



Medicaid Update

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Medicaid Coverage of Limited Infertility Benefit

Effective October 1, 2019, Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC) benefits will include medically necessary ovulation enhancing drugs and medical services related to prescribing and monitoring the use of such drugs for individuals 21 through 44 years of age experiencing infertility. This applies to MMC plans, including mainstream MMC plans, HIV Special Needs Plans (HIV SNPs), and Health and Recovery Plans (HARPs). FFS and MMC infertility benefits include office visits, hysterosalpingograms, pelvic ultrasounds, blood testing, and ovulation enhancing drugs included in the Medicaid formulary.

The ovulation enhancing drugs included in the Medicaid formulary are bromocriptine, clomiphene citrate, letrozole, and tamoxifen. FFS and MMC infertility benefits will be limited to coverage for three (3) cycles of treatment per lifetime. For Medicaid purposes, infertility is a condition characterized by the incapacity to conceive, defined by the failure to establish a clinical pregnancy after twelve (12) months of regular, unprotected sexual intercourse for individuals 21 through 34 years of age, or after six (6) months for individuals 35 through 44 years of age.

Medicaid FFS claims

Professional and institutional claims submitted to eMedNY for infertility services must include the appropriate infertility diagnosis code and the family planning indicator (“**A4**” condition code on institutional claims or a “**Y**” in the family planning box on professional claims). General billing guidelines can be accessed online at the corresponding link below:

- **Institutional**
https://www.emedny.org/ProviderManuals/AllProviders/General_Billing_Guidelines_Institutional.pdf
- **Professional**
https://www.emedny.org/ProviderManuals/AllProviders/General_Billing_Guidelines_Professional.pdf

Questions:

- 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.
- Medicaid MMC general coverage questions may be directed to OHIP, Division of Health Plan Contracting and Oversight at covques@health.ny.gov or (518) 473–1134.
- MMC reimbursement and/or billing requirements questions may be directed to the enrollee’s MMC plan. An MMC directory by plan can be found on the New York State Department of Health’s web site at: https://www.health.ny.gov/health_care/managed_care/plans/docs/mcp_dir_by_plan.pdf.
- Questions regarding FFS claiming may be directed to the eMedNY Call Center at (800) 343–9000.

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In This Issue...

Medicaid Coverage of Limited Infertility Benefit.....Cover

Policy and Billing

Attention Physicians, Nurse Practitioners, and Ordered Ambulatory Providers: Billing Update for Bacillus Calmette-Guerin Intravesical..... 3
Policy Clarification: Medical Marijuana 4

Pharmacy

Pharmacy Fee-for-Service Billing Guidance: Long Term Care and Foster Care (Child Care) Facilities 5

All Providers

Reminder: Safeguarding Electronic Prescribing Credentials - Practitioner Responsibilities 7
Reminder: Authorized Agents for Prior Authorizations of Prescription Drugs 8
Breastfeeding Grand Rounds 2019: Breastfeeding Recommendations for Women Impacted by Opioid Use Disorder and Infants with Neonatal Abstinence Syndrome 8
2019 Medicaid Managed Care Primary Care Providers, Access and Availability 9
New York Medicaid EHR Incentive Program 10

Provider Directory..... 12

Policy and Billing

Attention Physicians, Nurse Practitioners, and Ordered Ambulatory Providers: Billing Update for Bacillus Calmette-Guerin Intravesical

Effective July 1, 2019, providers billing for Bacillus Calmette-Guerin (BCG) intravesical must use code “**J9030: BCG LIVE INTRAVESICAL, 1 MG**”. Due to the current BCG (intravesical) drug shortage, providers in Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC) can use “**J9030**” to bill for single or multiple patient use of the single-use vial effective for dates of service on or after July 1, 2019.

Providers who opt to treat multiple patients using the single-use vial must adhere to the New York State Department of Health’s Health Advisory: *BCG Live (Intravesical) shortage: Use of single-use vials for multiple patients*, which can be found on the New York Health Commerce System website at: <https://commerce.health.state.ny.us>. In accordance with the Health Advisory, providers practicing in both Article 28 and non-Article 28 locations who will share single-use vials of BCG for multiple patients during this current shortage must take the following precautions:

1. Ensure that written protocols are readily available for all staff who will be involved in the reconstitution, administration, and disposal of BCG and related equipment. Ensure that these written protocols are based on the manufacturer’s instructions and the Center for Disease Control’s (CDC) safe injection practices guidelines except for the restriction on reuse of single-use vials.
2. Ensure that all staff who prepare and administer BCG are doing so within the scope of their professional practice and are supervised by a physician.
3. Ensure that this interim practice of sharing single-use vials of BCG is not allowed for any other medication and ensure that this interim practice does not continue after the shortage is resolved.
4. Ensure that other issues surrounding the practice of using a single-use vial for more than one patient, such as billing/insurance issues, have been adequately addressed.

Fee-for-Service Billing Guidance:

Single patient use

- If the entire single-use vial is administered to a single patient, bill for the entire vial
- If a portion of the single-use vial is administered to a single patient and the remaining drug is discarded, bill for the actual dose administered (per mgs) and for the waste (modifier JW). Please refer to the [May 2016 Medicaid Update](#) article titled “*Updated Guidance and Clarification on Use of the JW Modifier*” for additional information.

Multiple patient use

If a single-use vial is utilized for multiple patients, bill for the actual administered drug (per mgs) **only**.

Payment for drugs furnished by practitioners to their patients is based on the acquisition cost to the practitioner of the drug dose administered to the patient. For all drugs furnished in this fashion, it is expected that the practitioner will maintain auditable records of the actual itemized invoice cost of the drug, including the number of doses of the drug represented on the invoice. Refer to: www.emedny.org for additional information.

Questions:

- 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.
- MMC general coverage questions may be directed to OHIP Division of Health Plan Contracting and Oversight at: covques@health.ny.gov or (518) 473-1134.
- MMC reimbursement and/or billing requirement questions should be directed to the enrollee’s MMC plan.
- FFS claim questions should be directed to the eMedNY call center at (800) 343-9000.
- BCG Single-use vial health advisory questions should be directed to the Department of Health Bureau of Healthcare Associated Infections at: icp@health.ny.gov or (518) 474-1142.

Policy Clarification – Medical Marijuana

Medical marijuana is not a covered benefit under Medicaid. However, practitioner office visits related to patient evaluation and certification for medical marijuana is a Medicaid reimbursable service. New York State Medicaid has reason to believe that providers may be scheduling a follow-up visit solely for certification, and this visit is being billed to the patient on a private pay basis. Patient evaluation and certification for medical marijuana is considered a comprehensive array of services and cannot be fragmented. Payment for the practitioner certification is included in Medicaid’s payment for the office visit. Practitioners are therefore prohibited from requesting payment for medical marijuana certification from the member, regardless whether the certification is provided during the initial office visit or subsequent to the initial visit.

Questions on this matter may be directed to the Division of Program Development and Management, Office of Health Insurance Programs, at 518-473-2160.

Pharmacy

Pharmacy Fee-for-Service Billing Guidance: Long Term Care and Foster Care (Child Care) Facilities

All pharmacy claims included in the rate must be billed to the facility. Information on long term care (LTC) pharmacy claims can be found in the [June 2011 Special Edition Medicaid Update](#). Information regarding Foster Care (FC) pharmacy claims can be found at: https://www.health.ny.gov/health_care/medicaid/program/carveout.htm. The following process is necessary to successfully bill pharmacy claims that are not covered in the rate by identifying and billing the appropriate coverage. Additionally, this guidance must be followed **prior to** sending New York State Medicaid requests for retroactive claim overrides.

Third-Party Liability (TPL) and Medicaid Eligibility Coverage

Determine eligibility coverage by use of **any and all** resources available including:

- The facility billing office;
- Medicaid Eligibility Verification System (MEVS) & TPL (https://www.emedny.org/ProviderManuals/5010/MEVS%20Quick%20Reference%20Guides/5010_MEVS_Methods.pdf); and/or
- ePACES (<https://www.emedny.org/epaces/>).

Providers should check for TPL and eligibility coverage updates **at least twice monthly** following first date of service (DOS). **New York State Medicaid is always the payor of last resort; every effort must be taken to obtain correct billing information.**

If TPL is applicable, providers must bill the third-party insurer first, including commercial plans or Medicare, and bill Medicaid as secondary, if appropriate. Any claim issues must be resolved with the third-party insurer, including prior authorization (PA) requirements, prior to submitting the claim to Medicaid. **Note:** If the primary insurer does not cover a specific medication, Medicaid will not cover the claim. Failure to submit the claim to the third-party insurer will result in denial of the claim by Medicaid.

If the member has Medicare, providers will bill:

- Medicare Part B for Part B covered drugs. Information on Part B covered drugs can be found at: <https://www.medicare.gov/what-medicare-covers/what-part-b-covers>, or
- Medicare Part D for other prescription drugs. Information on Part D covered drugs can be found at: <https://www.medicare.gov/drug-coverage-part-d>.

If the member has Medicare Parts A or B (or both) and does not have Medicare Part D, providers will bill:

- Part D covered claims to Medicare Limited Income Newly Eligible Transition (LINET). Information on LINET can be found at: <https://www.cms.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/MedicareLimitedIncomeNET.html>. *Initiating Medicare Part D enrollment by utilizing LINET at first DOS will facilitate payment of claims.*

Billing Claims That Require Medicaid Prior Authorization (PA)

For members whose active eligibility status began after the date the pharmacy service was provided (retroactive billing):

- If date of notification of eligibility is within 90 days of DOS, call Magellan Health, Inc. at 877-309-9493. Contact can also be made at: <https://newyork.fhsc.com/contactus.asp>.
- If date of notification of eligibility is after 90 days of DOS, LTC/FC facility pharmacies may send the claim information for retro-PA consideration, **within 30 days from the date of notification of eligibility**, to the Medicaid Pharmacy unit at PPNO@health.ny.gov. **All claims submitted for PA after 30 days of eligibility determination will be denied.** Additional information on submitting claims over 90 from DOS

can be found at: https://www.emedny.org/HIPAA/QuickRefDocs/FOD-7001_Sub_Claims_Over_90_days_Old.pdf.

- Any claim submitted with a DOS **after** the date of notification of eligibility will be denied. The claim should have been billed on the DOS.

Reminders:

- **It is the responsibility of the providers, both the facility as well as the pharmacy, to actively and regularly seek TPL enrollment and Medicaid eligibility for their members.**
- It is the pharmacy's responsibility to bill timely and to the appropriate party, which may include the facility, commercial plan, Medicare, or Medicaid. Additional information regarding timely billing can be found at: https://www.emedny.org/ProviderManuals/AllProviders/Guide_to_Timely_Billing.pdf.
- All pharmacies must submit their transactions through the online Prospective Drug Utilization Review (Pro-DUR) program using the National Council for Prescription Drug Programs (NCPDP) transaction format. NCPDP format specifications can be found in the MEVS Manual available at: [https://www.emedny.org/ProviderManuals/5010/MEVS/MEVS_DVS_Provider_Manual_\(5010\).pdf](https://www.emedny.org/ProviderManuals/5010/MEVS/MEVS_DVS_Provider_Manual_(5010).pdf).
- All pharmacy claims are subject to Medicaid Pharmacy Program requirements, including PA and criteria requirements. Additional information on program requirements can be found at: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf.
- Upon claims submission, if the member is determined ineligible, the Pro-DUR transaction will adjudicate. If a PA message is received that states: **"UNABLE TO PROCESS A PHARMACY PA PLEASE CALL MAGELLAN"** the pharmacy should alert the prescriber, at first and every occurrence, to align medication therapy with the Preferred Drug Program (PDP) when appropriate. Additional information on the PDP can be found at: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf. This is the appropriate time to explore non-PA alternatives and facilitate payment. A PA will not be issued by the clinical call center for a patient who is ineligible.
- Original prescriptions must be filled within 60 days (30 days for controlled substances) of prescriber written/order date; a system edit will deny claims beyond this limitation. The same drug/strength/quantity, (i.e., prescription) cannot have more than one prescription number per same written date. **Bypassing the edit by giving a refill a new prescription number and new written date is considered fraudulent billing and subject to audit.**

Data Definitions:

- Eligibility Date – the date that begins active eligibility status.
- Date of Notification of Eligibility – the date eligibility was updated or activated in the Medicaid system.

All Providers

Reminder: Safeguarding Electronic Prescribing Credentials-Practitioner Responsibilities

Pursuant to New York State (NYS) Public Health Law §3302(37), an electronic prescription means “a prescription issued with an electronic signature and transmitted by electronic means in accordance with regulations of the commissioner of health and the commissioner of education and consistent with federal requirements.”

Federal requirements in Title 21 of the Code of Federal Regulation (CFR) §1311.102, Practitioner responsibilities, require that in order to electronically prescribe controlled substances:

(a) The practitioner must retain sole possession of the hard token, where applicable, and must not share the password or other knowledge factor, or biometric information, with any other person. The practitioner must not allow any other person to use the token or enter the knowledge factor or other identification means to sign prescriptions for controlled substances. Failure by the practitioner to secure the hard token, knowledge factor, or biometric information may provide a basis for revocation or suspension of registration pursuant to §304(a)(4) of the Act (21 U.S.C. 824(a)(4)).

(b) The practitioner must notify the individuals designated under §1311.125 or §1311.130 within one business day of discovery that the hard token has been lost, stolen, or compromised or the authentication protocol has been otherwise compromised. A practitioner who fails to comply with this provision may be held responsible for any controlled substance prescriptions written using his two-factor authentication credential.

The Federal Requirements for Electronic Orders and Prescriptions, in full, can be accessed online at: <https://www.deadiversion.usdoj.gov>.

Failure to meet these requirements may be considered an unacceptable practice under Title 18 of the New York Codes, Rules, and Regulations Part 515 (18 NYCRR §515.2). Providers who fail to meet these requirements may be subject to sanction by the Office of the Medicaid Inspector General (OMIG), as defined under Title 18 of the NYCRR §515.3, which may include censure or exclusion from the NYS Medicaid program.

OMIG is an independent office within the New York State Department of Health (DOH). OMIG is responsible for the investigation, detection, and prevention of Medicaid fraud, waste and abuse, including sanctioning providers and recovering overpayments in the Medicaid program.

Applicable NYS laws, regulations, rules and policies of the Medicaid program are set forth in NYS Public Health Law, NYS Social Services Law, the regulations of DOH (Titles 10, 14, and 18 of the NYCRR), DOH’s Medicaid Provider Manuals and *Medicaid Update* publications. Additional information can be found on the OMIG’s website at <https://www.omig.ny.gov>.

Reminder: Authorized Agents for Prior Authorizations of Prescription Drugs

Health care providers are required to complete the prior authorization (PA) process for various reasons, including prescribing a drug for which there is an equally effective lower cost alternative, safety concerns, and/or a potential for inappropriate use. In all cases, prescribers will need to provide their clinical rationale for why the drug should be covered. **Only the prescriber or the authorized agent** may initiate the PA request for both Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC) Plans. PA requests for FFS members need to be approved and validated through the Clinical Call Center at 1-877-309-9493. Providers should contact the MMC Plan for information on how to obtain a PA for MMC members.

Authorized Agent Requests:

- An authorized agent is an employee of the prescribing practitioner who has access to the patient's medical records; for example, a nurse or medical assistant.
- Pharmacists can **only** initiate PAs for an emergency 72-hour supply (5-day supply for medications to treat substance use disorders) when an emergency condition exists. An emergency condition is a condition that places the health or safety of the person afflicted with such condition or other person(s) in serious jeopardy.

Third party requests are prohibited; prescribers may not contract with or assign authority to dispensing pharmacists, manufacturers, or other persons or companies to initiate their PA requests.

The member must be given a choice of where to get their medications or supplies. Federal law prohibits limiting a Medicaid beneficiary's freedom of choice except under certain circumstances including but not limited to recipient restriction (§1902(a)(23) of the Social Security Act). Complaints from providers and enrollees involving steering should be sent to the Office of the Medicaid Inspector General (OMIG). The OMIG website contains online forms for complaints which can be found at: <https://www.omig.ny.gov/fraud/file-an-allegation>.

Breastfeeding Grand Rounds 2019: Breastfeeding Recommendations for Women Impacted by Opioid Use Disorder and Infants with Neonatal Abstinence Syndrome

Breastfeeding Grand Rounds (BFGR) 2019 will air on August 1, 2019 from 8:30 a.m. – 10:30 a.m. The 2019 BFGR live webcast will discuss the prevalence of Opioid Use Disorder (OUD) among pregnant women and neonatal abstinence syndrome (NAS) in infants. Health professionals, women, and their families should understand that breastfeeding can play a key role in the treatment of NAS by decreasing its duration and severity. This webcast will provide resources for identifying pregnant, breastfeeding, and post-partum women with OUD, strategies and tools to facilitate a discussion, and approaches to refer individuals to the most appropriate options for support and follow up.

This webcast is intended for local and state public health and healthcare professionals, paraprofessionals, clinicians (physicians, midwives, healthcare providers, nurses, registered dietitians), and lactation specialists and will offer Continuing Medical Education (CME), Continuing Nursing Education (CNE), Certified Health Education Specialist (CHES), Lactation Continuing Education Recognition Points (LCERP), or general continuing education credits. More information, including previous years' BFGR webcasts and registration information for the 2019 BFGR webcast, can be found at: <http://www.albany.edu/sph/cphce/bfgr.shtml>.

2019 Medicaid Managed Care Primary Care Providers: Access and Availability

Primary Care Providers (PCPs) (Family Practice, Internal Medicine, Obstetrics/Gynecology (OB/GYN), Pediatricians) who contract with Medicaid Managed Care (MMC) Plans must meet specific appointment and availability standards to ensure that enrolled Medicaid members have appropriate access to necessary health care. New York State routinely completes surveillance activities to evaluate compliance with the following appointment availability standards, (Medicaid Model Contract 15.2, Appointment Availability Standards):

- For urgent care: within twenty-four (24) hours of request.
- Non-urgent “sick” visit: within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated.
- Routine non-urgent, preventive appointments except as otherwise provided in this Section: within four (4) weeks of request.
- Initial prenatal visit: within three (3) weeks during first trimester, within two (2) weeks during the second trimester and within one (1) week during the third trimester.
- Adult baseline and routine physicals: within twelve (12) weeks from enrollment.
- Well child care: within four (4) weeks of a request;
- Initial family planning visits: within two (2) weeks of request.
- Members must reach a live voice when calling a provider after-hours (i.e., an answering service).

MMC Plans must require contracted PCPs and OB/GYNs to have the primary responsibility serving as the after-hours “on-call” telephone resource to members with medical problems. Providers should not routinely refer calls to an emergency room, unless the Medicaid member is experiencing a life-threatening health emergency.

Please Note: Providers are required to schedule appointments in accordance with appointment and availability standards noted above to be determined compliant with access to care requirements when contacted by an MMC Plan member. Providers **must not** require a new patient to complete prerequisites to schedule an appointment, such as:

- a copy of their medical record;
- a health screening questionnaire; and/or
- an immunization record.

The provider may request additional information from the new Medicaid member, if the appointment is scheduled at the time of the telephone request. The Department considers prerequisites to scheduling appointments as barriers in gaining access to health care services. Medicaid PCPs are advised to contact the MMC Plan if they are having difficulty meeting the above appointment and availability standards.

Questions may be sent to the Office of Health Insurance Programs (OHIP), Division of Health Plan Contracting and Oversight, Bureau of Managed Care Certification and Surveillance at: BMCCSmail@health.ny.gov.

New York Medicaid EHR Incentive Program

Distribution to Eligible Professionals & Eligible Hospitals Since the Start of the Program in 2011*

Number of Payments:	Distributed Funds:
39,045	\$972,441,858

*As of 6/10/2019

Through the New York (NY) Medicaid Electronic Health Record (EHR) Incentive Program eligible professionals (EPs) and eligible hospitals (EHs) in NY who adopt, implement, or upgrade certified EHR technology (CEHRT) and subsequently become meaningful users of CEHRT, can qualify for financial incentives. The Centers for Medicare and Medicaid Services (CMS) is dedicated to improving interoperability and patient access to health information. The NY Medicaid EHR Incentive Program is a part of the CMS Promoting Interoperability Program but will continue to operate under the current name, NY Medicaid EHR Incentive Program.

MEIPASS Opening Date for Payment Year 2018

The Medicaid EHR Incentive Program Administrative Support Service (MEIPASS) opens for Payment Year (PY) 2018 Attestations on July 1, 2019. The deadline to attest for PY 2018 is September 30, 2019. To attest for PY 2018 in MEIPASS starting on July 1, 2019 please visit: <https://meipass.emedny.org/ehr/login.xhtml>.

Greenway Health LLC Products

Greenway Health LLC identified that certain EHR products are calculating Promoting Interoperability (Meaningful Use) measures incorrectly, and they are working on fixing these issues. Providers who used any of the impacted Greenway products in 2019 should complete the "Greenway Health LLC Identification Form." This form is available to download in Microsoft Excel format at: https://www.health.ny.gov/health_care/medicaid/redesign/ehr/repository/docs/greenway_form.xlsx. Completed forms can be submitted as an attachment via email to attestation@health.ny.gov.

New York State (NYS) Regional Extension Centers (RECs)

NYS RECs offer free support to help providers achieve Meaningful Use of CEHRT. Support provided by NYS RECs includes but is not limited to: answers to questions regarding the program and requirements, assistance on selecting and using CEHRT, or help meeting program objectives. NYS RECs offer **free** assistance for all practices and providers located within New York.

Providers located **inside** the five boroughs of New York City (NYC) should contact:

NYC REACH

Phone: 1-347-396-4888

Website: <https://www.nycreach.org>.

Email: pcip@health.nyc.gov.

Providers located **outside** the five boroughs of NYC should contact:

New York eHealth Collaborative (NYeC)

Phone: 1-646-619-6400

Website: <https://www.nyehealth.org>

Email: ep2info@nyehealth.org

Webinars and Q&A Sessions

A calendar with the date and times of upcoming webinars, as well as registration information, can be found at: https://www.health.ny.gov/health_care/medicaid/redesign/ehr/calendar/.

NY Medicaid EHR Incentive Program Post-Payment Audit Education Series

NY Medicaid EHR Incentive Program has produced a series of Post-Payment Audit Educational tutorials to assist providers for preparation in the event of a post-payment audit. Links to available tutorials can be found at: https://www.health.ny.gov/health_care/medicaid/redesign/ehr/audit/.

Questions

The EHR Incentive Program has a dedicated support team ready to assist. Please contact the program at: **1-877-646-5410 (Option 2)** or via email at: hit@health.ny.gov.

Please Complete the New York Medicaid EHR Incentive Program Customer Satisfaction Survey

The NY Medicaid EHR Incentive Program values provider insight. The survey can be found at: https://www.surveymonkey.com/r/NY_EHR.

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.

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.emedny.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://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 questions?

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

Comments and Suggestions Regarding This Publication?

Please contact the editor, Georgia Wohnsen, at medicaidupdate@health.ny.gov.