Provider Bulletin
Molina Healthcare of New York, Inc.

May 2025

Table of Contents

Update to Billing Limits for Article 29-I VFCA Health Facility Interpreter Services Effective Immediately

Reimbursement for Interpreter Services for children/youth receiving care from an Article 29-I VFCA Health Facility (29-I) is available for services provided during a medically necessary encounter billed in conjunction with one of the following Other Limited Health-Related Service rate codes: 4588, 4589, 4590, 4591, 4592, 4593, 4594, 4595, 4596, 4597, 4598, 4685.

Previously, Interpreter Services provided by a 29-I were limited to two units per encounter. Effective immediately, the two-unit limit has been removed. Providers can submit claims and receive reimbursement for all units of Interpreter Services required to support the Medicaid-billable OLHRS encounter. The time billed for interpretation services cannot exceed the length of time of the encounter. The service is billed as follows:

Rate Code	Procedure code	Modifier	Billing Unit	Max Units	Description
4673	T1013		15 minutes	N/A	In person interpreter services
4673	T1013	GQ	15 minutes	N/A	Telephone interpreter services

The Article 29-I VFCA 29-I Health Facility Billing Manual has been updated to reflect this change and can be found on the 29-I page of the DOH website, along with a Guide to Edits at the following links:

- 29-I Health Facility Billing Manual (Version 2025-2) - *(Web)* - *(PDF)* - April 2025
- Guide to Edits 29 - I Health Facility Billing Manual (Version 2025-2) - *(PDF)* - April 2025

New Rate for Health Home Plus/AOT Effective April 1, 2024

Effective April 1, 2024, a new Medicaid rate (rate code 1876) has been approved for Health Home Plus Care Management for Health Home members who have an Assisted Outpatient Treatment (AOT) order, per the 2024-2025 New York State Enacted Budget. This new rate has been approved by the Centers for Medicare and Medicaid Services (CMS), and the New York State Division of Budget (DOB) on March 5, 2025.

- Health Home Plus rates are posted to the DOH website at: Health Home Rates

Notification of New Rate Codes with Procedure and Modifier Codes for Health Home (HH) Providers Billing for the Community Health Worker (CHW) Benefit Effective May 1, 2025

The December 2024 Medicaid Update: Health Homes Added to List of Eligible Providers for New York State Medicaid Community Health Worker Services indicates that effective January 1, 2025, for New York State (NYS) Medicaid fee-for-service (FFS), and effective April 1, 2025, for MMCPs, HH is added to the list of eligible providers for CHW services.

Effective May 1, 2025, new Medicaid rate codes have been added for HH CHW billing for FFS. Claims should be submitted using the established procedure and modifier codes listed below:

Rate Code	Procedure Code	Modifier
1886 - CHW	98960	U1, U3
1887 - CHW	98961	U1, U3
1888 - CHW	98962	U1, U3
1889 - CHW CV	98960	U3, U1
1890 – CHW CV	98961	U3, U1
1891 – CHW CV	98962	U3, U1

Note: CHW services are **not covered** for NYS Medicaid members enrolled in a HH program, a HH Care Coordination Organization, or who receive care coordination services through a certified community behavioral health clinic or Assertive Community Treatment **when receiving care management services from these providers**. HHs may be reimbursed for the provision of CHW services when provided to NYS Medicaid members **before or after** they receive other care management services from these entities and **not when they are enrolled in a HH program.**

Updated Telehealth Modifier Use for OMH-Licensed/Designated Outpatient Programs Grid and Audio-Only Modifier Change Effective July 1, 2025

Effective July 1, 2025, OMH providers should use modifier 93 for eligible telehealth audio-only mental health services. As such, audio-only modifier FQ is no longer represented in OMH's revised Telehealth Grid. This change has been made in alignment with CMS billing practices to allow for streamlined crossover claims processing between Medicare and Medicaid.

MMCPs and OMH providers must ensure that their systems are configured to comply with these billing changes for claims with dates of service on July 1, 2025, and thereafter. Please note that while the audio-only modifier FQ is no longer used for services licensed, designated, or otherwise authorized by OMH, there are other billing scenarios in which FQ may be an appropriate modifier, and MMCP systems must be configured to accept either FQ or 93, as appropriate.

You can review the changes related to the Telehealth Modifier Use of OMH-Licensed/Designated Outpatient Programs Grid (Telehealth Grid) that are applicable to Fee-For-Service Medicaid, MMCPs, and OMH Licensed/Designated providers as a resource when processing/billing claims for Telehealth Services. The Telehealth Grid was revised to reflect rate code changes that have been enacted since the previous Telehealth Grid was issued and to align with the upcoming modifier change for OMH services delivered via audio-only.

Changes to Prior Authorization Requirements – Effective 8/1/2025

Effective 8/1/2025, there is a change to Assertive Community Treatment (ACT) services. Prior authorization will be required **for members, both Adult and Youth, who have been enrolled in the ACT program for at least 12 months.**

Code	Description
H0040	Assertive community treatment program, per diem

Should you have any questions regarding the new prior authorization requirements, please contact Molina Healthcare's Utilization Management Department at 1-877-872-4716.

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.

Explanation of Payment Refund and Forwarding Balance Reporting Enhancement

Molina Healthcare Inc would like to provide some details regarding a forthcoming enhancement to the reporting of refunds received that are displayed on your Explanation of Payment and 835 files.

What is the Change?

Currently on your Explanation of Payment (EOP) and 835, refund amounts are listed on your payment with a reference ID of the Molina claimID and payment checkhistoryID (eg: 123456789R1-CHK123456789).

A forthcoming enhancement scheduled for 04/30/25 will update these sections on the EOP and 835 to change the reference ID from the Molina claim ID to your patient control number, allowing for faster reporting of these transactions. The setup of utilizing WO/72 code types will remain.
The updates are:

- Reference ID on the Explanation of Payment adjustment section will reflect your patient control number for the transactions related to each refund posting, followed by the CHKHSTID.
- Changes to the PLB segment on the 835.
    - Items labeled as Provider Return/Refund credit will be reflected on your 835 as adjustment code 72 with a reference ID of the patient control number and CHKHSTID for each refund.
    - Items labeled as Overpayment Recovery will be reflected on your 835 as adjustment code type WO with a reference ID of the patient control number and CHKHSTID for each refund.
    - This is our method of recording refunds received and will result in a net total of $0.00 on your payment.

What do providers need to do?

Please review your Explanation of Payment and 835's for payments issued after **04/30/25** to ensure these new PLB segment adjustment types process accurately within you or your clearinghouse systems. If you have questions, please contact Provider Services at MHNYProviderServices@MolinaHealthCare.Com.

Reminders:

- Provider roster/demographic changes should be sent to: MHNYNetworkOperations@MolinaHealthcare.com

Frequently Used Links

- Molina Provider Website: Molina Healthcare.com
- 2025 Provider Quick Reference Guide
- Forms: New York Providers Home (MolinaHealthcare.com) under the forms tab.
- Prior Authorization Lookup Tool - PA Lookup Tool
- Molina Healthcare Provider Manual
- Molina Provider Communications - Updates and Bulletins
- MHNYProviderServices - MHNYProviderServices@MolinaHealthCare.Com

Upcoming Trainings

2025 Quarterly Provider Town Hall Webinars

June 26, 2025	July 30, 2025	November 5, 2025
2025 Provider General Orientation **Time: 9:00 am. – 10:00 a.m.** **Registration Link:** **https://events.teams.microsoft.com/event/d14d521a-0** **a263-aba8a02272a8@5e625f8d-0b53-4f56-9e46-19fa1**	**2025 Claims & Billing Webinar** **Time: 9:00 am. – 10:00 a.m.** **Registration Link: Coming Soon**	**2025 Cost Recovery Webinar** **Time: 9:00 am. – 10:00 a.m.** **Registration Link: Coming Soon**