NEW YORK STATE | Department of Health

Medicaid Update

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New Medicare Card Replacement Initiative

In an effort to combat identity theft and safeguard taxpayer dollars, the United States Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 directing the Centers for Medicare & Medicaid Services (CMS) to remove any reference to Social Security Numbers (SSNs) from all Medicare cards by April 2019. This mandated national undertaking, formerly referred to by CMS as the Social Security Number Removal Initiative (SSNRI), is now known simply as the **New Medicare Card** replacement initiative.

The focal point of the New Medicare Card replacement initiative is the *Medicare Beneficiary Identifier (MBI)* which will replace a recipient's existing SSN-based Health Insurance Claim Number (HICN) currently inscribed on their Medicare benefits card. The MBI will be used for all Medicare transactions including eligibility status, claims, and billing. CMS will begin issuing MBIs and mailing new Medicare cards to active beneficiaries in April 2018 in advance of meeting the Congressionally-mandated deadline. Additionally, inactive Medicare beneficiaries will have an MBI assigned to their historical record but will not receive a new Medicare card.

In preparation for the national transition from HICN to MBI, all state agencies need to ready their respective Medicaid Management Information System (MMIS) and **all** associated downstream data systems to support usage of the MBI for "dual eligible" (Medicare and Medicaid) beneficiaries. As per CMS guidance, such programmatic changes must be made before October 2017 in order to allow a sufficient testing window prior to the April 2018 issuance of new Medicare cards. Each state's governing Medicaid authority is tasked by CMS to oversee and monitor statewide efforts and report overall progress to CMS on a regular basis.

The New York State Department of Health is working diligently to make programmatic changes in *eMedNY* in advance of the October 2017 testing deadline and likewise anticipates working with its Medicaid managed care organizations, providers, and other stakeholders to ensure a smooth transition. Downstream data partners are expected to make similar programmatic changes to their respective systems and to likewise work in concert with their respective stakeholder community.

For more information regarding the **New Medicare Card** replacement initiative, please feel free to visit any of the following resources:

- CMS Press Release: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-05-30.html
- General Information Portal: https://www.cms.gov/medicare/new-medicare-card/nmc-home.html
- Information for State Medicaid Agencies: https://www.cms.gov/Medicare/New-Medicare-Card/States/States.html
- Information for Providers: https://www.cms.gov/Medicare/New-Medicare-Card/Providers/Providers.html

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In This Issue…

NYS Medicaid FFS Program Pharmacists as Immunizers Fact Sheet

NYS Education Law (6527, 6801, 6909) and regulations (8NYCRR63.9) permits licensed pharmacists who obtain additional certification to administer the following vaccines: Influenza, pneumococcal, meningococcal, tetanus, diphtheria, and pertussis vaccines when administered to patients 18 or older, and Zoster vaccines, pursuant to either a patient specific order or a non-patient specific order. Administration of select vaccines by qualified pharmacists employed by, or under contract with, Medicaid enrolled pharmacies is reimbursable under NYS Medicaid.

The following conditions apply:

- Only Medicaid enrolled pharmacies that employ or contract with NYS certified pharmacists to administer vaccines will receive reimbursement for immunization services and products. Pharmacy interns cannot administer immunizations in New York State.

- Services must be provided and documented in accordance to NYS Department of Education laws and regulations. Visit: http://www.op.nysed.gov/prof/pharm/pharmimmunizations.htm for additional information.

- Pharmacies will only be able to bill for **Medicaid fee-for-service (FFS) non-dual enrollees**. Medicaid managed care enrollees will continue to access immunization services through their health plans. Dual eligible enrollees will continue to access immunization services through Medicare.

- Reimbursement for these vaccines will be based on a patient specific order or non-patient specific order. These orders must be kept on file at the pharmacy. The ordering prescriber's NPI is required on the claim for the claim to be paid.

- The Advisory Committee on Immunization Practices (ACIP)-recommended vaccines for individuals under the age of 19 are provided free of charge by the Vaccines for Children (VFC) program. Medicaid **will not** reimburse providers for vaccines for individuals under the age of 19 when available through the VFC program. Pharmacists are requested to refer VFC-eligible members to VFC-enrolled providers.

- Consistent with Medicaid immunization policy, pharmacies will bill the administration and acquisition cost of the vaccine using the appropriate procedure codes listed below. Please note that **National Drug Codes (NDC) are not to be used** for billing the vaccine product. Reimbursement for the product will be made at no more than the *actual* acquisition cost to the pharmacy. No dispensing fee or enrollee co-payment applies. Pharmacies will bill with a quantity of "1" and a day supply of "1".

Billing Instructions: Providers must submit via NCPDP D.0, in the Claim Segment field 436-E1 (Product/Service ID Qualifier), a value of "09" (HCPCS), which qualifies the code submitted in field 407-D7 (Product/Service ID) as a Procedure code. Lastly, in field 407-D7 (Product/Service ID), enter the Procedure code. Providers may submit up to 4 claim lines with one transaction. For example, providers may submit one claim line with the Procedure code 90656 (Influenza Virus Vaccine), and another claim line for Procedure code 90471 (Immunization Administration through 19 years of age and older). For administration (ages 19 and older) of multiple vaccines on the same date, code 90471 should be used for the first vaccine and 90472 for ANY other vaccines administered on that day. One line will be billed for 90472 indicating the additional number of vaccines administered (insert 1 or 2).

The following procedure codes should be billed for pharmacist administration of select influenza, pneumococcal and meningococcal vaccines for age 18 and over, and zoster for age 50 and over:

Procedure Code	Procedure Description
90620	Meningococcal recombinant protein and outer membrane vesicle vaccine, Serogroup B, 2 dose schedule, for intramuscular use
90621	Meningococcal recombinant lipoprotein vaccine, Serogroup B, 2 or 3 dose schedule, for intramuscular use
90653	Influenza virus vaccine (IIV), preservative free, for use in individuals 65 years of age and above, for intramuscular use
90656	Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years of age and above, for intramuscular use
90658	Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use
90661	Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use
90662	Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
90670	Pneumococcal conjugate vaccine, 13-valent, for intramuscular use
90672	Influenza virus vaccine, quadrivalent, live, for intranasal use in individuals 2 years of age through 49
90673	Influenza virus vaccine, trivalent, derived from recombinant DNA, preservative free, for intramuscular use for 18 years of age and older
90674	Influenza virus vaccine; quadrivalent, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use
90686	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use
90688	Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, with preservative, for intramuscular use
90714	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, for use in individuals seven years or older, for intramuscular use
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), for use in individuals 7 years or older, for intramuscular use
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years of age or older, for subcutaneous or intramuscular use
90733	Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use, age 2 years of age and older
90734	Meningococcal conjugate vaccine, Serogroups A,C,Y and W-135 (trivalent), for intramuscular use, age 11 through 55
90736	Zoster (shingles) Vaccine, live, for subcutaneous injection, age 50 and older
90471	Immunization **administration** (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid) **$13.23**
90472	Immunization **administration** (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure) **$13.23**

Note: The maximum fees for vaccine drugs are adjusted periodically by the State to reflect the estimated acquisition cost. Insert acquisition cost per dose in amount charged field on claim form. Questions regarding Medicaid reimbursement of immunizations may be directed to the Medicaid Pharmacy Program at 518 486-3209 or PPNO@health.ny.gov. Additional information on influenza can be found at NYS Department of Health's website at http://www.health.ny.gov/diseases/communicable/influenza/. CDC vaccine and immunization information can be found at http://www.cdc.gov/vaccines/.

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Reminder: Federal Mandate Regarding Copay Nonpayment

The NYS Medicaid Pharmacy Program has been notified some pharmacies are refusing to dispense medications to patients for their inability to pay the copayment. Social Security Act §1916 specifies that no Medicaid enrolled provider may deny care or services to an individual eligible for such care or services on account of such individual's inability to pay a deduction, cost sharing, or similar charge. As noted in the September 2011 Special Edition *Medicaid Update* cover-page and the March 2012 *Medicaid Update* page 15, confirms this Federal law applies to all Medicaid providers, both fee-for-service and managed care. **Providers may attempt to collect outstanding copayments through methods such as requesting the co-payment each time the member is provided services or goods, sending bills or any other legal means.**

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Billing Reminder for all Vision Care Providers

All fee-for-service (FFS) Medicaid providers are reminded to include the rendering provider ID or NPI on claims where the rendering provider is not the same as the billing provider. This applies to Optical Establishment providers enrolled with Category of Service 0401, 0402 or 0423 that employ Licensed Ophthalmic Dispensers (opticians) AND/OR Licensed Optometrists. For ophthalmic providers with Category of Service 0423, this rule applies even when the billing provider and the service provider are one and the same. Providers exempt from this rule include: Self-employed Ophthalmic Dispensers (opticians) enrolled with Category of Service 0404, Eye Prostheses Fitters with category of Service 0405 and Self-employed Optometrists enrolled with Category of Service 0422. Services rendered to Medicaid members at your service address may not be billed through any other provider number.

When any person has submitted or caused to be submitted claims for medical care, services or supplies for which payment should not have been made, the Department may require repayment of the amount overpaid. An overpayment includes any amount not authorized to be paid under the Medicaid Program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake.

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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All Providers

Integrated Services: Guidance for Licensed/Certified Facilities, Including Billing Under FFS and Medicaid Managed Care

This article is intended to inform providers about delivery of and billing for integrated services under fee-for-service (FFS) for sites using Ambulatory Patient Groups (APGs) and clarify which providers can offer integrated services, the amount of integrated services that can be delivered, licensure requirements, and the mechanisms for billing such services. This article is also intended to inform Managed Care Organizations (MCOs) about integrated services and the various ways providers are authorized to offer such services and the associated billing guidance that applies to integrated services providers.

Health care providers have long recognized that many patients have multiple physical and behavioral health care needs, yet services have traditionally been provided in silos. The integration of primary care, mental health and/or substance use disorder services can help improve the overall quality of care for individuals with multiple health conditions by treating the whole person in a more comprehensive manner.

To provide integrated services, dependent upon the type of integration selected, providers must possess at least one of the following licenses or certifications from the following host agencies: Department of Health (DOH) (PHL Article 28), Office of Mental Health (OMH) (MHL Article 31), or Office of Alcoholism and Substance Abuse Services (OASAS) (MHL Article 32).

Providing Integrated Services

There are three ways that a clinic provider may offer integrated services:

1. A provider that is either participating or **not** participating in Delivery System Reform Incentive Payment (DSRIP) 3.a.i may provide services that are at or below State-established annual visit thresholds (2008 Certificate of Need (CON) Reform for Ambulatory Services).
2. A provider that is participating in DSRIP 3.a.i that exceeds the 2008 CON thresholds but is providing services below a 49% threshold must seek waiver authority from its host agency to provide integrated services and sponsorship from a Performing Provider System (PPS).
3. A DSRIP or non-DSRIP provider may seek Integrated Outpatient Services (IOS) licensure from its host agency at any time.
    a. A **non-DSRIP** provider that is exceeding the 2008 CON threshold **must** obtain IOS licensure.
    b. A **DSRIP** provider that is exceeding a 49% threshold **must** obtain IOS licensure.

1. **DSRIP and non-DSRIP providers offering services below established annual visit thresholds (2008 CON Reform for Ambulatory Services Thresholds)**

   Prior to 2008, providers could not deliver services outside the scope of their licensure/certification without express authority from the state oversight agency that regulates the service (mental health, physical health, substance use disorder treatment). This construct required each provider to obtain multiple licenses/certifications to comprehensively treat complex patients. In an effort to improve quality of care, DOH, OMH and OASAS implemented Certificate of Need (CON) Reform to allow limited provision of services without additional licensure/certificate.

   - An Article 28 licensed provider may provide mental health services under a single license, as long as the services provided do not exceed the 2008 CON Reform for Ambulatory Services Threshold, which is the lesser of 10,000 visits annually or 30% of the total annual visits being for mental health services (site specific).
   - An Article 32 or Article 31 provider can provide up to 5% primary care services (site specific).
   - An Article 28 provider can only provide substance use disorder services after site-specific OASAS certification has been obtained (threshold is “0%”; i.e., cannot provide any substance use disorder (SUD) services without Article 32 certification).

In order for a DSRIP 3.a.i provider operating under the 2008 CON threshold (up to and including 10,000 visits or up to and including 30% of total annual visits at Article 28 facilities being for mental health or up to and including 5% of total annual visits at Article 31 or 32 facilities being for physical health) to bill for integrated services, the PPS lead must inform the Department's DSRIP team (at dsrip@health.ny.gov) that integrated services are being rendered and include site-specific information:

- Provider Name
- Provider Site Address
- Operating Certificate
- Medicaid Provider ID or NPI
- Host Agency Certification
- Services Integrated
- Locator Code (3 digits)
- Postal Code (+4 digits)

Additional information on 2008 CON reform can be found at: https://www.health.ny.gov/press/releases/2008/2008-03-04_con_reform_ambulatory_care_services.htm. Additional information on DSRIP and DSRIP 3.a.i can be found at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/ or: http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/regulatory_waivers/licensure_threshold_guidance.htm. Note: a non-DSRIP provider that is operating under the 2008 CON threshold does not need to inform the Department of its intent to provide integrated services.

2. DSRIP providers participating in 3.a.i that are above the 2008 CON Threshold, but at or below the 49% Threshold permitted under the DSRIP Program

If a DSRIP 3.a.i provider will exceed the 2008 CON threshold limits but will remain at or below a 49% threshold at a specific site, the provider must seek formal approval from the respective host agency (DSRIP Threshold Application). A licensed or certified provider may add primary care, mental health and/or substance use disorder services under a single license or certification, as long as the service to be added is not more than 49 percent of the provider's total annual visits ("DSRIP Project 3.a.i Licensure Threshold") and the patient initially presents to the provider for a service authorized by such provider's license or certification.

More information on this threshold and the application process can be found here: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/regulatory_waivers/draft_appl_instructions.htm.

3. DSRIP and non-DSRIP Providers operating under an Integrated Outpatient Service (IOS) licensure category

An alternative measure to improve integration of care was to enable service providers that hold or are in the process of obtaining at least two licenses or certifications across their organization to fully integrate services under the IOS regulations at authorized sites.

At any time, a DSRIP/ non-DSRIP provider has the option of fully integrating services under the IOS regulations. However, if a DSRIP provider will exceed the 49% threshold or a non-DSRIP provider will exceed the 2008 CON Reform for Ambulatory Services Thresholds, that provider may either apply to be an IOS provider or may apply for additional licensure or certification. Providers may not deliver services or bill Medicaid for services rendered above the licensure threshold amount unless the appropriate licensure or certification is in place at the time the service is rendered. Licensure and/or certification is site specific.

More information on IOS, including the application process, can be found here: https://www.health.ny.gov/facilities/cons/limited_review_application/lra_instructions_outpatient.htm. Regulations authorizing the provision of Integrated Services may be found at the following: OASAS: https://www.oasas.ny.gov/regs/documents/825.pdf, OMH: https://www.omh.ny.gov/omhweb/clinic_restructuring/integrated-services.html, DOH: http://www.health.ny.gov/regulations/recently_adopted/docs/2015-01-01_integrated_outpatient_services.pdf.

Co-Occurring Behavioral Health Care (Mental Health and Substance Use Disorder)

If an Article 31 of Article 32 provider wants to fully integrate behavioral health services they must submit a Threshold Application. Separate and apart from 2008 CON reform, Integrated Outpatient Service Licensure, and DSRIP, Article 31 and Article 32 providers have always had the ability to treat co-occurring substance use and mental health conditions when the patient presented with a primary diagnosis of mental health at an Article 31 or with a primary diagnosis of substance use disorder at an Article 32.

Reimbursement - DSRIP 3.a.i & IOS Participating Providers – Services Provided on the Same Day

Providers integrating services under the DSRIP 3.a.i Licensure Threshold or under IOS should submit one claim per visit, with all procedures/services rendered on the date of service (e.g., behavioral health services and primary care services). Payment will be processed through the APG grouper/pricer and paid in accordance with APG pricing rules associated with services normally billed under that APG rate code.

- When two evaluation and management (E&M) services are provided to a patient on the same date of service, both E&Ms may receive full payment. The provider should affix the separate practitioner (XP), separate encounter (XE) or unusual non-overlapping service (XU) modifier as appropriate on the E&M corresponding to the service that was integrated to allow the full payment and negate any consolidation that would normally apply. The primary diagnosis should be applicable to the first E&M and the secondary diagnosis should be applicable to the second E&M code, which should have the XP/XE/XU modifier.
- The 10% discount applied to behavioral health services is eliminated for DSRIP 3.a.i.and IOS providers.

DSRIP providers will be supplied site-specific rate codes to use for integrated services under Project 3.a.i. This will allow the DSRIP providers to track their threshold and to allow correct payment logic (both E&Ms will pay in full, eliminating the 10% discounting for the additional (second) integrated service).

DSRIP Fee-for-Service Rate Codes:

- 1102 - DOH DTC APG ART 28 INTEGRATED SVC (DSRIP)
- 1104 - DOH OPD APG ART 28 INTEGRATED SVC (DSRIP)
- 1060 - DOH DTC APG ART 28 IS MR/DD/TBI (DSRIP)
- 1062 - DOH OPD APG ART 28 IS MR/DD/TBI (DSRIP)
- 1106 - OMH DTC APG ART 31 INTEGRATED SVC (DSRIP)
- 1108 - OMH DTC APG ART 31 INTEGRATED SVC-SED (DSRIP)
- 1110 - OMH OPD APG ART 31 INTEGRATED SVC (DSRIP)
- 1112 - OMH OPD APG ART 31 INTEGRATED SVC-SED (DSRIP)
- 1114 - OASAS DTC APG ART 32 INTEGRATED SVC (DSRIP)
- 1116 - OASAS DTC APG MMTP INTEGRATED SVC (DSRIP)
- 1118 - OASAS OPD APG ART 32 INTEGRATED SVC (DSRIP)
- 1120 - OASAS OPD APG MMTP INTEGRATED SVC (DSRIP)

When DSRIP or non-DSRIP providers are reaching their respective threshold limits and/or hold multiple licensures or certifications, they can apply to be an IOS provider (See number 3). Once they are approved, they will receive the **Integrated Outpatient Services (IOS) rate codes**.

Integrated Outpatient Services (IOS) Fee-for-Service Rate Codes:

- 1480 - OMH DTC APG ART 31 INTEGRATED OUTPATIENT SVC
- 1483 - OMH DTC APG ART 31 INTEGRATED OUTPATIENT SVC-SED
- 1486 - OASAS DTC APG ART 32 INTEGRATED OUTPATIENT SVC
- 1594 - DOH OPD APG ART 28 INTEGRATED OUTPATIENT SVC
- 1597 - DOH DTC APG ART 28 INTEGRATED OUTPATIENT SVC
- 1003 - DOH DTC APG ART 28 MR/DD/TBI INTEGRATED OUTPATIENT SVC
- 1000 - DOH OPD APG ART 28 MR/DD/TBI INTEGRATED OUTPATIENT SVC
- 1122 - OMH OPD APG ART 31 INTEGRATED OUTPATIENT SVC
- 1124 - OMH OPD APG ART 31 INTEGRATED OUTPATIENT SVC-SED
- 1130 - OASAS DTC APG MMTP INTEGRATED OUTPATIENT SVC
- 1132 - OASAS OPD APG ART 32 INTEGRATED OUTPATIENT SVC
- 1134 - OASAS OPD APG MMTP INTEGRATED OUTPATIENT SVC

Reimbursement - Applicable to non-DSRIP, non-IOS Providers

Providers should submit one APG claim per visit with all procedures/services rendered on the date of service (e.g., behavioral health services and primary care services). Reimbursement will be based on the traditional APG grouper/pricer logic, including consolidation and discounting. No additional payment will be made for two E&Ms billed for the same recipient/same date of service.

Reimbursement - FQHCs

Federally Qualified Health Centers (FQHC) that have not opted into APGs should bill their all-inclusive prospective payment system (PPS) rate, which encompasses all services furnished to a patient on the same day.

Managed Care

Integrated services are reimbursable in fee-for-service Medicaid and Medicaid Managed Care. Medicaid MCOs are financially responsible to pay:

- Integrated license providers for all covered procedures/services including medical/physical and behavioral health care rendered to enrolled recipients in accordance with the current Medicaid Managed Care/Family Health Plus/HIV SNP Model Contract;
- Medicaid fee-for-service equivalent rates for mental health and/or substance use disorder procedures delivered by hospital-based and free-standing clinics dually licensed and/or certified under Article 28 of the Public Health Law, and Article 31 or Article 32 of the Mental Hygiene Law; and
- Medicaid fee-for-service equivalent rates, including modifiers affecting reimbursement, for mental health and substance use disorder procedures delivered by programs licensed, certified or designated pursuant to either Article 31 or Article 32 of the Mental Hygiene Law.

MCOs and providers may negotiate alternative payment arrangements including VBP arrangements. These must be approved by DOH in partnership with OMH and OASAS (Section 29 of Part B of Chapter 59 of the Laws of New York of 2016), when they effect licensed, certified or designated behavioral health providers.

MCOs are not required to pay the Medicaid FFS equivalent rates for medical/physical health services that are outside the scope of those services required pursuant to OMH/OASAS regulation.

For questions related to Medicaid FFS policy, please contact the Office of Health Insurance Programs, Division of Program Development and Management at (518) 473-2160. Billing questions for individuals enrolled in Medicaid Managed Care Plans should be directed to the individual enrollee's Medicaid Managed Care Plan. For questions related to the DSRIP Program, please contact dsrip@health.ny.gov.

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NY 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 $830 million*** in incentive funds have been distributed ***within 27,217*** payments to New York State Medicaid providers.

Eligible Professionals & Eligible Hospitals Total	
Payments Made: 27,217	Amount Paid: $830,208,626

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 9 CQMs to 6, 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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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.