NEW YORK STATE | Department of Health

Medicaid Update

The Official Newsletter of the New York State Medicaid Program

October 2017
Volume 33 | Number 10

HIV SNPs Population Expansion

Special Needs Plans (HIV SNPs) are a comprehensive health plan option in New York City designed to meet the health care needs of consumers living with HIV/AIDS and other identified high-need populations. In addition to the full Medicaid benefit package, HIV SNPs cover enhanced HIV services, care coordination, and behavioral health Home and Community-Based Services for eligible enrollees.

Effective November 1, 2017, eligible transgender consumers will be able to enroll in HIV SNPs, regardless of HIV status. HIV SNPs are required to verify eligibility for HIV SNP enrollment under four categories: (1) HIV/AIDS (2) homeless (3) transgender (4) dependent children up to age 21. The HIV SNP shall confirm that Enrollee applicants are eligible to enroll in an HIV SNP within 90 days of enrollment, except that such confirmation is not required for the Enrollee applicant's related children.

Confirming HIV SNP transgender eligibility

HIV SNPs can verify transgender eligibility by obtaining from the Medicaid applicant/recipient (A/R) either:

a. a signed and dated statement from a physician, nurse practitioner or physician assistant who has treated, or reviewed and evaluated the gender-related medical history of the A/R. The statement must include language stating that the A/R has undergone appropriate clinical treatment for a person diagnosed with gender dysphoria; or
b. a copy of a Certified Amended Birth Certificate; or a passport; or a New York State Driver's License; or a Non-Driver ID card; or a statement from the Social Security Administration reflecting the change in gender designation may be submitted in lieu of the provider statement.

HIV SNP enrollment allows for breaking enrollment lock-in

A qualified HIV SNP enrollee has the ability to transfer from a mainstream managed care plan to an HIV SNP or from HIV SNP to HIV SNP at any time. The mainstream managed care model contract requires a 12-month lock in to the plan selected, unless good cause to break the lock-in is demonstrated. The 12-month lock-in provision does not apply to any enrollee transferring from MMC to an HIV SNP or from one HIV SNP to another HIV SNP

Consumers who have Medicaid coverage through the New York State of Health Marketplace (NYSoH) may select HIV SNP enrollment by logging into their account and navigating to the plan selection page where HIV SNPs appear as a choice to Medicaid Managed Care eligible individuals. NYSoH consumers may also contact the NYSoH Customer Service line at 855-355-5777 to request enrollment in a HIV SNP.

Questions about this article can be directed to the Bureau of Program Implementation and Enrollment at 518-473-1134 or by email to OMCmail@health.ny.gov.

Andrew M. Cuomo
Governor
State of New York

Howard A. Zucker, M.D., J.D.
Commissioner
New York State
Department of Health

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs
The Medicaid Update is a monthly publication of the New York State Department of Health.

In This Issue…

Policy & Billing Guidance

New York State Medicaid Expands Coverage to Include Real-Time Continuous Glucose Monitors for Individuals with Type 1 Diabetes

New York State (NYS) Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC) will begin covering real-time continuous glucose monitors (RT-CGM) for members who have a diagnosis of type 1 diabetes when the patient meets the criteria outlined in this policy. This expansion of services is effective November 1, 2017, for FFS and January 1, 2018, for MMC.

RT-CGM is a glucose monitoring technology that continuously measures and displays interstitial glucose levels. Alarms and alerts are used to notify members when their blood glucose level is exceeding or falling below specified thresholds. This information is used by members to self-manage their diabetes.

NYS Medicaid coverage of a RT-CGM may be available for members who meet each of the following criteria. The member must:

- Have a diagnosis of type 1 diabetes
- Be under the care of an endocrinologist who orders the device
- Currently be performing at least four finger-stick glucose tests daily
- Be on an insulin treatment plan that requires frequent adjustment of insulin dosing
- Be able, or have a caregiver who is able, to hear and view RT-CGM alerts and respond appropriately.

MMC Plan Billing

Providers participating in a MMC should check with the individual health plans to determine how each MMC plan will implement this policy. Questions regarding MMC reimbursement and/or documentation requirements should be directed to the enrollee's MMC plan.

FFS Billing

Prior approval is required for CGM devices. For specific FFS billing instructions, please see the Durable Medical Equipment (DME) Manual and provider communication, which can both be found at the following link: https://www.emedny.org/ProviderManuals/index.aspx.

Questions regarding Continuous Glucose Monitoring Prior Approval or Dispensing Validation System (DVS) authorization for Medicaid FFS members should be directed to the Durable Medical Equipment Program at (800) 342-3005. Policy questions regarding Medicaid FFS may be directed to the Office of Health Insurance Programs (OHIP), Division of Program Development and Management at (518) 473-2160. Questions regarding Medicaid fee-for-service billing or claims should be directed to the eMedNY Call Center at 1-800-343-9000.

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Attention Pharmacy Providers: Coordination of Benefits (COB) Processing Change for Other Payer ID and Other Payer ID Qualifier

Effective December 21, 2017, when submitting a claim with Third Party Liability (TPL), Medicaid FFS will now require the submission of "03" in the National Council for Prescription Drug Programs (NCPDP) field 339-6C Other Payer ID Qualifier, and the 6-digit Issuer Identification Number (IIN), formerly termed Bank Identification Number (BIN), in field 340-7C Other Payer ID. Please note the length of the IIN will move to an 8-digit number in the near future. Once that occurs, instructions will be provided on how to proceed.

The following is a list of values reported in fields 339-6C and 340-7C that are considered acceptable:

Acceptable values for field 339-6C-(Other Payer ID Qualifier):

- 03-IIN-(Issuer Identification Number) previously known as BIN-Bank Information Number – use for TPL
- 05-Medicare Part B – use for Medicare Part B Carrier Number
- 99-Other – use for Medicare MCO

Acceptable values for field 340-7C-(Other Payer ID):

- When field 339-6C contains “03”-(IIN)-previously known as BIN, enter the 6-digit numeric IIN in field 340-7C.
- When field 339-6C contains “05”-(Medicare Part B), enter the Medicare Part B Carrier Number in field 340-7C.
- When field 339-6C contains “99”-(Other), enter “13” for Medicare MCO in field 340-7C.

If the above values are not reported correctly, the claim will fail pre-adjudication edit NCPDP Reject Code “7C”-(Missing/Invalid Other Payer ID Code).

When a patient requests a prescription to be filled at the pharmacy, the pharmacy collects information on their prescription benefit program. This information is important to the Medicaid program to ensure that Medicaid is the payer of last resort and that all available third-party insurance is utilized and captured prior to billing Medicaid. One piece of information is the name of the health plan/Pharmacy Benefit Manager (PBM). When the pharmacy system includes the IIN/BIN in the electronic transaction that the pharmacy sends to the payer for the prescription, the Medicaid program is able to further validate and/or capture this information to be utilized in recovery efforts. The IIN/BIN is a field in the Telecommunication Standard that is used for the routing and identification in pharmacy claims. The IIN field will either be filled with the American National Standards Institute (ANSI) IIN or the NCPDP Processor (BIN) IIN, depending on which one the health plan has obtained.

This information can also be found in the eMedNY NCPDP D.0 Companion guide on the eMedNY website at: https://www.emedny.org/HIPAA/5010/transactions/index.aspx. For billing questions please contact the eMedNY Call Center at 1-800-343-9000.

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NYS Medicaid Fee-for-Service NCPDP D.0 Billing Clarification For 340B Drug Claims

This is a clarification for submitting NYS Medicaid fee-for-service (FFS) 340B pharmacy claims in the NCPDP format. 340B drug claims submitted via the NCPDP D.0 format need to be properly identified as 340B and submitted at the 340B acquisition cost.

The following fields are required on 340B drug claims submitted in the NCPDP format:

- Value of '**20**' in field **420-DK**, Submission Clarification Code; **and**
- Value of '**08**' in field **423-DN**, Basis of Cost Determination; **and**
- 340B acquisition cost in field **409-D9,** Ingredient Cost Submitted

Editing will be put in place in December 2017 that will require a pharmacy to submit all three fields when identifying a NCPDP pharmacy drug claim as 340B. Additionally, editing will check the ingredient cost submitted against the drug's 340B ceiling price as defined by the Health Resources and Services Administration (HRSA).

Pharmacies are still expected to submit field **426-DQ**, Usual and Customary Cost, as the lowest net charge that a non-Medicaid, 340B eligible patient would pay for the same prescription.

The above guidance clarifies previous billing guidance for NYS Medicaid FFS 340B claims submitted via the NCPDP D.0 format by specifying that 340B acquisition cost **must** be reported in field 409-D9, Ingredient Cost Submitted.

Billing questions regarding the FFS program should be directed to the eMedNY Call Center at (800) 343-9000.

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OPWDD Respite Providers Responsible for Transportation

Effective July 1, 2017, the New York State Office for People with Developmental Disabilities (OPWDD) implemented a revised fee methodology along with programmatic changes for respite services provided under the Home and Community Based Services (HCBS) Waiver. As part of the methodology change, approved OPWDD respite providers have responsibility for transporting individuals to and from the respite programs they operate. Travel time can now be billed to Medicaid as part of the respite service to cover the cost of transporting individuals who participate in the respite programs. Therefore, New York State Department of Health will not be authorizing requests for separately billed fee-for-service Medicaid transportation to and from OPWDD respite programs. Questions about this policy should be directed to OPWDD's Waiver Management Unit at peoplefirstwaiver@opwdd.ny.gov. Questions about billing respite services to Medicaid can be directed to OPWDD's Central Operations Bureau at central.operations@opwdd.ny.gov.

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All Providers

Child/Teen Health Program (CTHP) | Early and Periodic Screening Diagnosis, and Treatment (EPSDT)

New York State Medicaid's CTHP/EPSDT Provider Manual has been updated on eMedNY (https://www.emedny.org/ProviderManuals/) to include the most recent Bright Futures Periodicity Schedule. Links and telephone numbers have also been updated.

Federal law requires complete well-child examinations with screening services through **EPSDT**, including screening for potential developmental, mental, behavioral, and/or substance use disorders. **EPSDT** also finances diagnostic and treatment services, if medically necessary, for these conditions. New York State's EPSDT program is called the Child/Teen Health Program (CTHP) (Title 18 NYCRR Section 508).

CTHP provides a comprehensive array of prevention, diagnostic, and treatment services for all Medicaid eligible infants, children, and adolescents under age 21, as specified in Section 1905(r) of the Social Security Act (the Act). This also includes members under 21 who are enrolled in a Medicaid managed care plan. Medicaid managed care plans must adopt practice guidelines consistent with current standards of care and follow the CTHP standards for provision of care.

The CTHP benefit is more robust than the Medicaid benefit for adults and is designed to ensure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal of CTHP/ EPSDT is to ensure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting.

CTHP/EPSDT:

- Early: Assessing and identifying problems early;
- Periodic: Checking children's health at periodic, age-appropriate intervals;
- Screening: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems;
- Diagnostic: Performing diagnostic tests to follow up when a risk is identified; and
- Treatment: Control, correct, or reduce health problems found.

Go to the New York State eMedNY website to view the CTHP/EPSDT provider manual at https://www.emedny.org/ProviderManuals/. Select provider manual Child/Teen Health Program (C/THP) - Early Periodic Screening Diagnosis and Treatment (EPSDT).

Child/Teen Health Program (C/THP) - Early Periodic Screening Diagnosis and Treatment (EPSDT)

Questions regarding CTHP/EPSDT policy should be directed to (518) 473-2160.

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Implementation of the Consumer-Directed Fiscal Intermediary Authorization Process

This is a follow up to the *Medicaid Update* article issued to all providers in August 2017 (Volume 33, Number 8) regarding the enacted 2017-18 New York State Budget, which created a new Authorization process for all Consumer-Directed Fiscal Intermediaries (FIs).

Specifically, Section 1, Part E of Chapter 57 of the Laws of 2017 amended the New York State Social Services Law (SSL) §365-f by adding two new subdivisions, 4-a and 4-b. The purpose of these changes is to improve oversight of this service model and the FIs, and to better align SSL §365-f with the Consumer-Directed Personal Assistance Program (CDPAP) regulations under Title 18 NYCRR §505.28.

The new Authorization process will impact existing and new FIs, and will be required for both FIs that contract with Local Departments of Social Services (LDSS) and those that contract with Managed Care Organizations (MCOs).

This article provides an overview of this new process, to inform not only FIs, but also the LDSSs and MCOs that contract with FIs across the state.

Chapter 57

The changes to the SSL improve oversight of the Consumer-Directed service model statewide. The specific changes to the SSL:

1. Better define what an FI is, and what such entities **are** and **are not** responsible for;
2. Create a new Authorization process which will be required for all FIs;
3. Grant the Department of Health (Department) the authority to revoke, suspend, limit or annul an FI's Authorization in the event the FI is found to be out of compliance; and
4. Provide FIs with the option to challenge determinations under this new subdivision via a proceeding under Article 78 of the New York Civil Practice Law and Rules.

Chapter 57 outlines the activities in which an FI should not be engaged, such as recruiting and hiring personal assistants, as set forth in the Consumer-Directed regulations under Title 18 NYCRR §505.28. It has never been, nor will it ever be, appropriate for an FI to participate in such activities.

Effective Date

While the specific provisions of Chapter 57 are deemed to be in effect as of April 1, 2017, the Department will begin accepting FI Authorization applications on November 1, 2017. As of November 1, 2017, **all** existing FIs will have thirty (30) days to submit their FI Authorization application to the Department.

Fiscal Intermediary Authorization Application

Entities must submit an application for FI Authorization if they are:

- Seeking **initial** approval as an Authorized Fiscal Intermediary; or
- Responding to a letter instructing them to **renew** their Fiscal Intermediary Authorization; or
- Reporting a change of ownership or operator, an acquisition or a change in control of an existing Authorized Fiscal Intermediary pursuant to SSL Section 365-f and Part 505.28 of Title 18 NYCRR; or
- Seeking **reinstatement** or **reactivation** of a previous Fiscal Intermediary Authorization.

There is no fee to file an application for FI Authorization. The application must be submitted electronically, and can be found here: https://www.health.ny.gov/health_care/medicaid/redesign/mrt_10003.htm. Hard copies will not be accepted.

In addition, all marketing and outreach materials must be submitted with the FI Authorization application. These must be submitted electronically, as attachments to the application, and will be reviewed to determine if marketing materials are consistent with New York State guidance on Consumer Directed Program/Service.

Once signed and notarized, completed applications and any attachments may be saved in Portable Document Format (PDF), and sent to: FIAuthorization@health.ny.gov with *FI Authorization* as the subject line.

Receipt of the application will be acknowledged via email. Each application will be assigned an application number which should be used in all correspondence referring to the application. The application number will be sent via email once it is generated. If the application is determined to be incomplete it will be returned for revision and resubmission.

When completing the application, the following sources may be of assistance:

- Article 5 of the Social Services Law.
- 18 NYCRR Part 505.28 – Consumer-Directed Personal Assistance Program.

Application Review

The process for applicants seeking approval requires staff review and recommendations by the Office of Health Insurance Programs, Division of Long Term Care (DLTC) concerning the application. DLTC will conduct a preliminary review of the application and all attachments to ensure the application is complete and that all supporting documentation has been received. If any documentation is missing, the applicant will be notified via email regarding what information is missing and instructed on how to submit the missing data.

Upon completion of the full application review, applicants will receive either an approval or denial letter via email. The approval letter will detail the next steps that must be taken in order to complete the authorization process. The denial letter will provide the applicant with information about the grievance process and related procedures.

If the FI is not already enrolled as a Medicaid provider, the FI must enroll with the New York State (NYS) Medicaid program upon receipt of their FI Authorization approval. This must be done via the Provider Enrollment portal on the eMedNY website, and the FI Authorization approval letter must be included as part of that application package. Once approved as a Consumer-Directed FI in the NYS Medicaid program, the FI Authorization will be complete.

An FI Authorization will be in effect for a period of five (5) years. The Department will issue renewal notices as the end of the authorization period nears. Marketing and outreach materials will need to be submitted to the Department upon Authorization renewal. Changes in information such as a new email address or telephone number may be submitted via email to: FIAuthorization@health.ny.gov. More substantial changes, such as a change in ownership, would require a new FI Authorization application.

Contracting with a Fiscal Intermediary

In order for an FI to contract with a LDSS and/or a MCO, the FI must have the following from the Department:

- An FI Authorization approval letter (issued by DLTC); and
- A valid Consumer-Directed service provider identification number (issued by eMedNY).

All *existing* FIs will be permitted to continue operating while their FI Authorization application is under review. Additionally, all MCOs and LDSSs should ensure that their policies and procedures are appropriately and expeditiously updated to reflect these new requirements.

Questions or comments regarding the FI Authorization process can be sent to: FIAuthorization@health.ny.gov.

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Mandatory Compliance Program Certification Requirement under Title 18 of the New York Codes, Rules and Regulations (NYCRR) §521.3(b)

Reminder

This is a reminder from the New York State Office of the Medicaid Inspector General (OMIG) for all providers subject to the New York State (NYS) Social Services Law Section 363-d (SSL §363-d) Mandatory Compliance Program Requirement and the required annual December compliance program certification.

The annual certification period begins December 1, 2017. The NYS Social Services Law Compliance Program Certification Form (SSL Certification Form) will be available on OMIG's website. Up until that time, the 2016 certification form will be available on the website for newly enrolling and revalidating Medicaid providers.

OMIG will post a webinar on its website explaining the SSL Certification Form that will be used starting in December 2017. OMIG will issue communications via its listserv and social media channels once the webinar is posted. To subscribe to OMIG's listserv, please visit: https://omig.ny.gov/omig-email-list-subscriptions.

OMIG has actively monitored providers' adherence to SSL §363-d and Part 521 of Title 18 of the New York Codes, Rules and Regulations (NYCRR) since 2009. The regulation mandates all required providers under the Medicaid program in the categories listed below to adopt, implement, and maintain an effective compliance program that meets the regulatory requirements. If you are required to have a compliance program, you are required to certify on OMIG's website in December of each year at: www.omig.ny.gov.

Required providers include:

- persons subject to the provisions of Article 28 or 36 of the NYS Public Health Law;
- persons subject to the provisions of Article 16 or 31 of the NYS Mental Hygiene Law; or
- other persons, providers or affiliates who provide care, services or supplies under the Medicaid program, or persons who submit claims for care, services or supplies for or on behalf of another person or provider for which the Medicaid program is or should be reasonably expected by a provider to be a substantial portion of their business operations.

Under 18 NYCRR §521.2 (b), "substantial portion" of business operations means any of the following:

1. *when a person, provider or affiliate claims or orders, or has claimed or has ordered, or should be reasonably expected to claim or order at least $500,000 in any consecutive 12-month period from the Medical Assistance Program;*
2. *when a person, provider or affiliate receives or has received, or should be reasonably expected to receive at least $500,000 in any consecutive 12-month period directly or indirectly from the Medical Assistance Program; or*
3. *when a person, provider or affiliate who submits or has submitted claims for care, services, or supplies to the Medical Assistance Program on behalf of another person or persons in the aggregate of at least $500,000 in any consecutive 12-month period.*

Each compliance program must contain the eight elements required under SSL §363-d and 18 NYCRR §521.3 (c). Upon applying for enrollment in New York's Medicaid program, and during the month of December each year thereafter, 18 NYCRR §521.3 (b) requires those providers who are subject to the mandatory compliance program obligation to certify using a form on OMIG's website that a compliance program meeting the requirements of the regulation is in place. OMIG recommends that required providers test the operation of their compliance program and make any adjustments necessary so that in December, the Medicaid provider is prepared to certify that its compliance program meets the requirements of SSL §363-d and 18 NYCRR §521.3 (c).

Required providers may be considered to have engaged in an unacceptable practice under the Medicaid program, and may be subject to potential administrative actions, if they fail to adopt, implement, and maintain a compliance program required by SSL §363-d and 18 NYCRR Part 521 or if they fail to certify in December that they have a compliance program that meets the regulatory requirements.

Please note that the Department of Health is revalidating Medicaid providers' enrollment in the Medicaid program. As part of the revalidation process, required providers will be asked to submit evidence that they met the December SSL certification obligation. Certifying in December and retaining a copy of the SSL Certification Confirmation and/or confirmation emails will help Medicaid providers complete the revalidation process.

Please Be Advised: 18 NYCRR §521.1 states that for required providers to be eligible to receive Medicaid payments for care, services or supplies, or to be eligible to submit claims for care, services, or supplies for or on behalf of another person, required providers must adopt and implement an effective compliance program.

It is the responsibility of a required provider to determine if:

1. they have a compliance plan that meets the requirements of SSL §363-d and 18 NYCRR §521.3 (c); and
2. the compliance program is effective.

Required providers must assess their compliance programs to determine whether they can certify that they do or do not have a compliance program in place that meets the requirements of SSL §363-d and 18 NYCRR Part 521.

The *Compliance Program Review Guidance* published October 26, 2016 on OMIG's website in the Compliance Library is a comprehensive outline of what OMIG uses when it conducts compliance program reviews of required providers' compliance programs and is one of several resources available on OMIG's website. Also on the website is a listing of *OMIG's Compliance Program Assessment Results*, which identifies the compliance requirements with the most frequent insufficiencies.

OMIG recommends visiting its website to review compliance-related information and resources; please see: https://omig.ny.gov/compliance. The Compliance Library provides copies of current forms, publications and other resources that are helpful in conducting a self-assessment.

If you have any questions, please contact OMIG's Bureau of Compliance at (518) 408-0401 or compliance@omig.ny.gov.

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NYS Medicaid EHR Incentive Program Update

The NY Medicaid Electronic Health Records (EHR) Incentive Program provides financial incentives to eligible professionals and hospitals to promote the transition to EHRs. Providers who practice using EHRs are in the forefront of improving quality, reducing costs and addressing health disparities. Since December 2011, ***over $855 million*** in incentive funds have been distributed ***within 29,149*** payments to New York State Medicaid providers.

Eligible Professionals & Eligible Hospitals Total	
Payments Made: 29,149	**Amount Paid: $855,713,924**

CMS Announces IPPS Final Rule

On August 14, 2017, the Centers for Medicare & Medicaid Services (CMS) issued the Inpatient Prospective Payment System (IPPS) Final Rule, which has implications for the NY Medicaid Electronic Health Records (EHR) Incentive Program.

Changes include:

- Modifying the 2018 Meaningful Use (MU) reporting period for Eligible Professionals (EPs) from a full year to a minimum 90-day period
- Finalizing policies to allow healthcare providers to use either the 2014 Edition of Certified Electronic Health Record Technology (CEHRT), 2015 Edition of CEHRT, or a combination of both, for Program Year 2018
- Modifying the 2017 Clinical Quality Measure (CQM) reporting period for EPs from a full year to be a minimum 90-day period
- Reducing the number of CQMs that EPs must report on for 2017 from nine CQMs to six. The six can be from any policy domain, but they must be relevant to the EP's scope of practice
- Reducing the overall pool of CQMs from 64 to 53 – to align with those available to clinicians reporting eCQMs via their EHR for the Merit-based Incentive Payment System (MIPS)

For more information on how the IPPS Final Rule will affect EPs participating in the NY Medicaid EHR Incentive Program, sign up for one of our upcoming webinars:

EP Meaningful Use Modified Stage Two (https://register.gotowebinar.com/rt/1888878884687701249)
EP Meaningful Use Stage Three (https://register.gotowebinar.com/rt/4102315645751061507)

Contact us at 877-646-5410 option 2 or hit@health.ny.gov. Questions? We have a dedicated support team ready to assist.

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New York State of Health (NYSoH) Updated Provider Contacts

Providers servicing New York State of Health (NYSoH) Medicaid members in need of Recipient Restriction changes, Exception coding to allow Medicaid payment for case management services, Exclusion coding, or who experience certain life changing events can now utilize our updated points of contact. NYSoH Medicaid recipients are identified in ePACES with H78 displayed in the Office field.

NYSoH Restrictions

Fee for service individuals active in Recipient Restriction Program looking to change restricted providers. Individuals enrolled in managed care must contact the plan to request change.

hxrestrict@health.ny.gov	**(518) 457-0761 voice	(518) 474-4959 fax

NYSoH Exceptions

Individuals in receipt of Comprehensive Medicaid Case Management Services including but not limited to Early Intervention. Submission of case management entry requests.

hxrestrict@health.ny.gov	**(518) 457-0761 voice	(518) 474-4959 fax

NYSoH Exclusions

Individuals participating in Residential Rehabilitation Services for Youth (RRSY). Submission of admission/discharge notices.

hxrestrict@health.ny.gov	**(518) 457-0761 voice	(518) 474-4959 fax

NYSoH Level of Care Transitions

Individuals in need of certain services that are not available on NYSoH. Services include Managed Long Term Care, adults or children in need of Waiver Services, fee for service Personal Care, fee for service short-term (up to 29 days) rehabilitation, all consumers (fee for service or managed care) in need of long-term (permanent placement) in nursing home, Intermediate Care Facility, Congregate Care Facility, Foster Care Home Managed Care disenrollments, Medicaid Buy-in Program for Working People with Disabilities and Medicare Savings Program requiring Medicare enrollment.

hxfacility@health.ny.gov	(518) 473-6397 voice	(518) 474-9062 fax

Questions may be referred to the Bureau of Medicaid Eligibility and Marketplace Integration, Office of Health Insurance Programs at (518) 473-6397.

**indicates updated contact number

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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 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).

Do you have 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.

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

Need to change your address? Does your enrollment file need to be updated because you have experienced a change in ownership? Do you want to enroll another NPI? Did you receive a letter advising you to revalidate your enrollment?
Visit https://www.emedny.org/info/ProviderEnrollment/index.aspx and choose the link appropriate for you (e.g., physician, nursing home, dental group, etc.).

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, Chelsea Cox, at medicaidupdate@health.ny.gov.