

October 2025 Provider Bulletin

Coordination of Benefits: Timely Filing Limits and Post-Payment Recovery Process

The Molina Cost Recovery team may initiate Coordination of Benefits (COB) recoveries close to or beyond Medicare's timely filing deadline, which is 12 months from the Date of Service (DOS). When recoveries are initiated after this timeframe, providers may be unable to bill the primary payer, which can affect claim reimbursement.

To help avoid this issue, providers should ensure CMS guidelines are followed -

[Your Billing Responsibilities](#) | [CMS](#):

- Identify the correct primary insurance before submitting claims
- Submit claims within the required Medicare filing window

Process for COB Post Payment Recoveries

Medicare requires that claims be submitted within 12 months of the DOS. Claims filed after this period are typically denied, though exceptions may apply under certain Medicaid regulations - [What are the exceptions to Medicare's general timely filing period?](#) | [Medicaid](#).

When Molina applies a COB recovery, the following steps should be taken when billing the primary payer:

1. **Submit the Molina cost recovery letter** as documentation when filing the claim with Medicare. This may support an exception under Medicare regulation 42 CFR § 424.44(b).
2. **Refile the claim with Molina** for the Medicaid payment, following the standard procedures outlined in Molina's Provider Manual.
3. **Include a copy of the Explanation of Benefits (EOB)** when submitting the Medicaid claim.

For additional guidance, please refer to Molina's timely filing and claims processing policies:

- **Essential Plans Provider Manual:** [Molina Healthcare of New York, Inc. Provider Manual 2025](#)
- **Managed Care, HARP, and CHP Provider Manual:** [Molina Healthcare of New York, Inc. Provider Manual](#)

In this newsletter you can expect:

[Coordination of Benefits: Timely Filing Limits and Post-Payment Recovery Process](#)

[CMS-0057 Interoperability & Prior Authorization Rule \(2026-2027\)](#)

[New York Medicaid Health Plan Payment Policy: Physician Assistants](#)

[Zeroing out of OASAS Opioid Treatment Program \(OTP\) Bundle Rate](#)

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CMS-0057 Interoperability & Prior Authorization Rule (2026-2027)

Effective 1/1/2026 the New York turnaround time will be updated to align with the CMS0057 Prior Authorization rule: please see the chart for how the changes will affect expected turnaround times for our Managed Medicaid, HARP and CHP lines of business:

Request type	Turnaround Time through 12/31/25	Turnaround time starting 1/1/2026	Change
Urgent	Initial Request- 72 Hours* Concurrent Request- 1BD*	Initial Request- 72 Hours* Concurrent Request- 1BD*	No Change
Emergent (Unplanned Inpt hospitalization)	Initial request- 1 BD* Continued stay- 1 BD*	Initial request- 1 BD Continued stay- 1 BD*	No Change
Standard	Initial Request- 3BD but no greater than 14 calendar days* Concurrent Request- 1BD but no greater than 14 calendar days* *Extension of up to 14 days permitted in certain circumstances.	Initial Request- 3BD but no greater than 7 calendar days* Concurrent Request- 1BD but no greater than 7 calendar days* *Extension of up to 14 days permitted in certain circumstances.	Changing the turnaround time from 14 to 7 days

New York Medicaid Health Plan Payment Policy: Physician Assistants

What's New

Changes to Physician Assistant reimbursement to align with the NYS Medicaid Program Physician Policy Guidelines: [Physician Manual Policy Guidelines.pdf](#)

Effective 09/01/25, Molina Healthcare's reimbursement guidelines for Registered Physician Assistants (RPAs) will be updated to require the following:

- Services rendered by a registered physician's assistant (RPA) must be in accordance with the provisions outlined in Article 131A of the NYS Education Law and Article 37 of the NYS Public Health Law.
- License requirements are established by the NYSED, and can be found at: [NYS Physician Assistant: License Requirements](#)

Reimbursement

The services of RPAs will be reimbursed as follows:

- Payment will be made to the physician who employs the RPA.
- Payment will be according to the standard fees that physicians normally receive. This applies whether the physician, the employed RPA, or both individuals provide the service.
- Molina will allow Payment for RPA direct claims, but will be discounted by 15%.
- The physician for a service may make no duplication or increase in charges, solely because an RPA has provided assistance.
- The only exception is "Physician Assistant Services for Assist at Surgery". Please refer to the Fee Schedule for instructions on the use of Modifier '-AS'.
<http://www.emedny.org/ProviderManuals/Physician/>
- All claims for Medicaid reimbursement that are submitted by physicians must include an indication of those services or procedures that were rendered by or in conjunction with the RPA and also the name and Medicaid provider identification number of the RPA who rendered the care.
- The professional component for all services provided by a physician assistant (PA) in an Article 28 hospital outpatient department, hospital inpatient setting, emergency department, ambulatory surgery setting and diagnostic and treatment center (D&TC) for Medicaid fee-for-service patients is included in the APG or APRDRG payment to the facility.
- Supervising physicians and physician groups may not bill Medicaid separately for PA services provided in these settings.

Resources Available:

[Physician_Manual_Policy_Guidelines.pdf](#) / NYS Physician assistant: License Requirements

Zeroing out of OASAS Opioid Treatment Program (OTP) Bundle Rate (Effective November 3, 2025)

Beginning July 1, 2024, providers were given the option to bill OTP bundle services either under the existing OTP bundle rate codes or the APG methodology. The May memorandum also indicated that OASAS would zero out the bundle rate codes (7969-7976) after a short transition period.

As of November 4, 2024, all OASAS programs were expected to exclusively bill OTP bundle services under the APG methodology using procedure codes G2067, G2068, G2078 and G2079.

Providers may choose to bill other relevant APG procedure codes (e.g., H0020, 90834, etc.) instead of the bundle procedure codes.

Within the APG methodology, providers may switch between using the bundled and unbundled billing approaches as often as weekly, based on their preference.

As most providers and plans have now updated their systems to accommodate OTP bundle billing through the APG methodology, OASAS will officially zero out OTP bundle rate codes 7969-7976 effective November 3, 2025.

Certification Statement for Provider Billing Medicaid (ETIN) Reminder

The New York State Office of the Medicaid Inspector General (OMIG) requires that participating MCO providers:

- Submit a copy of their Certification Statement for Provider Billing Medicaid (ETIN) form to each MCO where they are a participating provider:
 - Upon signing the provider agreement
 - Annually thereafter

 **Learn more about our process:** [Certification Statement for Provider Billing Medicaid \(ETIN\)](#)

Reminders



Reminder for Front Desk Staff

(Not for Member Distribution)



Soon, some of your patients who are Molina members will receive the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey in the mail. This survey asks them about their patient experience, including visits to your practice / facility.

You play a key role in making patients feel supported and cared for. Here are some simple ways to help:

- ✓ Schedule follow-up visit or routine visits (e.g., 2-week newborn checks, 4-week postpartum visits) before the patient leaves the office.
- ✓ Offer patients appointment reminders via email / text.
- ✓ Assist patients with adding appointment reminders to their calendar if needed.
- ✓ Teach patients how to schedule appointments online or via the patient portal when available.
- ✓ Ask patients if they would like to be added to a cancellation list to get an earlier appointment if one becomes available.

The CAHPS® Survey helps us improve together so patients stay engaged and achieve better health outcomes. Thank you for the kindness and professionalism you show every day. It truly makes a difference!

Submit Itemized Bills for Inpatient Claims and Timely Payment

To ensure proper reimbursement and reduce payment delays, providers should:

- Submit itemized bills for all inpatient claims when the date of service exceeds the authorization.
- Itemized billing is essential for:
 - ✓ Validating services rendered
 - ✓ Applying correct payment methodologies
 - ✓ Maintaining compliance with reimbursement policies

 **Tip:** Prompt submission of itemized bills helps ensure timely and accurate reimbursement.



Reminders

Cultural & Language Tools Are Now in Availability

How to Access on Availability:

1. Log in to the [Availability Essentials portal](#).
2. Select **Molina Healthcare** under **Payer Spaces**.
3. Click the **Resources** tab.
4. Choose **Culturally and Linguistically Appropriate Services Provider Training Resources/Disability Resources and Links**.

Self-Disclosure Program Reminder

Medicaid entities/providers are required to report, return, and explain any overpayments to the OMIG Self-Disclosure Program:

- Within 60 days of identification OR
- By the cost report due date, whichever is later.



Reference:

Social Services Law (SOS) § 363-d(6)



Learn more about our process:

[Self-Disclosure Program](#)

Frequently Used Links

- **Molina Provider Website:**
 - [Molina Healthcare.com](#)
 - [Molina Provider Communications - Updates and Bulletins](#)
 - [Molina Healthcare Provider Manual](#)
 - [Access and Availability Standards](#)
 - [2025 Provider Quick Reference Guide](#)
- **Forms:**
 - [New York Providers Home \(MolinaHealthcare.com\)](#) under the **Forms** tab.
- **Prior Authorization Lookup Tool**
 - [PA Lookup Tool](#)
- **Provider Roster / Demographic Updates:**
 - [MHNYSocialNetworkOperations@MolinaHealthcare.com](#)
- **Credentialing Updates**
 - [MHNYSocialProviderContracting@MolinaHealthcare.com](#)
- **MHNY Provider Services:**
 - [MHNYSocialProviderServices@MolinaHealthCare.com](#)