NEW YORK STATE | Department of Health

Medicaid Update

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Update to the New York State Patient Centered Medical Home Billing Guidance

Effective January 1, 2026, the New York State (NYS) Medicaid program updated the *New York State Patient Centered Medical Home (PCMH) Billing Guidance*, located at: https://www.health.ny.gov/technology/nys_pcmh/docs/2026_billing_manual.pdf, to include the following information:

- guidance for 2026 related to the NYS Patient Centered Medical Home (PCMH) Medicaid Managed Care (MMC) incentive enhancement;
- an updated NYS PCMH payment table;
- additional questions and answers added to assist providers with quality reporting requirements and payments;
- information about NYS PCMH provider revocation risk in the NYS PCMH recognition requirements section; *and*
- a link to a search tool for claim denial reasons.

The information in the *New York State Patient Centered Medical Home Billing Guidance* applies to all NYS PCMH-recognized providers and MMC Plans. Providers should visit the NYS Department of Health "New York State Patient-Centered Medical Home (NYS PCMH)" web page, located at: https://www.health.ny.gov/technology/nys_pcmh/, to access the guidance and additional resources.

Questions and Additional Information:

- Questions related to the NYS PCMH program and attestation should be directed to PCMH@health.ny.gov.
- Questions related to Social Care Networks (SCNs) should be directed to NYHER@health.ny.gov. Additional information regarding SCNs can be found on the NYS Department of Health "Social Care Networks (SCN)" web page, located at: https://www.health.ny.gov/health_care/medicaid/redesign/sdh/scn/.
- Questions related to Child Health Plus (CHPlus) should be directed to CHPlus@health.ny.gov.
- Additional information regarding NYS Medicaid and the CHPlus NYS PCMH incentive enhancement information can be found in the *Reminder: New York State Medicaid and Child Health Plus Patient-Centered Medical Home Quality Reporting Begins in 2026* article published in the December 2025 issue of the *Medicaid Update*, located at: https://www.health.ny.gov/health_care/medicaid/program/update/2025/docs/mu_no12_dec25_pr.pdf.
- Providers should refer to the NYS Department of Health "PCMH Attestation: Frequently Asked Questions (FAQ's)" web page, located at: https://www.health.ny.gov/technology/nys_pcmh/attestation_faqs.htm, for frequently asked questions and answers.
- Questions related to quality reporting should be directed to the My NCQA website, located at: https://my.ncqa.org/.

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In This Issue…

New York State Medicaid Updated Coverage Criteria for Wireless Capsule Endoscopy

This article provides updated policy guidance on the coverage criteria for wireless capsule endoscopy for New York State (NYS) Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC) Plans. This procedure is reimbursed when a NYS Medicaid-enrolled trained gastroenterologists performs this procedure using Food and Drug Administration (FDA)-cleared devices consistent with the criteria described in this article.

NYS Medicaid covers wireless capsule endoscopy in the evaluation of NYS Medicaid members when conventional endoscopy is unable to identify or rule out pathology, further evaluation is necessary, and consistent with the clinically appropriate use of wireless capsule endoscopy. Wireless capsule endoscopy is also covered for NYS Medicaid members when there are contraindications for conventional endoscopy. Documentation supporting medical necessity must be retained for a minimum of six years following the date of NYS Medicaid payment and is subject to audit.

Wireless capsule endoscopy is contraindicated for use in individuals with known or suspected fistulas, strictures, or gastrointestinal obstruction (unless patency is confirmed prior to use). Wireless capsule endoscopy will not be reimbursed when performed for colon cancer screening.

The current list of conditions with support in published guidelines where wireless capsule endoscopy may be indicated when the above criteria are met include:

- polyposis syndromes;
- iron deficiency anemia with suspected gastrointestinal bleeding;
- upper gastrointestinal inflammatory disease;
- suspected or refractory malabsorptive syndromes;
- gastrointestinal bleeding, excluding hematemesis; and
- any other condition in which there is high clinical suspicion for an upper gastrointestinal tract pathology for which wireless capsule endoscopy is medically necessary and supported by evidence-based published guidelines put forth by recognized gastroenterological and/or surgical societies.
- **Please note:** Use for conditions lacking published guideline support may not be covered.

NYS Medicaid FFS Billing

Current Procedural Terminology (CPT) Code	CPT Code Description
91110	Imaging of digestive tract done from the inside of the digestive tract, esophagus through ileum.
91111	Imaging of esophagus done from the inside of the esophagus.

Questions and Additional Information:

- 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 Division of Program Development and Management 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, located at: https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers_Managed_Care_Information.pdf.

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Prohibited Prior Authorization Requests

As a reminder, **third party requests for prior authorization (PA) are prohibited**. Only prescribers or their authorized agent may submit a PA request. An authorized agent is an individual employed by the same professional practice as the prescribing practitioner and has access to the medical records of the patient (e.g., nurse or medical assistant). The practitioner is responsible for the activities of the authorized agent. A practitioner may not outsource the authority of obtaining a PA. A pharmacy may not offer to obtain PA on behalf of a practitioner.

Third party entities are **not** authorized to request PA nor enter into an agreement with a prescriber to obtain PA or appeal a PA determination on the behalf of the prescriber. Such conduct is contrary to the official rules and regulations of the New York State (NYS) Department of Health and violates:

- Title 18 of the New York Codes, Rules and Regulations (NYCRR) §504.3, located at: https://regs.health.ny.gov/content/section-5043-duties-provider;
- Title 18 of the NYCRR §504.7, located at: https://regs.health.ny.gov/content/section-5047-continued-enrollment-termination;
- Title 18 of the NYCRR §515.2, located at: https://regs.health.ny.gov/content/section-5152-unacceptable-practices-under-medical-assistance-program; *and*
- NYS Public Health Law Article 2-A Title 1 §273 (3) and (5), located at: https://www.nysenate.gov/legislation/laws/PBH/273.

Pharmacies and practitioners found to be engaging in such conduct are at risk for termination or exclusion from the NYS Medicaid program.

Please note:

- When presented with a prescription for a drug that requires PA, the pharmacist must notify the prescriber that PA is required and notify the patient once the prescriber has obtained the PA.
- Pharmacy providers who integrate with CoverMyMeds® can initiate electronic prior authorization (ePA) requests on behalf of the NYS Medicaid member for submission by the prescriber. CoverMyMeds® directs the case to the queue of the prescriber and prompts the prescriber to complete and submit the ePA request.

Questions and Information:

- Additional information can be found in the following *Medicaid Update* articles:
  - *Pharmacy Program Integrity Spotlight* article published in the July 2023 issue of the *Medicaid Update*, located at: https://www.health.ny.gov/health_care/medicaid/program/update/2023/docs/mu_no12_jul23_pr.pdf;
  - *NYRx, the New York State Medicaid Pharmacy Prior Authorization Programs Update* article published in the July 2024 issue, located at: https://health.ny.gov/health_care/medicaid/program/update/2024/docs/mu_no7_jul24_pr.pdf;
  - *Reminder: Prescribers May Initiate NYRx Pharmacy Prior Authorizations with CoverMyMeds® or PAXpress®* article published in the December 2025 issue of the *Medicaid Update*, located at: https://www.health.ny.gov/health_care/medicaid/program/update/2025/docs/mu_no12_dec25_pr.pdf.
- The policy is detailed in the *NYRx, Medicaid Pharmacy Program – Pharmacy Manual Policy Guidelines*, located at: https://www.emedny.org/ProviderManuals/Pharmacy/PDFS/Pharmacy_Policy_Guidelines.pdf.
- Additional information regarding this guidance can be found in the *NYRx Electronic Prior Authorization via CoverMyMeds How-To Guide: Prescribers, Prescriber's Authorized Agents, and Pharmacies*, located at: https://newyork.fhsc.com/downloads/providers/NYRx_EO_notification_cmm_how_to_guide.pdf.
- NYRx coverage and policy questions should be directed by telephone to (518) 486-3209 or by email to NYRx@health.ny.gov.

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Expansion of Remote Patient Monitoring Delivered by Clinical Staff and for Prenatal/Postpartum Services

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, 2026, NYS Medicaid will reimburse RPM Current Procedural Terminology (CPT) codes **"99470"** and **"99445"**. Medicaid Managed Care (MMC) Plans must comply with this coverage by **March 1, 2026**. The new codes provide greater flexibility to reimburse providers for shorter durations of monitoring and management under existing NYS Medicaid covered RPM services.

RPM Delivered by Clinical Staff

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 include 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 who deliver RPM must confirm that they operate within their scope of practice.

CPT code **"99470"** is a companion code to **"99457"** that allows providers to bill for a lower duration of 10 to 19 minutes of clinical time. Do not report **"99470"** in the same 30-day period as **"99457"**. In each calendar month, providers may report:

- **"99470"** for 10 to 19 minutes of treatment management services; *or*
- **"99457"** for at least 20 minutes of treatment management services.

Prenatal and Postpartum RPM Services

In an effort to reduce maternal and infant morbidity and mortality, NYS Medicaid reimburses an additional allowance for RPM during pregnancy and up to 84 days postpartum using CPT code **"99453"** for set-up and patient education and CPT code **"99454"** for monitoring. CPT code **"99445"** is now part of a duration-based series with CPT code **"99454"**. Do not report CPT code **"99445"** in the same 30-day period as CPT code **"99454"**.

For each 30-day period of RPM for prenatal and postpartum services, providers may report:

- CPT code **"99445"** for two days up to 15 days of monitoring; *or*
- CPT code **"99454"** for at least 16 days up to 30 days of monitoring.

Prenatal and postpartum RPM services must be billed with the **HD** modifier. Providers should refer to the NYS Department of Health *Telehealth Policy Manual*, located at: https://www.health.ny.gov/health_care/medicaid/redesign/telehealth/docs/provider_manual.pdf, for complete RPM billing guidance.

CPT Code	Description	NYS Medicaid Rate
99470	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring one real-time interactive communication with the patient/caregiver during the calendar month; **first 10 minutes**. *This may be bill code once per calendar month, regardless of the number of parameters monitored. Providers should not report services for less than 10 minutes or more than 19 minutes. Providers should not report in conjunction with **99091** or **99457**.*	$22.42
99445 (prenatal and postpartum services only)	Remote monitoring of physiologic parameters(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate); initial set-up and patient education on use of equipment devices(s) supply with daily recording(s) transmission, **two to 15 days in a 30-day period**. *Providers may be bill code once in a 30-day period and must be billed with the **HD** modifier. Providers should not report CPT code **99445** in the same 30-day period as CPT code **99454**. Providers should not report CPT code **99445** in conjunction with codes for more specific physiologic parameters.*	$41.58

Questions and Additional Information:

- Medicaid fee-for-service (FFS) billing and claims questions should be directed to the eMedNY Call Center at (800) 343-9000.
- Medicaid FFS telehealth coverage and policy questions should be directed to the Office of Health Insurance Programs Division of Program Development and Management by telephone at (518) 473-2160 or by email at telehealth.policy@health.ny.gov.
- Medicaid Managed Care (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, located at: https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers_Managed_Care_Information.pdf.

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New Policy Allowing for Treatment in Place Payments for New York State Medicaid

Effective for services provided on or after October 1, 2024, emergency ambulance services stemming from a 911 call that results in treatment in place (TIP) will be reimbursed based on the New York State (NYS) Medicaid rate at the appropriate base rate, without additional fees for mileage.

All rates are published in the *NYS Medicaid Transportation Fee Schedule*, located at: https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.emedny.org%2FProviderManuals%2FTransportation%2FPDFS%2FTransportation_Fee_Schedule.xls&wdOrigin=BROWSELINK. Claims in this category should be billed through eMedNY using the appropriate base rate procedure Healthcare Common Procedure Coding System (HCPCS) code and the new destination modifier:

W modifier – "'Treatment in place' means the administration of emergency medical services, as defined by Public Health Law (PHL) §3001, by an employee or volunteer of an ambulance service. Such services shall be consistent with protocols promulgated pursuant to article 30 of PHL." For additional information, providers should refer to the Social Services Law, Article 5, Title 11, §367-Y, located at: https://www.nysenate.gov/legislation/laws/SOS/367-Y.

"Emergency medical service' means initial emergency medical assistance including, but not limited to, the treatment of trauma, burns, respiratory, circulatory, and obstetrical emergencies." For additional information, providers should refer to the NYS PHL, Article 30, §3001 (1), located at: https://www.nysenate.gov/legislation/laws/PBH/3001.

For information regarding Transportation to an Alternate Destination (TAD), providers should refer to the *Ambulance Providers* article published in the October 2024 issue of the *Medicaid Update*, located at: https://www.health.ny.gov/health_care/medicaid/program/update/2024/docs/mu_no11_oct24_pr.pdf.

As a reminder, claims in the "Transportation to an Alternate Destination" category should be billed through eMedNY using the appropriate base rate procedure HCPCS code and the destination modifier:

- **C** modifier – Community Mental Health Center (including Substance Use Disorder Center)
- **F** modifier – Federally Qualified Health Center
- **O** modifier – Physician Office
- **U** modifier – Urgent Care Facility

Under the Centers for Medicare and Medicaid Services Emergency Triage, Treat, and Transport Model (ET3), TIP and TAD were allowable for participating ambulance-level services. ET3 ended on December 31, 2023; however, NYS continued to allow payments for TAD but not TIP. NYS is now authorized to provide reimbursement for TIP services. Additional information can be found in the following *Medicaid Update* articles:

- *Ambulance Providers: Emergency Triage, Treat, and Transport* article published in the October 2023 issue of the *Medicaid Update*, located at: https://www.health.ny.gov/health_care/medicaid/program/update/2023/docs/mu_no15_oct23_pr.pdf; *and*
- *The CMS Emergency Triage, Treat, and Transport Model with the Department of Health Parallel Model* article published in the November 2021 issue of the *Medicaid Update*, located at: https://www.health.ny.gov/health_care/medicaid/program/update/2021/docs/mu_no13_nov21_pr.pdf.

Questions

Questions regarding this new policy should contact Medicaid Transportation by email at medtrans@ny.health.gov or by telephone at (518) 473-2160.

2026 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" (see "Appendix" on page 21 of this issue) at the time they begin to provide services to their patients.

Effective January 1, 2026, the federal maximum Community Spouse Resource Allowance increased to $162,660.00, while the community spouse monthly income allowance increased to $4,066.50. The maximum family member monthly allowance increased to $902.00. 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, 2026	**Federal Maximum Community Spouse Resource Allowance: *$162,660.00*** **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, 2026	**Community Spouse Minimum Monthly Maintenance Needs Allowance: An amount up to *$4,066.50*** (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, 2026	**Family Member Monthly Allowance (for each family member): An amount up to *$902.00*** (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.

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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 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.

The NYS Department of Health annually reviews the surgical volumes of all hospitals and ambulatory surgical centers and releases an updated list of low-volume facilities, **effective April 1, 2026**. The NYS Department of Health has completed its annual review of all-payer breast cancer surgical volumes for 2022 through 2024 using the Statewide Planning and Research Cooperative System (SPARCS) database. Two hundred twenty-three low-volume hospitals and ambulatory surgery centers throughout NYS were identified. These facilities have been notified of the restriction, **effective April 1, 2026**. The policy does not restrict a facility's ability 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.

For the list of hospitals & ambulatory surgery centers where NYS Medicaid **will not** pay for breast cancer surgery, providers should refer to the NYS Department of Health "Hospitals & Ambulatory Surgery Centers Where Medicaid Will Not Pay for Breast Cancer Surgery" web page, located at: https://www.health.ny.gov/health_care/medicaid/quality/surgery/cancer/breast/no_contract.htm. For the list of hospitals & ambulatory surgery centers where NYS Medicaid **will** pay for breast cancer surgery, providers should refer to the NYS Department of Health "Hospitals & Ambulatory Surgery Centers Where Medicaid Will Pay for Breast Cancer Surgery" web page, located at: https://www.health.ny.gov/health_care/medicaid/quality/surgery/cancer/breast/contract.htm.

Questions

Questions should be directed to the NYS Department of Health at hcre@health.ny.gov.

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NYRx Pharmacy Drug Coverage: Claims Processing Enhancements and Reminders

The New York State (NYS) Department of Health has enhanced claims editing for products not covered by NYRx, the NYS Medicaid Pharmacy program. The following information provides details of these edits.

Claim Edit Details

National Drug Code Not Covered

When a National Drug Code (NDC) does not appear on the eMedNY "Medicaid Pharmacy List of Reimbursable Drugs" web page, located at: https://www.emedny.org/info/formfile.aspx, the pharmacy should review the list for a covered option or discuss possible alternatives with the prescriber. Claims billed to NYRx with an NDC that is not covered will be rejected with the following claims edit:

Edit #	Edit Description	NCPDP Reject Message
00551	Item not eligible for payment on fill date.	**MR**: Product not on formulary.

Drugs Without Federal Rebate Agreement

Pursuant to Social Security Act (SSA) §1927(a), located at: https://www.ssa.gov/OP_Home/ssact/title19/1927.htm, drug manufacturers are required to participate in the Medicaid Drug Rebate Program (MDRP) for coverage. Drugs manufactured without MDRP participation are not covered. Providers should consult the eMedNY "Medicaid Pharmacy List of Reimbursable Drugs" web page, located at: https://www.emedny.org/info/formfile.aspx, for a list of covered alternatives. Additional information regarding this topic can be found in the *Medicaid FFS Removing NDCs* article published in the October 2018 issue of the *Medicaid Update*, located at: https://www.health.ny.gov/health_care/medicaid/program/update/2018/oct18_mu.pdf. Claims billed to NYRx for drugs without a federal rebate agreement will be rejected with the following claims edit:

Edit #	Edit Description	NCPDP Reject Message
02351	NDC not federal participant.	**AC**: Product not covered; non-participating manufacturer.

Drug Efficacy Study Implementation Drugs

The Drug Efficacy Study Implementation (DESI) program implemented by the Food and Drug Administration (FDA) requires drugs be proven safe and effective. Drugs that are identified by the FDA with DESI codes **"5"** and **"6"** were classified by FDA as lacking substantial evidence of effectiveness and are not available for reimbursement, and will be rejected with the following claims edit:

Edit #	Edit Description	NCPDP Reject Message
02352	NDC is a DESI drug.	**70**: NDC not covered. *Requires additional MEVS. Denial code **722**: NDC DESI code is invalid.

NDC Excluded from State Plan Coverage

NYS Medicaid reimburses for drugs included on the eMedNY "Medicaid Pharmacy List of Reimbursable Drugs" web page, located at: https://www.emedny.org/info/formfile.aspx. The following are examples of drugs/drug uses which are not reimbursable by NYS Medicaid in accordance with policy and/or state or federal legislation:

- Drugs used for the treatment of anorexia, weight loss or weight gain pursuant to SSA §1927(d)(2), located at: https://www.ssa.gov/OP_Home/ssact/title19/1927.htm.
- Drugs for the treatment of sexual dysfunction pursuant to SSA §1927(d)(2), located at: https://www.ssa.gov/OP_Home/ssact/title19/1927.htm, and Social Services Law §365-a(4)(f), located at: https://www.nysenate.gov/legislation/laws/SOS/365-A.
- Drugs indicated for cosmetic use or hair growth pursuant to SSA §1927(d)(2), located at: https://www.ssa.gov/OP_Home/ssact/title19/1927.htm.
- Any contrast agents, used for radiological testing (these are included in the fee of the radiologist).
- Drugs packaged in unit doses for which bulk product exists.

Claims billed to NYRx with an NDC that is excluded from State Plan coverage will be rejected with the following claims edit:

Edit #	Edit Description	NCPDP Reject Message
02353	NDC excluded from State Plan coverage.	**70**: NDC not covered.

Medical Supplies and Durable Medical Equipment

Medical Supplies billed to NYRx using the Healthcare Common Procedure Coding System (HCPCS) code from the NYS Department of Health *DME Procedure Codes & Coverage Guidelines*, located at: https://www.emedny.org/ProviderManuals/DME/PDFS/DME_Procedure_Codes.pdf, should be submitted in the 11-digit NDC field with leading zeros. Durable medical equipment, prosthetic devices, prosthetics, orthotics, and supplies providers that submit claims using an NDC number, will be rejected with the following claims edit:

Edit #	Edit Description	NCPDP Reject Message
02354	Procedure code required instead of NDC.	**8J**: Incorrect product/service ID for processor/payer. *Additional MEVS Denial Code **705**: NDC/Advanced Primary Care not covered.

Termination Dates

NYRx routinely receives termination data when NDCs have been discontinued by the manufacturer. Drugs identified as terminated by the manufacturer are not covered. Providers should refer to the eMedNY "Medicaid Pharmacy List of Reimbursable Drugs" web page, located at: https://www.emedny.org/info/formfile.aspx, for alternative NDCs. Claims billed to NYRx that have a terminated NDC number will be rejected with the following claims edit:

Edit #	Edit Description	NCPDP Reject Message
01600	Terminated NDC number.	**825**: Claim date of service is outside of the product FDA/Nonlinear Solvers and Differential Equations marketing date.

Frequently Rejected Drugs as of March 2026

Edit #	Edit Description	NCPDP Reject Message	NDC Name	Manufacturer	Resolution and Additional Information
02351	NDC not federal participant.	**AC**: Product not covered, non-participating manufacturer.	Polyethylene Glycol 3350 Powder	• Padagis® • NorthStarRX® LLC • Major	Providers should refer to the eMedNY "Medicaid Pharmacy List of Reimbursable Drugs" web page, located at: https://www.emedny.org/info/formfile.aspx, for alternative. Pursuant to SSA §1927(a), located at: https://www.ssa.gov/OP_Home/ssact/title19/1927.htm, drug manufacturers are required to participate in the MDRP for coverage.
			Guaifenesin 400mg tablet	• Marlex® • Reliable-1 Labs LLC • Richmond Pharm	
			Diclofenac sodium 1 percent gel	Aurohealth LLC	
			Metformin HCL 1000mg tablet	• PD-Rx Pharmaceutials, Inc. • Golden State Medical Supply, Inc.	
			Vascepa 1GM capsule	Amarin Pharma, Inc.	**Effective October 1, 2024**, Amarin Pharma, Inc. withdrew from MDRP. For additional information, providers should refer to the Vascepa "Copay Savings Program" web page, located at: https://vascepa.copaysavingsprogram.com.
			Xifaxan 550mg tablets	Salix Pharmaceuticals® (a Bausch Health Company)	**Effective October 1, 2025**, Salix Pharmaceuticals® subsidiary or Bausch Health Company withdrew from MDRP.
02352	NDC is a DESI drug.	**70**: NDC not covered. *Requires additional MEVS. Denial code **722**: NDC DESI code is invalid.	Hydrocortisone Acetate 25mg suppository	• Padagis® • Rising Pharmaceuticals®	N/A

Edit #	Edit Description	NCPDP Reject Message	NDC Name	Manufacturer	Resolution and Additional Information
02353	NDC exclude from State Plan.	**70**: NDC not covered.	Zepbound 2.5mg/0.5ml	Eli Lilly and Company	Drugs indicated for weight loss are not covered pursuant to SSA §1927(d)(2), located at: https://www.ssa.gov/OP_Home/ssact/title19/1927.htm.
			Wegovy 0.25mg/0.5 ml	Novo Nordisk®	
			Ammonium Lactate 12 percent Lotion	Various	Drugs indicated for cosmetic use or hair growth pursuant to SSA §1927(d)(2), located at: https://www.ssa.gov/OP_Home/ssact/title19/1927.htm, are not covered by NYRx. Topical products without an FDA-covered indication are excluded from coverage.

For more information on NYRx drug coverage criteria, drug coverage limitations, and claims processing, providers should refer to the *NYRx Pharmacy Drug Coverage: Claims Processing Enhancements and Reminders* article published in the April 2025 issue of the *Medicaid Update*, located at: https://www.health.ny.gov/health_care/medicaid/program/update/2025/docs/mu_no04_apr25_pr.pdf.

Resources:

- *eMedNY Edit/Error Knowledge Base (EEKB) Search Tool* (https://www.emedny.org/HIPAA/5010/edit_error/index.aspx)
- *NYRx Pharmacy Rejections – How to Identify and Resolve* document (https://newyork.fhsc.com/downloads/providers/NYRx_EO_notification_20240717.pdf)
- *New York State eMedNY Billing Guidelines – Pharmacy* (located on the eMedNY "Pharmacy Manual" web page, located at: https://www.emedny.org/ProviderManuals/Pharmacy/index.aspx)
- *NYRx, The Medicaid Pharmacy Program: Top Edit Resource* document (https://www.emedny.org/nyrx/Top_Edit_Resource.pdf)

Questions:

- Questions regarding this guidance should be directed to NYRx@health.ny.gov.
- NYRx billing/claims question should be directed to the eMedNY Call Center at (800) 343-9000. The eMedNY Call Center hours are Monday through Friday from 7 a.m. to 10 p.m., and Saturday through Sunday from 8:30 a.m. to 5:30 p.m.

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Clarification and Reminder:
Pharmacy Providers Servicing Requirements for NYRx Members

NYRx, the New York State (NYS) Medicaid Pharmacy program, requires NYS Medicaid member consent prior to requesting a renewal or new prescription from a prescriber and before submitting a claim for a refill.

Pharmacies should not directly outreach to prescribers for renewals, or refill a prescription, without a NYS Medicaid member or NYS Medicaid member designee request *first*. Additionally, pharmacies may not enroll their NYRx members in automatic refill programs.

New Prescriptions/Renewals

A NYS Medicaid member, who has exhausted prescription refills, may obtain a renewal in one of the following three ways:

- The NYS Medicaid member may contact their prescriber for a renewal.
- The NYS Medicaid member may contact their pharmacy for a renewal and give the pharmacy consent to contact the prescriber on their behalf.
- The pharmacy may contact the NYS Medicaid member to inquire if a renewal is necessary, obtain consent if necessary, and then contact the prescriber on their behalf.

Reminders regarding original prescriptions:

- A prescription/fiscal order must originate from the office of the prescriber.
- A prescription/fiscal order must maintain the same original prescription number and date written throughout the life of the order; it may not receive a new number for same original date.
- A faxback may not be used to bill a prescription/fiscal order to NYS Medicaid.
- A fax received as a failed electronic prescription drug order may not be used to bill a prescription drug to NYS Medicaid.
- A fax received as a failed electronic fiscal over the counter drug order is an original order and may be used to bill NYS Medicaid.
- A fax received at the pharmacy, that is not on an *Official NYS Prescription Program Order Form* (DOH-250), located at: https://www.health.ny.gov/forms/doh-250, with its unique serial number, is not an original prescription.
- Prescribers may choose by their professional judgement to prescribe where allowed by law:
    - up to a 90-day supply on most maintenance medications when the NYS Medicaid member has been stabilized and has been taking their medication on a consistent basis, and there are no concerns about storage of the extended supply; *and*
    - a 30-day supply and up to 11 refills.
- Non-controlled prescriptions remain active and refillable up to one year after date written.

Refills

A NYS Medicaid member may obtain a refill by one of the following ways:

- the NYS Medicaid member may contact their prescriber for a refill;
- the NYS Medicaid member or their designee may contact their pharmacy requesting a refill; *or*
- the pharmacy may contact the NYS Medicaid member to inquire if a refill is necessary, obtain consent if necessary, and then submit a claim for dispensing on their behalf.

Early Fill

NYRx ensures an ample supply of medication(s) to accommodate for most temporary absences and allows a 90-day supply for most maintenance medications. A pharmacy claim will pay if more than 75 percent of the previously dispensed amount has been used, or up to a 10-day supply of medication is remaining of the cumulative amount that has been dispensed over the previous 90 days (the more stringent rule will apply). NYS Medicaid members can still refill their prescription(s) early, allowing for an ample supply of their medication(s) on hand.

Prescribers may use their professional judgement to prescribe:

- Up to a 90-day supply on most maintenance medications when the member has been stabilized and has been taking their medication on a consistent basis, and there are no concerns about storage of the extended supply.
- Most non-controlled prescriptions up to 12 fills (original and 11 refills).

Pharmacies may also assist NYS Medicaid members by:

- mailing the medication, per Medicaid Policy, to the temporary location of the NYS Medicaid member;
- refilling up to allowable amounts outlined above; *and/or*
- contacting the prescriber for a new prescription for a larger day supply, if available.

Please note: Early filling of more than the allowed amount for vacation or a temporary absence, as stated above for NYS Medicaid members, is not permissible.

Questions

Questions regarding this policy should be directed to NYRx@health.ny.gov.

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Pharmacy Reminder: Coordination of Benefits Processing Instructions for New York State Medicaid

All New York State (NYS) Medicaid providers are required to bill applicable third parties that may be liable for a claim before billing NYS Medicaid as described in *Reminder: Coordination of Benefits Billing Protocols for Providers; New York State Medicaid is the Payer of Last Resort* article published in the November 2024 issue of the *Medicaid Update*, located at: https://www.health.ny.gov/health_care/medicaid/program/update/2024/docs/mu_no12_nov24_pr.pdf. NYS Medicaid is always the payer of last resort. Federal regulations require that all other available resources be used before NYS Medicaid considers payment. Through coordination of benefits (COB), NYS Medicaid will pay the patient responsibility for correctly submitted NYS Medicaid coverable claims, up to the NYS Medicaid allowed amount.

Providers must exhaust all existing benefits prior to billing NYS Medicaid. Providers should always ask a NYS Medicaid member if they have other third-party coverage to ensure the proper COB. Pharmacies are responsible for submitting claims to other coverage before submitting claims to NYS Medicaid. Pharmacies are required to coordinate with the proper primary payer. This includes submitting a claim under the appropriate coverage benefit, medical or pharmacy.

Certain services may be rejected by the primary payer due to errors in claims submission. Coverage should still be pursued in these situations including, but not limited to:

- Prior authorization (PA) must be obtained from the primary payer.
- Medicare Part D was billed for services covered by Medicare Part B, or Medicare Part B was billed for services covered by Medicare Part D.
- A claim was submitted to the wrong or inactive third parties, causing claims to bypass incorrectly (third-party claims that incorrectly bypass the primary plan responsibility of payment is considered inaccurate billing and may be subject to audit recoveries).
- The incorrect benefit was billed (medical versus pharmacy).
- An inappropriate service code was billed [National Drug Code (NDC) versus Healthcare Common Procedure Coding System (HCPCS) code].
- The pharmacy is not contracted with the primary payer of the NYS Medicaid member [resolve by obtaining an override, enrolling with the Third-Party Liability (TPL), or advising the NYS Medicaid member and prescriber to use a network pharmacy].

Pharmacies that have difficulty billing primary insurance for the above situations should advise prescribers and NYS Medicaid members of potential delays as well as options for resolution. If claim issues are resolved, the pharmacies may then resubmit the claims to NYS Medicaid after the claims are properly adjudicated with the primary payer.

Reminder

Providers must maintain evidence and documentation, which are subject to audit, for a minimum of six years following the date of NYS Medicaid payment and/or longer, as set forth in their agreements with a Medicaid Managed Care Organization. This evidence should include, but not be limited to, denials of claims by responsible TPL Plans, other applicable TPL plan responses, and payment information. Prescribers are responsible for prescribing, per plan formulary, and to pursue any claim issues such as, but not limited to:

- necessary PAs or appeals;
- prescription alternatives (for a non-formulary or non-preferred drug);
- necessary changes (quantity supply, day supply, etc.); *and*
- selection of an in-network pharmacy that is agreeable to the NYS Medicaid member.

It is important to use the proper codes for both primary payer ID and qualifier to receive the correct payment. If the following values are not reported correctly, the claim will fail pre-adjudication and return 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

NYRx will not accept a combination of Other Coverage Code of **"3"** in NCPDP field **308-C8** (*Other Coverage Code*) with reject codes in field **472-6E** (*Other Payer Reject Codes*) indicating another third-party is responsible for payment. Only reimbursable over the counter (OTC) drugs may be submitted in this manner when the product is not covered as a benefit from the primary payer or principal provider. The pre-adjudication edit will return NCPDP Reject Code "6E - M/I Other Payer Reject Code", for all other entries.

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

If value code **"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 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

Additional information regarding the fields shown above can be found in the e 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), located at: https://www.emedny.org/HIPAA/5010/transactions/NCPDP_D.0_Companion_Guide.pdf. Billing questions should be directed to the eMedNY Call Center at (800) 343-9000.

Workers' Compensation and COB

If a patient has a work-related injury, for which they have an open Workers' Compensation case, Workers' compensation coverage must be utilized prior to billing the NYRx. Claims billed to NYRx as the primary payer when another party is responsible will be rejected with the following claims edit:

Edit #	Edit Description	NCPDP Reject Message
01631	Client Has Other Insurance	**13** – M/I Other Coverage Code and Additional MEVS Reject Code **717** – Client Has Other Insurance

If the drug claim is *not* related to the Workers' Compensation case of the patient, such as a maintenance medication for an unrelated chronic condition, NYRx may be billed as the primary payer with an Eligibility Clarification Code. Upon verifying the drug is not related to Workers' Compensation case, the pharmacy may bill NYRx as primary with the Eligibility Clarification Code of **"2"** in field **309-C9** (*Eligibility Clarification Code*). Providers must ensure all other responsible payers are included on the claim, if applicable.

Billing Reminders:

- Providers must bill accurately.
- Providers must accept NYS Medicaid payment as payment in full.
- Providers submit claims only for services actually furnished.
- All inaccurate or false claim submissions resulting in NYS Medicaid payment are subject to audit and recovery and may result in NYS Medicaid enrollment termination for the provider.

Questions:

- Questions regarding billing COB claims should be directed to eMedNY at (800) 343-9000.
- Questions regarding this policy should be directed to NYRx@health.ny.gov.

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Provider Directory

Office of the Medicaid Inspector General:

For suspected fraud, waste, or abuse complaints/allegations, please call 1-877-87 FRAUD, (877) 873-7283 or visit the Office of Medicaid Inspector General (OMIG) website, located at: www.omig.ny.gov.

Medicaid Prescriber Education Program:

For current information on best practices in pharmacotherapy, please visit the following web page and website:

- NYS Department of Health "Medicaid Prescriber Education Program" web page (https://www.health.ny.gov/health_care/medicaid/program/prescriber_education/presc-educationprog)
- New York State Medicaid Prescriber Education Program website (http://nypep.nysdoh.suny.edu/)

eMedNY:

For a number of services, including: change of address, updating an enrollment file due to an ownership change, enrolling another National Provider Identifier, or revalidating an existing enrollment, please visit the eMedNY "Provider Enrollment" web page, located at: https://www.emedny.org/info/ProviderEnrollment/index.aspx, and choose the appropriate link based on provider type.

Beneficiary Eligibility:

Please call the Touchtone Telephone Verification System at (800) 997-1111 and/or refer to the *New York State Programs Medicaid Eligibility Verification System Instructions for Completing a Telephone Transaction*, located at: https://www.emedny.org/ProviderManuals/5010/MEVS%20Quick%20Reference%20Guides/5010_MEVS_Telephone_Quick_Reference_Guide.pdf, to successfully complete an eligibility transaction.

Questions Regarding Billing and Performing Medicaid Eligibility Verification System Transactions:

Please call the eMedNY Call Center at (800) 343-9000.

Provider Manuals/Companion Guides, Enrollment Information/Forms/Training Schedules:

Please visit the eMedNY website, located at: www.emedny.org.

Providers Interested in Listening to Check/EFT Amounts for the Current Week:

Please call (866) 307-5549 (available Thursday evenings, for one week, per the check/EFT amount of the current week).

Provider Training:

Please enroll online via the eMedNY "Provider Training" web page, located at: https://www.emedny.org/training/index.aspx, for training opportunities. For individual training requests, please call (800) 343-9000.

Comments and Suggestions Regarding the *Medicaid Update*:

Please contact the editor, Angela Lince, at medicaidupdate@health.ny.gov.

Providers: OMIG Self-Disclosure Obligation Reminder

Pursuant to Social Services Law §363-d and Title 18 of the New York Codes, Rules and Regulations SubPart 521-3, any person who has received an overpayment under the New York State (NYS) Medicaid program is required to report, return, and explain the overpayment through the OMIG Self-Disclosure program. Self-disclosure information and resources, including submission instructions and required forms are located on the OMIG "Self-Disclosure" web page, at: https://omig.ny.gov/provider-resources/self-disclosure. Contact the OMIG Self-Disclosure Unit by telephone at selfdisclosures@omig.ny.gov or by email at (518) 402-7030.

Appendix

Information Notice to Couples with an Institutionalized Spouse

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), located at: https://health.ny.gov/forms/doh-5298.pdf (see "Appendix" on page 24 of this issue). New York City residents may contact the Human Resources Administration Medicaid Helpline at (888) 692-6116.

Resource 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. $162,660.00 (the amount of the spousal share up to the maximum amount permitted under federal law for 2026).

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 $4,066.50 a month for 2026); ***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 $902.00 for 2026 (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), located at: https://www.nysenate.gov/legislation/laws/SOS/366-C, 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.

Spousal Refusal and Undue Hardship Concerning a Community Spouse's Refusal to Provide Necessary Information

For purposes of determining Medicaid eligibility for the institutionalized spouse, a community spouse must cooperate by providing necessary information about their resources. Refusal to provide the necessary information shall be reason for denying Medicaid for the institutionalized spouse as Medicaid eligibility cannot be determined. If the applicant or recipient demonstrates that denial of Medicaid would result in undue hardship for the institutionalized spouse and an assignment of support is executed or the institutionalized spouse is unable to execute such assignment due to physical or mental impairment, Medicaid shall be authorized. However, if the community spouse refuses to make such resource information available, the New York State Department of Health or local department of social services, at its option, may refer the matter to court for recovery from the community spouse of any Medicaid expenditures for the institutionalized spouse's care.

Undue hardship occurs when:

1. A community spouse fails or refuses to cooperate in providing necessary information about their resources;
2. The institutionalized spouse is otherwise eligible for Medicaid;
3. The institutionalized spouse is unable to obtain appropriate medical care without the provision of Medicaid; ***and***
    a. The community spouse's whereabouts are unknown; ***or***
    b. The community spouse is incapable of providing the required information due to illness or mental incapacity; ***or***
    c. The community spouse lived apart from the institutionalized spouse immediately prior to institutionalization; ***or***
    d. Due to the action or inaction of the community spouse, other than the failure or refusal to cooperate in providing necessary information about their resources, the institutionalized spouse will need protection from actual or threatened harm, neglect, or hazardous conditions if discharged from an appropriate medical setting.

An institutionalized spouse will not be determined ineligible for Medicaid because the community spouse refuses to make their resources in excess of the community spouse resource allowance available to the institutionalized spouse if:

1. The institutionalized spouse executes an assignment of support from the community spouse in favor of the social services district; ***or***
2. The institutionalized spouse is unable to execute such assignment due to physical or mental impairment.

Income Contribution from the Community Spouse

The amount of money that Medicaid will request as a contribution from the community spouse will be based on their income and the number of certain individuals in the community household depending on that income. Medicaid will request a contribution from a community spouse of 25 percent of the amount their otherwise available income that exceeds the minimum monthly maintenance needs allowance plus any family member allowance(s). If the community spouse feels that they cannot contribute the amount requested, the community spouse has the right to schedule a conference with the local department of social services to try to reach an agreement about the amount the community spouse is able to pay. Pursuant to Social Services Law §366(3)(a), located at: https://www.nysenate.gov/legislation/laws/SOS/366, Medicaid **must** be provided to the institutionalized spouse if the community spouse fails or refuses to contribute their income towards the institutionalized spouse's cost of care. However, if the community spouse fails or refuses to make their income available as requested, then the New York State Department of Health or the local department of social services, at its option, may refer the matter to court for a review of the community spouse's actual ability to pay.

Request for Assessment – Spousal Impoverishment Form

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

Request for Assessment – Spousal Impoverishment

Date: _____

Institutionalized Spouse's Name: _____

Address: _____

_____

Telephone Number: _____

Community Spouse's Name: _____

Current Address: _____

_____

Telephone Number: _____

I/we request an assessment of the items checked below:

☐ Couple's countable resources and the community spouse resource allowance

☐ Community spouse monthly income allowance

☐ Family member allowance(s)

☐ Check if you are a representative acting on behalf of either spouse. Please call your local department of social services if we do not contact you within 10 days of this request.

NOTE:
If an assessment is requested without a Medciaid application, the local department of social services may charge up to $25 for the cost of preparing and copying the assessment and documentation.

Signature of Requesting Individual _____

Address and telephone number is different from above

_____

_____

_____

DOH-5298 (01/23)

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