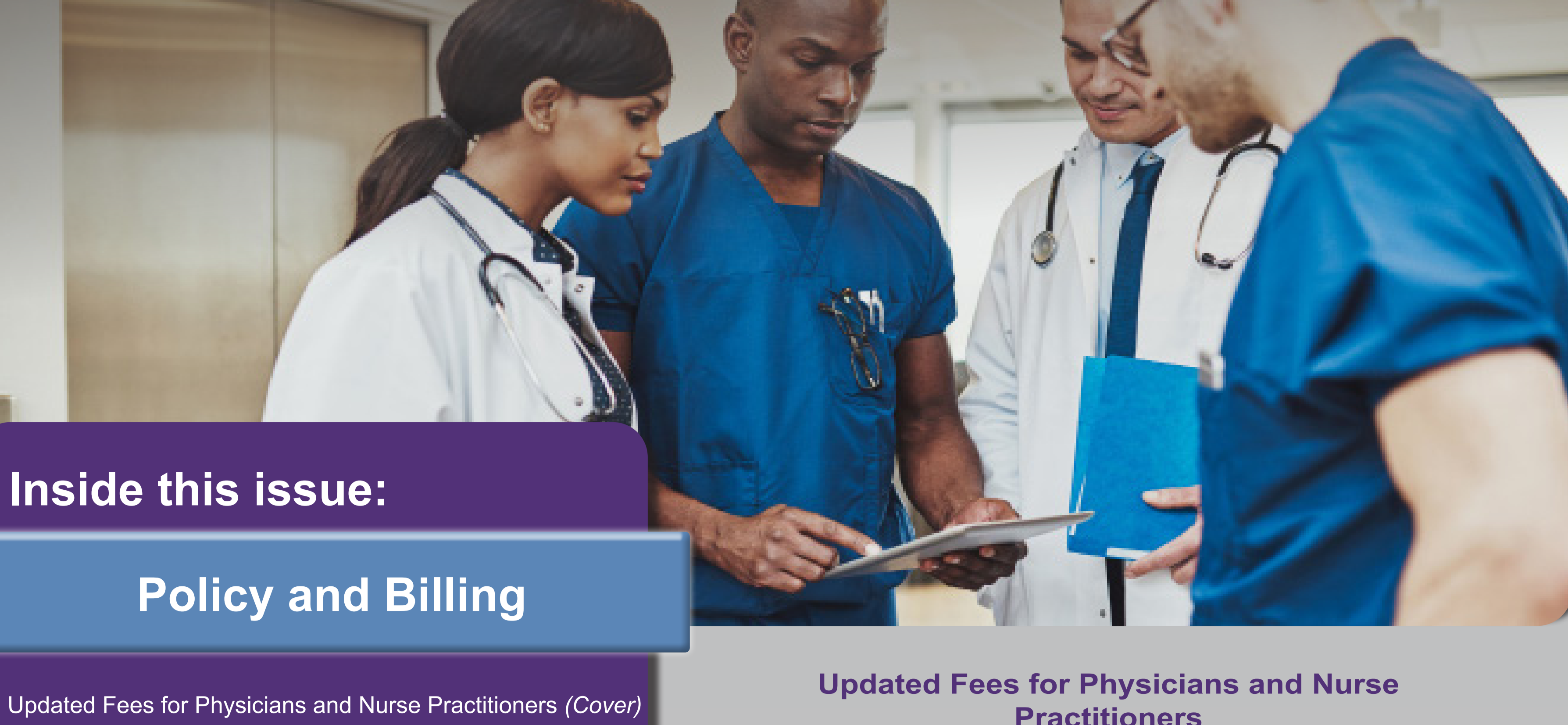


Medicaid Update



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Updated Fees for Physicians and Nurse Practitioners

As part of the New York State (NYS) Enacted Budget for Fiscal Year (FY) 2023-2024, the NYS Department of Health (DOH) #99-39 requires Tribal 638 outpatient facilities be paid using the outpatient per visit rate. IHS clinics are reimbursed at an all-inclusive threshold rate for all medical or behavioral health services provided to NYS Medicaid members during qualifying threshold visits. The all-inclusive threshold rate includes all facility and professional fees associated with the services rendered. Providers can refer to the [IHS Federal Register notice](#), for more information.

- The following impacted fees schedules include:
- [NYS Medicaid Physician Drug and Drug Administration Services Fee Schedule](#)
 - [NYS Medicaid Physician Medicine Services Fee Schedule](#)
 - [NYS Medicaid Physician Radiology Services Fee Schedule](#)
 - [NYS Medicaid Physician Surgery Services Fee Schedule](#)

- Additionally, fees for procedure codes found on the above fee schedules will also be updated on the following fee schedules:
- [Physician Enhanced Program Fee Schedule](#)
 - [NYS Medicaid Ordered Ambulatory Services Fee Schedule](#)
 - [NYS Medicaid Podiatry Services Fee Schedule](#)
 - [NYS Medicaid Laboratory Services Fee Schedule](#)
 - [NYS Medicaid Hearing Aid/Audiology Services Fee Schedule](#)
 - [NYS Medicaid Midwife Services Fee Schedule](#)
 - [NYS Medicaid Nurse Practitioner Services Fee Schedule](#)
 - [NYS Medicaid Vision Care Services Fee Schedule](#)

Providers can refer to the [eMedNY "Provider Manuals" web page](#) for updated fee schedules by selecting a category within the "Select a Provider Manual" box.

Questions
 Questions regarding the updated fees for physicians and NPs 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.

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Policy and Billing

Medicaid Fee-for-Service Guidance for New York State Indian Health Service Providers

The New York State (NYS) Department of Health (DOH) reimburses Tribal Clinics designated as an Indian Health Service (IHS) provider based on an All-Inclusive Rate (AIR), in accordance with State Plan Amendment (SPA) #99-39. SPA #99-39 requires Tribal 638 outpatient facilities be paid using the outpatient per visit rate. IHS clinics are reimbursed at an all-inclusive threshold rate for all medical or behavioral health services provided to NYS Medicaid members during qualifying threshold visits. The all-inclusive threshold rate includes all facility and professional fees associated with the services rendered. Providers can refer to the [IHS Federal Register notice](#), for more information.

All medical services provided in a tribal clinic rendered to NYS Medicaid fee-for-service (FFS) members and Medicaid Managed Care (MMC) enrollees must be billed to NYS Medicaid/the MMC Plan using the all-inclusive "1610" threshold rate code. It is required to use AIR code "1610" for services rendered to both American Indians/American Natives (AIs/ANs) and non-AIs/ANs. Behavioral health services rendered by clinics that have met all applicable standards for licensure, and have been approved to provide behavioral health services by either the NYS Office of Mental Health (OMH) or NYS Office of Addiction Services and Supports (OASAS), as appropriate, must be billed using the following all-inclusive rate codes:

- "1907" – OMH (AIR)
- "1908" – OASAS (AIR)

MMC Plans are required to accept and process IHS provider claims on the institutional claim form and pay the full AIR. Claims may not be accepted/process on the professional claim form.

Please note: The Saint Regis Mohawk Tribe is currently the only tribe assigned OMH and OASAS rate codes.

All medical and behavioral health services rendered by federally recognized tribal clinics designated as IHS providers are exempt from the Ambulatory Patient Group (APG) reimbursement methodology and are reimbursed via the federal AIR. Services provided by the following practitioners/programs qualify as IHS threshold visits and meet the requirements for payment of the AIR:

- Physicians;
- Physician Assistants (PAs);
- Nurse Practitioners (NPs);
- Licensed Midwives (LMs);
- Licensed Clinical Social Workers (LCSWs)/Licensed Master Social Workers (LMSWs)/Licensed Mental Health Counselors (LMHCs)/Licensed Marriage and Family Therapists (LMFTs);
- Licensed Behavior Analysts (LBAs)/Certified Behavior Analyst Assistants (CBAAs);
- Dentists/Dental Hygienists;
- Psychologists;
- Optometrist/Opticians;
- Physical Therapists (PTs)/Occupational Therapists (OTs)/Speech-Language Pathologists (SLPs);
- Podiatrists;
- Registered Dietitians;
- Registered Nurses (RNs), Pharmacists, Respiratory Therapists [AIR reimbursement is limited to only those providing diabetes self-management training (DSMT) and asthma self-management training (ASMT)];
- OMH Article 31 Licensed Clinics;
- OASAS Article 32 Certified Outpatient Programs; **and**
- OASAS Article 32 Opioid Treatment Programs.

Please Note: If a NYS Medicaid member/enrollee is seen for both medical and behavioral health services **on the same date of service and the IHS provider has been assigned the AIR and OMH/OASAS rate codes**, two separate claims should be billed: One claim for the medical services with rate code "1610" and a second claim for the behavioral health services using the appropriate OMH/OASAS rate codes shown above.

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](#).

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eVisits

Effective October 1, 2023, the New York State (NYS) Medicaid Fee-for-Service (FFS) program will reimburse for eVisits. eVisits are a type of Virtual Check-In involving patient-initiated communications with a medical provider through a text-based and Health Insurance Portability and Accountability Act (HIPAA)-compliant digital platform, such as a patient portal. eVisits occur through asynchronous communication; it is neither real-time nor face-to-face. Additional detail on telehealth modalities can be found in the [February 2023 Comprehensive Guidance Regarding Use of Telehealth Including Telephonic Services After the Coronavirus Disease 2019 Public Health Emergency Special Edition Issue of the Medicaid Update](#). They are intended to remotely assess non-urgent conditions and prevent unnecessary in-person visits. Coverage of eVisits reimburses providers for the problem-focused communication and medical decision-making they do outside of normal visits.

eVisits may be provided to established patients only (though the presenting problem may be new). The patient must initiate the communication and the problem must require a physician or other qualified practitioner's professional's evaluation, assessment, and management. **Claims for eVisits may not be submitted for contact initiated by the provider, whether individualized or as part of an outreach program.** Communication of test results, scheduling appointments, medication refills, and any other communications outside the scope of evaluation and management are not considered eVisits.

Billing for eVisits is based on cumulative time spent with a single patient within a seven-day period. For example, if five to ten minutes are spent with a single patient for an eVisit over a seven-day period, procedure code "99421" may be billed (see table below). For an encounter with a qualify as an eVisit, the patient must not have been seen for the same clinical issue within the previous seven days.

Patient Rights and Consent

The provider shall obtain verbal or written consent for communication-based technology services (CBTS) annually. Written consent is not required, but the provider must document informed consent for CBTS in the chart of the patient before an eVisit can occur.

Documentation

The following information must be documented and retained in the medical record for each eVisit:

- the patient-initiated inquiry and the presenting problem of the patient;
- the clinical assessment and recommendations of the provider; and
- the total amount of service time related to the eVisit.

Providers offering eVisits are required to follow all state and federal privacy laws regarding the exchange of patient information.

Billing
 Providers who can independently bill for evaluation and management (E&M) procedure codes [physicians, nurse practitioners (NPs), midwives] may bill Current Procedure Terminology (CPT) codes "99421", "99422", and "99423". Providers who may not independently bill for E&M procedure codes [e.g., licensed clinical social workers (LCSWs), clinical psychologists, speech language pathologists (SLPs), physical therapists (PTs), occupational therapists (OTs)] may bill CPT codes "98970", "98971", and "98972".

eVisits are billed using time-based codes. The service time is cumulative up to a seven-day period. The seven-day period starts upon the review of the initial patient communication by the provider. The provider must begin their review within three business days of the patient inquiry. For example, if a patient initiates an eVisit on Monday, the provider must begin review on or before Thursday. Service time may include review of pertinent patient records, interaction with clinical staff about the presenting problem, and subsequent communications which are not included in a separately reported service.

eVisit CPT codes may be billed once per seven-day period (using the last date of communication within the seven-day period as the date of service). eVisits may not be billed if the patient inquiry is related to a visit within the previous seven days of the initial digital communication. If the eVisit leads to an E&M visit, the eVisit should not be billed, but the time spent on the communication can be incorporated into the separately billed E&M visit.

CPT Code	Description	NYS Medicaid Rate
99421	Online digital evaluation and management service, for an established patient, for up to seven days, cumulative time during the seven days; five to 10 minutes.	\$12.18
99422	Online digital evaluation and management service, for an established patient, for up to seven days cumulative time during the seven days; 11 to 20 minutes.	\$23.81
99423	Online digital evaluation and management service, for an established patient, for up to seven days, cumulative time during the seven days; 21 or more minutes.	\$38.76
98970	Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the seven days; five to 10 minutes.	\$9.42
98971	Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the seven days; 11 to 20 minutes.	\$16.61
98972	Qualified non-physician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the seven days; 21 or more minutes.	\$25.74

To bill the above CPT codes, providers must meet all elements of the code, and must adhere to the American Medical Association (AMA) guidelines related to frequency of billing these codes, as well as billing restrictions when the eVisit leads to a face-to-face encounter.

Questions and Additional Information:

- Medicaid 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 (OHIP) Division of Program Development and Management (DPDM) 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](#).

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New York State Directed Payment Approved for Labor and Delivery Hospitals to Reduce Low-Risk Cesarean Delivery Rates

Updates are highlighted in yellow

The New York State (NYS) Medicaid program has received approval from the Centers for Medicare and Medicaid Services (CMS) for a state-directed Quality Incentive Payment. Labor and delivery hospitals in NYS with over 500 Medicaid Managed Care (MMC) deliveries in State Fiscal Year (SFY) 2022 are eligible for performance payments. Performance payments will be earned if eligible labor and delivery hospital with low-risk Cesarean section delivery rates are reduced to their individual measurement year targets in SFY 2024 and 2025. A total of \$38 million will be awarded to eligible hospitals that earn the payments over the two-year period.

The low-risk Cesarean delivery rate was developed using NYS MMC encounter data to mirror the Joint Commission Nulliparous, Term, Singleton, Vertex (NTSV) measure. In the first measurement year (MY1), which is SFY 2024, hospitals will receive a performance payment for achieving a **one percent reduction** in their individual baseline low-risk Cesarean delivery rate. Hospitals that begin with a low baseline rate will receive a performance payment for maintaining a rate at or below a rate of **14 percent**. Payments will be distributed from MMC organizations to contracted hospitals that meet performance targets.

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

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Office of the Medicaid Inspector General Announces Updates to the Self-Disclosure Program

The New York State (NYS) Office of the Medicaid Inspector General (OMIG) Self-Disclosure program is the mechanism for entities to return NYS Medicaid fund overpayments they have identified through self-review. NYS Medicaid entities are required to regularly review their billings and report, return, and explain any identified overpayments they've received to the NYS OMIG Self-Disclosure program within sixty days of identification, or by the date any corresponding cost report was due, whichever is later. For additional information, providers can refer to the [NYS Social Services Law \(SOS\) §363-d\(6\)](#).

In response to feedback from NYS Medicaid stakeholders, the NYS OMIG Self-Disclosure program has been revised to include two pathways for entities to report, return and explain overpaid NYS Medicaid funds. In addition to the existing Full Self-Disclosure process, NYS OMIG has developed an Abbreviated Self-Disclosure process that NYS Medicaid entities may utilize to report and explain identified overpayments resulting from routine and transactional errors or meet other defined characteristics and have already been voided or adjusted. Additional information about the abbreviated process can be found in the [Self-Disclosure Program Requirements – Instructions & Guidelines](#).

Overpaid claims that are appropriate for the Abbreviated Self-Disclosure Process should be voided or adjusted as applicable once identified, and within 60 days of that identification must be reported and explained to OMIG, in aggregate, using the new [Self-Disclosure Abbreviated Statement](#) forms, located on the [NYS OMIG "Self-Disclosure Abbreviated Statement" web page](#).

As a best practice, NYS Medicaid entities using the Abbreviated Self-Disclosure Process may submit [Self-Disclosure Abbreviated Statement](#) forms monthly (by the 5th of each month) to report qualifying voids and adjustments from the previous month. NYS OMIG anticipates the first full month of reports to be in September 2023 and the first monthly reporting to be October 5, 2023.

NYS OMIG has published updated documents and information to facilitate the implementation of the Abbreviated Self-Disclosure Process as part of a monthly review of NYS Medicaid billings and ongoing compliance efforts, conducted by the provider. NYS OMIG will continue to solicit questions and feedback from NYS Medicaid stakeholders and will monitor the use of this new process to inform additional updates. Additional Abbreviated Self-Disclosure Process updates include:

- guidance providing an overview of the NYS OMIG Self-Disclosure program, the two Self-Disclosure Processes available, and the statutes and regulations that require the report, return and explain NYS Medicaid overpayments;
- Frequently Asked Questions (FAQs) providing examples of overpayment scenarios to assist NYS Medicaid entities in determining which Self-Disclosure Process is appropriate for the report, return and explain of their identified overpayment. Examples are provided for overpayments appropriate to the Full Self-Disclosure Process and overpayments appropriate for the Abbreviated Self-Disclosure Process; and
- [Self-Disclosure Abbreviated Statement](#) forms including the Abbreviated Statement spreadsheet and secure file transmission for monthly or as needed reporting.

To review all NYS OMIG Self-Disclosure documents or to obtain additional information and resources regarding the NYS OMIG Self-Disclosure program, providers can visit the [NYS OMIG "Self-Disclosure" website](#).

Questions
 Questions regarding the NYS OMIG Self-Disclosure program should be directed to the NYS OMIG Self-Disclosure Unit by email at selfdisclosures@omig.ny.gov or by telephone at (518) 402-7030.

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Medicaid Fee-for-Service Covers Adult Vaccinations Without Cost-Sharing

Effective for dates of service on or after October 1, 2023, New York State (NYS) Medicaid will cover, without cost-sharing obligations, vaccines and their administration for any outpatient clinic visit in which an approved adult vaccine, recommended by the Advisory Committee on Immunization Practices (ACIP), was administered as part of the visit.

Billing Instructions for Fee-for-Service

Clinics should append modifier "33" to the applicable Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) code for the ACIP-recommended vaccine when submitting an outpatient Ambulatory Patient Group (APG) or Ordered Ambulatory (OA) claim to NYS Medicaid. Reporting modifier "33" on the claim line will exempt the entire claim from member cost-sharing. Clinics should use modifier "33", as indicated above, until further notice.

The eMedNY system logic is currently updated in the process of being updated to automatically bypass all member cost-sharing requirements for any outpatient clinic visit in which an approved adult vaccine, recommended by ACIP, was administered. Clinics should continue to append modifier "33" on the claim until system changes have been completed. Additional information will be communicated to providers in a future issue of the [Medicaid Update](#), upon system completion.

Questions and Additional Information:

- Medicaid fee-for-service (FFS) billing and claim questions should be directed to the eMedNY Call Center at (800) 343-9000.
- Medicaid FFS medical 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](#).

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Provider Directory

- Office of the Medicaid Inspector General:**
For suspected fraud, waste or abuse complaints/allegations, call 1-877-877FRAUD, (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 page 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.

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