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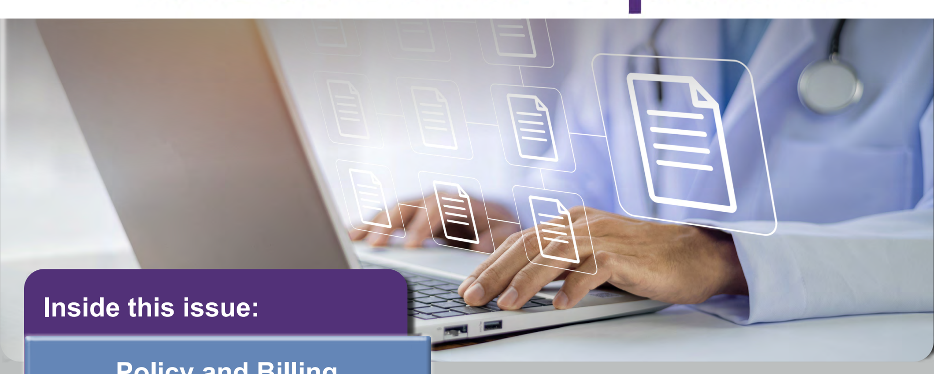

Inside this issue:

Policy and Billing

Expansion of Remote Patient Monitoring Coverage to Clinical Staff *(Cover)*

Independent Practitioner Services Fee Updates for Individuals with Developmental Disabilities

Federally Qualified Health Centers and Rural Health Centers Reimbursement for Community Health Worker Services

Ambulance Providers

New York State Medicaid Fee-for-Service Coverage for Vaccinations Administered by Providers

New York State Patient-Centered Medical Home Program

All Providers

eConsults in the Dental Setting

Provider Directory

Expansion of Remote Patient Monitoring Coverage to Clinical Staff

Remote patient monitoring (RPM) uses digital technologies to collect medical data and other personal health information from the New York State (NYS) Medicaid member in one location and electronically transmit that information to health care providers in a different location for assessment and recommendations.

Effective January 1, 2025, NYS Medicaid will reimburse RPM Current Procedural Terminology (CPT) code **"99457"**. Medicaid Managed Care (MMC) Plans must comply with this coverage, by March 1, 2025. This service may be delivered by clinical staff; however, the service must be ordered by a physician or other qualified health care professional. Clinical staff includes individuals under the direction of a physician or qualified health care professional who do not independently bill professional services, such as pharmacists and some registered dieticians. Providers delivering RPM must confirm that they operate within their scope of practice. Clinical staff may not order nor modify prescriptions. This service is not intended for retail pharmacists.

Providers should refer to the *Telehealth Policy Manual – New York State Medicaid Fee-for-Service Provider Policy Manual*, for additional details on RPM CPT codes and billing guidance.

CPT Code	Description	NYS Medicaid Rate
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes. *May be billed once each 30 days, regardless of the number of parameters monitored. Do not report for services less than 20 minutes.*	$41.80

Questions and Additional Information:
- NYS Medicaid fee-for-service (FFS) billing and claims questions should be directed to the eMedNY Call Center at (800) 343-9000.
- NYS Medicaid FFS telehealth coverage and policy questions should be directed to the Office of Health Insurance Programs (OHIP) Division of Program Development and Management (DPDM) by telephone at (518) 473-2160 or by email at telehealth.policy@health.ny.gov.
- MMC enrollment, reimbursement, billing, and/or documentation requirement questions should be directed to the specific MMC Plan of the enrollee.
- MMC Plan contact information and plan directory can be found in the eMedNY *New York State Medicaid Program Information for All Providers - Managed Care Information* document.

↑Back to Top

Policy and Billing

Independent Practitioner Services Fee Updates for Individuals with Developmental Disabilities

The New York State (NYS) Department of Health (DOH) and the NYS Office for People With Developmental Disabilities (OPWDD) are implementing retroactive fee updates for Independent Practitioner Services for Individuals With Developmental Disabilities (IPSIDD). The fee updates are the result of approved Cost of Living Adjustments (COLAs) for the July 1, 2021; April 1, 2022; April 1, 2023; and April 1, 2024 periods. The updated fee schedules are located on the NYS DOH "Mental Hygiene Services Fees" web page. With respect to claims processing, the fees were loaded and active for new claim submissions beginning in cycle 2462.

To accommodate the fee updates retroactively, a special input of prior paid claims will be processed in cycle 2465. The special input will result in payment of the difference between the original paid amounts and the updated fee amounts for the impacted periods. The retro payment differentials will be identified on the corresponding remittance statement and identify the claim adjustments with edit reason code **"01999"** [claim has been special input by NYS Family Assistance (FA)]. Due to the age of the claims impacted, the process may span multiple cycles with respect to payment and 835 remittance statements the claims are identified on.

Questions:
- Questions regarding this process should be directed to OPWDD at central.operations@opwdd.ny.gov.
- Questions regarding the IPSIDD fees should be directed to NYS DOH at MHRS@health.ny.gov.
- General questions about professional claim submissions should be directed to the eMedNY Call Center at (800) 343-9000.

↑Back to Top

Federally Qualified Health Centers and Rural Health Centers Reimbursement for Community Health Worker Services

Effective immediately, New York State (NYS) Medicaid fee-for-service (FFS) providers and NYS Medicaid Managed Care (MMC) Plans must reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) for services rendered by a Community Health Worker (CHW). FQHCs/RHCs will be reimbursed a separate payment amount in lieu of the Prospective Payment System (PPS) rate when the CHW service is the only service provided.

CHW services include health advocacy, health education and health navigation support, aimed at improving health outcomes and overall health literacy and preventing the development of adverse health conditions, injury, illness, or the progression thereof. A CHW is a public health worker, not otherwise recognized as a licensed or certified NYS Medicaid provider type. At this time, CHWs are not an enrollable NYS provider type, and their services are billed by a NYS Medicaid-enrolled qualified health care practitioner who is responsible for supervising the services rendered by the CHW.

FQHC NYS Medicaid FFS Billing Guidance

CHW services provided as a stand-alone service will be carved out of the FQHC all-inclusive PPS rate and must be billed to NYS Medicaid FFS as an Ordered Ambulatory (OA) claim submission. The FQHC/RHC should bill an OA claim to NYS Medicaid utilizing the CHW Current Procedural Terminology (CPT) codes referenced below. A PPS claim should not be billed to NYS Medicaid when the only service(s) provided to the NYS Medicaid member were rendered by a CHW. An Ambulatory Patient Group (APG) claim should also not be billed by FQHCs that have opted into APGs. The FQHC/RHC may only bill an APG/PPS claim if CHW services are provided to the NYS Medicaid member as part of a comprehensive encounter when other medically necessary services are also provided. CHW services must be provided on-site at the FQHC; off-site CHW services are not reimbursable.

CHW services must be billed to NYS Medicaid using the CPT codes and corresponding U-modifier combinations listed below. The modifier combinations must be appended on the claim line, consecutively, in that order.

Please note: When billing for CHW services that are not community violence prevention services, **modifiers U1** and **U3** must be included consecutively, in this order, for CPT codes **"98960"**, **"98961"** or **"98962"**. For community violence prevention services provided by a CHW, **modifiers U3** and **U1** must be included consecutively, in this order, for CPT codes **"98960"**, **"98961"** or **"98962"**.

CHW services are only available for specific populations and settings. Providers should refer to the resources provided below, for additional policy and billing guidelines pertaining to CHW services:
- eMedNY "Community Health Worker Services Manual" web page
- *Community Health Worker Services for Pregnant and Postpartum People* article published in the September 2023 issue of the *Medicaid Update*
- *Expanded Eligibility for Community Health Worker Services* article published in the December 2023 issue of the *Medicaid Update*

CPT Code	Modifier	Description	Unit	NYS Medicaid Rate
98960	**U1** and **U3**	Self-management education and training face-to-face using a standardized curriculum for an individual NYS Medicaid member, each 30 minutes.	• 12 units total for adult populations. • 24 units total for pediatric population (under 21 years of age). • 30 minutes = 1 unit. • Services must be a minimum of 16 minutes and a maximum of 37 minutes.	$35.00
98961		Self-management education and training face-to-face using a standardized curriculum for two to four NYS Medicaid members, each 30 minutes.		$16.45
98962		Self-management education and training face-to-face using a standardized curriculum for five to eight NYS Medicaid members, each 30 minutes.		$12.25

Questions and Additonal Information:
- NYS Medicaid FFS claim questions should be directed to the eMedNY Call Center at (800) 343-9000.
- NYS Medicaid FFS coverage and policy questions should be directed to the Office of Health Insurance Programs (OHIP) Division of Program Development and Management (DPDM) by telephone at (518) 473-2160 or by email at FFSMedicaidPolicy@health.ny.gov.
- MMC reimbursement, billing, and/or documentation requirement questions should be directed to the MMC Plan of the enrollee.
- MMC Plan contact information can be found in the eMedNY *New York State Medicaid Program Information for All Providers – Managed Care Information* document.

↑Back to Top

Ambulance Providers

Recent changes to social services (a new section 367-Y) allows ambulance providers to receive New York State (NYS) Medicaid reimbursement for treatment in place (TIP) and for transports to alternative health care settings [sometimes referred to as "transport to alternative destinations (TAD)"], subject to all terms and conditions set forth in the statute, located on the NYS Senate "Senate Bill S8486C" web page.

Ambulance providers may begin receiving reimbursement for TADs/health care settings. These alternative health care settings are defined in the statute and shown in the table below.

Alternative Health Care Settings	Appropriate Destination Modifier
A CRISIS STABILIZATION CENTER OR CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC OPERATING PURSUANT TO ARTICLE THIRTY-SIX OF THE MENTAL HYGIENE LAW	C
A FACILITY UNDER SECTION 7.17 OF THE MENTAL HYGIENE LAW	C
A FACILITY PROVIDING ADDICTION DISORDER SERVICES OR BEHAVIORAL HEALTH SERVICES, AS SUCH TERMS ARE DEFINED BY SECTION 1.03 OF THE MENTAL HYGIENE LAW	C
A DIAGNOSTIC AND TREATMENT CENTER ESTABLISHED PURSUANT TO ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW, OR AN UPGRADED DIAGNOSTIC AND TREATMENT CENTER DESIGNATED AS SUCH PURSUANT TO SECTION TWENTY-NINE HUNDRED FIFTY-SIX OF THE PUBLIC HEALTH LAW	U
A FEDERALLY QUALIFIED HEALTH CENTER	F
AN URGENT CARE CENTER, WHICH FOR THE PURPOSES OF THIS SECTION SHALL MEAN A FACILITY THAT PROVIDES EPISODIC CARE RELATED TO AN ACUTE ILLNESS OR MINOR TRAUMAS THAT ARE NOT LIFE-THREATENING OR PERMANENTLY DISABLING	U

NYS Medicaid reimbursement to ambulance providers for TIP is **not** yet available. This is because before NYS Medicaid can be claimed the statute requires approval from the Centers for Medicare and Medicaid Services (CMS). The request to CMS is an administrative process and is already underway. The NYS Department of Health (DOH) will advise ambulance providers when approval is granted.

Questions
Questions regarding TIP and TAD should be directed to the NYS DOH Medical Transportation Unit by telephone at (518) 473-2160 or by email at MedTrans@health.ny.gov.

↑Back to Top

New York State Medicaid Fee-for-Service Coverage for Vaccinations Administered by Providers

This article provides New York State (NYS) Medicaid fee-for-service (FFS) vaccine coverage policy and consolidates existing NYS FFS billing policies for vaccinations provided by NYS Medicaid-enrolled office based practitioners, ordered ambulatory providers, Article 28 outpatient facilities [including hospital outpatient departments, Federally Qualified Health Centers (FQHCs), Diagnostic and Treatment Centers (D&TCs), Local County Health Departments (LCHDs)] and School Based Health Centers (SBHCs). This article provides billing instructions for vaccines:
- available via the Vaccines for Children (VFC) program;
- not available via the VFC program for children under 19 years of age;
- available for adults 19 years of age and older; and
- available to NYS Medicaid FFS members and Medicaid Managed Care (MMC) enrollees in a SBHC.

Vaccine Coverage Policy

NYS Medicaid FFS covers medically necessary adult and child vaccinations administered as recommended by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP). Once ACIP has voted in favor of a change in vaccine recommendations, NYS Medicaid FFS will adopt the new recommendation. Additional information on ACIP vaccine recommendations and guidelines can be found on the CDC "Vaccine-Specific Recommendations" web page.

VFC Program Overview

The VFC program is a federally funded program that provides vaccines at no cost to eligible children under 19 years of age. VFC vaccines are distributed to enrolled VFC providers to administer to VFC-eligible children. VFC providers may also obtain other publicly funded vaccines to serve children eligible under other criteria. NYS Medicaid will reimburse providers for the **administration** of VFC-available vaccines to NYS Medicaid members under 19 years of age. NYS Medicaid ***will not*** reimburse providers for the cost of vaccines available through the VFC program.

Vaccines available through the VFC program are subject to change. The CDC maintains a current list of VFC available vaccines, located on the CDC "Current CDC Vaccine Price List" web page.

Publicly Purchased Vaccines for Adult NYS Medicaid Members

The Vaccines for Adults (VFA) program is intended for adults without access to vaccines and for the control of vaccine-preventable disease outbreaks. Vaccines for routine immunization of NYS Medicaid members, 19 years of age and older, must be purchased by the provider. NYS Medicaid members, 19 years of age and older, are only eligible for publicly purchased vaccines from select providers under specific conditions, such as for outbreak response measures.

Practitioners and Ordered Ambulatory

The following is vaccine billing guidance for office-based practitioners and providers billing vaccinations as an ordered ambulatory service. Ordered ambulatory services are those services provided in a clinic setting on the order and/or referral of a qualified health care provider not affiliated with the clinic providing the ordered ambulatory service.

VFC Program Vaccine Administration for Children Under 19 Years of Age
To be reimbursed for the administration of vaccines supplied by or available through the VFC program, providers will be required to bill using the current procedural terminology (CPT) code of the vaccine/toxoid administered, along with the **modifier SL** (indicating the administration of a vaccine supplied by or available through the VFC program or a vaccine supplied at no cost) and the vaccine administration CPT code **"90460"**.

CPT Code	Description
90460	IMMUNIZATION ADMINISTRATION THROUGH 18 YEARS OF AGE VIA ANY ROUTE OF ADMINISTRATION, WITH COUNSELING BY PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL; FIRST OR ONLY COMPONENT OF EACH VACCINE OR TOXOID ADMINISTERED)

Adults and Non-VFC Program Vaccines for Children Under 19 Years of Age
Administration of vaccines (*except for vaccines supplied at no cost*) for adults, 19 years of age and over, and for the administration of vaccines not provided by or available through the VFC program (e.g., travel related vaccines) for children under 19 years of age, providers will be required to bill the specific CPT code of the vaccine/toxoid administered at the actual acquisition cost with the appropriate vaccine administration CPT code listed below.

CPT Code	Description
90471	IMMUNIZATION ADMINISTRATION (INCLUDES PERCUTANEOUS, INTRADERMAL, SUBCUTANEOUS, OR INTRAMUSCULAR INJECTIONS); 1 VACCINE (SINGLE OR COMBINATION VACCINE/TOXOID)
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)
90473	IMMUNIZATION ADMINISTRATION BY INTRANASAL OR ORAL ROUTE; ONE VACCINE (SINGLE OR COMBINATION VACCINE/TOXOID)
90474	IMMUNIZATION ADMINISTRATION BY INTRANASAL OR ORAL ROUTE; EACH ADDITIONAL VACCINE (SINGLE OR COMBINATION VACCINE/TOXOID) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
90480	IMMUNIZATION ADMINISTRATION BY INTRAMUSCULAR INJECTION OF SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARSCOV-2) (CORONAVIRUS DISEASE [COVID-19]) VACCINE, SINGLE DOSE

Please note: Providers should refer to the fee schedules available on the eMedNY "Provider Manuals" web page, for the current reimbursement rates for the vaccine administration CPT codes listed above. For the administration of any vaccines supplied at no cost to NYS Medicaid members, 19 years of age and older, providers will be required to bill using the CPT code of the vaccine/toxoid administered, along with **modifier FB** (indicating a vaccine supplied at no cost) and the appropriate vaccine administration CPT code.

Article 28 Facilities

The following is vaccine billing guidance for Article 28 hospital outpatient departments, FQHCs, D&TCS, and LCHDs that bill using the Ambulatory Patient Group (APG) reimbursement methodology.

Vaccine Administration for Children Under 19 Years of Age
Vaccines supplied by or available through the VFC program for children under 19 years of age are reimbursed via APGs. Providers will be required to bill the CPT code of the vaccine/toxoid administered with **modifier SL** (indicating the administration of a vaccine supplied by or available through the VFC program or a vaccine supplied at no cost) to be reimbursed for the administration of the vaccine. Providers should refer to the NYS DOH "NYS APG Modifiers" web page for current reimbursement when appending **modifier SL**. No separate or additional vaccine administration CPT code is needed.

Vaccine Administration for Adults and Non-VFC Program Vaccines for Children Under 19 years of Age
Vaccinations for NYS Medicaid members 19 years of age and older are reimbursed via APGs. Providers are to bill the vaccine/toxoid CPT code administered to receive the APG line-item reimbursement. A separate reimbursement, as per the *NYS DOH APG-Based Weights History File*, will be made for the administration of the influenza and/or pneumococcal vaccine for adults 19 years of age and older when the following vaccine administration codes are added to the claim:
- Influenza – **"G0008"**
- Pneumococcal – **"G0009"**

All other vaccinations administered to NYS Medicaid members, 19 years of age and older, and vaccines for NYS Medicaid members under the age of 19 years not covered by the VFC program (e.g. travel-related vaccines), are also reimbursed via APGs using the CPT code of the vaccine/toxoid administered. No separate vaccine administration CPT code is required. Reimbursement for vaccine administration is included within the APG reimbursement made to the facility.

Providers that administer any vaccines supplied at no cost, including influenza and pneumococcal, to NYS Medicaid members, 19 years of age and older, must use **modifier FB** (indicating a vaccine supplied at no cost) with the CPT code of the vaccine/toxoid administered. Providers will be reimbursed for the administration of the vaccine. Providers should refer to the NYS DOH "NYS APG Modifiers" web page, for current reimbursement when appending **modifier FB**. No separate or additional vaccine administration CPT code is required.

FQHCs

FQHCs that receive the Federal Prospective Payment System (PPS) rate may submit a PPS threshold clinic claim if the vaccine is administered as part of an encounter in which a significant procedure and/or medical visit accompanies the vaccination.

FQHCs that bill under the PPS rate should not submit a claim for reimbursement seeking the PPS threshold clinic visit rate when the ***only*** service provided to a NYS Medicaid member is a vaccine administration. Instead, FQHCs should seek reimbursement for the vaccine and vaccine administration as an ordered ambulatory service by using the guidance provided in the "Practitioners and Ordered Ambulatory" section above, as well as the *NYS Medicaid Ordered Ambulatory Services Fee Schedule*, located on the eMedNY "Free Standing or Hospital Based Ordered Ambulatory Manual" web page.

SBHCs

Influenza and pneumococcal vaccinations provided at SBHCs for either NYS Medicaid FFS members or MMC enrollees are billable using the following, non-APG rate codes:
- Influenza – Rate code **"1381"**
- Pneumococcal – Rate code **"1383"**

Providers are to use the CPT code of the vaccine/toxoid administered with the appropriate rate code (listed above) to be reimbursed **$25.10** for the administration of influenza and/or pneumococcal vaccines supplied by or available through the VFC program. No separate or additional vaccine administration CPT code is required.

SBHCs should bill all other vaccinations utilizing one of the APG rate codes listed below. The provider must append **modifier SL** to the CPT code of the vaccine/toxoid administered (indicating the administration of a vaccine supplied by or available through the VFC program or a vaccine supplied at no cost) to be reimbursed for the administration of the vaccine. Providers should refer to the NYS DOH "NYS APG Modifiers" web page, for current reimbursement when appending the **modifier SL**. No separate or additional vaccine administration CPT code is required.
- Hospital Outpatient Department SBHC – Rate codes: Visit **"1444"**; Episode **"1450"**
- D&TC SBHC – Rate codes: Visit **"1447"**; Episode **"1453"**

Non-Patient Specific Standing Orders for Providers

When provided within their scope of practice, licensed health care practitioners may administer vaccines under non-patient specific or standing orders. The list of vaccines that can currently be administered under non-patient specific orders and the New York State Education Department (NYSED) protocol requirements can be found on the NYSED "Non-Patient Specific Standing Order and Protocol Guidelines" web page.

Additional Information and Questions:
- Additional information on the VFC program and child eligibility requirements are located on the CDC "Current CDC Vaccine Price List" web page.
- Questions regarding the VFC program and/or the VFA program should be directed to nyvfc@health.ny.gov.
- NYS Medicaid FFS coverage and policy questions should be directed to the Office of Health Insurance Programs (OHIP) Division of Program Development and Management (DPDM) at (518) 473-2160.
- MMC reimbursement, billing, and/or documentation requirement questions should be directed to the MMC Plan of the enrollee.
- NYS Medicaid FFS claim questions should be directed to the eMedNY Call Center at (800) 343-9000.

↑Back to Top

New York State Patient-Centered Medical Home Program

The New York State (NYS) Department of Health (DOH) is committed to supporting health care promotion and disease prevention with access to high quality care for individuals through the primary care model known as the **New York State Patient-Centered Medical Home (NYS PCMH) program**. In 2018, NYS DOH collaborated with the National Committee for Quality Assurance (NCQA), creator of the PCMH program, to develop this exclusive transformation model for all eligible primary care providers in NYS. At that time, the Advanced Primary Care (APC) Incentive Payment program ended to allow for the NYS implementation and transition into the NYS PCMH model. Additional information regarding NYS PCMH can be found on the NCQA "New York State Patient-Centered Medical Home (NYS PCMH) Recognition Program" web page.

Providers that achieve NYS PCMH recognition are eligible to receive payments provided in the form of either per member per month (PMPM) capitation payments for Medicaid Managed Care (MMC), including mainstream NYS Medicaid, Health and Recovery Plans (HARPs), and Human Immunodeficiency Virus-Special Needs Plans (HIV-SNPs), and Child Health Plus (CHPlus) members; or as a per-visit "add-on" payment for eligible claims billed for services provided to NYS Medicaid fee-for-service (FFS) members. Providers should refer to *Column A* in the "NYS PCMH Payment" table below.

NYS PCMH Managed Care Incentive

Retroactive to April 1, 2024, primary care providers recognized under the NYS PCMH program are entitled to an incentive enhancement of $4.00/PMPM for MMC enrollees and CHPlus members under 21 years of age, and $2.00/PMPM for individuals 21 years of age and older, in addition to the current $6.00/PMPM payment.

MMC Plans will be expected to calculate retroactive payments and furnish these payments to NYS PCMH-recognized providers in their networks. In 2025, to receive this enhanced incentive payment (in addition to the $6.00/PMPM), providers will be required to develop a workflow to refer patients to a Social Care Network (SCN) and submit an attestation by March 31, 2025, confirming their SCN participation. From April 1, 2024 through March 31, 2025, all NYS PCMH providers will receive the incentive enhancement. Providers should refer to *Column B* in the "NYS PCMH Payment" table below.

Effective April 1, 2025, NYS PCMH providers that submit SCN attestation by March 31, 2025, will continue to receive the incentive enhancement. Providers should refer to *Column C* in the "NYS PCMH Payment" table below. NYS PCMH providers that do not attest to participation in an SCN will receive the $6.00/PMPM NYS PCMH payment without the incentive enhancement. Providers should refer to *Column D* in the "NYS PCMH Payment" table below.

PCMH practices can submit attestations after the March 31, 2025 deadline and the PCMH practice will be included in the subsequent participation list for the additional $2.00 and $4.00 enhancement. PCMH practices that submit attestations after March 31, 2025 will forfeit the $2.00 and $4.00 enhancement beginning April 1, 2025 until the attestation is received. NYS DOH will release more details about the attestation form and process in the coming weeks. The attestation form will be available on the NYS Health Commerce System (HCS) website.

The attestation will be completed once, per physical site location, covering all recognized providers at that location. In preparation, practices should check access to their NYS Health Commerce website accounts. A link to the attestation form will be emailed to all NYS PCMH practices for completion using the NYS PCMH contact email address(es) on file with NCQA.

In order for MMC, HARP, HIV SNP, and CHPlus plans to calculate PCMH incentive enhancement payment, there will be an "SCN Indicator" on the monthly NYS PCMH file posted to the Health Commerce System that will track provider completion of the attestation. Plans will calculate provider payment based on the information corresponding to the "SCN Indicator".

SCNs have been established via the NYS DOH 1115 Waiver Amendment, "New York Health Equity Reform" (NYHER). NYS DOH recently announced contracts with regional entities, which will serve as lead entities for the regional SCNs. SCNs are developing networks of community-based organizations to deliver social care services to eligible NYS Medicaid members. NYS Medicaid members will be screened using the Centers for Medicare & Medicaid Services (CMS) *Accountable Health Communities Health-Related Social Needs Tool* and those with unmet social needs will receive navigation to existing state, federal and local resources. MMC enrollees who meet specific clinical criteria may be eligible for health-related social need services related to housing, nutrition, transportation, and care management. NYS Medicaid members. Additional information regarding SCNs can be found on the NYS DOH "Social Care Networks (SCN)" web page. The enhanced PCMH payments are intended to help providers connect with and provide referrals to regional SCNs to promote access to health-related social needs for NYS Medicaid members.

NYS PCMH Payment

	A	B		C		D	
Incentive	January 1, 2024 through March 31, 2024	April 1, 2024 through March 31, 2025		April 1, 2025 with SCN Attestation		April 1, 2025 without SCN Attestation	
Ages	All ages	Under 21 years of age	21 years of age and over	Under 21 years of age	21 years of age and over	Under 21 years of age	21 years of age and over
PMPM add-on for Mainstream MMC, HIV-SNPs and HARP Providers	$6.00	$10.00	$8.00	$10.00	$8.00	$6.00	$6.00
PMPM add-on for CHPlus Providers	$6.00	$10.00	N/A	$10.00	N/A	$6.00	N/A
PMPM add-on for Adirondack (ADK) Providers* (MMC)	$7.00	$11.00	$9.00	$11.00	$9.00	$7.00	$7.00
PMPM add-on for Adirondack (ADK) Providers* (CHPlus)	$7.00	$11.00	N/A	$11.00	N/A	$7.00	N/A
FFS incentive add-on for Professional Claims	$29.00	$29.00	$29.00	$29.00	$29.00	$29.00	$29.00
FFS incentive add-on for Institutional Claims	$25.25	$25.29	$25.25	$25.25	$25.25	$25.25	$25.25

*In the ADK program, PCMH-recognized providers operating in specific ADK regions in NYS are eligible to receive the PMPM enhancement in addition to their established baseline of $7.00/PMPM.

MMC Operating Report Changes

Cost Report Changes per the MMC Operating Report and HIV Special Needs Operating Report
NYS PCMH payments changed from a calendar year (CY) (January 1, 2024 through December 31, 2024) to a State Fiscal Year (SFY) (April 1, 2024 through March 31, 2024). To accommodate this change, health care plans must report Medical Home expenses in every quarter on a year-to-date basis, instead of only reporting 2Q, 3Q, and 4Q (Annual).

MMCOR and HIV Special Needs Operating Report (SNPOR)-Medical Home Tables were added to the 1Q 2024 reports for NYS Medicaid, HARP, and HIV-SNP lines of business. The timing of medical home payments to Plans will remain at two times per year but will be based on SFY instead of CY. The following example will provide guidance for transition into SFY calendar:
- **2023 final CY payment:** State pays health care plan July 1, 2023 through December 31, 2023.
- **2024 transition into SFY:** State pays health care plan January 1, 2024 through March 31, 2024, April 1, 2024 through September 30, 2024, etc.

Aid Categories by Age
Changes are coming regarding the way PCMH spend is categorized by aid category. Beginning with the end-of-year cost report, health care plans will be required to break out the following premium groups into kids (under 21 years of age) and adults (21 years of age and older) on the cost reports (Table 30s), retroactively to April 1, 2024:
- MMCOR, NYS Medicaid line of business, NYS Medicaid SSI
- HIV SNPOR, HIV SNP line of business, HIV-Negative SSI (Homeless), HIV-Negative Transgender and TANF HIV-Negative Transgender SSI

All other aid categories used for PCMH spend reporting are already broken out by age group.

Lines of Business Eligible to Receive PCMH Incentive Payments
Providers currently in a line of business with NYS Medicaid FFS, mainstream Managed Care, CHPlus, HIV-SNPs, and Health and Recovery Plans (HARPs), are eligible to receive NYS Medicaid PCMH.

Incentive payments are **not** applicable to services provided to dual-eligible members (members in receipt of both Medicare and NYS Medicaid), NYS Medicaid members with third-party health insurance (TPHI), or individuals with the Essential Plan (EP), Qualified Health Plan (QHP), Managed Long-Term Care (MLTC) Plan, and Program of All-Inclusive Care for the Elderly (PACE).

Questions and Additional Information:
- Additional information regarding the NYS PCMH program can be found on the NYS DOH "New York State Patient-Centered Medical Home (NYS PCMH)" web page.
- For a list of published *Medicaid Update* articles on NYS Medicaid PCMH initiatives, providers can refer to the NYS DOH "DOH Medicaid Update Index" web page, under the "Patient Centered Medical Home (PCMH)" topic.
- General questions regarding PCMH should be directed to pcmh@health.ny.gov.
- MMC reimbursement and billing requirement questions should be directed to the specific MMC Plan of the enrollee.
- Questions regarding SCNs should be directed to NYHER@health.ny.gov.

↑Back to Top

All Providers

eConsults in the Dental Setting

Effective January 1, 2025, for New York State (NYS) Medicaid fee-for-service (FFS) members and Medicaid Managed Care (MMC) enrollees, providers can be reimbursed for eConsults in the dental setting. eConsults, also known as electronic consultations or interprofessional consultations between a dentist and another medical health care professional [physician, physician assistant (PA), nurse practitioner (NP), midwife (MW)], are intended to improve access to specialty expertise by assisting the treating/requesting provider with the care of the patient, without patient contact, with the consultative provider on medical issues that may affect the planned dental treatment of the patient. Providers should refer to the *eConsults* article published in the January 2024 issue of the *Medicaid Update*, for additional information on reimbursement of eConsults.

The consultative provider should respond to the eConsult request within three business days. The response should include recommendations and rationale that warrant a re-consult or referral. To bill NYS Medicaid for Current Dental Terminology (CDT) code **"D9311"**, there is an expectation that the requesting or consultative dentist will spend 15 minutes or more of dental consultative time. eConsults must not be used for the purpose of arranging a referral for an in-person visit. They may be used for patients with or without an existing relationship with the consultative provider.

The complete record of the eConsult must be documented in the patient chart. Both the treating/requesting provider and the consultative provider can bill for the eConsult. This includes any consultation required for dental services that are integral to the clinical success of a primary medical service. To bill NYS Medicaid for eConsults, the provider must be enrolled in NYS Medicaid.

For individuals enrolled in MMC, providers should refer to the individual MMC Plan for implementation details, reimbursement fees and billing instructions.

Current Dental Terminology (CDT) Code	Billed By	Description	NYS Medicaid Rate
D9311	Dentist, consultative or requesting provider	Consultation with a Medical Health Care Professional Treating dentist consults with a medical health care profes-sional concerning medical issues that may affect patient's planned dental treatment.	$28.46

Questions:
- NYS Medicaid FFS coverage and policy questions should be directed to the Office of Health Insurance Programs (OHIP) Division of Program Development and Management (DPDM) at (518) 473-2160 or dentalpolicy@health.ny.gov.
- For MMC reimbursement, billing, and/or documentation requirement questions should be directed to the specific MMC Plan of the enrollee. MMC Plan contact information can be found in the eMedNY *New York State Medicaid Program Information for All Providers - Managed Care Information* document.
- NYS Medicaid FFS claim questions should be directed to the eMedNY Call Center at (800) 343-9000.

↑Back to Top

Provider Directory

Office of the Medicaid Inspector General:
For suspected fraud, waste or abuse complaints/allegations, call 1-877-87FRAUD, (877) 873-7283, or visit Office of Medicaid Inspector General (OMIG) web site.

Provider Manuals/Companion Guides, Enrollment Information/Forms/Training Schedules:
Please visit the eMedNY website.

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

For questions about billing and performing MEVS transactions:
Please call the eMedNY Call Center at (800) 343-9000.

Provider Training:
Please enroll online for a provider seminar. 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:
- DOH Prescriber Education Program page
- Prescriber Education Program in partnership with SUNY

eMedNY
For a number of services, including: change of address, updating an enrollment file due to an ownership change, enrolling another NPI, or revalidating an existing enrollment, please visit eMedNY's Provider Enrollment page and choose the appropriate link based on provider type.

Comments and Suggestions Regarding This Publication
Please contact the editor, Angela Lince, at medicaidupdate@health.ny.gov.

↑Back to Top

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