New Medicare Card Replacement Initiative: MBI to be Returned on Eligibility Response

The eMedNY System is being enhanced to comply with the Centers for Medicare and Medicaid Services' New Medicare Card Replacement Initiative. **Effective September 20, 2018**, the Eligibility Response for clients enrolled in both Medicare and Medicaid will return the new Medicare Beneficiary (MBI), if available, when using the following access methods for Eligibility verification:

- ARU
- Electronic Provider Assisted Claim Entry System (ePACES)
- POS Devices
- 270/271 Transactions

Until 12/31/2019, if the MBI is not available for the client, the HICN (Health Insurance Claim Number) will be returned by the access methods noted above. **After 01/01/2020,** only the MBI will be returned by the access methods noted above.

Providers who use ePACES to verify eligibility should inform their staff or agent(s) that on 9/20/2018 the ePACES Eligibility Response Medicare Information Section's "Health Insurance Claim Number HIC" label will read "Medicare Identifier."

Providers who use the POS device to verify eligibility should inform their staff or agent(s) that even though the HICN Tag will not change**,** the MBI will be displayed if available, as of 9/20/2018. As with other access methods for eligibility, if the MBI is not available, HICN will be displayed until 1/1/2020. *The MBI is unique in that it contains only numbers and uppercase letters (no special characters) and will not contain the letters S, L, O, I, B, or Z.*

If you have any questions, please contact the eMedNY Call Center at 1-800-343-9000. More information on the New Medicare Card Replacement Initiative is available at https://www.emedny.org/info/MBI/index.aspx.

In This Issue…

Special Income Standard for Housing Expenses

A special income standard to help pay for housing expenses is available for certain nursing home residents and adult home residents who are on Medicaid and can safely transition to the community.

Some nursing home residents and adult home residents on Medicaid may be able to be safely discharged back to the community but may not have adequate income under regular Medicaid eligibility rules to afford housing in the community. A special income standard is available to provide an additional dollar amount of income that is added to the Medicaid income level to help individuals who qualify pay for housing expenses in the community.

The special income standard for housing expenses is available to individuals receiving Medicaid coverage of nursing facility services, other than short-term rehabilitation services, who are discharged from a nursing home to the community and enroll in, or remain enrolled in, a Medicaid Managed Long Term Care (MLTC) plan. It is also available to individuals who are in receipt of Medicaid while residing in an adult home, are discharged from an adult home to the community, and, if eligible, enroll in an MLTC plan. An adult home is statutorily defined as an adult care facility established and operated for the purpose of providing long-term residential care, room, board, housekeeping, personal care (either directly or indirectly), and supervision to five or more adults who are unrelated to the operator. Note: Individuals who meet the definition of an "institutionalized spouse" for spousal impoverishment budgeting purposes, and where post-eligibility rules are used to determine Medicaid eligibility, do not qualify for the special income standard for housing expenses.

The special income standard is used when calculating the former nursing home or adult home resident's income eligibility for Medicaid. The amount of the special income standard for housing expenses varies based on the region of the State where the individual resides and is subject to an annual increase based on increases to the Medicaid income levels and U.S. Department of Housing and Urban Development (HUD) rates. The dollar amount of the special income standard for housing is a set amount regardless of the actual amount of the individual's housing expenses.

The special income amounts for 2018 are:

Region	Amounts
Central Region	$417
Northeastern Region	$467
Western Region	$365
North Metropolitan Region	$935
New York City	$1,305
Long Island	$1,274
Rochester	$424

A Medicaid recipient may be eligible for the special income standard if he/she:
- is at least 18 years of age;
- has been a resident of a nursing home for at least 30 days where Medicaid made payment to the facility, is discharged to the community and enrolls in, or remains enrolled in, an MLTC plan;
- has been a resident of an adult home in receipt of Medicaid, is discharged to the community and, if eligible, enrolls in an MLTC plan; and
- has a housing expense, such as rent or a mortgage.

How nursing home administrators, adult home operators and MLTC plans should identify individuals who are eligible for the special income standard:

Nursing home administrators, nursing home discharge planning staff, adult home operators and MLTC plans are encouraged to identify individuals who may qualify for the special income standard, if they can be safely discharged back to the community from a nursing home and enroll in, or remain enrolled in, an MLTC plan; or safely discharged back to the community from an adult home and, if eligible, enroll in a MLTC plan. Once an individual has been accepted into an MLTC plan, the MLTC plan must notify the individual's local department of social services that the transition has occurred and that the individual may qualify for the special income standard. The special income standard will be effective upon enrollment into the MLTC plan, or, for nursing home residents already enrolled in an MLTC plan, the month of discharge to the community.

Questions regarding the special income standard may be directed to DOH at 518-474-8887.

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New Duplicate Editing for Pharmacy and Medical Crossover Claims

On September 20, 2018, system enhancements were added to the eMedNY system to identify duplicate crossover claims for Medicare Part B drugs/supplies that are submitted by Pharmacies via the National Council for Prescription Drug Programs (NCPDP) and Professional format.

Two new claim edits:
- Edit 02278- (Duplicate of a Pharmacy Claim) will be set to Pay and Reverse. When an in-process professional crossover claim contains a procedure code that is associated with a National Drug Code (NDC) on a pharmacy claim that is already paid in history for the client, the system will pay the incoming crossover claim and reverse the pharmacy claim. The pharmacy provider will see the reversed claim on their 835 or paper remittance.
- Edit 02279- (Duplicate of a Medical Crossover Claim Line), NCPDP Reject Code "83"- (Duplicate Paid/Captured Claim) will deny the in-process pharmacy claim when a medical crossover claim is found for the same client and the pharmacy claim National Drug Code (NDC) and history crossover claim procedure code are associated.

If providers have any questions about the association of procedure code to NDC code, refer to the following:
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2018ASPFiles.html
- https://www.dmepdac.com/crosswalk/2018.html
Note: Medicaid only reimburses for those drugs that are in the federal rebate program.

Please contact the eMedNY Call Center at (800) 343-9000 for questions regarding this billing requirement or any billing issue.

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New Edit to Validate Submitted Procedure Codes and Associated National Drug Codes (NDCs)

On September 20, 2018, enhancements were added to the eMedNY system to validate submitted procedure codes and their associated NDCs. A new edit will ensure that the submitted NDC reported on a professional claim is associated with the submitted procedure code.

New claims edit 02280- (Procedure Code and Drug Code Not Associated) will be set to deny when a procedure code is submitted with an NDC and they are not associated for the following claim types:

- Referred Ambulatory
- Practitioner

If providers have any questions regarding the association of the Procedure Code to the NDC, refer to the following:

- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2018ASPFiles.html
- https://www.dmepdac.com/crosswalk/2018.html
  Note: Medicaid only reimburses for those drugs that are in the federal rebate program.

Please contact the eMedNY Call Center at (800) 343-9000 for questions regarding this billing requirement or any billing issue.

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Reminder: Documentation Required for Medicare and Third-Party Insurance Primary Submissions

All crossover claims submitted from Medicare and other third-party billing should accurately reflect payments received from other insurers to allow correct calculation of Medicaid reimbursement amounts. The Explanation of Benefits and other documentation supporting Medicare and third-party reimbursement amounts must be kept for audit or inspection by the Department of Health, Office of the Medicaid Inspector General (OMIG), the Office of the State Comptroller (OSC) or other state or federal agencies responsible for audit functions.

Additionally, for any claim submitted to Medicaid with a zero-fill reimbursement from Medicare or a third-party insurer, the provider must retain evidence that the claim was initially billed to Medicare and/or the third-party insurer and was denied **before** seeking reimbursement from Medicaid. The exception to this policy in which providers may bill Medicaid directly without first receiving a denial is for items that are statutorily not covered by the Medicare program. Providers are responsible for retaining the statutory exemption from Medicare for audit or inspection.

Update - Clinic and Inpatient Claims Pending Review for Edit 02159

Effective **October 1, 2018**, eMedNY **edit 02159** (Delay Reason Code 3 (authorization delays invalid) will **pend** for review for clinic and inpatient claim types. **CARC 29** (Claim Adjustment Reason Code 29) with no Remittance Advice Remark Code (RARC) will be reported on the 835 remittances if the claim is denied. Claims pending for review will appear on the **Pended Claims Report with edit 02159** until the claim adjudication is finalized. On a Claim Status Request, Healthcare Claim Status Code 718 will be reported while the claim is pended for manual review.

We encourage providers to confirm that Delay Reason Code 3 is appropriate before submitting these claims. If Delay Reason Code 3 is appropriate, the provider must send supporting documentation for its use within 60 days from the date of claims submission to the following address:

>   New York State Department of Health
>   Attn: Medical Pended Claims
>   431B Broadway
>   Menands, NY 12204-2836

Please include the corresponding 16-digit Medicaid Transaction Control Number (TCN) of the pended claim(s) found on your Medicaid remittance. Final status of adjudicated claims will appear on the provider remittance statement. Failure to submit the documentation within 60 days will result in the claim being denied.

Please visit the *eMedNY.org website Timely Billing Information* section (https://www.emedny.org/info/TimelyBillingInformation_index.aspx) for slides from the most recent webinar on Timely Billing that includes common examples for the appropriate use and documentation for delay reason code 3 as well as other delay reasons used in Medicaid Claims processing..

General questions for claims submission should be directed to CSRA at 1-800-343-9000. Questions on specific claims that are pended for review should be directed to the Bureau of Medical Review, Pended Claims Unit at 1-800-342-3005 (option 3).

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Matching Origin Codes to Correct Prescription Serial Number in Medicaid Fee-for-Service (FFS)

Reminder: Prescriptions billed to Medicaid FFS require the appropriate origin code and corresponding serial number; the information describes the format the prescription was received. Serial numbers are a unique alpha numeric number on the bottom right of an Official New York Prescription Form (ONYSRx). The table below describes all the different circumstances a prescription may be obtained at various pharmacy types; and will assist in choosing the correct match.

It has been noticed that many pharmacies are billing with **incorrect information**; there has been and continue to be audits on these fields submitted by pharmacies. Please utilize the following chart to make the serial number determination:

Origin Code	Corresponding Serial	Description
1	Unique ONYSRx #	Written - Prescriptions prescribed in NY will be on Official New York Prescription forms with a designated serial number to use.
1	ZZZZZZZZ	Written - Prescriptions prescribed from out-of-state providers or by prescribers within a federal institution (e.g., US Department of Veterans Affairs) or Indian Reservation.
2	99999999	Telephone - Prescriptions obtained via oral instructions or interactive voice response using a telephone.
2	SSSSSSSS	Telephone – Fiscal orders obtained via oral instructions using a telephone. *
3	EEEEEEEE	Electronic - Prescriptions obtained via SCRIPT or HL7 standard transactions, or electronically within closed systems. **
4	Unique ONYSRx #	Facsimile – ONYSRx Prescriptions obtained via fax machine transmission.
4	SSSSSSSS	Facsimile – Fiscal Orders not on a ONYSRx obtained via fax machine transmission. *
4	NNNNNNNN	Facsimile - Prescriptions obtained via fax machine transmission for **nursing home** patients (excluding controlled substances) in accordance with written procedures approved by the medical or other authorized board of the facility.
5	TTTTTTTT	Pharmacy - this value is used to cover any situation where a new Rx number needs to be created from an existing valid prescription such as traditional transfers, intra-chain transfers, file buys, software upgrades/migration, and any reason necessary to give it a new number. ***
5	99999999	Pharmacy - this value is appropriate for "Pharmacy dispensing" when applicable such as non-patient specific orders, BTC (behind the counter), Plan B, established protocols, etc.
5	DDDDDDDD	Pharmacy - this value is used to cover prescriptions dispensed as Medically Necessary during a Declared State of Emergency (excluding controlled substances).

Footnotes:
* Dispensing provider is required to obtain the original signed Fiscal order from the ordering provider within 30 days.
** Fail-over electronically transmitted prescriptions that come to the pharmacy as a facsimile are invalid. Reference:
http://www.op.nysed.gov/prof/pharm/pharmelectrans.htm
*** Remember to use original date prescribed as "written date" when processing prescription transfers. Transfers are not allowed for controlled substances in New York State.

For questions on this billing requirement, providers may contact the eMedNY Call Center at (800) 343-9000.

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NYS Medicaid FFS Program Pharmacists as Immunizers Fact Sheet

New York State (NYS) Education Law (6527, 6801, 6802, 6909) and regulations (8 NYCRR 63.9) permits licensed pharmacists who obtain additional certification to administer the following vaccines: Zoster, pneumococcal, meningococcal, tetanus, diphtheria, and pertussis vaccines when administered to patients 18 years of age or older; Influenza vaccines when administered to patients two years of age and older.

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 NYS.

- Services must be provided and documented in accordance with NYS Department of Education laws and regulations. Visit http://www.op.nysed.gov/prof/pharm/pharmimmunizations.htm for additional information, including the reporting of all immunizations administered to persons less than 19 years of age to NYS DOH using the NYS Immunization Information System (NYSIIS) or to the New York Citywide Immunization Registry.

- Pharmacies will only be able to bill for **Medicaid fee-for-service non-dual enrollees**. Dual eligible enrollees will continue to access immunization services through Medicare.

- Medicaid Managed Care members will continue to access immunization services through their health plans. For Medicaid Managed Care Organization (MCO) billing guidance please contact the plan.

- 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 to Medicaid members (both FFS and MCO) free of charge by the Vaccines for Children (VFC) program.

  o Pharmacies wishing to administer VFC-available vaccines to Medicaid members **under 19 years of age must** be enrolled in the VFC program and obtain vaccines through the VFC program.

  o Payment is available for the **administration fee of a VFC vaccine** with procedure code 90460 for administration to members less than 19 years of age.

  o NYS Medicaid should **never** be billed for the cost of **any** vaccine for persons under 19 years of age when it is available through the VFC program. This applies to both FFS and MMC members. **Pharmacies that bill Medicaid for the cost of vaccines available through VFC are subject to recovery of payment.**

- Consistent with Medicaid immunization policy, pharmacies will bill the administration fee and, when applicable, acquisition cost of the vaccine using the appropriate procedure codes. Procedure codes can be found here: https://www.emedny.org/ProviderManuals/Pharmacy/index.aspx. Please note that **NDCs are not to be used** for billing the vaccine product. Reimbursement for the cost of the vaccine for ages 19 and above 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 four (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 19 years of age and older). For administration of multiple vaccines on the same date to patients ages 19 and older, code 90471 should be used for the first vaccine and 90472 for ANY other vaccines administered on that day. One line should be billed for 90472 indicating the additional number of vaccines administered (insert quantity of 1 or 2). Use 90460 for administration of first or subsequent doses to members less than 19 years of age.

Please check the following site for updates on procedure codes for vaccines, under 'OTC and Supply Fee Schedule': https://www.emedny.org/ProviderManuals/Pharmacy/index.aspx.

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
90682	Influenza virus vaccine, quadrivalent, (RIV4), derived from recombinant DNA, 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
90750	Zoster (shingles) Vaccine, age 50 and older for intramuscular use
90756	Influenza virus vaccine, quadrivalent, antibiotic free, for intramuscular use

The procedure codes below should be used for the actual administration of the vaccines listed above by a pharmacist:

Procedure Code	Procedure Description
90473	Immunization **administration** of seasonal influenza intranasal vaccine **$8.57**
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**
90460	Immunization **administration** of free vaccine through VFC Program for ages under 19 years **$17.85**

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: Handling Prescription Transfers in Medicaid Fee for Service

Transfers for Medicaid Fee For Service (FFS) are allowed for eligible prescriptions as first published in the April 2015 *Medicaid Update.* All eligible non-control prescription drug and Over The Counter (OTC) drug transfers should be done in accordance with New York State Education Department (NYSED) prescription requirements: http://www.op.nysed.gov/prof/pharm/part63.htm including only one fill may be transferred at a time from either a new unfilled non-control electronic prescription or refill remaining on a prescription from the original pharmacy.

In addition to the NYSED requirements NYS Medicaid requires:

- Submission of non-control prescription drug and OTC drug transfers with origin code value of 5 in the origin code field (419-DJ).
- The serial number field (454-EK) is a required field when submitting a claim to NYS Medicaid; use the value of TTTTTTTT in the serial number field to indicate a prescription transfer, in lieu of reporting the original prescription's Official Prescription Form Serial Number.
- Prescriptions may be refilled no more than 180 days after it has been initiated by the prescriber. The original written or prescribed date is required to be submitted on the claim. **Changing a written date to bypass the edit is considered fraudulent billing and is auditable.**
- For transfer billing guidance in Medicaid Managed Care plans, providers should check with the individual plans.

For billing questions please contact Computer Sciences Corporation at 1-800-343-9000. For policy questions the provider may contact the Pharmacy Department at 518-486-3209 or ppno@health.ny.gov.
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Attention: New Provider Enrollment Section on eMedNY

The Provider Enrollment section of www.eMedNY.org has been enhanced with the following features:
- Easier navigation
- Forms are more accessible
- Requirements and instructions are more clearly defined
- Improved interaction and performance

For a help document, visit:
https://www.emedny.org/info/ProviderEnrollment/HELP_GUIDE_NEW_ENROLLMENT_SECTION.pdf.

Some of the enhancements include:
- **Provider Index Page - Filtered Provider Listing**
  The provider listing on the main provider enrollment index page can now be filtered by enrollment type, simply by clicking on the desired radio button or image next to that radio button. The list will then be filtered, displaying only the provider types in that grouping.

- **Enrollment Guide Page**
  The enrollment guide page has been updated to be easy to read and clearly outlines necessary steps for different types of enrollment.

- **Individual Provider Pages – New Layout**
  A **Quick Box** to get information including link to enrollment form, category of service, change of address form and whether an application fee is required.

- **Five Expandable Sections** outlining instructions and requirements including general overall Instructions and print guidelines, additional instructions for certain enrollment form fields, requirements and additional forms, maintenance forms, and mailing instructions.

For questions, please contact the eMedNY Call Center at 800-343-9000.
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NY Medicaid EHR Incentive Program

The [NY Medicaid Electronic Health Record (EHR) Incentive Program](#) promotes the transition to EHRs by providing financial incentives to eligible professionals and hospitals. Providers who demonstrate Meaningful Use of their EHR systems are leading the way towards Interoperability, which is the ability of healthcare providers to exchange and use patient health records electronically. The ultimate goal is to increase patient involvement, reduce costs, and improve health outcomes. Since December 2011 over **$928 million** in incentive funds has been distributed **through 35,736** payments to New York State Medicaid providers.

Since 2011, Eligible Professionals & Eligible Hospitals have received:

Number of Payments:	Distributed Funds:
35,736	$928,904,653

Eligible Professionals (EPs) are asking: "I have completed participation in the NY Medicaid EHR Incentive Program for six years. What now?" **Congratulations!** We recognize and appreciate the efforts made to complete six years, the maximum number allowed for participation with the NY Medicaid EHR Incentive Program. Under this program, EPs can receive up to a total of $63,750 over the six years that they choose to participate in the program. Participation years do not need to be consecutive, however, EPs must have begun participation in the NY Medicaid EHR Incentive Program by 2016. The last year to receive an incentive payment is 2021.

Webinar Schedule for October 2018
We've added a new Webinar! *Security Risk Analysis (SRA)* is intended for EPs who are attesting to Modified Stage 2 or Stage 3 for 2018

Webinar	Date	Time
Meaningful Use Modified Stage 2	October 9, 2018	10:00am-11:00am
Meaningful Use Stage 3	October 12, 2018	11:00am-12:00pm
Modified Stage 2 for New Meaningful Users	October 25, 2018	2:00pm-3:00pm
2018 MU Public Health Reporting	October 17, 2018	2:00pm-3:00pm
New! Security Risk Analysis (SRA)	October 30, 2018	9:00am-10:00am

Reminder: 2018 Meaningful Use Registration for Public Health
To meet the 2018 Meaningful Use Public Health Reporting requirements for the NY Medicaid EHR Incentive Program, providers must complete their registration of intent in the Meaningful Use Registration for Public Health (MURPH) System**. Registration of intent must be completed before or within 60 days of the start of the provider's 2018 EHR reporting period.**

2017 MU Attestation Tutorial Series
NY Medicaid EHR Incentive Program has produced a series of MEIPASS tutorials to help you with your 2017 Modified Stage 2 or Stage 3 Meaningful Use Attestation:
- [Part 1: Beginning the Attestation Process](#)
- [Part 2A: Attesting to Modified Stage 2](#)
- [Part 2B: Attesting to Stage 3](#)
- [Part 3: Clinical Quality Measure (CQM) Reporting](#)
- [Part 4: eSignature and Attestation Submission](#)

Customer Satisfaction Survey

The NY Medicaid EHR Incentive Program is looking for feedback. We want to continue to provide quality services to Medicaid providers throughout New York State so, we have developed and launched a new program survey. The survey is short (it takes less than two minutes to complete!) and we welcome your valuable insight. Please visit http://www.surveymonkey.com/r/ny_ehr to complete the survey.

Visit Our Website

Find the following information and much more at: https://www.health.ny.gov/ehr.
- Payment Year 2017 and 2018 Requirements – Modified Stage 2 and Stage 3
- 2017 Meaningful Use MEIPASS Tutorial Series
- Eligible Hospital Requirements
- Public Health Reporting Objective Information
- Post-Payment Audit Guidance
- Frequently Asked Questions (FAQs)
- Materials and Information – Document Repository
- Sign up to receive LISTSERV® messages - NY Medicaid EHR Incentive Program and Public Health

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

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Reminder: View Your ETIN Decertification Date in ePaces

The electronic Provider Assisted Claim Entry System (ePACES) allows you to view the date the Electronic Transmitter Identification Number (ETIN) enrolled in ePACES will be decertified. It is important to recertify your ETIN annually in order to prevent any interruption in services such as eligibility verification, claim submission, claim status inquiry, and access to eMedNY remittances.

To view the ePACES ETIN decertification date:
1. Login to ePACES at: https://www.emedny.org/epaces/.
2. Select "**Submitter**" under the Support Files section on the left-hand side of the page.
3. The ETIN and the decertification date of the ETIN will display. (The ETIN must be recertified by this date.)

Please be sure to use this information to maintain your ETIN certification as a submitter with eMedNY in order to prevent interruption of service. *If your ETIN is about to expire, the form and instructions to recertify are here: https://www.emedny.org/info/ProviderEnrollment/ProviderMaintForms/490501_ETIN_CERT_Certification_Statement_Cert_Instructions_for_Existing_ETINs.pdf.*

To learn more about ePACES visit: https://www.emedny.org/selfhelp/ePACES/ePACES_GeneralInfo.aspx. For questions about ETINs or ePACES contact the eMedNY Call Center at 1-800- 343-9000.

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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 https://www.emedny.org/.

Providers wishing to listen to the current week's check/EFT amounts:
Please call (866) 307-5549 (available Thursday PM for one week for the current week's amount).

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 https://www.emedny.org/training/index.aspx. For individual training requests, call (800) 343-9000.

Beneficiary Eligibility:
Call the Touchtone Telephone Verification System at (800) 997-1111.

Medicaid Prescriber Education Program:
For current information on best practices in pharmacotherapy, please visit the following websites:
http://www.health.ny.gov/health_care/medicaid/program/prescriber_education/presc-educationprog

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

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