



Medicaid Update

The Official Newsletter of the New York State Medicaid Program

June 2021

Volume 37 | Number 7

Special Edition

Comprehensive Guidance Regarding Use of Telehealth including Telephonic Services

The intent of this guidance is to extend the expansion for the ability of **all** Medicaid providers in **all** situations to use a wide variety of communication methods to deliver services remotely during the Coronavirus Infectious Disease 2019 (COVID-19) federally declared Public Health Emergency (PHE), to the extent it is appropriate for the care of the member.

This continuation is effective immediately and shall remain in effect for the remainder of the federally declared PHE, or until the issuance of subsequent guidance by the New York State (NYS) Department of Health (DOH) prior to the expiration of such PHE declaration.

Telehealth services will be reimbursed under the specialized rules described in this guidance. The guidance is designed to facilitate access to services through telemedicine and telephonic means where necessary. This guidance relaxes rules on the types of clinicians, facilities, and services eligible for billing under telehealth rules.

This guidance additionally addresses some access issues including technological barriers to telehealth by allowing clinicians and health care organizations to bill for telephonic services if they cannot provide the audiovisual technology traditionally referred to as “telemedicine”.

This guidance replaces previously issued guidance regarding telehealth and telephonic communication services during the COVID-19 PHE (*Medicaid Update* March 2020 Volume 36, Numbers 3, 4, 5,6, and 9).

This guidance does not change any other Medicaid program requirements with respect to authorized services or provider enrollment and does not expand authorization to bill Medicaid beyond service providers who are currently enrolled to bill Medicaid fee-for-service (FFS) or contracted with a Medicaid Managed Care (MMC) Plan.

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

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I. General Information

Effective for dates of service on or after March 1, 2020, for the duration of the federally declared PHE, NYS Medicaid will reimburse telephonic assessment, monitoring, and Evaluation and Management (E&M) services provided to members in cases where face-to-face visits may not be recommended and it is appropriate for the member to be evaluated and managed by telephone. This guidance supports the policy that members should be treated through telehealth provided by all Medicaid qualified practitioners and service providers, including telephonically, wherever possible to avoid member congregation with potentially sick patients. Telephonic communication will be covered when provided by any qualified practitioner or service provider. All telephonic encounters documented as appropriate by the provider would be considered medically necessary for payment purposes in Medicaid FFS or MMC. All other requirements in delivery of these services otherwise apply.

The following information applies to all Medicaid providers and providers contracted to serve Medicaid members under MMC Plans. However, the Office of Mental Health (OMH), the Office for People with Developmental Disabilities (OPWDD), the Office of Addiction Services and Supports (OASAS), and the Office of Children and Family Services (OCFS) have issued separate guidance on telehealth and regulations that will align with state law and Medicaid payment policy for Medicaid members being served under their authority.

II. Telephonic Reimbursement Overview

Payment for telephonic encounters for health care and health care support services is supported in six different payment pathways utilizing the usual provider billing structure. See the table below for the billing pathways available for telephonic encounters during the COVID-19 PHE by both FFS and MMC:

Billing Lane	Telephonic Service	Applicable Providers	Fee or Rate	Historical Setting	Rate Code or Procedure	Place of Service (POS) Code	Modifier	Notes
Lane 1	E&M Services	Physicians, Nurse Practitioners (NPs), Physician Assistants (PAs), Midwives, Dentists, Registered Nurses (RNs)	Fee	Practitioner's Office	Physicians, NPs, PAs, Midwives: "99441" , "99442" , and "99443" RNs on staff with a practitioner's office: "99211" Dentists: "D9991"	POS should reflect the location where the service would have been provided face-to-face.	Append "GQ" modifier for "99211" only. Modifier "GQ" is for tracking purposes.	New or established patients. Only use "99211" for telephonic services delivered by an RN on staff with a practitioner and the practitioner bills Medicaid. Append the "GQ" modifier.
Lane 2	Assessment and Patient Management	All other practitioners billing fee schedule (e.g., Psychologist)	Fee	Practitioner's Office	Any existing Procedure Codes for services appropriate to be delivered by telephone.	POS should reflect the location where the service would have been provided face-to-face.	Append modifier "GQ" for tracking purposes.	Billable by Medicaid enrolled providers. New or established patients.
Lane 3	Off-site E&M Services [non-Federally Qualified Health Center (FQHC)]	Physicians, NPs, PAs, Midwives	Rate	Clinic or Other (e.g., ambulatory surgery, day program)	Rate Code "7961" for non-School-Based Health Centers (SBHC) Rate Code "7962" for SBHC Report appropriate procedure code for service provided, e.g., "99201" – "99215"	POS Not Applicable (N/A) Service location Zone Improvement Plan (ZIP) Code + 4 should reflect the location that describes where the service would have historically been provided face-to-face.	Not required	New or established patients. All-inclusive payments. No professional claim is billed.

<p>Lane 4</p>	<p>FQHC Off-site Licensed Practitioner Services</p>	<p>Physicians, NPs, PAs, Midwives, and Other Licensed Practitioners who have historically billed under these rate codes such as Social Workers and Psychologists</p>	<p>Rate</p>	<p>Clinic</p>	<p>Rate Code “4012” for non- SBHC Rate Code “4015” for SBHC Report procedure code for service provided, e.g., “99201” – “99215”.</p>	<p>POS N/A - Service location ZIP Code + 4 should reflect the location that describes where the service would have historically been provided face-to-face.</p>	<p>Not required</p>	<p>New or established patients. Wrap payments are available for these rate codes.</p>
<p>Lane 5</p>	<p>Assessment and Patient Management</p>	<p>Other practitioners (e.g., Social Workers, Dieticians, Dentists, home care aides, RNs, therapists, and other home care workers).</p>	<p>Rate</p>	<p>Clinic or other Includes FQHCs Non-Licensed Practitioners, Day Programs, Adult Day Health Care (ADHC) programs, and Home Care Providers. ADHC should bill if not meeting definition for Lane 6 comprehensive payment.</p>	<p>Non- SBHC: <ul style="list-style-type: none"> • Rate Code “7963” (for telephone 5 – 10 minutes) • Rate Code “7964” (for telephonic 11 – 20 minutes) • Rate Code “7965” (for telephonic 21 – 30 minutes) SBHC: <ul style="list-style-type: none"> • Rate code “7966” (for telephone 5 – 10 minutes) • Rate code “7967” (for telephonic 11 – 20 minutes) • Rate code “7968” (for telephonic 21 – 30 minutes) </p>	<p>POS N/A - Service location ZIP Code + 4 should reflect the location that describes where the service would have historically been provided face-to-face</p>	<p>Procedure code and modifier not required. However, correct procedure codes should be utilized in the claim, where applicable.</p>	<p>Billable by a wide range of providers including Day Programs and Home Care (e.g., aide supervision, aid orientation, medication adherence, patient check-ins). However, see Licensed Home Care Services Agencies (LHCSA)/ Certified Home Health Agency (CHHA) assessments and RN visits which get billed under existing rates in Lane 6. New or established patients. Report National Provider Identifier (NPI) of supervising physician as Attending.</p>

Lane 6	Other Services (not eligible to bill one of the above categories)	All provider types [e.g., Home Care, ADHC programs, health home, Home and Community Based Services (HCBS), Peers, School Supportive, Hospice]	Rate	All other as appropriate	All appropriate rate codes as long as appropriate to delivery by telephone	POS N/A - Service location ZIP Code + 4 should reflect the location that describes where the service would have historically been provided face-to-face	Procedure Code and Modifier not required. However, correct procedure codes and the "GQ" modifier should be utilized in the claim, where applicable.	Covers all Medicaid services not covered above. Includes LHCSA and CHHA assessments, evaluations, and RN visits. ADHC bills in Lane 6 if they meet minimum guidance standards.
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**MMC Plans may have separate detailed billing guidance but cover all services appropriate to deliver through telehealth, including telephonic, means to properly care for the member during the PHE.*

Telephonic Payment Chart Explained

The chart has two basic sections. Lanes 1 and 2 are for use by fee schedule billers (primarily practitioners in office-based settings). Lanes 3 through 6 are for all other billers that primarily bill rates for clinic and other services. Practitioners that usually bill the fee schedule directly should bill for telephonic services using Lanes 1 and 2 based on practitioner types noted. Clinics should bill using Lanes 3 through 5 depending on FQHC status and practitioner type. Lane 5 is for clinics, non-licensed practitioners and FQHCs to use for the noted practitioners and should be used for any and all patient assessment and management services that are appropriate to be billed telephonically unless otherwise noted. Lane 6 is reserved for all other services that do not fit into the first five lanes. More guidance will be issued on Lane 6 adding to the noted services, but it is expected that over 90 percent of all Medicaid telephonic billing should fall into Lanes 1 through 5.

III. Telehealth

A. 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. For purposes of the PHE, this definition is expanded to include audio-only conversations. Therefore, during the PHE, telehealth includes telephonic, telemedicine, store and forward, and remote patient monitoring. Telemedicine is the term used in this guidance to denote two-way audiovisual communication. During the PHE, all telehealth applications will be covered at all originating and distant sites as appropriate to properly care for the patient.

B. 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. Originating sites during the PHE can be anywhere the member is located including the member's home. There are no limits on originating sites during the PHE.

C. Distant Site

The distant site is the site where the telehealth provider is located while delivering health care services by means of telehealth. During the PHE, any site within the fifty United States (US) or US' territories, is eligible to be a distant site for delivery and payment purposes, including FQHCs and providers' homes, for all patients including patients dually eligible for Medicaid and Medicare.

D. 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. Telemedicine includes teledentistry.

E. 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 or in the case of the PHE is imprudent.
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.

F. 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 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.

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.

G. Telephonic (Audio-only)

Telephonic service uses two-way electronic audio-only communications to deliver services to a patient at an originating site by a telehealth provider located at a distant site. For complete billing instructions for Telephonic services, refer to Section II Telephonic Reimbursement Overview of this document.

IV. Telehealth Providers

During the PHE any provider, who is authorized to deliver Medicaid billable services, including Article 29-I Health Facilities, is eligible to provide services via telehealth, but services shall be appropriate for telehealth and shall be within the provider's scope of practice.

V. Confidentiality

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). However, during the COVID-19 federally declared PHE, the Department of Health and Human Services Office for Civil Rights (OCR) has issued a Notification of Enforcement Discretion for telehealth remote communications at: <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html>. OCR will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the emergency.

All providers must take steps to reasonably ensure privacy during all patient-practitioner interactions.

VI. Patient Rights and Consents

The practitioner shall confirm the member's identity and provide the member with basic information about the services that he/she will be receiving via telehealth. Written consent by the member is not required. Telehealth sessions/services shall not be recorded without the member's consent.

VII. Billing Rules for Telehealth Services

Modifiers to be Used When Billing for Telemedicine, Store-and-Forward, and RPM

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 <i>AMA’s CPT Professional Edition 2018 Codebook</i> . The Current Procedural Terminology (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 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.

POS Code to be Used when Billing for Telemedicine, Store-and-Forward, and RPM Applicable When Billing Professional Claims

POS Code	Description
“02”	The location where health services and health-related services are provided or received, through a telecommunication technology. When billing telemedicine, store-and-forward, and remote patient monitoring services, providers must bill with POS code “02” and continue to bill modifier “95”, “GT” or “GQ”.

A. Billing for Teledentistry Services

When billing for teledentistry services, modifiers cannot be used by dentists. Additional guidance was issued in the January 2020 *Medicaid Update* (see link below) which allows for two dental codes “D9995” and “D9996” to be used in place of modifiers. Both dental codes “D9995” and “D9996” along with “Q3014” were added to the dental fee schedule as published in the January 2020 (https://www.health.ny.gov/health_care/medicaid/program/update/2020/docs/jan20_mu.pdf) and June 2020 (https://www.health.ny.gov/health_care/medicaid/program/update/2020/docs/mu_no11_jun20.pdf) issues of the *Medicaid Update*.

B. General Billing Guidelines

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.

C. Fee-for-Service Billing for Telemedicine by Site and Location (not telephonic)

When services are provided via telemedicine to a member located at an originating site, the servicing provider should bill for the telemedicine encounter as if the provider saw the member face-to-face using the appropriate billing rules for services rendered. The CPT code for the encounter must be appended with the applicable modifier (“95” or “GT”).

Article 28 Clinic Originating Sites Billing Under Ambulatory Patient Groups (APGs) for Telemedicine (not telephonic)

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, emergency room) and a physician is on-site assisting or attending to the member during a telemedicine encounter, a physician claim cannot be billed to Medicaid.
 - b. When the originating site is an Article 28 hospital (outpatient department, emergency room) and a separate and distinct medical service, unrelated to the reason for the telemedicine encounter, is provided by a physician, 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.

Article 28 Distant Sites Billing Under APGs for Telemedicine (not telephonic)

1. Institutional Component (Distant Site)
 - a. When the distant-site practitioner is physically located at the Article 28 distant site or is providing service from the practitioner's home during the PHE, 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”**).
2. Practitioner (Professional) Component (Distant Site)
 - a. When the distant site is an Article 28 hospital outpatient department and telemedicine services are being provided by a physician, the physician should bill Medicaid using the appropriate CPT code appended with the applicable modifier (**“95”**).

Office Setting or Other Secure Location – Billing by Originating and/or Distant-Site Practitioner for Telemedicine (not telephonic)

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 including the practitioner's home, 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”**).

Hospital Inpatient Billing for Telemedicine (not telephonic)

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 All Patient Revised - Diagnosis Related Group (APR-DRG) payment to the facility.

Skilled Nursing Facility Billing for Telemedicine (not telephonic)

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.

FQHCs Billing for Telemedicine (not telephonic)

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. Consistent with Medicaid telehealth guidance issued in February 2019, when services are provided via telemedicine to a patient located at an FQHC originating site, the originating site may bill only the FQHC off-site 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 off-site services rate code ("4012").
3. **FQHCs That Have Not "Opted Into" APGs – FQHC Distant Sites:**
 - a. If a provider who is on-site at an FQHC or is providing service from the practitioner's home during the PHE via telemedicine to a member who is in their place of residence or other location including an originating site that is another provider's office or clinic, the FQHC may bill the PPS rate and report the applicable modifier ("95" or "GT") on the procedure code line.
4. Wrap payments are available for any telehealth services, including telephonic services reimbursed by an MMC Plan, under qualifying PPS and off-site rate codes.

D. Application-Specific Telehealth Billing Rules **Telephonic (Audio-only)**

See Section II: Telephonic Reimbursement Overview.

Store-and-Forward Technology

1. Reimbursement will be made to the consulting distant-site practitioner.
2. 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.
3. 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].
2. A fee of \$48.00 per month will be paid for RPM.
3. Providers are not to bill "99091" more than one time per member per month.

E. Medicaid Managed Care Considerations

1. MMC Plans are required to cover, at a minimum, services that are covered by Medicaid FFS and also included in the MMC benefit package, when determined medically necessary and must provide telehealth coverage as described in this guidance. MMC Plans may establish claiming requirements (e.g., specialized coding) that vary from FFS billing instructions in this guidance.
2. Absent existing state mandated rates or negotiated rates for telehealth/telephonic services, MMC Plans must reimburse network providers at the same rate that would be reimbursed for providing the same service via a face-to-face encounter.
3. MMC Plans may not limit member access to telehealth/telephonic services to solely the MMC Plans telehealth vendors and must cover appropriate telehealth/telephonic services provided by other network providers.
4. Questions regarding MMC reimbursement and/or documentation requirements should be directed to the member's MMC Plan.

VIII. Options to Support Members with Limited or Lack of Access to Devices and Services

The following is a listing of helpful resources compiled for emergency assistance:

- **Free Wi-Fi/internet**
 - Charter Communications (Spectrum) and Comcast are giving households with K-12 and college students, and those who qualify as low-income complimentary Wi-Fi for 60 days.
 - Families who do not have the service will also receive free installation of the service.
 - Both companies are expanding Wi-Fi hotspots to the public within the company's available regions.
 - Call (844) 488-8395 (Charter) or (855) 846-8376 (Comcast) to enroll.
 - Individuals must call company after 60 days, or they will be automatically billed.
- **Unlimited data**
 - Charter, Comcast, AT&T, and Verizon are offering unlimited data plans to customers until May 13, 2021, for no additional charge.
- **SafeLink Wireless**
 - Eligibility requirements must be met, which are set by each State where the service is provided.
 - To qualify for Lifeline, subscribers must either have an income that is at or below 135 percent of the federal Poverty Guidelines, or participate in one of the following assistance programs:
 - Medicaid
 - Supplemental Nutrition Assistance Program (SNAP) Food Stamps
 - Supplemental Security Income (SSI)
 - Federal Public Housing Assistance (Section 8)
 - Veterans and Survivors Pension Benefit
 - Service is limited to one person per household
 - Call **1-800-SafeLink (723-3546)** for enrollment and plan changes support
 - Subscribers can use their own phones:
 - SafeLink Keep Your Own Smartphone plan requires a compatible or unlocked Smartphone. Most GSM Smartphones are compatible.
 - Subscribers can get up to 350 minutes and 3GB of data, which includes voice minutes and unlimited texts, voicemail, nationwide coverage and 4G LTE on 4G LTE compatible devices.

IX. Questions:

- Medicaid FFS telehealth/telephonic coverage and policy questions may be directed to the Office of Health Insurance Programs (OHIP) Division of Program Development and Management (DPDM) at (518) 473-2160 or via email at Telehealth.Policy@health.ny.gov.
- Medicaid FFS coverage and policy questions may be directed to OHIP DPDM at (518) 473-2160 or FFSMedicaidPolicy@health.ny.gov.
- Questions regarding MMC reimbursement and/or documentation requirements should be directed to the enrollee's MMC Plan.
- 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, waste or abuse complaints/allegations, call 1-877-87FRAUD, (877) 873-7283, or visit Office of Medicaid Inspector General (OMIG) web site at: www.omig.ny.gov.

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

Please visit the eMedNY website at: 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:

Please enroll online for a provider seminar 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 web sites:

- DOH Prescriber Education Program page: https://www.health.ny.gov/health_care/medicaid/program/prescriber_education/presc-educationprog.
- Prescriber Education Program in partnership with SUNY: <http://nypep.nysdoh.suny.edu/>.

eMedNY

For a number of services, including: change of address, updating an enrollment file due to an ownership change, enrolling another National Provider Identifier (NPI), or revalidating an existing enrollment, please visit the eMedNY Provider Enrollment page at: <https://www.emedny.org/info/ProviderEnrollment/index.aspx>, and choose the appropriate link based on provider type.

NY Medicaid Electronic Health Record (EHR) Incentive Program

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

Comments and Suggestions Regarding This Publication

Please contact the editor, Angela Lince, at medicaidupdate@health.ny.gov.