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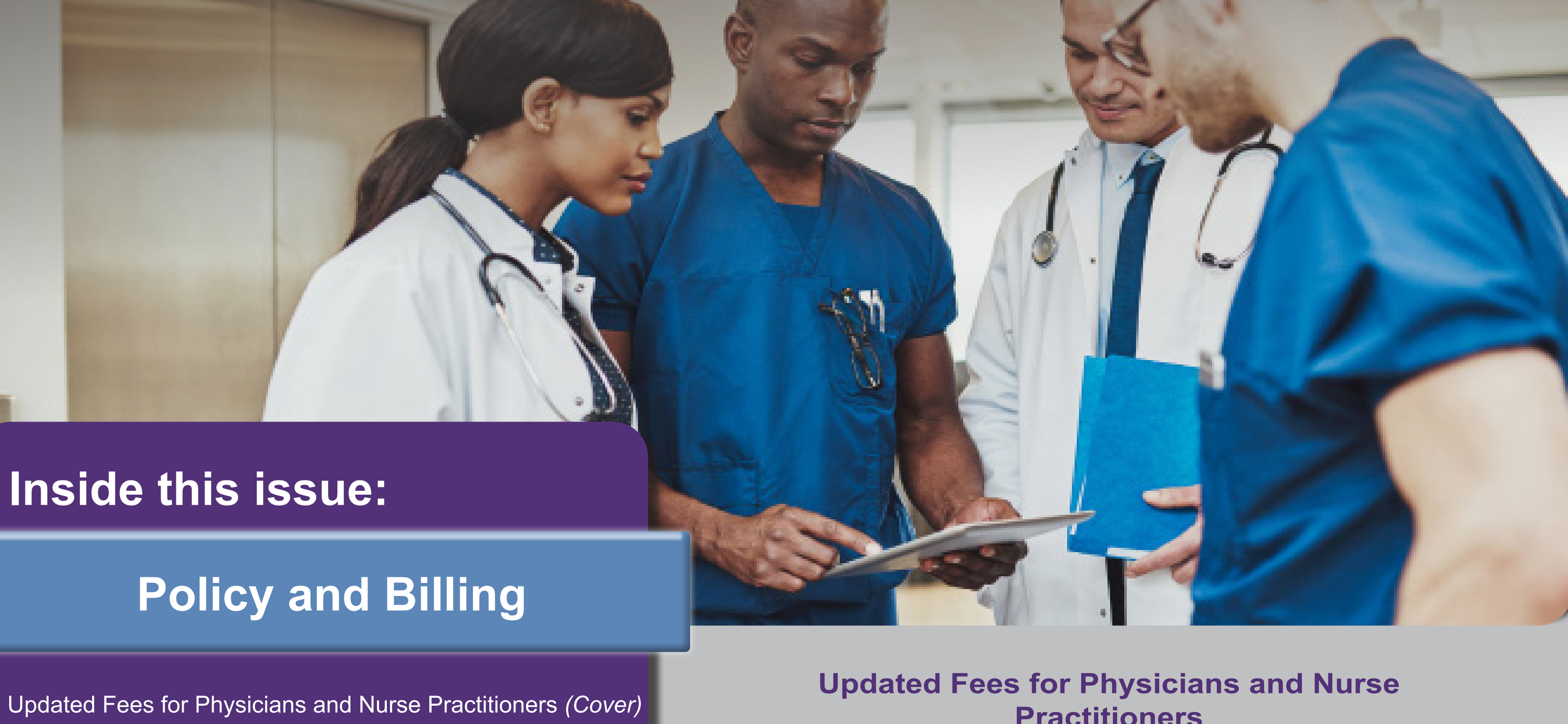
Medicaid Update



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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) was authorized to benchmark NYS Medicaid fee-for-service (FFS) reimbursement rates to 80 percent of current Medicare reimbursement rates for non-facility services. This change will impact the following *NYS Physician Fee Schedules* for: *Medicine*, *Drug*, *Surgery*, and *Radiology*. Additionally, it will benchmark nurse practitioners (NPs) to 95 percent of the newly established physician fees. This investment in the physician and primary care workforce is expected to improve access to primary and preventative care for NYS Medicaid members. **Effective October 1, 2023**, fees for over 7,000 procedure codes on the *NYS Physician Fee Schedules* will increase. **Please note:** Procedure codes appearing on multiple fee schedules will be updated on each schedule.

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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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/processe 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; the exchange 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 to 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:

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