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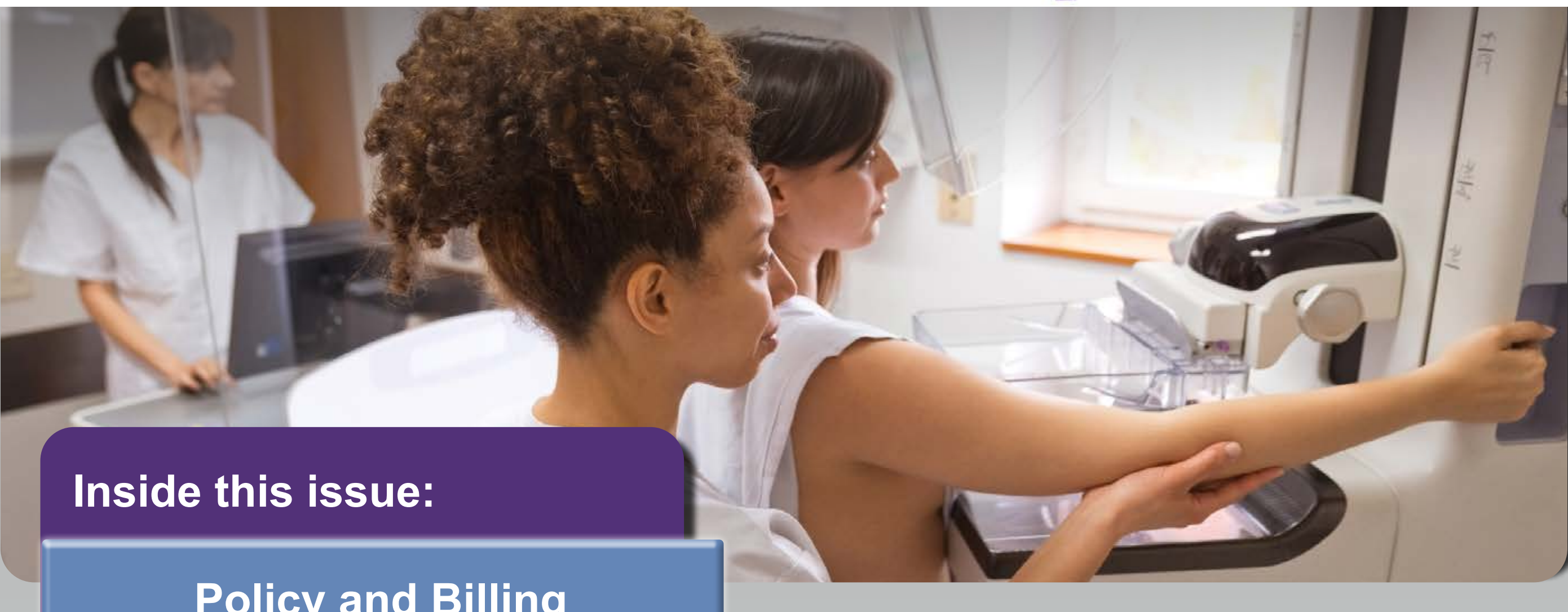


Inside this issue:

Policy and Billing

Reminder: New York State Medicaid Expands Coverage of Predictive and Prognostic Tests for Breast Cancer Treatment (Cover)
Reminder: Coverage of Licensed Mental Health Counselor and Licensed Marriage and Family Therapist Services Provided in Article 28 Outpatient Hospital Clinics and Free-Standing Diagnostic and Treatment Centers
Medicaid Fee-for-Service Comprehensive Guidance for New York State Federally Qualified Health Centers and Rural Health Clinics
Pharmacy Providers: NYRx Pickup and Delivery Policy
Doula Services for Pregnant and Postpartum People

All Providers

New York State Department of Health Telehealth Provider Survey Results Now Available
Essential Plan Coverage for Pregnant Enrollees and Their Newborns
Medicaid Breast Cancer Surgery Centers
Practitioner Administered Drug Search Tool Now Available on the eMedNY Website
2024 Spousal Impoverishment Income and Resource Levels Increase
Information Notice to Couples with an Institutionalized Spouse
Request for Assessment – Spousal Impoverishment Form

Provider Directory

Reminder: New York State Medicaid Expands Coverage of Predictive and Prognostic Tests for Breast Cancer Treatment

This article serves as a reminder following the *New York State Medicaid Expansion of Prognostic Tests for Breast Cancer Treatment* article published in the December 2023 issue of the *Medicaid Update*, **effective December 1, 2023**, New York State (NYS) Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC) expanded its coverage of predictive and prognostic breast cancer assays eligible for reimbursement to include **Breast Cancer Index®** and **MammaPrint®**, in addition to **Oncotype DX®**, **EndoPredict®** and **Prosigna®**.

This article further serves to clarify that **Breast Cancer Index®** is a predictive and prognostic genomic test that assists practitioners in making determinations regarding the appropriate duration of extended endocrine therapy (EET), supporting its routine clinical use in the management of patients beyond five years. EET beyond five years has been shown to reduce the risk of recurrence in some women with hormone receptor positive (HR+), early-stage breast cancer.

MammaPrint®, **Oncotype DX®**, **EndoPredict®** and **Prosigna®** are predictive and prognostic gene expression tests that assist practitioners in making determinations regarding the effective and appropriate use of chemotherapy in female or male patients with malignant neoplasms of the breast, when all the following criteria are met:

- The test results will aid the patient and practitioner in making the decision regarding chemotherapy (i.e., when chemotherapy is a therapeutic option and is not precluded due to any other factor).
- The tumor is estrogen receptor positive (ER+), progesterone receptor positive (PR+), or both.
- The tumor is human epidermal growth factor receptor 2 (HER2) negative.
- The tumor ("T") is T1 or T2.
- The tumor is node-negative or one to three positive nodes.

Please note: NYS Medicaid criteria for these tests are in accordance with current National Comprehensive Cancer Network (NCCN) Guidelines.

Additional information on NYS Medicaid coverage of prognostic breast cancer assays may be found in the *New York State Medicaid Expansion of Prognostic Tests for Breast Cancer Treatment* article published in the July 2019 issue of the *Medicaid Update*.

Questions and Additional Information:

- 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.
- FFS billing/claim questions should be directed to the eMedNY Call Center at (800) 343-9000.
- 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.
- Additional laboratory information and billing guidance is available in the eMedNY *New York State Medicaid Program Fee-for-Service Laboratory Procedure Codes and Coverage Guidelines Manual*.

Back to Top

Policy and Billing

Reminder: Coverage of Licensed Mental Health Counselor and Licensed Marriage and Family Therapist Services Provided in Article 28 Outpatient Hospital Clinics and Free-Standing Diagnostic and Treatment Centers

This article is intended to notify providers that State Plan Amendment (SPA) approval has been granted from the Centers for Medicare and Medicaid Services (CMS), allowing free-standing diagnostic and treatment centers (D&TCs) to bill New York State (NYS) Medicaid for services provided by Licensed Mental Health Counselors (LMHCs) and Licensed Marriage and Family Therapists (LMFTs), within their scope of practice, as defined by the NYS Education Department (NYSED).

As a reminder, per the *Coverage of Licensed Mental Health Counselor and Licensed Marriage and Family Therapist Services Provided in Article 28 Outpatient Hospital Clinics and Free-Standing Diagnostic and Treatment Centers* article published in the January 2023 issue of the *Medicaid Update*, Article 28 hospital outpatient departments (OPDs) and free-standing D&TCs, School-Based Health Centers (SBHCs) and Federally Qualified Health Centers (FQHCs), as well as Rural Health Clinics (RHCs), should use the rate codes listed below to request reimbursement from NYS Medicaid for mental health counseling when provided by LMHCs and LMFTs.

Article 28 Clinics

Hospital OPDs and free-standing D&TCs should use the following rate codes:

Rate Code	Rate Description	Reimbursement
4222	Individual LMHC/LMFT Services 20 to 30 minutes with patient	$44.10
4223	Individual LMHC/LMFT Services 45 to 50 minutes with patient	$66.69
4224	Family Services LMHC/LMFT with or without patient present	$44.10

SBHCs

SBHCs should use the following rate codes:

Rate Code	Rate Description	Reimbursement
3260	SBHC-Individual LMHC/LMFT Services 20 to 30 minutes with patient	$44.10
3261	SBHC-Individual LMHC/LMFT Services 45 to 50 minutes with patient	$66.69
3262	SBHC-Family services LMHC/LMFT with or without patient present	$75.30

FQHCs/RHCs

FQHCs and RHCs that have opted out of Ambulatory Payment Groups (APGs) should bill the Prospective Payment System (PPS) rate.

For additional information regarding mental health counseling services provided in Article 28 outpatient hospital clinics, as well as free-standing D&TCs, providers may refer to the *Licensed Clinical Social Worker, Licensed Mental Health Counselor, and Licensed Marriage and Family Therapist Service Coverage* article published in the December 2022 issue of the *Medicaid Update*.

Questions and Additional Information:

- Fee-for-service (FFS) claim questions should be directed to the eMedNY Call Center at (800) 343-9000.
- 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.
- Medicaid Managed Care (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

Medicaid Fee-for-Service Comprehensive Guidance for New York State Federally Qualified Health Centers and Rural Health Clinics

The following article provides comprehensive policy and billing guidance pertaining to Article 28 clinics designated as Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).

Prospective Payment System

FQHCs and RHCs are reimbursed for New York State (NYS) Medicaid-covered services under an all-inclusive Prospective Payment System (PPS) rate as specified under §1902(bb) of the Social Security Act. The all-inclusive "threshold" rate includes all facility and professional fees associated with the services rendered to the NYS Medicaid member during the threshold visit. An eligible threshold visit is billable each time a NYS Medicaid member crosses the threshold of the FQHC/RHC and receives services from one of the qualified health care practitioners referenced below without regard to the number of services provided or time spent with the member during that visit. FQHCs/RHCs may only bill a single threshold visit per NYS Medicaid member per day.

FQHCs/RHCs should submit a single PPS claim for an eligible threshold visit utilizing the assigned rate code for each date of service the NYS Medicaid member is seen at the FQHC/RHC and include on the claim all of the specific Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes for any/all service(s) rendered to the NYS Medicaid member on the date of service (DOS), including any evaluation and management/preventative medicine codes, significant procedures, and any associated ancillaries performed. Multiple medical and/or behavioral health encounters with more than one health care practitioner that take place on the same DOS constitute a single visit.

Eligible Threshold Visit

An eligible threshold visit is defined as a medically necessary, face-to-face (either in person or via telehealth), medical or behavioral health service rendered by a qualified practitioner. To view the list of qualified practitioners for a threshold visit, providers should refer to the *Medicaid Fee-for-Service Comprehensive Guidance for New York State Federally Qualified Health Centers and Rural Health Clinics* article in this month's issue.

Does Not Qualify as an Eligible Threshold Visit

Services provided by a practitioner other than a qualified practitioner do not qualify as an eligible/billable threshold visit. To view all factors in which do not qualify as an eligible threshold visit, providers should refer to this month's issue.

To view FQHC/RHC PPS rate codes, providers should refer to this month's issue.

To view alternate rate setting methology information, providers should refer to this month's issue.

To view Medicaid Managed Care (MMC) information, providers should refer to this month's issue.

Questions and Additional Information:

- FFS coverage and policy questions should be directed to 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.
- OHIP DHPCO is responsible for ensuring that the applicable laws and regulations relative to the MMC contracts are adhered to. Additional information and/or questions should be directed to bmcfhelp@health.ny.gov.
- FFS claim questions should be directed to the eMedNY Call Center at (800) 343-9000.
- FFS provider enrollment questions should be directed to eMedNY Provider Enrollment at (800) 343-9000.

Back to Top

Pharmacy Providers: NYRx Pickup and Delivery Policy

Prescription and over the counter (OTC) drugs dispensed pursuant to a prescription or fiscal order submitted to New York State (NYS) Medicaid for reimbursement for any portion, may be picked up at the pharmacy provider or may be delivered free of charge to the NYS Medicaid fee-for-service (FFS) member or Medicaid Managed Care (MMC) enrollee home or current residence including facilities and shelters. Additional information regarding signature, pick-up and delivery requirements can be found in the Pharmacy and Durable Medical Equipment, Prosthetics, Orthotics and Supplies Policy Manuals, located on the eMedNY "Provider Manuals" web page. This article supersedes the *Clarification Regarding Pharmacy and Practitioner Dispensing of Drugs Requiring Administration by a Practitioner* article published in the May 2023 issue of the *Medicaid Update* and the *Reminder: Pharmacy Delivery Policy* article published in the July 2019 issue of the *Medicaid Update*.

Delivery Policy

All shipping and/or delivery costs shall be the responsibility of the provider of the service; however, the pharmacy is responsible for the delivery of product to the intended recipient. Prior to processing a drug claim, the pharmacy must confirm the drug is needed and that the drug had not been discontinued, changed or is no longer necessary (e.g., the NYS Medicaid member had changed pharmacy provider). The confirmation must be maintained in the patient record of the NYS Medicaid member. Automatic refills are not permitted. Prior to delivery, the pharmacy must obtain consent from the NYS Medicaid member or the individual authorized to consent on the behalf of the NYS Medicaid member to deliver. Consent shall be maintained in the patient record of the NYS Medicaid member and only the NYS Medicaid member or the individual authorized may receive the delivery.

If the provider uses a shipping service [e.g., FedEx, United States Postal Service (USPS), or courier] or any other delivery method, the proof of delivery documentation must include a complete record of tracking the item(s) from the pharmacy to the NYS Medicaid member. This would include the detailed description of prescriptions including prescription numbers, fiscal orders being delivered and the delivery tracking information from the delivery service, including date and time of delivery, outlined by the provider. Additionally, a handwritten or electronic signature of the recipient or authorized agent at time of delivery is required for all out-of-state (OOS), instate controlled substance or instate facility (site of administration) deliveries. Delivery industry tracking receipts (e.g., FedEx or USPS tracking receipts) qualify as a signature for receipt of delivery for instate non-controlled substance deliveries only.

A single signature (or "tracking receipt" as noted above) of the recipient or authorized agent verifying receipt will be sufficient for all the medications in the delivery. Electronic signatures of the recipient or authorized agent for receipt or electronic tracking slips for delivery are permitted only if retrievable on audit. The pharmacy is responsible for drug integrity and must deliver intact, usable drugs, under the appropriate storage conditions. The pharmacy is responsible to replace lost, stolen or mis-directed drugs at no additional cost to the NYS Medicaid member or NYS Medicaid Program. Pharmacy providers who deliver medication without NYS Medicaid member or authorized individual consent will be required to accept the return of the medication, credit \NYS Medicaid the claim and destroy those d rugs per State Law. All NYS Medicaid claims for drugs not picked up or delivered must be reversed within 14 days. All State counseling laws apply. Additional information can be found on the New York State Education Department (NYSED) "Questions and Answers for Pharmacists and Pharmacies July 10, 2003" web page.

Questions and Additional Information:

- NYRx claim questions should be directed to the eMedNY Call Center at (800) 343-9000.
- NYRx coverage and policy questions should be directed to the NYS Medicaid Pharmacy Policy Unit by telephone at (518) 486-3209 or by email at NYRx@health.ny.gov.

Back to Top

Doula Services for Pregnant and Postpartum People

Effective March 1, 2024, New York State (NYS) Medicaid will reimburse for doula services for all pregnant and postpartum NYS Medicaid members needing the service. Between March 1, 2024, through September 30, 2024, doula services will be carved out of the Medicaid Managed Care (MMC) benefit package. NYS Medicaid-enrolled doula providers may bill Medicaid fee-for-service (FFS) for covered doula services, including doula services provided to MMC enrollees during this period. **Effective October 1, 2024**, doula services will be covered by MMC Plans [inclusive of mainstream MMC Plans, Human Immunodeficiency Virus-Special Needs Plans (HIV-SNPs), as well as Health and Recovery Plans (HARPs)]. Doula services provided to MMC enrollees between March 1, 2024 and September 30, 2024 will be billed to Medicaid FFS. Doula services provided on or after October 1, 2024, will be billed to the MMC Plan of the enrollee.

NYS Medicaid members, including NYS Medicaid members enrolled in MMC, are eligible for doula services during pregnancy and up to 12 months after the end of a pregnancy, regardless of the pregnancy outcome. If a NYS Medicaid member becomes pregnant within the 12 months following a prior pregnancy, their eligibility for doula services will start over with the new pregnancy; any unused perinatal doula services from the prior pregnancy will not carry over.

NYS Medicaid members, including NYS Medicaid members enrolled in MMC, will be eligible for coverage of doula services under the statewide Medicaid doula services benefit regardless of the amount of doula services they may have received through Medicaid's Erie County Doula Service Pilot program. This article supersedes all previously published articles pertaining to doula services. The Erie County Doula Service Pilot program ended as of February 29, 2024, and this statewide doula services benefit and the associated policy and billing guidance take the place of the coverage, policy, and billing guidance provided under the pilot program.

Doula services are a preventative health service, and as such, must be recommended by a physician or other licensed practitioner of the healing arts acting within their scope of practice under State law to be eligible for NYS Medicaid reimbursement. Licensed providers of perinatal and maternity care services are to discuss the benefits of doula care with NYS Medicaid members, and as long as it is clinically appropriate, to provide all such enrollees with a recommendation for doula services.

A doula is a public health worker, not otherwise recognized as a licensed or certified NYS Medicaid provider type, that provides direct support, education and advocacy to the pregnant, postpartum and post-pregnant populations. The doula will directly enroll as a NYS Medicaid doula services provider and will bill NYS Medicaid directly for doula services. The NYS Medicaid-enrolled doula does not require supervision. Doula services will include up to eight perinatal visits by a doula during and after pregnancy and one labor and delivery support encounter. Additionally, doula services may include:

- intermittent support that aligns with personal and cultural preferences during the prenatal, childbirth, postpartum and newborn periods, inclusive of all pregnancy outcomes;
- education, guidance, health navigation, and connections to community-based resources related to childbirth and parenting;
- development of a birth plan and continuous labor support;
- patient-centered advocacy, and physical, emotional, and nonmedical support;
- facilitation of communication between the NYS Medicaid member and medical providers; and
- discussion of the importance of perinatal and pediatric health services provided by a licensed health provider during pregnancy and labor and delivery, and after pregnancy and the birth of the infant.

To view information regarding billing Medicaid FFS during the MMC carve out, providers should refer to the Doula Services for Pregnant and Postpartum People article in this month's issue.

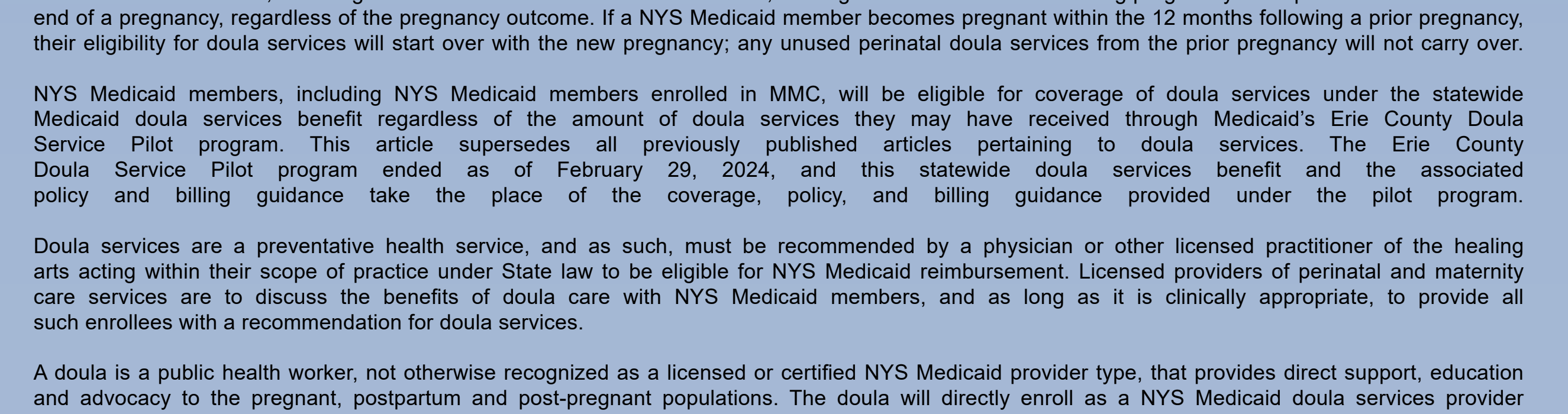
To view Medicaid FFS information, providers should refer to the Doula Services for Pregnant and Postpartum People article in this month's issue.

To view information regarding MMC billing instructions, providers should refer to the Doula Services for Pregnant and Postpartum People article in this month's issue.

Questions and Additional Information:

- Additional information can be found in the *New York State Medicaid Program Doula Manual Policy Guidelines*, located on the eMedNY "Doula" web page.
- Medicaid FFS claim questions should be directed to the eMedNY Call Center at (800) 343-9000.
- FFS coverage and policy questions should be directed to MaternalandChild.HealthPolicy@health.ny.gov.
- MMC 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



All Providers

New York State Department of Health Telehealth Provider Survey Results Now Available

The *Telehealth Provider Survey* results are now available on the New York State (NYS) Department of Health (DOH) Medicaid Telehealth website via infographic.

Background

In order to better understand NYS health care provider perspectives on telehealth during and after the Coronavirus Disease 2019 (COVID-19) public health emergency (PHE), NYS DOH conducted the *Telehealth Provider Survey*, which was active from August 2023 to October 2023. All NYS health care providers, whether they have used telehealth services or not, were encouraged to complete the survey. Survey results are being used to inform future telehealth policy development in NYS.

Questions

All questions regarding the *Telehealth Provider Survey* results infographic should be directed to NYS DOH at Telehealth.Policy@health.ny.gov.

Back to Top

Essential Plan Coverage for Pregnant Enrollees and Their Newborns

In an effort to continue to address the affordability of health insurance for New Yorkers, New York State (NYS) received approval to expand the Essential Plan (EP) to New Yorkers with incomes up to 250 percent of the Federal Poverty Level (FPL), **effective April 1, 2024**. In addition, under the Section 1332 State Innovation Waiver, pregnant individuals who were enrolled in EP prior to reporting their pregnancy will stay enrolled in EP after reporting their pregnancy. Pregnant individuals are still required to update their NY State of Health (Marketplace) account with their pregnancy information, regardless of which program they are enrolled in at the point they become pregnant. After reporting their pregnancy, EP-enrolled individuals will no longer be moved to NYS Medicaid as they would have been before the waiver was approved. EP enrollees who remain enrolled in EP after reporting their pregnancy will not receive an Unborn Client Identification Number (CIN) or Common Benefit Identification Card (CBIC) for their unborn as they would have if they were enrolled in NYS Medicaid.

At this time, individuals enrolled in EP need to apply for coverage for their newborns as soon as possible, but no later than three months after birth. Babies born to individuals who remained enrolled in EP during their pregnancy will not be considered a *deemed newborn*, as defined in Social Services Law (SOS) §366-g; however, they will have a NYS Medicaid determination performed once they are added to the NY State of Health account of their family. Once a newborn has been determined eligible for NYS Medicaid, they will receive a notice indicating the start date of their coverage and a CBIC. If the newborn is eligible to enroll in a Medicaid Managed Care (MMC) Plan, a plan would need to be selected for them as they will not automatically be enrolled into the NYS Medicaid version of their birthing parent's EP. If the birthing individual applies for coverage for the newborn after the month of birth, a retroactive eligibility determination should be requested. The retroactive period will assist in effectuating coverage back to the month of birth of the newborn.

Allowing the pregnant individual to stay enrolled in EP rather than transitioning to NYS Medicaid will help to maintain consistent coverage for pregnant individuals during their pregnancy. However, if the pregnant individual wishes to enroll in NYS Medicaid, they will need to contact NY State of Health Customer Service at (855) 355-5777.

Questions and Additional Information:

- FFS claim questions should be directed to the eMedNY Call Center at (800) 343-9000.
- Newborn eligibility and policy questions should be directed to MedicaidNewbornQuestions@health.ny.gov.

Back to Top

Medicaid Breast Cancer Surgery Centers

Research shows that five-year survival rates are higher for patients who have their breast cancer surgery performed at high-volume facilities. Therefore, it is the policy of the New York State (NYS) Department of Health (DOH) that NYS Medicaid members receive mastectomy and lumpectomy procedures associated with a breast cancer diagnosis at high-volume hospitals and ambulatory surgery centers defined as averaging 30 or more all-payer surgeries annually over a three-year period. Restricted low-volume facilities will not be reimbursed for breast cancer surgeries provided to NYS Medicaid members.

Each year, NYS DOH reviews the list of low-volume facilities and releases an updated list, **effective April 1, 2024**. NYS DOH has completed its annual review of all-payer breast cancer surgical volumes for 2020 through 2022 using the Statewide Planning and Research Cooperative System (SPARCS) database. Two hundred and fifteen restricted low-volume hospitals and ambulatory surgery centers throughout NYS were identified. These facilities have been notified of the restriction, **effective April 1, 2024**. The policy does not restrict the ability of the facility to provide diagnostic or excisional biopsies and post-surgical care (chemotherapy, radiation, reconstruction, etc.) for NYS Medicaid members. For mastectomy and lumpectomy procedures related to breast cancer, NYS Medicaid members should be directed to high-volume providers in their area.

To view the list of hospitals and ambulatory surgery centers where Medicaid **will not pay** for breast cancer surgery, providers should refer to the NYS DOH "Hospitals & Ambulatory Surgery Centers Where Medicaid Will Not Pay for Breast Cancer Surgery" web page. To view the list of hospitals and ambulatory surgery centers where Medicaid **will pay** for breast cancer surgery, providers should refer to the NYS DOH "Hospitals & Ambulatory Surgery Centers Where Medicaid Will Pay for Breast Cancer Surgery" web page.

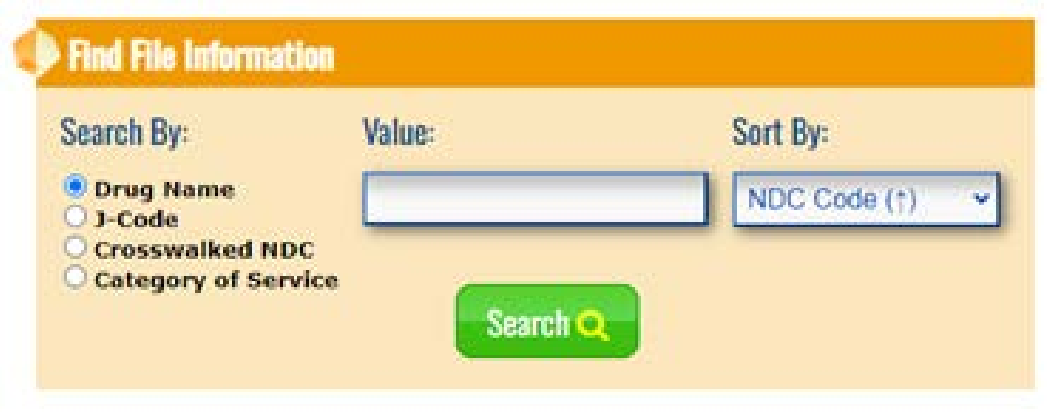
Questions

Questions should be directed to hcre@health.ny.gov.

Back to Top

Practitioner Administered Drug Search Tool Now Available on the eMedNY Website

The 2005 Federal Deficit Reduction Act (DRA) requires providers to report the National Drug Code (NDC) when billing for practitioner administered drugs (PADs) to New York State (NYS) Medicaid and existing reporting requirements. A new resource, **Practitioner Administered Drug (PAD) Search Tool**, is now available on the eMedNY "Practitioner Administered Drug (PAD) Search Tool" web page, which allows providers to search for covered drugs administered by a health care practitioner in physician offices or other outpatient clinical settings. The PAD Search Tool, shown below, provides helpful billing information regarding physician-administered drugs that are billed to the medical benefit using an appropriate Healthcare Common Procedure Coding System (HCPCS) code and NDC.



Find File Information

Search By:
- ● Drug Name
- ○ J-Code
- ○ Crosswalked NDC
- ○ Category of Service

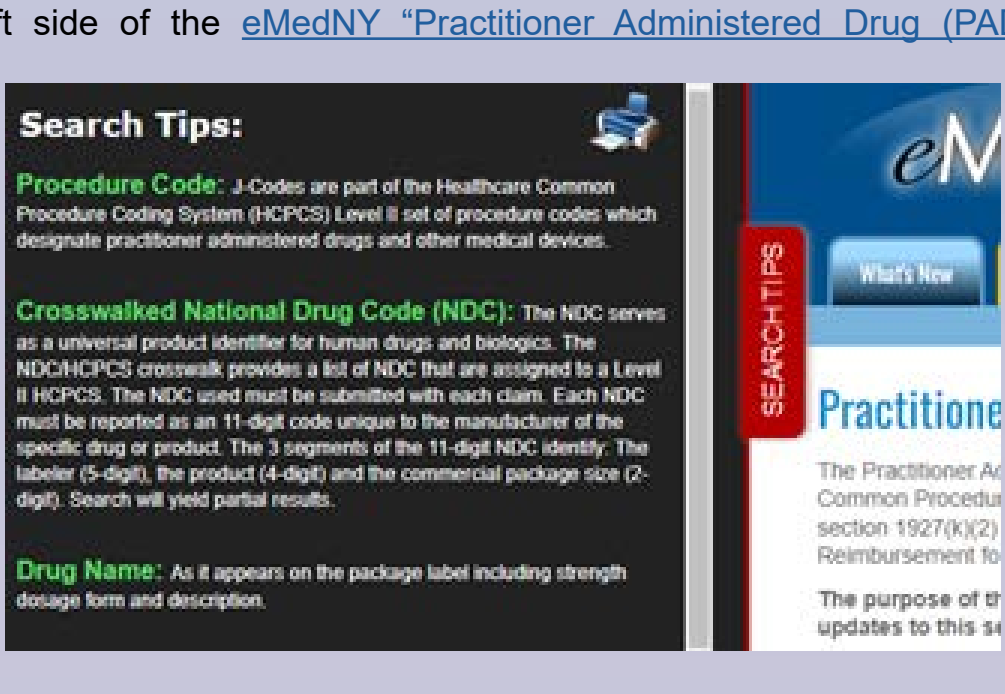
Value:

Sort By: NDC Code (↑)

Users may search the PAD Search Tool using the following criteria:

- **Drug name** using a minimum of four characters (partial searches of the drug name are accepted and produce matching results);
- **HCPCS code** using the complete five-digit code;
- **NDC** using a minimum of four-digits; and
- **Category of Service (COS)** using the complete four-digit number.

The PAD Search Tool aims to assist providers in utilizing the correct HCPCS and NDC billing units, as required by 2005 Federal DRA. Providers should utilize the "Search Tips" toolbar on the left side of the eMedNY "Practitioner Administered Drug (PAD) Search Tool" web page, for definitions and further descriptions.



Search Tips:

Procedure Code: J-Codes are part of the Healthcare Common Procedure Coding System (HCPCS) Level II set of procedure codes which designate practitioner administered drugs and other medical devices.

Crosswalked National Drug Code (NDC): The NDC serves as a universal product identifier for human drugs and biologics. The NDC/HCPCS crosswalk provides a list of NDC that are assigned to a Level II HCPCS. The NDC used must be submitted with each claim. Each NDC must be reported as an 11-digit code unique to the manufacturer of the specific drug or product. The 3 segments of the 11-digit NDC identify: The labeler (5-digit), the product (4-digit) and the commercial package size (2-digit). Search will yield partial results.

Drug Name: As it appears on the package label including strength dosage form and description.

Results can be expanded to view further information about the drug and HCPCS code. Information related to both the NDC unit type and HCPCS billing unit are displayed in the "Billing Unit Type" and "HCPCS Code Dosage Description" fields, respectively. To review drugs covered under the pharmacy benefit, providers should continue to utilize the *New York State Department of Health List of Medicaid Reimbursable Drugs*, located on the eMedNY "Medicaid Pharmacy List of Reimbursable Drugs" web page.

Clarification Regarding Billing Units

When completing sections pertaining to NDC, providers should utilize the "Billing Unit Type" displayed on the PAD Search Tool as the basis for quantity. This is typically a volumetric unit (gram or milliliter) administered to the patient. In the "Search Result Example" provided below, the drug is available in a package size of 10 mg with a concentration of 40 mg/1 ml. If the dose administered is 40 mg, the value entered in the NDC quantity field would be 1 ml. Providers must ensure this section is completed for unlisted codes **"J3490"** and **"J3590"**.

When completing sections pertaining to the HCPCS code, providers should utilize the "HCPCS Code Dosage Description" field as the basis for units billed. In the "Search Result Example" provided below, HCPCS unit is represented as 10 mg per unit. Therefore, a 40 mg dose would be billed as 4 units of 10 ml. This value is unique to each HCPCS code.

To view a search result example, providers should refer to the *Practitioner Administered Drug Search Tool Now Available on the eMedNY Website* article in this month's issue.

To view the electronic claim example to better understand which fields map to the PAD Search Tool, providers should refer to this month's issue.

To view the 150003 paper claim example to better understand which fields map to the PAD Search Tool, providers should refer to this month's issue.

Questions and Additional Information:

- Additional information regarding the 150003 paper claim form can be found in the eMedNY *New York State 150003 Billing Guidelines*.
- NYRx claim questions should be directed to the eMedNY Call Center at (800) 343-9000.
- NYRx Pharmacy coverage and policy questions should be directed to the NYS Medicaid Pharmacy Policy Unit by telephone at (518) 486-3209 or by email at NYRx@health.ny.gov.

Back to Top

2024 Spousal Impoverishment Income and Resource Levels Increase

Providers of nursing facility services, certain home and community-based waiver services, and services to individuals enrolled in a Managed Long Term Care Plan are required to print and distribute the *Information Notice to Couples with an Institutionalized Spouse* at the time they begin to provide services to their patients.

Effective January 1, 2024, the federal maximum Community Spouse Resource Allowance increased to $154,140.00, while the community spouse monthly income allowance increased to $3,853.50. The maximum family member monthly allowance increased to $852.00. This information should be provided to any institutionalized spouse, community spouse, or representative acting on their behalf to avoid unnecessary depletion of the amount of assets a couple can retain under the Medicaid program spousal impoverishment eligibility provisions.

Income and Resource Amounts

Date	Allowance
January 1, 2024	**Federal Maximum Community Spouse Resource Allowance: *$154,140.00*** **Please note:** A higher amount may be established by court order or fair hearing to generate income to raise the community spouse's monthly income up to the maximum allowance. **Please note:** The State Minimum Community Spouse Resource Allowance is $74,820.00.
January 1, 2024	**Community Spouse Minimum Monthly Maintenance Needs Allowance: An amount up to *$3,853.50*** (if the community spouse has no income of their own). **Please note:** A higher amount may be established by court order or fair hearing due to exceptional circumstances that result in significant financial distress.
January 1, 2024	**Family Member Monthly Allowance (for each family member): An amount up to *$852.00*** (if the family member has no income of their own).

Please note: If the institutionalized spouse is receiving Medicaid, any change in income of the institutionalized spouse, the community spouse, and/or the family member may affect the community spouse income allowance and/or the family member allowance. Therefore, the social services district should be promptly notified of any income variations.

Back to Top

Information Notice to Couples with an Institutionalized Spouse

- "Information Notice to Couples with an Institutionalized Spouse" is available as a PDF.
- "Additionally, the *Request for Assessment – Spousal Impoverishment* form should be printed and distributed.

Medicaid is an assistance program that may help pay for the costs of your or your spouse's institutional care, home and community-based waiver services, or enrollment in a Managed Long Term Care Plan. The institutionalized spouse is considered medically needy if their resources are at or below a certain level and the monthly income after certain deductions is less than the cost of care in the facility. Federal and State laws require that spousal impoverishment rules be used to determine an institutionalized spouse's eligibility for Medicaid. These rules protect some of the income and resources of the couple for the community spouse. **Please note:** Spousal impoverishment rules do not apply to an institutionalized spouse who is eligible under the Modified Adjusted Gross Income rules.

If you or your spouse are:

1. In a medical institution or nursing facility and are likely to remain there for at least 30 consecutive days; ***or***
2. Receiving home and community-based services provided pursuant to a waiver under §1915(c) of the federal Social Security Act and are likely to receive such services for at least 30 consecutive days; ***or***
3. Receiving institutional or non-institutional services and are enrolled in a Managed Long Term Care Plan; ***and***
4. Married to a spouse who does **not** meet any of the criteria set forth under items 1 through 3 listed above, these income and resource eligibility rules for an institutionalized spouse may apply to you or your spouse.

If you wish to discuss these eligibility provisions, please contact your local department of social services to request an assessment of the total value of your or your spouses combined countable resources, even if you have no intention of pursuing a Medicaid application. It is to the advantage of the community spouse to request such an assessment to make certain that allowable resources are not depleted by you for your spouse's cost of care. To request such an assessment, please contact your local department of social services or complete and mail the *Request for Assessment – Spousal Impoverishment* form (DOH-5298). New York City residents may contact the Human Resources Administration Medicaid Helpline at (888) 692-6116.

Resourceful Information
Effective January 1, 1996, the community spouse is allowed to keep resources in an amount equal to the greater of the following amounts: 1. $74,820.00 (the NYS minimum spousal resource standard); ***or*** 2. $154,140.00 (the amount of the spousal share up to the maximum amount permitted under federal law for 2024).

For purposes of this calculation, "spousal share" is the amount equal to one-half of the total value of the countable resources of you and your spouse at the beginning of the most recent continuous period of institutionalization of the institutionalized spouse. The most recent continuous period of institutionalization is defined as the most recent period you and your spouse met the criteria listed in items 1 through 4 (listed under the "If you or your spouse are" section above). In determining the total value of the countable resources, we will not count the value of your home, household items, personal property, car, or certain funds established for burial expenses.

The community spouse may be able to obtain additional amounts of resources to generate income when the otherwise available income of the community spouse, together with the income allowance from the institutionalized spouse, is less than the maximum community spouse monthly income allowance, by requesting a fair hearing or commencing a family court proceeding against the institutionalized spouse. You can contact your local department of social services or an attorney about requesting a Medicaid fair hearing. Your attorney can provide more information about commencing a family court proceeding. You may be able to get a lawyer at no cost by calling your local Legal Aid or Legal Services Office. For names of other lawyers, call your local or State Bar Association.

Either spouse, or a representative acting on their behalf, may request an assessment of the couple's countable resources at the beginning or any time after the beginning of a continuous period of institutionalization. Upon receipt of such request and all relevant documentation, the local district will assess and document the total value of the couple's countable resources and provide each spouse with a copy of the assessment and the documentation upon which it is based. If the request is not filed with a New York State Medicaid application, the local department of social services may charge up to $25.00 for the cost of preparing and copying the assessment and documentation.

Income Information
A spouse may request an assessment/determination of: 1. The community spouse monthly income allowance (an amount of up to $3,853.50 a month for 2024); ***and*** 2. A maximum family member allowance for each minor child, dependent child, dependent parent, or dependent sibling of either spouse living with the community spouse of $852.00 for 2024 (if the family member has no income of their own).

The community spouse may be able to obtain additional amounts of the institutionalized spouse's income, due to exceptional circumstances resulting in significant financial distress, then would otherwise be allowed under the Medicaid program, by requesting a fair hearing or commencing a family court proceeding against the institutionalized spouse. Significant financial distress means exceptional expenses which the community spouse cannot be expected to meet from the monthly maintenance needs allowance or from amounts held in resources. These expenses may include but are not limited to recurring or extraordinary non-covered medical expenses (of the community spouse or dependent family members who live with the community spouse); amounts to preserve, maintain, or make major repairs to the home; and amounts necessary to preserve an income-producing asset. Social Services Law §366-c(2)(g) and §366-c(4)(b) require that the amount of such support orders be deducted from the institutionalized spouse's income for eligibility purposes. Such court orders are only effective back to the filing date of the petition. Please contact your attorney for additional information about commencing a family court proceeding.

If you wish to request an assessment of the total value of your or your spouse's countable resources, a determination of the community spouse resource allowance, community spouse monthly income allowance, or family member allowance(s) and the method of computing such allowances, please contact your local department of social services. New York City residents should call the Human Resources Administration Medicaid Helpline at (888) 692-6116.

To view information regarding spousal refusal and undue hardship concerning a community spouse's refusal to provide necessary Information, providers should refer to the *Information Notice to Couples with an Institutionalized Spouse* article in this month's issue.

To view information regarding income contribution from the community spouse, providers should refer to this month's issue.

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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