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New York State
Medicaid Update

IN THIS ISSUE...

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STATE OF NEW YORK
DEPARTMENT OF HEALTH

State Health Department Designates Bariatric Surgery Centers for Medicaid in NYC

The NYS Department of Health (NYSDOH) recently announced that five New York City hospitals have received designation as Bariatric Specialty Centers. **Effective for discharges on and after January 1, 2010,** (pending Office of the State Comptroller contract approval), only these selected hospitals will be reimbursed for bariatric surgery for Medicaid fee-for-service recipients who reside in the five boroughs of New York City. This policy applies to reimbursement for bariatric surgical procedures defined by APR-DRG 403 and all associated inpatient care. Claims for bariatric surgery submitted from institutions other than those listed below after January 1, 2010 will be denied.

The five designated New York City hospitals include:

> **Harlem Medical Center (Manhattan)**
> **St. Luke's Roosevelt (Manhattan)**
> **Brookdale Medical Center (Brooklyn)**
> **Lutheran Medical Center (Brooklyn)**
> **Montefiore Medical Center (Bronx)**

These hospitals have demonstrated experience in performing bariatric surgery and have developed pre and post surgical programs to ensure that Medicaid beneficiaries receive the best care and have the best surgical outcomes.

Also, effective January 1, 2010, Medicaid Managed Care (MMC) enrollees requiring bariatric surgery will be limited to these designated Bariatric Specialty Centers or a hospital that meets Centers for Medicare and Medicaid Services' (CMS) minimum facility standards, and is designated either by the American College of Surgeons and/or the American Society for Metabolic and Bariatric Surgery.

A list of these facilities are available for viewing at: http://www.cms.hhs.gov/MedicareApprovedFacilitie/bsf/list.asp. Please contact Michael Lindsey at (518) 486-9012 with any questions.

PLEASE NOTE: Increase in Practitioner and Clinic Medicaid Reimbursement for Administration of H1N1 Flu Vaccine Provided to Patients Under Age 19

Effective October 1, 2009, Medicaid increased the H1N1 flu administration fee from **$13.23 to $17.85** for vaccine provided to persons under age 19. Please refer to the following Article 28 Clinic and Office-Based Practitioner charts for revised billing instructions. General information as well as detailed billing instructions, for both seasonal and H1N1 flu administration, is available in the October 2009 Medicaid Update Special Edition.

Additionally, under a recent Executive Order issued by Governor Paterson, pharmacies can now provide seasonal and H1N1 flu immunizations to persons under age 18. Separate, specific billing instructions will be provided to pharmacies.

Updated: Medicaid Article 28 Clinic FFS Billing Chart

Immunization Type	Code For Vaccine	Code for Administration	Medicaid Reimbursement for Vaccine	Medicaid Reimbursement for Administration	Vaccine for Children Program (VFC)
		Age 19 and older			***Up to Age 19***
Seasonal Flu	90655 90656 90657 90658 90660	G0008 for intramuscular administration 90473 for intranasal or oral administration	Actual Acquisition Cost	**$13.23** **$8.57**	**Enhanced administration fee of $17.85** Bill vaccine procedure code as an ordered ambulatory service and append with "SL" modifier *(do not bill an administration code)*
Pneumococcal	90669 90732	G0009 for intramuscular administration	Same as Above	**$13.23**	Same as Above
H1N1	90663 (*does not need to be reported for age 19 and older)*	90470 for any route of administration	$0 *(vaccine supplied for free)*	**$13.23**	***New Payment Policy*** **Enhanced administration fee of $17.85** Bill vaccine procedure code 90663 as an ordered ambulatory service and append with "SL" modifier *(do not bill an administration code)*

-continued-

PLEASE NOTE: Increase in Practitioner and Clinic Medicaid Reimbursement for Administration of H1N1 Flu Vaccine Provided to Patients Under Age 19 **(continued)**

Updated: Medicaid Office-Based Practitioner FFS Billing Chart

Immunization Type	Code For Vaccine	Code for Administration	Medicaid Reimbursement for Vaccine	Medicaid Reimbursement for Administration *(Amount varies based on billing provider)*	Vaccine for Children Program (VFC)
		Age 19 and older			***Up to Age 19***
Seasonal Flu	90655 90656 90657 90658	G0008 for intramuscular administration	Actual Acquisition Cost	**$13.23** – physician **$11.25** – nurse practitioner or licensed midwife	**Enhanced administration fee of $17.85** Bill vaccine procedure code and append with "SL" modifier *(do not bill an administration code)*
	90660	90473 for intranasal or oral administration		**$8.57** – physician **$7.28** – nurse practitioner or licensed midwife	
Pneumococcal	90669 90732	G0009 for intramuscular administration	Same as Above	**$13.23** – physician **$11.25** – nurse practitioner or licensed midwife	Same as Above
H1N1	90663 *(does not need to be reported for age 19 and over)*	90470 for any route of administration	$0 *(vaccine supplied for free)*	**$13.23** – physician **$11.25** – nurse practitioner or licensed midwife	***New Payment Policy*** **Enhanced administration fee of $17.85** Bill vaccine procedure code 90663 and append with "SL" modifier *(do not bill an administration code)*

Medicare Crossover Update

Information for Providers Who Do Not Want to Receive Paper Remittances

Effective December 3, 2009, Medicare will automatically send crossover claims for "dual eligibles" (clients with both Medicare A and/or B and NY Medicaid coverage) directly to eMedNY. eMedNY will process the claims and reimburse the submitted deductibles, co-insurance, and copays (patient responsibility (PR)) to Medicaid providers. Providers will no longer need to submit a separate claim for patient responsibility directly to Medicaid. Details of the Medicare Crossover process can be found in the September and October 2009 editions of the Medicaid Update. **Please note that automatic crossovers do not apply to Medicare pharmacy claims.**

While the Medicare crossover process will not change the content of the Medicaid remittances (paper or electronic), all crossover claims will be reported on paper remittances unless providers select a default Electronic Transmitter Identifier Number (ETIN). Providers who currently receive paper remittance from Medicaid and wish to continue receiving them in the future do not need to take any action.

Providers who receive electronic remittances and wish to have their crossover claims also reported on the electronic remittance need to select a default ETIN from eMedNY. If you have already selected a default ETIN, the crossover claims will be reported on that electronic remittance. If you do not know if you have a default ETIN, please call the eMedNY Call Center at the number below to verify if a default ETIN has been selected.

To set-up a default ETIN, providers must complete the Default ETIN Selection Form available at: http://www.emedny.org/info/ProviderEnrollment/Provider%20Maintenance%20Forms/Electronic%20Remittance%20Request%20Form.pdf

Providers with only one ETIN will still need to select it as the default, or their crossover claims will be reported on paper remittances. **Questions?** Please call the eMedNY Call Center at (800) 343-9000.

Laboratory and Radiological Medicaid Claims Containing General ICD-9 Diagnostic Codes Will Deny

Effective December 1, 2009, all orders for laboratory or radiology procedures must indicate the diagnosis by use of the appropriate ICD-9-CM code. Use of general ICD-9-CM codes such as those listed below or other non-specific codes does not satisfy this requirement. The following ICD-9 diagnosis codes are invalid as primary diagnosis codes for purposes of Medicaid reimbursement:

- ***V72.5 – Radiological examination, not elsewhere classified***
- ***V72.6 – Laboratory examination***

Claims submitted after December 1, 2009, with non-specific diagnoses will be denied. **Questions?** Please contact the Bureau of Policy Development and Coverage at (518) 473-2160.

Instructions for Beneficieries Enrolled in Medicare Managed Care Plans

Effective February 2010, the NYS Department of Health (NYSDOH) will implement a new data source to identify Medicare managed care plans and update their Medicare managed care information (plan code and coverages) to eMedNY. **The NYSDOH has developed the following billing guidelines to assist providers with proper and timely claim submission of electronic claims:**

Medicaid Recipients with Medicare Managed Care (HMO/MCO) Coverage

- *Medicare Advantage plans are identified by a Claim Filing Indicator Code of 16 - Health Maintenance Organization (HMO) Medicare Risk - in loop 2320, data element SBR09. This code value will satisfy eMedNY's Medicare editing requirements.*
- *eMedNY edit number 2016, "Medicare MCO Qualifier 16 conflicts with Part A/B Qualifiers" was implemented on February 1, 2007. This edit will fail when the claim contains a Claim Filing Indicator Code of 16 along with a code of MA - Medicare Part A or MB - Medicare Part B.*
- *If the patient is enrolled in a Medicare Advantage plan there should be no Part A or Part B coverage entered on the claim for the same period.*
- *Claims spanning a period of time where the patient did have Medicare coverage under both fee-for-service and a managed care plan must be split billed.*

Instructions for Claims other than Nursing Homes

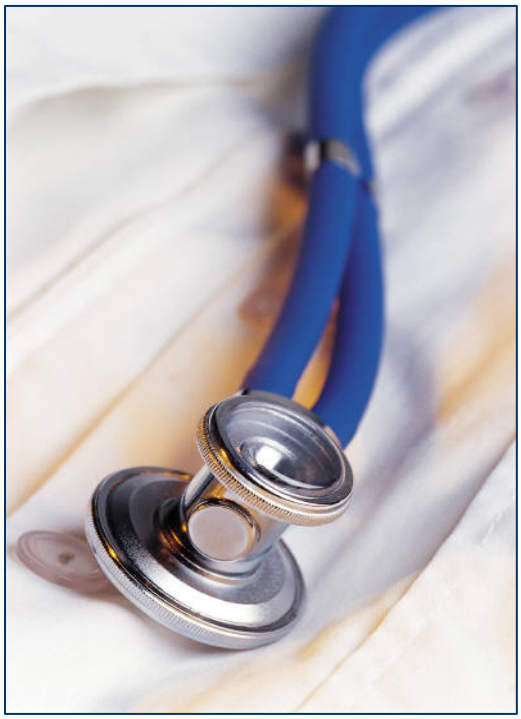
- *Medicaid will recognize the following Claim Adjustment Reason Codes (CARCs) as Patient Responsibility: 1 - Deductible, 2 - Coinsurance, 3 - Co-payment, and 122 - Psychiatric Reduction. The Claim Adjustment Group Code must be PR, "Patient Responsibility." All other CARCs with Claim Adjustment Group Code of "PR" will be treated as coinsurance.*
- *For all claim types except Nursing Home claims, when the Claim Filing Indicator Code of 16 is sent, the Medicaid payment amount will equal the Patient Responsibility total amount.*

Nursing Home Claims

- *If all days on the claim are reported as Medicaid Covered Days (loop 2300, QTY*CA) the system will determine the Medicaid value of the claim (Rate * Days = the amount Medicaid would have paid as the primary payer) and subtract the total of all prior payers' payments to receive the remaining balance.*
- *For Medicaid recipients with nursing home inpatient coverage through a Medicare Managed Care plan, the Patient Responsibility - Deductible, Coinsurance, and copay as appropriate can be billed. All the days must be entered as Medicare Coinsurance Days (loop 2320, QTY*CD). The reimbursement amount will be the total Patient Responsibility (deductible, coinsurance and copay).*
- *An eMedNY edit number 2059, "Medicaid Days invalid on Medicare Managed Care Claim" was implemented on February 1, 2007. If a Nursing Home claim has both Medicaid full days and Coinsurance days with MCO involvement, then the claim will be denied for edit 2059. The claim must be split and two claims must be billed separately.*

Questions? Please contact the eMedNY Call Center at (800) 343-9000.

Mandatory Compliance Program Certification Required by December 31, 2009



A new Part 521, entitled Provider Compliance Programs, was added to Title 18 of the New York State Codes, Rules and Regulations and became effective July 1, 2009. Pursuant to New York Social Services Law 363-d (3) (b), providers have 90 days thereafter to comply. This regulation requires all Medicaid providers who fall under the following categories to adopt and implement a compliance program by October 1, 2009:

- ***persons subject to the provisions of articles 28 or 36 of the New York State Public Health Law;***
- ***persons subject to the provisions of Articles 16 or 31 of the New York State Mental Hygiene Law;***
- ***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 eight elements required under 18 NYCRR § 521.3. 18 NYCRR 521.3 (b) which requires providers to certify to the department that a compliance program meeting the requirements of the regulation is in place, upon applying for enrollment in the medical assistance program, and during the month of December each year thereafter.

The deadline for providers to certify is **December 31, 2009**. The regulation, certification form, and FAQ's are available on the OMIG Website at www.omig.state.ny.us.

Medicaid Outpatient Coding Edits Reminder

Effective December 1, 2009, New York Medicaid will change the status of the following coding edits to deny payment.

Code	Description	Current Status	New Status
00070	*Proc. Code Invalid*	*Pay & Report (3)*	*Set to Deny*
00148	*Secondary Diag. Not On File*	*Ignore (1)*	*Set to Deny*
00170	*Proc. Code Not On File*	*Pay & Report (3)*	*Set to Deny*
00218	*Proc. Code Invalid For Cat. of Serv.*	*Pay & Report (3)*	*Set to Deny*

All providers billing Medicaid including those billing hospital based and freestanding outpatient services, including behavioral health services, are responsible for submitting complete and accurate claims data.

The ICD-9 diagnosis and HCPCS/CPT-4 procedure coding submitted on claims must be inclusive of all services relating to the visit and must be in accordance with the most recent coding updates for all reimbursement methodologies under which the claim is being adjudicated.

This action will support the accuracy and completeness of Medicaid claims data. It will also ensure that complete data is available for preparing the Upper Payment Limit (UPL) calculations for the Centers for Medicare and Medicaid Services (CMS).

Incomplete and inaccurate data in UPL calculations may result in the inability to meet this critical test and a possible reduction of federal financial participation for all Medicaid outpatient services.

Providers should review their claiming and billing processes to ensure that claims data is both accurate and complete. Specifics regarding the new claims edits will be shared with providers and their associations prior to implementation.

Questions? Please contact Philip Mossman at (518) 474-1673.

Medicaid Beneficiaries Cannot Be Billed for the Cost of a Non-Related Transplant Donor Search

Medicaid beneficiaries, including those enrolled in Family Health Plus or a Medicaid Managed Care, are **not** to be held financially responsible and/or billed for the cost of an unrelated donor search in preparation for a transplant (e.g., bone marrow/stem cell).

The costs incurred for an unrelated donor search are included in Medicaid's payment to the facility under the Diagnosis Related Group (DRG) payment methodology. In the event that a donor match cannot be located and the transplant never occurs, the DRG claim would not be paid, and the costs incurred for the donor search would be reported on the facility's Institutional Cost Report (ICR).

Important Reminders:

- A **hospital** that accepts a Medicaid enrollee as a patient, including those individuals enrolled in Family Health Plus or a Medicaid Managed Care, accepts responsibility for making sure that the patient receives all **medically necessary** care and services.
- Other than for legally established co-payments, a Medicaid or Family Health Plus enrollee **should never be required to bear any out-of-pocket expenses** for medically necessary services.
- This policy applies regardless of whether the treating practitioner is enrolled in Medicaid.

Questions? Please contact the Bureau of Policy Development and Coverage at (518) 473-2160.

Transportation Providers:

Medicaid Enrollment Does Not Supplant Local Regulations

Title 18 NYCRR §505.10(e)(6) indicates that providers must, regardless of Medicaid enrollment status, comply with applicable regulatory requirements. For ambulette, taxi and livery companies, this may include local licensure by a municipality or a Taxi and Limousine Commission. Failure to comply with local regulations may result in termination from Medicaid enrollment, as well as action by the local regulatory entity. Please contact the Medicaid Transportation Policy Unit via e-mail at: MedTrans@health.state.ny.us.

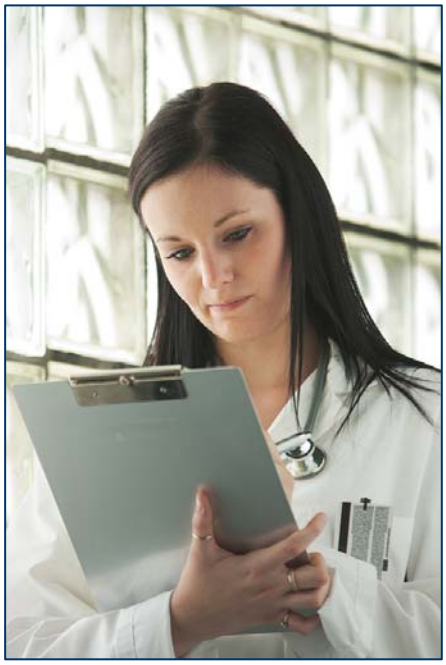
Ambulette Providers:

Inappropriate Use of the Star of Life Symbol on Ambulette Vehicles

The "Star of Life" logo is to be used to identify emergency response vehicles that respond to an emergency situation that may necessitate medical care. It is inappropriate for this symbol to be affixed to a vehicle operated by a non-medical provider.

Please contact the Medicaid Transportation Policy Department at (518) 408-4825 or via e-mail at: MedTrans@health.state.ny.us.

Distribution of Medically Fragile Enhanced Rate



Based on legislative and regulatory authority, private duty nursing providers were notified in 2007 that Medicaid pays an enhanced fee to eligible independent and agency Private Duty Nursing (PDN) providers of continuous pediatric private duty nursing services. The enhanced fee is a 30 percent add-on to payable claims submitted by enrolled PDN providers, who have submitted appropriate attestation to have Specialty 579 added to their enrollment files. Payment of the enhanced fee began in August 2007 with dates of service retroactive to January 1, 2007.

The Department notified providers that the legislative intent is to pay the entire 30 percent add-on, net of any fixed costs, to the nurses directly providing the service to the patient. Examples of fixed costs include the nursing agency (employer) share of Social Security, tax withholdings and other pro rata premiums such that after payment of such fixed costs, the nursing agency provider neither gains nor loses as a result of the 30 percent add-on. Nursing agency providers were advised to review their payment records and ensure that any add-on monies received are paid to their nurses in accordance with the above clarification.

There are no other allowable uses of the 30 percent add-on. The rate enhancement can only be paid to the qualified private duty nurse who actually provided the nursing services to the medically fragile child, for which Medicaid has reimbursed the Licensed Home Care Services Agency (LHCSA). Rates of payment for continuous nursing services provided by a LHCSA to a medically fragile child, whether provided by registered nurses or licensed practical nurses who are employed by or under contract with such agencies, are to be reimbursed with a rate enhancement of 30% added on to the standard rate.

LHCSAs are required to use such enhanced rates to increase payments to registered nurses and licensed practical nurses who provide such services. The add-on cannot be retained by the LHCSA, and can only be paid to the nurse providing the services, because the 30% add-on to the rate constitutes reimbursement only for services actually provided to a medically fragile child. The relevant legislative authority characterizes the add-on as an increased rate for services rendered to the medically fragile child, and provides that the enhanced rate is payable only to the qualified private duty nurse.

In cases where a nurse is no longer employed by the agency receiving the enhanced rate, the agency must locate the nurse and pay her/him those amounts. If the agency has difficulty locating the nurse, New York State Labor Law, Department of Labor regulations, State Finance Law, Abandoned Property Law, and other state statutes and regulations would apply to the proper disposition of amounts due to the nurse. These amounts cannot be aggregated with or comingled with other funds and then used by the agency to pay any other nurses, even for other services rendered to the same or other medically fragile patients. There are no other appropriate uses for these funds. Sign-on hiring fees, quality performance bonuses, raises for agency nurses, payment to keep a nurse on the case while the patient is hospitalized, or payment to nurses who did not actually provide the specific services for which the Medicaid reimbursement is paid to the agency provider are not appropriate uses for these funds.

Questions? Please contact the Provider Relations and Utilization Management Division at (800) 342-3005.

PLEASE NOTE: Change in Billing Procedures for Medicaid Pharmacy Administration of H1N1, Pneumococcal, and Seasonal Flu Vaccine Provided to Enrollees Under Age 19

Effective October 15, 2009, the administration of select vaccines by qualified pharmacists employed by, or under contract with, Medicaid enrolled pharmacies is reimbursable under New York State Medicaid. Administration of vaccines are conducted pursuant to New York State Education Law and regulations (8NYCRR63.9) which permits licensed pharmacists who obtain additional certification to administer influenza and pneumococcal vaccinations to adults 18 years of age and older. Since the H1N1 vaccine will be provided free of charge by the Centers for Disease Control and Prevention (CDC), Medicaid will not reimburse providers for the H1N1 vaccine.

The seasonal flu and pneumococcal vaccines for individuals under the age of 19 are being provided free of charge by the Vaccines for Children (VFC) program. Therefore, effective November 10, 2009, Medicaid will not reimburse providers for the seasonal flu and pneumococcal vaccines for individuals under the age of 19. For VFC enrollment information, go to: http://nyhealth.gov/prevention/immunization/vaccines_for_children.htm.

Updated: Medicaid Pharmacy FFS Billing Chart

Immunization Type	Code For Vaccine	Code for Administration	Medicaid Reimbursement for Vaccine	Medicaid Reimbursement for Administration *(Amount varies based on billing provider)*	Vaccine for Children Program (VFC)
		Age 19 and older			***Up to Age 19***
Seasonal Flu	90656 90658	G0008 for intramuscular administration	Actual Acquisition Cost	**$13.23**	**$13.23** Bill vaccine administration code only *(do not bill vaccine procedure code)*
	90660	90473 for intranasal or oral administration		**$8.57**	$8.57 Bill vaccine administration code only *(do not bill vaccine procedure code)*
Pneumococcal	90732	G0009 for intramuscular administration	Same as Above	**$13.23**	**$13.23** Bill vaccine administration code only *(do not bill vaccine procedure code)*
H1N1	90663 *(does not need to be reported)*	90470 for any route of administration	$0 *(vaccine supplied for free)*	**$13.23**	**$13.23** Bill vaccine administration code only *(do not bill vaccine procedure code)*

Questions regarding Medicaid pharmacy reimbursement of immunizations may be directed to the Medicaid Pharmacy Program at (518) 486-3209 or via e-mail to: PPNO@health.state.ny.us.

Mandatory Generic Drug Program Update

The New York State Medicaid Mandatory Generic Drug Program requires prior authorization for brand-name prescriptions with an A-rated generic equivalent. **Effective December 1, 2009,** new prescriptions for the brand-name drugs listed below will require prior authorization:

Bleph-10 10% eye drops	**Pamine 2.5 mg tablet**
Fioricet-Codeine 30-50-325-40 capsule	**Pamine forte 5 mg tablet**
Keppra 100 mg/ml oral solution	**Vicodin 5-500 tablet**
Keppra 250 mg, 500 mg, 750 mg, 1000 mg tablet	**Wellbutrin XL 150 mg tablet**
Lamictal 5 mg, 25 mg dispersible tablet	**Zantac 15 mg/ml syrup**
Lamictal 25 mg, 100 mg, 150 mg, 200 mg tablet	**Zerit 1 mg/ml solution**
Neocidin eye drops	**Zerit 15 mg, 20 mg, 30 mg, 40 mg capsule**
Nitro-Dur 0.1 mg/hr, 0.4 mg/hr patch	

Prescriptions written prior to **December 1, 2009,** but filled on or after this date, including refills, will not require prior authorization. However, when the current prescription expires, a prior authorization will be required for the patient to continue to receive the brand-name drug.

PLEASE NOTE: Brand-name drugs that are on the Medicaid Preferred Drug List do not require prior authorization and are not subject to the Medicaid Mandatory Generic Drug Program prior authorization requirements. For pharmacy billing questions, please call (800) 343-9000. For Medicaid pharmacy policy questions, please call (518) 486-3209.

ATTENTION PHARMACISTS ...
CHANGE IN BILLING FOR EMERGENCY CONTRACEPTION (Plan B, Plan B One Step, Next Choice)

Effective immediately, Plan B, Plan B One-Step, and Next Choice, dual-labeled emergency contraceptive products, can now be dispensed to Medicaid eligible females 17 years and older as an over-the- counter (OTC) product without a fiscal order. The prescriber identification/license number field for pharmacy claims may be left blank for these products and the claim will still be processed.

The "dummy" MMIS identification number that was issued for Plan B (OTC) has been discontinued and no longer has to be reported on the claim. A prescription is still required for these emergency contraceptive products for females 16 years and younger.

Questions? Please contact the Bureau of Policy Development and Coverage at (518) 473-2160.

Limited Income NET Program Announcement for Individuals with both Medicare and Medicaid

The Centers for Medicare & Medicaid Services (CMS) has redesigned the WellPoint Point-of-Sale Facilitated Enrollment (POS FE) process. **Effective January 1, 2010,** the program will be known as the Limited Income Newly Eligible Transition program, or Limited Income NET, and will be administered by Humana.

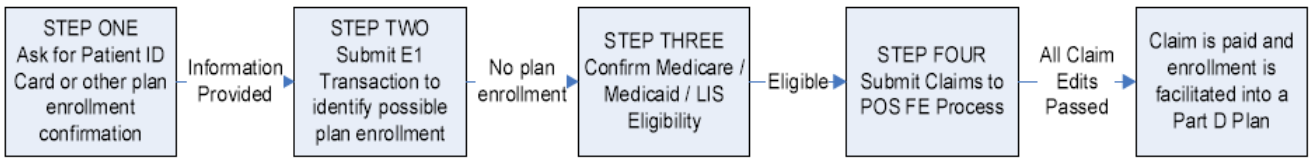
Beginning January 1, 2010, pharmacy providers must use the following BIN/PCN to submit claims for the 2010 Limited Income NET program: BIN = 610649, PCN = 05440000. More information on the Limited Income NET program is available online at:

www.cms.hhs.gov/LowIncSubMedicarePresCov/03_MedicareLINET.asp#TopOfPageET.asp#TopOf Page.

WellPoint will continue to accept claims through midnight (EST), December 31, 2009. Pharmacy providers with questions about claims submitted to the POS FE process prior to January 1, 2010 must call the NextRx Pharmacy Benefits line at (800) 957-5147.

Four Steps for Pharmacists

The following four steps provide a quick reference guide for using the POS FE process:



Questions? Please contact the Bureau of Pharmacy Policy and Operations at (518) 486-3209.

Protected Health Information (PHI) Fact Sheet

What is Protected Health Information (PHI)?

HIPAA Privacy Rule defines PHI as individually identifiable health information about the past, present, or future physical or mental health or condition (including the provision of his/her health care, insurance, payment status, etc.) of an individual held or transmitted by a covered entity or its business associate, in any form. PHI is information that is recorded electronically, on paper, or orally about an individual.

PHI must be protected from unauthorized use or disclosure by the Covered Entity under HIPAA regulations. Stricter enforcement and penalties for breaches, unauthorized use and unauthorized disclosure are on the horizon under the HITECH Act enacted under the American Recovery and Reinvestment Act of 2009. Covered entities include: health care providers, health plans, and health care clearinghouses.

What is considered PHI?

- **Date of birth** ■ **Gender** ■ **Medical records number** ■ **Health plan beneficiary number**
- **License number** ■ **Social Security Number** ■ **Explanation of Benefits (EOB)**
- **Diagnosis and procedure codes or any other information that can be used to identify an individual**

The US Department of Health and Human Services has fully defined what constitutes PHI. For more guidance on PHI, please see the Privacy Rule at: http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/index.html.

In order to safeguard the individually identifiable health information listed above, we must all ensure to implement reasonable and appropriate security measures. Sending data to Computer Services Corporation (CSC) via the established communications methods (ePACES, eMedNY eXchange, FTP, the Bulletin Board System, and SOAP) ensures the security of PHI during transmission.

What if I need to send PHI to eMedNY?

If you need to submit PHI to eMedNY, please follow these simple guidelines:

- Make sure PHI that is being faxed or e-mailed is going to the correct receiver, and that you include a confidentiality statement on your cover letter.
- Never send PHI through e-mail unless it is in a password protected attachment.

For more information on the Privacy Rule visit: http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html.

By providing counseling, pharmacotherapy, and referrals, you can double your patients' chances of successfully quitting. For more information, please visit www.talktoyourpatients.org or call the NY State Smokers' Quitline at 1-866-NY-QUITS (1-866-697-8487).

Quick Reference Guide

Office of the Medicaid Inspector General: For general inquiries or provider self-disclosures please call (518) 473-3782. For suspected fraud complaints/allegations please call 1-877-87FRAUD (1-877-873-7283). www.omig.state.ny.us

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 or e-mail: emednyproviderrelations@csc.com.

Enrollee Eligibility:
Call the Touchtone Telephone Verification System at any of the following numbers:
(800) 997-1111, (800) 225-3040, (800) 394-1234.

Address Change?
Questions should be directed to the eMedNY Call Center at: (800) 343-9000.

Fee-for-Service Providers:
A change of address form is available at:
http://www.emedny.org/info/ProviderEnrollment/allforms.html.

Rate-Based/Institutional Providers:
A change of address form is available at:
http://www.emedny.org/info/ProviderEnrollment/allforms.html.

Do you suspect that a Medicaid provider or an enrollee has engaged in fraudulent activities?
PLEASE CALL: 1-877-87FRAUD OR (212) 417-4570

Your call will remain confidential. You may also complete a complaint form online at www.omig.state.ny.us

Does your enrollment file need to be updated because you've experienced a change in ownership?
Fee-for-Service Providers please call (518) 402-7032
Rate-Based/Institutional Providers please call (518) 474-3575

Comments and Suggestions Regarding This Publication?
Please contact the editor, Kelli Kudlack, at: medicaidupdate@health.state.ny.us.