NEW YORK STATE Department of Health

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Medicaid Update

Inside this issue:

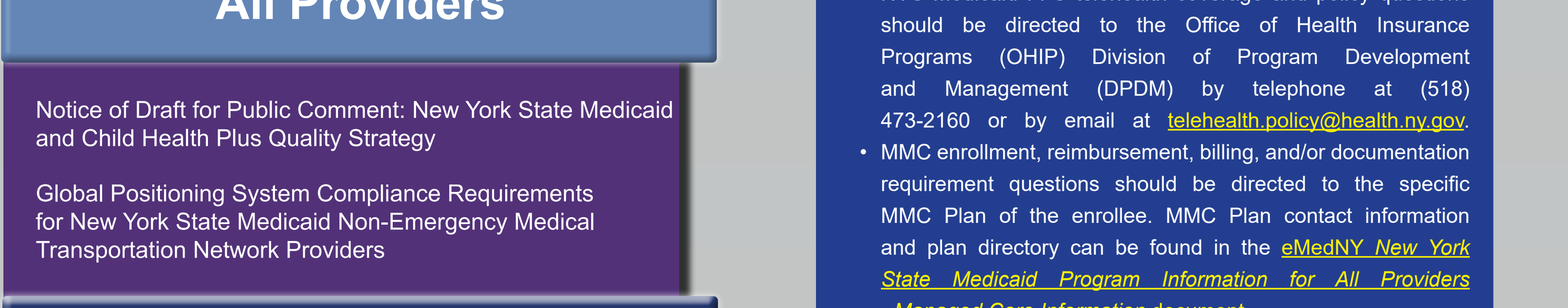
New York State Medicaid Telehealth Policy Manual

On May 13, 2024, the New York State (NYS) Medicaid program published the *Telehealth Policy Manual* on the NYS Department of Health (DOH) "NY Medicaid Telehealth" web page. Information provided in the *Telehealth Policy Manual* applies to all NYS Medicaid-enrolled providers and Medicaid Managed Care (MMC) Plans, **effective immediately**. The *Telehealth Policy Manual* expands on and supersedes previous NYS Medicaid telehealth guidance. It includes information on covered modalities, billing rules, restrictions for specific services and populations, as well as post-Public Health Emergency (PHE) policies. The *Telehealth Policy Manual* will be updated periodically. Alerts about changes to NYS Medicaid telehealth policy will be communicated through future Medicaid Update articles and incorporated into the *Telehealth Policy Manual.*

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

Removal of Prior Authorization/Dispensing Validation System Step for Physical Therapy, Occupational Therapy and Speech Therapy Visits

Effective July 1, 2024, New York State (NYS) Medicaid fee-for-service (FFS) will end prior authorization (PA) for medically necessary therapy visits. This change eliminates unnecessary administrative requirements and aligns with the 2021 removal of visit limits, which was announced in the *Change to Physical Therapy, Occupational Therapy, and Speech Therapy Visit Limit* article published in the April 2021 issue of the *Medicaid Update*. Providers submitting claims to NYS Medicaid FFS will no longer need to obtain a PA through the PA/Dispensing Validation System (DVS).

Questions and Additional Information:

- Policy questions for NYS Medicaid FFS members should be directed to the Office of Health Insurance Programs (OHIP) by telephone at (518) 473-2160 or by email at FFSMedicaidPolicy@health.ny.gov.
- Additional information regarding rehabilitation services can be found in the *eMedNY Rehabilitation Services Manual*.

Back to Top

Fee-for-Service Dental Claim Submission Guidance When Third-Party Liability Payment Involved

New York State (NYS) Medicaid continues to work to increase provider compliance with properly reporting correct Coordination of Benefits (COB) information on claims submitted for beneficiaries who have primary insurance. The COB claim to NYS Medicaid must accurately reflect the primary payers' adjudication of the claim as reported in the Explanation of Benefits (EOB).

When the primary insurance is a Medicare Advantage Plan / Medicare Part C with dental coverage:

- Claims for services involving a third-party payment by a Medicare Advantage Plan **greater than zero dollars (>$0)** must be submitted using the ***electronic*** claim format. This also includes electronic submission of by-report procedure codes if a payment was made by a Medicare Pact C Plan.
- The payor code for Medicare Advantage Plans is the 16-health maintenance organization (HMO) and must be indicated on all electronic claims when Medicare Advantage is primary.
- It is the responsibility of the provider to submit the claim using the appropriate claim format with their usual or customary fee indicated along with reporting the Medicare Advantage Plan deductible amount, co-insurance amount, co-payment amount and paid amount.

Please note: A provider of a Medicare Part C benefit cannot attempt to recover any co-payment or co-insurance amount directly from Medicare and NYS Medicaid dually eligible individuals. The provider is required to accept the Medicare Part C health plan payment and any NYS Medicaid payment as payment in full for the service. The NYS Medicaid member may not be billed for any Medicare Part C co-payment/co-insurance amount that is not reimbursed by NYS Medicaid.

When the primary insurance is a private or commercial plan with dental coverage (not Medicare Advantage / Medicare Part C):

- Claims for services involving a third-party payment by private or commercial insurance plan (not Medicare Advantage), whether **equal to or greater than zero dollars (= or > $0)** may be submitted using either the ***electronic or paper*** claim format depending upon whether claim attachments are necessary (e.g., use paper claim format if the procedure code requires a report).
- It is the responsibility of the provider to submit the claim indicating their usual or customary fee along with reporting the amount paid by the private dental insurance plan in the "Other Insurance Paid" or "Other Payer Paid Amount" field.

Questions and Additional Information:

- Billing guidelines can be found on the eMedNY homepage.
- General billing questions should be directed to the eMedNY Call Center at (800) 343-9000.
- NYS Medicaid fee-for-service (FFS) questions regarding this guidance should be directed to dental@health.ny.gov.
- Questions regarding Medicaid Managed Care (MMC) reimbursement and/or documentation requirements should be directed to the MMC Plan of the enrollee. For MMC Plan information, providers should refer to the eMedNY *New York State Medicaid Program Information for All Providers - Managed Care Information* document.

Back to Top

Pharmacy Reminder: Coordination of Benefits Processing with Other Payer ID and Other Payer ID Qualifier for Pharmacy Claims

New York State (NYS) Medicaid providers are required to bill applicable third parties that may be liable for a claim before billing NYS Medicaid. NYS Medicaid is always the payor of last resort and federal regulations require that all other available resources be used before NYS Medicaid considers payment.

The following chart illustrates the appropriate value choices for the required field for each payer type. If the values are not reported correctly, the claim will fail the pre-adjudication edit National Council for Prescription Drug Programs (NCPDP) Reject Code **"7C"** (*Missing/Invalid Other Payer ID Code*).

Payer Type	339-6C (*Other Payer ID Qualifier*)	340-7C (*Other Payer ID*)	351-NP (*Other Payer-Patient Responsibility Amount Qualifier*)
Commercial Third Party Liability (TPL)	**99**	**99**	**01**, **04**, **05**, **06**, **07**, **09**, or **12**
Medicare Part B	**05**	Carrier #	**01** or **07**
Medicare Part C, Medicare Advantage, Medicare Managed Care	**99**	**13**	**01**, **04**, **05**, **06**, **07**, **09**, or **12**

Other Coverage Code "2" (Field 308-C8) – Patient Has Other Coverage This Claim Covered

The following codes are valid entries to be returned for field 351-NP (Other Payer-Patient Responsibility Amount Qualifier) when the claim is submitted to primary insurance:

"01" = Deductible
"04" = Amount reported from previous payer as exceeding periodic benefit maximum
"05" = Co-pay amount
"06"* = Patient pay amount
"07" = Co-insurance amount
"09" = Health plan assistance amount
"12" = Coverage gap amount

**NYRx and NCPDP recommends the use of the component pieces; however, if the components do not sum to patient pay amount, the use of 351-NP (Other Payer-Patient Responsibility Amount Qualifier) value of "06" is allowed.*

Other Coverage Code "3" (Field 308-C8) – Patient Has Other Coverage This Claim Not Covered

The following codes are the ***only valid entries*** for field **472-6E** (*Other Payer Reject Codes*) when the Other Coverage Code of **"3"** is submitted in field **308-C8** (*Other Coverage Code*) when the claim represents an over the counter (OTC) product not covered as a benefit from the other payer. The pre-adjudication edit will return the NCPDP Reject Code (**"DE3988"**) "6E - M/I Other Payer Reject Code" for all other entries.

"70" = Product/service not covered
MR = Product not on formulary

Other Coverage Code "4" (Field 308-C8) – Patient Has Other Coverage Payment Not Collected

If value code of **"4"** is submitted in field 308-C8 for situations where the prior payer did not make a payment, the system will enforce that the following conditions are met:

- NCPDP field **431-DV** (*Other Payer Amount Paid*) is equal to zero;
- NCPDP field **351-NP** (*Other Payer-Patient Responsibility Amount Qualifier*) is present from the primary payer;
- **353-NR** (*Other Payer-Patient Responsibility Amount Count*) is present from the primary payer; and
- **352-NQ** (*Other Payer-Patient Responsibility Amount*) segment is included from the primary payer.

If any of the above conditions are **not** met, the system will deny the claim and return NCPDP Reject code **"536"** (*Other Payer - Patient Responsibility Amount Qualifier Value Not Supported*).

The following codes are valid entries for field **351-NP** (*Other Payer-Patient Responsibility Amount Qualifier*) when the Other Coverage Code of **"4"** is submitted in field **308-C8** (*Other Coverage Code*):

Blank = Not Specified
"01" = Deductible
"04" = Amount Reported from previous payer as Exceeding Periodic Benefit Maximum
"05" = Co-pay Amount
"06"* = Patient Pay Amount
"07" = Co-insurance Amount
"09" = Health Plan Assistance Amount
"12" = Coverage Gap Amount

**NYRx and NCPDP recommends the use of the component pieces; however, if the components do not sum to patient pay amount, the use of 351-NP (Other Payer-Patient Responsibility Amount Qualifier) value of "06" is allowed.*

The following codes are ***invalid entries*** for field **351-NP** (**Other Payer-Patient Responsibility Amount Qualifier**) when the Other Coverage Code of **"4"** is submitted in field **308-C8** (*Other Coverage Code*). The pre-adjudication edit will return the NCPDP Reject Code **"536"** (*Other Payer-Patient Responsibility Amount Qualifier Value Not Supported*).

"02" = Product/Selection/Brand Drug Amount
"03" = Sales Tax Amount
"08" = Product Selection/Non-Preferred Formulary Selection Amount
"10" = Provider Network Selection Amount
"11" = Product/Selection/Brand Non-Preferred Formulary Selection Amount
"13" = Processor Fee Amount
"14" = Grace Period Amount
"15" = Catastrophic Benefit Amount
"16" = Unbalanced patient pay response received from previous payer
"17" = Regulatory fee as reported by previous payer
"18" = Spend down as reported by previous payer

Additional information regarding the fields shown above can be found in the eMedNY *New York State Department of Health NYS DOH) Office of Health Insurance Programs (OHIP) Standard Companion – Transaction Information* document (NCPDP D.0 Companion Guide). Billing questions should be directed to the eMedNY Call Center at (800) 343-9000.

Questions and Additional Information:

- *eMedNY Prospective Drug Utilization Review/Electronic Claims Capture and Adjudication ProDUR/ECCA Provider Manual*
- Questions regarding billing Coordination of Benefits (COB) claims can be directed to eMedNY at (800) 343-9000.
- For information about Medicare, providers should:
  - visit the Medicare website;
  - call (800) MEDICARE (1-800-633-4227) / TTY users should call (877) 486-2048.
- For NYS Medicaid members needing assistance with personalized health insurance counseling:
  - visit the NYS Health Insurance Information Counseling and Assistance Program (HIICAP) "Program Description" web page; and/or
  - call (800) 701-0501.
- Questions regarding this policy should be directed to NYRx@health.ny.gov.

Back to Top

Fiscal Intermediary Administrative Payment Changes

Effective August 1, 2024, Fiscal Intermediary (FI) administrative payments will move to a non-risk distribution methodology for Medicaid Managed Care enrollees. **Please note:** The effective date has been delayed one month from prior communication to allow time for contracting efforts to be completed. This change applies to all MMC enrollees, except for those participating in the Program of All-Inclusive Care for Elderly (PACE) program or the Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) Plan.

Per Centers for Medicare & Medicaid Services (CMS) feedback, the new payment structure will be done consistent with prior non-risk managed care payment arrangements such as Home and Community Based Service (HCBS) distributions. Funding for FI administrative payments will be removed from plan capitation and paid on a managed fee-for-service (FFS) basis. **Effective August 1, 2024**, the Fiscal Intermediaries will bill the Managed Care Organizations (MCOs) according to the three-tier monthly schedule for each MMC enrollee receiving consumer directed personal care services. MCOs pay Fiscal Intermediaries the exact amount of the three tier monthly, per MMC enrollee rate according to Prompt Pay guidelines. MCOs will bill the State based on the three tiered monthly, per member rate schedule via the newly established rate codes and the State will pay the MCO accordingly.

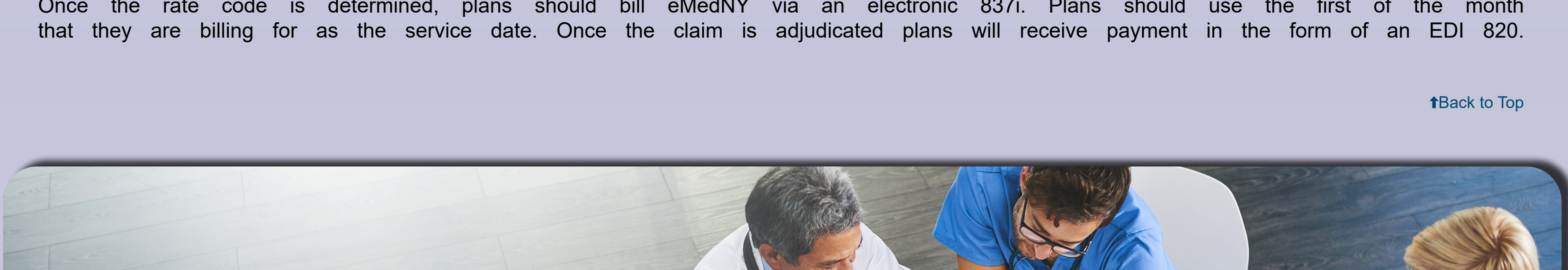
The three tier per MMC enrollee schedule found below should be used to appropriately capture the directed level of administrative funding a Fiscal Intermediary can receive for services based on the number of Direct Care hours a consumer received in a given month.

Tier	Rate Code	Number of Direct Care Hours Per Month Per Consumer	FI Monthly Reimbursement
1	2443	One to 159 hours	$146.45
2	2444	160 to 479 hours	$387.84
3	2445	480 hours and above	$1,046.36

Plans should bill eMedNY the rate code that correlates with the number of service hours the MMC enrollee received in the month they are billing. As the direct care hours of the consumer may increase or decrease over the course of a month, plans should submit claims for FI admin costs no earlier than the first day of the month, immediately following the month for which reimbursement services are being claimed.

Once the rate code is determined, plans should bill eMedNY via an electronic 837i. Plans should use the first of the month that they are billing for as the service date. Once the claim is adjudicated plans will receive payment in the form of an EDI 820.

Back to Top



All Providers

Notice of Draft for Public Comment: New York State Medicaid and Child Health Plus Quality Strategy

The New York State (NYS) Department of Health (DOH) seeks public comment to the proposed 2023-2025 NYS Medicaid and Child Health Plus (CHPlus) Quality Strategy. The Quality Strategy is a federal requirement for states delivering services through managed care. It requires states to establish a comprehensive quality improvement strategy, assess the quality of care that NYS Medicaid and CHPlus members receive and establish measurable goals with targets for improvement. A draft of the proposed Quality Strategy and additional information about the Quality Strategy are available on the NYS DOH "Medicaid and CHPlus Quality Strategy" web page.

Submission and Review of Public Comments

Prior to finalizing the proposed Quality Strategy, NYS DOH will consider all written comments received. These comments will be summarized in the final submitted version. Written comments will be accepted by email at qualitystrategy@health.ny.gov, with "Quality Strategy" in the subject line, or by mail at:

Department of Health
Office of Health Insurance Programs
99 Washington Ave, One Commerce Plaza, Suite 1605
Albany, NY 12210

The notice of public comment is slated to appear in the State Register on Tuesday, June 18, 2024. All comments must be postmarked or emailed within 30 calendar days after publication in the State Register.

Questions

Questions regarding this notice should be directed to the NYS DOH Bureau of Health Access, Policy, and Innovation by email at qualitystrategy@health.ny.gov or by telephone at (518) 473-2160.

Back to Top

Global Positioning System Compliance Requirements for New York State Medicaid Non-Emergency Medical Transportation Network Providers

Effective April 3, 2023, the New York State (NYS) Department of Health (DOH) requires all transportation providers to be fully Global Positioning System (GPS)-compliant. For a trip to be considered fully GPS-compliant, the transportation provider must submit the starting point, end point and all GPS coordinates along the trip ("breadcrumb data") to the Transportation Management Broker, Medical Answering Services, LLC (MAS).

In the upcoming weeks, NYS DOH will require all network transportation providers* to share GPS data on all NYS Medicaid transports. Failure to share required GPS information will result in inability to attest to trip completion and may result in non-payment. MAS will work directly with network transportation providers in the upcoming weeks to determine and communicate specific effective dates. The use of GPS data will be used to increase program integrity, ensure enrollee safety, aid in the development of future policies and assist in the reduction of fraud, waste, and abuse.

**Ambulance providers are exempt from the GPS requirements as they are sharing similar information with the NYS DOH Bureau of Emergency Medical Services.*

Questions

Questions should be directed to the Medicaid Transportation Unit by telephone at (518) 473-2160 or by email at MedTrans@health.ny.gov.

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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