must be delivered by providers acting within their scope of practice.
3. Reimbursement will be made in accordance with existing Medicaid policy related to supervision and billing rules and requirements.
4. When services are provided by an Article 28 facility, the telehealth practitioner must be credentialed and privileged at both the originating and distant sites in accordance with Section 2805-u of PHL. The law can be viewed at the following link: <http://public.leginfo.state.ny.us/lawssrch.cgi?NVLWO> (Select LAWS; select PBH; select Article 28; select 2805u)

## **D. Confidentiality**

All services delivered via telehealth must be performed on dedicated secure transmission linkages that meet the minimum federal and state requirements, including but not limited to: 45 CFR Parts 160 and 164 (HIPAA Security Rules); 42 CFR, Part 2; PHL Article 27-F; and MHL Section 33.13. Transmissions must employ acceptable authentication and identification procedures by both the sender and the receiver. Additionally:

1. HIPAA requires that a written "business associate agreement" (BAA), or contract that provides for privacy and security of protected health information (PHI) be in place between the telehealth provider and the supporting telehealth vendor.
2. Privacy must be maintained during all patient-practitioner interactions.
3. All existing confidentiality requirements that apply to medical records (including, but not limited to: 45 CFR Part 160 and 164; 42 CFR Part 2; PHL Article 27-F, and MHL Section 33.13) shall apply to services delivered by telehealth, including the actual transmission of service, any recordings made during the telehealth encounter, and any other electronic records.

## **E. Patient Rights and Consents**

The practitioner shall provide the member with basic information about the services that he/she will be receiving via telehealth and the member shall provide his/her consent to participate in services utilizing this technology. Telehealth sessions/services shall not be recorded without the member's consent. Culturally competent translation and/or interpretation services must be provided when the member and distant practitioner do not speak the same language. If the member is receiving ongoing treatment via telehealth, the member must be informed of the following patient rights policies at the initial encounter.

Documentation in the medical record must reflect that the member was made aware of the policies outlined below.

Patient rights policies must ensure that members receiving telehealth services:

1. Have the right to refuse to participate in services delivered via telehealth and must be made aware of alternatives and potential drawbacks of participating in a telehealth visit versus a face-to-face visit;
2. Are informed and made aware of the role of the practitioner at the distant site, as well as qualified professional staff at the originating site who are going to be responsible for follow-up or ongoing care;
3. Are informed and made aware of the location of the distant site and all questions regarding the equipment, the technology, etc., are addressed;
4. Have the right to have appropriately trained staff immediately available to them while receiving the telehealth service to attend to emergencies or other needs;
5. Have the right to be informed of all parties who will be present at each end of the telehealth transmission; and
6. Have the right to select another provider and be notified that by selecting another provider, there could be a delay in service and the potential need to travel for a face-to-face visit.

## F. Failure of Transmission

All telehealth providers must have a written procedure detailing a contingency plan in the case of a failure of transmission or other technical difficulty that renders the service undeliverable via telehealth. Policies and procedures must be available upon audit. If the service is undelivered due to a failure of transmission or other technical difficulty, a claim should not be submitted to Medicaid.

## G. Billing Rules for Telehealth Services

### 1. Modifiers to be Used When Billing for Telehealth Services

Modifier	Description	Note/Example
95	Synchronous telemedicine service rendered via real-time interactive audio and video telecommunication system	Note: Modifier 95 may only be appended to the specific services covered by Medicaid and listed in Appendix P of the AMA's CPT Professional Edition 2018 Codebook. The CPT codes listed in Appendix P are for services that are typically performed face-to-face but may be rendered via a real-time (synchronous) interactive audio-visual telecommunication system.
GT	Via interactive audio and video telecommunication systems	Note: Modifier GT is only for use with those services provided via synchronous telemedicine for which modifier 95 cannot be used.
GQ	Via asynchronous telecommunications system	Note: Modifier GQ is for use with Store-and-Forward technology

25	Significant, separately identifiable evaluation & management (E&M) service by the same physician or other qualified health care professional on the same day as a procedure or other service	Example: The member has a psychiatric consultation via telemedicine on the same day as a primary care E&M service at the originating site. The E&M service should be appended with the 25 modifier.
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**2. Place of Service (POS) Code to be Used when Billing for Telehealth Services**

POS Code	Description
02	The location where health services and health-related services are provided or received, through telehealth telecommunication technology. When billing telehealth services, providers must bill with place of service code 02 and continue to bill modifier 95, GT or GQ.

**3. General Billing Guidelines**

Only one clinic payment will be made when both the originating site and the distant site are part of the same provider billing entity. In such cases, only the originating site should bill Medicaid for the telemedicine encounter. The CPT code billed should be appended with the applicable modifier (GT or 95). (e.g., Hospital X has multiple sites for primary and specialty care. A member at one of the primary care sites requires a telemedicine consultation with a specialist located at a distant site within the system of Hospital X.)

For individuals with Medicare and Medicaid, if Medicare covers the telehealth encounter, Medicaid will reimburse the Part B coinsurance and deductible to the extent permitted by state law. If a service is within Medicare's scope of benefits (e.g., physician), but Medicare does not cover the service when provided via telehealth, Medicaid will defer to Medicare's decision and will not cover the telehealth encounter at this time.

**4. Fee-for-Service Billing for Telemedicine by Site and Location**

When services are provided via telemedicine to a member located at an originating site as defined in Section A of this issue, the servicing provider should bill for the telemedicine encounter as if the provider saw the member face-to-face in the office or Article 28 clinic setting using the appropriate billing rules for services rendered. The CPT code for the encounter must be appended with the applicable modifier (95 or GT).

**4-a. Article 28 Clinic Originating Sites Billing Under Ambulatory Patient Groups (APG)**

1. Institutional Component (Originating Site)
  - a. When services are provided via telemedicine to a member located at an Article 28 originating site (outpatient department/clinic, emergency room), the originating site may bill only CPT code Q3014 (*telehealth originating-site facility fee*) through APGs to recoup administrative expenses associated with the telemedicine encounter.

- b. When a separate and distinct medical service, unrelated to the telemedicine encounter, is provided by a qualified practitioner at the originating site, the originating site may bill for the medical service provided in addition to Q3014. The CPT code billed for the separate and distinct service must be appended with the 25 modifier.

## 2. Practitioner (Professional) Component (Originating Site)

- a. When the originating site is an Article 28 hospital (outpatient department/clinic, emergency room) and a physician is onsite assisting or attending to the member during a telemedicine encounter, a physician claim cannot be billed to Medicaid.
- b. When a separate and distinct medical service, unrelated to the reason for the telemedicine encounter, is provided by a physician at the originating site, the physician may bill for the medical service provided. The CPT code billed for the separate and distinct service must be appended with the 25 modifier. The professional component for all practitioner types, other than physicians, is included in the APG payment to the originating-site facility.
- c. When the originating site is an Article 28 free-standing diagnostic and treatment center (DTC), the professional component for all practitioners, including physicians, is included in the APG payment to the facility.

## 4-b. Article 28 Distant Sites Billing Under APGs

### 1. Institutional Component (Distant Site)

- a. When the distant-site practitioner is physically located at the Article 28 distant site, the distant site may bill Medicaid under APGs for the telemedicine encounter using the appropriate CPT code for the service provided. The CPT code must be appended with the applicable modifier (95 or GT). When the distant-site practitioner is not physically located on-site at the Article 28 facility, the distant site cannot submit an APG claim to Medicaid.

### 2. Practitioner (Professional) Component (Distant Site)

- a. When the distant site is an Article 28 hospital outpatient department/clinic and telemedicine services are being provided by a physician, the physician should bill Medicaid using the appropriate CPT code for the service provided appended with the applicable modifier (95). The professional component for all practitioner types, other than physicians, is included the APG payment to the distant-site facility.
- b. When the distant site is an Article 28 free-standing DTC, the professional component for all practitioners, including physicians, is included in the APG payment to the facility.

#### **4-c. Office Setting or Other Secure Location – Billing by Originating and/or Distant-Site Practitioner**

1. Practitioner (Professional) Component (Originating Site)
  - a. When a telemedicine service is being provided by a distant-site practitioner to a member located in a private practitioner's office (originating site), the originating-site practitioner may bill CPT code Q3014 to recoup administrative expenses associated with the telemedicine encounter.
  - b. When a telemedicine service is being provided by a distant-site practitioner to a member located in a private practitioner's office (originating site) and the originating-site practitioner provides a separate and distinct medical service unrelated to the telemedicine encounter, the originating-site practitioner may bill for the medical service provided in addition to Q3014. The CPT code billed for the separate and distinct medical service must be appended with the 25 modifier.
  
2. Practitioner (Professional) Component (Distant Site):
  - a. If the distant-site practitioner is providing services via telemedicine from his/her private office or other secure location, the practitioner should bill the appropriate CPT code for the service provided. The CPT code should be appended with the applicable modifier (95 or GT).

#### **4-d. Hospital Inpatient**

When a telemedicine consult is being provided by a distant-site physician to a member who is an inpatient in the hospital, payment for the telemedicine encounter may be billed by the distant-site physician. Other than physician services, all other practitioner services are included in the APR-DRG payment to the facility.

#### **4-e. Skilled Nursing Facility**

When the telehealth practitioner's services are included in the nursing home's rate, the telehealth practitioner must bill the nursing home. If the telehealth practitioner's services are not included in the nursing home's rate, the telehealth practitioner should bill Medicaid as if he/she saw the member face-to-face. The CPT code billed should be appended with the applicable modifier (95 or GT). Practitioners providing services via telehealth should confirm with the nursing facility whether their services are in the nursing home rate.

#### 4-f. Federally Qualified Health Centers (FQHC)

1. **FQHCs That Have "Opted Into" APGs:** FQHCs that have "opted into" APGs should follow the billing guidance outlined above for sites billing under APGs.
2. **FQHCs That Have Not "Opted Into" APGs - FQHC Originating Sites:**
  - a. When services are provided via telemedicine to a patient located at an FQHC originating site, the originating site may bill only the FQHC offsite services rate code (4012) to recoup administrative expenses associated with the telemedicine encounter.
  - b. When a separate and distinct medical service, unrelated to the telemedicine encounter, is provided by a qualified practitioner at the FQHC originating site, the originating site may bill the Prospective Payment System (PPS) rate in addition to the FQHC offsite services rate code (4012).
  - c. If a provider who is onsite at an FQHC is providing services via telemedicine to a member who is in their place of residence or other temporary location, the FQHC should bill the FQHC off-site services rate code (4012) and report the applicable modifier (95 or GT) on the procedure code line.
  - d. If the FQHC is providing services as a distant site provider, the FQHC may bill their PPS rate.

#### 5. Application-Specific Telehealth Billing Rules

##### Store-and-Forward Technology

1. Reimbursement will be made to the consulting distant-site practitioner.
2. Reimbursement for consultations provided via store-and-forward technology will be paid at 75 percent of the Medicaid fee for the service provided.
3. The consulting distant-site practitioner must provide the requesting originating-site practitioner with a written report of the consultation in order for payment to be made.
4. The consulting practitioner should bill the CPT code for the professional service appended with the telehealth modifier "GQ."

##### Remote Patient Monitoring (RPM)

1. Telehealth services provided by means of RPM should be billed using CPT code **"99091"** (*Collection and interpretation of physiologic data (e.g., Electrocardiography (ECG), blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training and licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days*).
2. A fee of \$48.00 per month will be paid for RPM. To bill for RPM, a minimum of 30 minutes per month must be spent collecting and interpreting the member's RPM data.
3. Providers are not to bill **"99091"** more than one time per member per month.

4. Providers should bill for RPM services on the last day of each month in which RPM is in use.
5. FQHCs that have opted out of APGs are unable to bill for RPM services at this time.

## **6. Medicaid Managed Care Considerations**

1. Medicaid Managed Care (MMC) plans are required to cover, at a minimum, services that are covered by Medicaid fee-for-service and also included in the MMC benefit package, when determined medically necessary.
2. Questions regarding MMC reimbursement and/or billing requirements should be directed to the member's MMC plan.

## **H. Telehealth and Value Based Payments (VBP)**

Value Based Payments (VBP) offer the opportunity to include and promote telehealth services to facilitate practice workflow and efficiency, while increasing member and provider satisfaction. Services delivered via telehealth may be particularly advantageous where access to specialty care, such as psychiatric care, is limited, when the member is unable to travel to the clinic/office due to a medical or behavioral health condition, or where weather significantly impacts continuity of care, as examples. MMC plans and providers should work on ways to bundle telehealth services into VBP contracts to incentivize flexible use of telehealth as part of total cost of care, integrated primary care, and other population-or episode-based arrangements.

## **I. Questions**

1. Medicaid FFS coverage and policy questions may be directed to the Office of Health Insurance Programs (OHIP) Division of Program Development and Management at (518) 473–2160.
2. Medicaid Managed Care (MMC) general coverage questions may be directed to OHIP Division of Health Plan Contracting and Oversight (DHPCO) at [covques@health.ny.gov](mailto:covques@health.ny.gov) or (518) 473-1134.
3. Questions regarding MMC reimbursement and/or billing requirements should be directed to the enrollee's MMC plan.
4. Questions regarding FFS claiming should be directed to the eMedNY Call Center at (800) 343-9000.

## Provider Directory

### Office of the Medicaid Inspector General:

For suspected fraud or abuse complaints/allegations, call 1-877-87FRAUD, (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 website at <https://www.emedny.org/>.

### Providers wishing to listen to the current week's check/EFT amounts:

Please call (866) 307-5549 (available Thursday PM for one week for the current week's amount).

### For 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, please enroll online at <https://www.edmedny.org/training/index.aspx>. 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: [http://www.health.ny.gov/health\\_care/medicaid/program/prescriber\\_education/presc-educationprog](http://www.health.ny.gov/health_care/medicaid/program/prescriber_education/presc-educationprog)

<http://nypep.nysdoh.suny.edu/home>

### 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: <https://www.emedny.org/info/ProviderEnrollment/index.aspx> and choose the appropriate link based on provider type.

### Medicaid Electronic Health Record (EHR) Incentive Program:

Contact the New York Medicaid EHR Call Center at (877) 646-5410.

### Comments and/or suggestions regarding this publication:

Please contact the editor, Georgia Wohnsen, at [medicaidupdate@health.ny.gov](mailto:medicaidupdate@health.ny.gov).