April 2026 Provider Bulletin

Strengthening Provider Partnerships Across New York

Molina Healthcare of New York is currently undergoing strategic growth and has expanded our staff resources to strengthen both onsite and field-based provider engagement. We remain committed to partnering with practices that are interested in growing alongside us.

Our team offers onsite training and support for practice staff, including education on Molina products and the establishment of clear points of contact to assist with day-to-day operations. Through these collaborative efforts, our goal is to enhance provider relationships and deliver meaningful support that improves practice efficiency and supports quality patient care.

If you are interested in growing your Molina patient panel or would like to learn more about how we leverage our field-based teams and community-based partners, please contact the following representatives based on your service area:

Alex Bastidas - Downstate Director of Sales & Business Development Growth & Community Engagement
(914) 348-5646 | Alex.Bastidas@MolinaHealthcare.com
***Serving downstate Affinity by Molina Healthcare counties: Bronx, Kings, Nassau, New York, Orange, Queens, Richmond, Rockland, Suffolk, and Westchester**

Camilo Barrera - Upstate Director of Sales & Business Development Growth & Community Engagement
(315) 816-2068 | Camilo.Barrera@MolinaHealthcare.com
***Serving upstate Molina Healthcare counties: Allegany, Broome, Cattaraugus, Chautauqua, Chenango, Cortland, Erie, Genesee, Livingston, Monroe, Onondaga, Ontario, Orleans, Tioga, Tompkins, Wayne, and Wyoming**

Need Quick Answers?

Find the **2026 NY Medicaid Provider Quick Reference Guide** under the **Contact Us** dropdown on the **Molina Provider website**

In this newsletter you can expect:

The Role of the Care Management Team in Supporting Molina of New York's HIV Population

At Molina Healthcare of New York, comprehensive and coordinated care for members living with HIV is a critical component of our mission to improve health outcomes and reduce disparities among vulnerable populations. The Care Management (CM) team plays a central role in ensuring that members with HIV receive timely, person-centered-, and continuous care across the full spectrum of medical, behavioral, and social needs.

Care Coordination and Clinical Support

Molina's Care Management team serves as a key connector between members, HIV specialty providers, primary care clinicians, behavioral health professionals, pharmacies, and community-based- organizations. Care managers work proactively to support linkage to care, retention in care, and adherence to antiretroviral therapy (ART). Through regular outreach and individualized care planning, the team helps ensure that members attend routine medical visits, complete recommended laboratory monitoring (including viral load and CD4 testing), and receive guideline concordant- treatment.

For members with complex clinical needs—such as co-occurring chronic conditions, transplant history, or advanced HIV disease—care managers collaborate closely with treating providers to support treatment plans, facilitate referrals, and prevent avoidable hospitalizations or emergency department utilization.

Addressing Behavioral Health and Substance Use Needs

Recognizing the high prevalence of behavioral health conditions and substance use disorders among individuals living with HIV, Molina's Care Management team integrates behavioral health screening and coordination into routine care management activities. Care managers help connect members to mental health services, substance use treatment programs, and psychosocial support, ensuring that behavioral health needs do not become barriers to HIV treatment adherence or overall health.

This integrated approach supports whole person- care and aligns with Molina's commitment to reducing stigma while promoting engagement in care.

Social Determinants of Health and Community Linkages

Social determinants of health (SDOH) such as housing instability, food insecurity, transportation barriers, and legal or financial challenges disproportionately affect people living with HIV. Molina care managers routinely assess SDOH needs and connect members to community based- resources, including Social Care Networks (SCN), housing supports, nutrition programs, transportation assistance, and Ryan White–funded services when appropriate.

By addressing non-medical drivers of health, the Care Management team helps stabilize members' living situations and supports sustained engagement in HIV care.

Member Education and Empowerment

Education is a cornerstone of effective HIV management. Molina care managers provide ongoing education related to HIV disease management, medication adherence, prevention strategies, and health maintenance. Through culturally competent and trauma-informed-communication, care managers empower members to actively participate in their care and make informed decisions that support long-term viral suppression and quality of life-.

Quality, Compliance, and Health Equity

The Care Management team also plays an essential role in supporting Molina's quality improvement initiatives and regulatory requirements related to HIV care. By promoting adherence to evidence-based- clinical guidelines and closing care gaps, care management contributes to improved performance on quality measures, reduced health disparities, and better outcomes for members living with HIV.

In summary, Molina of New York's Care Management team is integral to delivering coordinated, equitable, and high-quality- care for members living with HIV. Through clinical coordination, behavioral health integration, SDOH support, and member empowerment, care management helps ensure that individuals with HIV can achieve viral suppression, improved health outcomes, and a higher quality of life.

Connecting with Molina of New York's Care Management Team

Referrals or further inquiries regarding Molina of New York's Care Management program may be sent to MHNY.CareManagement@MolinaHealthcare.com. You may also contact Angela Cespedes at Angela.Cespedes@MolinaHealthcare.com or 718-536-2536 and Amy Barry at Amy.Barry@MolinaHealthcare.com or 315-273-0037.

Billing Guidance For Backup Power Wheelchair Repairs (K0899TW-TW)

Effective January 1, 2026 for Fee-for-Service (FFS) and March 1, 2026 for Managed Care, in limited instances, Group 2, Group 3, Group 4, Group 5, and Group 6 power wheelchairs (PWC) with or without power options, are eligible for use as a backup PWC when the user has been provided with a new, primary PWC.

Overview

- **Eligible wheelchairs:** Group 2 through Group 6 PWCs that were previously used as the member's primary source of mobility.
- **Method of authorization:** direct bill - no prior approval is necessary.
- **HCPCS code/modifier**: Reimbursement for repair of any backup PWC regardless of group or code at purchase requires use of HCPCS code K0899 with the TW modifier.
- **Limits:** Repairs for backup PWCs will be reimbursed up to $5000 over a period of 5 years.

Detailed Billing Guidance:

- When submitting a claim for K0899-TW, the Reimbursement form for Backup Wheelchair Repairs (found here: Reimbursement Form for Backup PWC Repairs) should be completed by the billing provider (DME vendor), and the attestation should be signed by the provider's Assistive Technology Professional (ATP).
- Parts will be reimbursed at the typical MRA for the code for that part. Parts that do not have a Maximum Reimbursable Amount (MRA) will be reimbursed at cost +51%.
- Invoices must be provided, showing all dealer discounts for parts and to support pricing of components at cost plus 51%.
- Labor performed by the billing provider will be reimbursed at the MRA for K0739 which is currently $18.18. Please itemize the type of labor and number of units requested. Up to 8 units are available, if additional labor is needed, please provide rationale on the form.
- Please note: If any fields are left blank on the form, or invoices are missing, the claim will be denied, and a new claim would need to be filed.

For questions related to policy and coverage guidelines, contact the Bureau of Medical Review at 1-800-342-3005 or OHIPMedPA@health.ny.gov.

For questions related to billing, call GDIT at 1-800-343-9000

Reference:

New York State Department of Health. DME *Communications: Backup Power Wheelchair Repairs (K0899-TW) Reimbursement Form*.

Available at: https://www.emedny.org/ProviderManuals/DME/communications.aspx

Coordination of Benefits Billing Protocols for Providers: Medicaid is the Payer of Last Resort

The New York State (NYS) Department of Health reminds providers that Medicaid is responsible for paying claims for covered items or services only after all other available payment options have been exhausted. Medicaid is always the payor of last resort; federal regulations require that all other available resources be utilized before Medicaid is responsible for making payment. If a Medicaid member has Medicare, and/or other third-party insurance coverage, the benefits of that coverage must be fully utilized before billing the NYS Medicaid program. Providers should always ask NYS Medicaid members if they have other third-party coverage to ensure the proper coordination of benefits.

All claims submitted for NYS Medicaid members with Medicare and/or other third-party coverage must accurately reflect payments and denials received from other insurers to allow for the correct calculation of NYS Medicaid reimbursement amounts. The Explanation of Benefits (EOB) and other documentation supporting Medicare and third-party reimbursement amounts must be kept and made available for audit or inspection by NYS Department of Health, NYS Office of the Medicaid Inspector General (OMIG), NYS Office of the State Comptroller (OSC), or other state or federal agencies responsible for audit functions.

Importance of Submitting Claim Adjustment Reason Codes (CARCs)

Providers are reminded that NYS Medicaid claims involving third-party liability must include the appropriate CARC from the primary insurance. CARCs are essential to ensure NYS Medicaid to accurately process claims and determine the correct payment amount. Without the correct CARC, claims may be miscalculated, potentially resulting in NYS Medicaid overpayments or underpayments.

Requirement to Bill Primary Insurance, Even If Not Enrolled

Providers who are not enrolled with a primary insurance payer must still attempt to submit the claim to that primary insurer before billing Medicaid. This process is crucial for Medicaid's role as the payer of last resort and ensures compliance with third-party liability rules. A formal denial from the primary insurer serves as required documentation to support the Medicaid claim and provides a clear audit trail. If the primary payer issues a CARC with the denial, providers should include this code in their electronic submission to Medicaid, as CARCs are essential for accurate claims processing and helps prevent incorrect payment. If the primary payer will not accept or adjudicate a claim from a non-participating provider, the provider is required to retain clear evidence that the claim submission was first attempted with the primary payer.

(Continued on next page)

Coordination of Benefits Billing Protocols for Providers: Medicaid is the Payer of Last Resort (Continued)

Handling Zero-Fill Claims

For purposes of this guidance, a "zero fill" claim refers to a claim submitted to a primary payer that was denied as a non-covered benefit and for which no payment was made by the primary insurer. For any claim submitted to Medicaid as a zero fill, the provider must retain documentation that clearly demonstrates the claim was first submitted to the primary payer. This documentation is essential to confirm that all other payment sources were exhausted before billing Medicaid, which aligns with Medicaid's payer-of-last-resort policy.

Providers must maintain documentation demonstrating that the services rendered are a non-covered benefit by the primary payer. Acceptable documentation includes a claim denial issued within the calendar/benefit year of the claim, verifying that the services are not within the scope of the commercial payer coverage. This documentation may be required for submission to NYS Department of Health to ensure proper processing and payment of claims that were zero-filled. An exception is made for services statutorily not covered by Medicare; in such cases, the provider may bill Medicaid directly without requiring prior submission to Medicare to obtain a claim denial.

Provider Responsibilities:

- **Identify Other Payers:** Providers must identify all other potential payers for services rendered. This includes but is not limited to; Medicare, commercial/third-party insurance, Workers' Compensation, Compensation and/or the Medical Indemnity Fund.
- **Bill All Prior Payers:** Providers must bill all identified prior payers and exhaust all available coverage options before submitting a claim to Medicaid. Documentation of these efforts must be maintained and made available upon request.
- **Submit Corrected Claims:** If payments are received from other payers after Medicaid has reimbursed a claim, providers are required to submit corrected claims to Medicaid and refund any overpayments.

To ensure compliance with Medicaid billing policies, providers should regularly review and update their billing practices, including periodically checking for any changes in statutory non-covered services, to confirm that all available coverage options have been fully utilized before submitting claims to Medicaid. Providers should review, verify, and update any non-coverage information at least annually or whenever significant payer policy changes occur. This process supports Medicaid's role as the payer of last resort by ensuring that only non-covered services are billed to Medicaid.

Private Duty Nursing (PDN) Billing Reminder

To ensure accurate and timely reimbursement, newly contracted Private Duty Nursing (PDN) providers must bill using the correct HCPCS code and appropriate modifier combination.

Please review the billing guidance below:

Code	Modifier	Code Description
S9123		Nursing Care, in the Home by Registered Nurse, per hour
S9123	U1	Nursing Care, in the Home by Registered Nurse, high tech fee, per hour
S9123	U2	Nursing Care, in the Home by Registered Nurse, Medically Fragile Trained
S9123	U3	Nursing Care, in the Home by Registered Nurse, high tech fee, Medically Fragile Trained, per hour
S9123	U4	Nursing Care, in the Home by Registered Nurse, Medically Fragile Trained and Directory
S9123	U5	Nursing Care, in the Home by Registered Nurse, high tech fee, Medically Fragile Trained and Directory, per hour
S9124		Nursing Care, in the home, by Licensed Practical Nurse, per hour
S9124	U1	Nursing Care, in the home, by Licensed Practical Nurse, high tech fee, per hour
S9124	U2	Nursing Care, in the home, by Licensed Practical Nurse, Medically Fragile Trained, per hour
S9124	U3	Nursing Care, in the home, by Licensed Practical Nurse, high tech fee, Medically Fragile Trained, per hour
S9124	U4	Nursing Care, in the home, by Licensed Practical Nurse, Medically Fragile Trained and Directory, per hour
S9124	U5	Nursing Care, in the home, by Licensed Practical Nurse, high tech fee, Medically Fragile Trained and Directory, per hour

Shared Case Billing Guidelines: A shared case occurs when more than one member at the same location receives PDN services during the same span of hours from a single nurse.

Billing requirements for shared cases: The first member should be billed at the full hourly rate. • The second member must be billed using the TT modifier. • Reimbursement for the second member will be reduced by 50%

Important Reminder: Submitting claims with the correct HCPCS codes and modifiers helps prevent claim denials and payment delays. Please review your billing practices to ensure compliance with these requirements. For questions regarding PDN billing, please contact Provider Services.

Medicaid Billing Updates for OASAS-Certified Outpatient Programs

(Part 1)

New York State Office of Addiction Services and Supports (OASAS) has issued updated Medicaid billing guidance impacting OASAS-certified outpatient providers. These changes affect billing rate codes, MAT billing structure, medical visit codes, E&M modifiers, and drug reimbursement, and are effective April 6, 2026.

Providers are responsible for ensuring billing practices comply with this guidance and with Molina Healthcare of New York (Molina NY) Medicaid billing requirements.

Optional COP Billing Using an Additional Rate Code

Applies to: COPs only

COP providers may continue billing under a single COP rate code or may elect to use two rate codes to distinguish Medication Assisted Treatment (MAT) services from non-MAT services:

- **Reminder:** If you continue billing exclusively under rate code 1036 or 1039 (for both MAT and non-MAT), MAT patients must still be billed weekly (Monday–Sunday); non-MAT may be billed weekly or daily/visit.
- **MAT patients must be billed using:**
  - 1564 (freestanding COPs) or 1567 (hospital-based COPs)
  - MAT claims must be billed weekly (Monday–Sunday)
  - Weekly MAT claims should include all services provided during the week (APG or bundle methodology, including bundle carve-outs).
  - MAT status is determined at the patient level. Treat the patient as MAT for a given week if they: (1) have methadone or buprenorphine dispensed face-to-face by the program, (2) have take-home medication in hand, or (3) are clinically in MAT status per the treatment plan (patients who skip dosing but continue clinical services remain MAT; if the treatment plan no longer includes MAT, the patient is no longer MAT).
- **Non-MAT patients must be billed using:**
  - 1036 (freestanding) or 1039 (hospital-based)
  - Weekly billing is optional for non-MAT services

Providers choosing the two-rate-code option may need to request reactivation of rate codes 1564 or 1567 through OASAS.

Elimination of Medical Visit Rate Codes

Applies to: All OASAS-certified outpatient programs

Effective 4/6/2026, all OASAS medical visit rate codes will be eliminated. Physical health Evaluation & Management (E&M) services must now be billed using applicable CPT/HCPCS codes under the program's primary billing rate code, rather than separate medical visit rate codes.

The following OASAS medical visit rates codes will be zeroed out:

- 1468 - OASAS - ARTICLE 32 MEDICAL VISIT
- 1471 - OASAS - MMTP MEDICAL VISIT
- 1552 - OASAS APG - ARTICLE 32 CLINIC MEDICAL VISIT
- 1555 - OASAS APG - MMTP CLINIC MEDICAL VISIT
- 1558 - OASAS APG - HOSP ARTICLE 32 OP REHAB MEDICAL VISIT
- 1570 - OASAS APG - ARTICLE 32 OP REHAB MEDICAL VISIT

Key Billing Reminders:

- For MAT patients, physical health services are included with weekly MAT claims when billed under rate codes 1564 or 1567
- For non-MAT patients, physical health services are billed under 1036 or 1039 for the applicable dates of service
- For OTP weekly bundles, medication management E&M services are included in the bundle and may not be billed separately. Physical health E&M services and psychiatric evaluations are excluded from the bundle and may be billed separately when medically necessary and properly documented.
- For clinics and COPs not billing a weekly bundle, E&M services remain separately billable when consistent with APG methodology.

Medicaid Billing Updates for OASAS-Certified Outpatient Programs

(Part 2)

Off-Site Services

Applies to: Freestanding programs only

- Off-site services are not permitted for hospital-based programs. Billing must use the following rate codes:
  - 1088 – Mobile methadone services
  - 1080 – All other off-site services (MAT and non-MAT)

APG Drug Fee and Peer Recovery Support Updates

Applies to: All OASAS-certified outpatient programs

- J2315 (Naltrexone, depot form) maximum units reduced to 1, with adjusted reimbursement
- Peer Recovery Support (G0536):
  - Each unit represents 30 minutes
  - Maximum of 12 units
  - Updated procedure-based weight applies to G0536 only

New E&M Modifier Requirements

Applies to: All OASAS-certified outpatient programs

These modifier requirements apply to all OASAS outpatient services where E&M (or related) codes are billed, including rate code 1540 clinics. Providers should append one of the following modifiers to any E&M code:

- **HF** – Medication management
  - **Bundle note (G0267/G0268):** Medication management is included in the weekly bundle—do not bill a separate medication management E&M (HF) when a bundle code is on the claim.
  - **Other E&Ms:** Non–medication management E&Ms may be billed separately (including on the same claim as the bundle) when medically necessary and documented.
- **HE** – Psychiatric evaluation
- **P1 / P2 / P3 Physical health care**
  - Use P1–P3 when the E&M represents physical health care (i.e., it is not medication management and not a psychiatric evaluation):
    - P1: Normal healthy patient
    - P2: Patient with mild systemic disease
    - P3: Patient with severe systemic disease
- **APG billing:** Two E&Ms may be billed on the same claim when separate and distinct (e.g., HF and P1–P3).

After-Hours MAT Services

Applies to: OTPs and COPs dispensing methadone or buprenorphine

Programs dispensing MAT services after 3:00 PM may bill procedure code 99051 in addition to other services rendered on that date.

- Bill 99051 once per date of service when after-hours services are provided, and ensure documentation supports the service was completed after 3:00 PM.
- When billing weekly bundles, 99051 must be reported on the actual date(s) of after-hours service.
- Claims containing 99051 may be submitted under rate code 1036 (MAT only), 1039 (MAT only), 1564, 1567, or 1088 (if off-site), as applicable.

Medicare Crossover Billing for MAT Complex Care Management

Applies to: OTPs and COPs dispensing MAT

Providers billing Medicare codes G0534 or G0535 must also include Medicaid code 90882 on the Medicare claim with the GY modifier and the appropriate number of 5-minute units (maximum 4) to support correct Medicaid crossover processing.

ADDITIONAL INFORMATION

The full OASAS Medicaid billing guidance, including detailed regulatory specifications, is available in the official state notification: *April 2026 Medicaid Billing Guidance – Including DOH Comments (3.13.26 v3).pdf*.

Providers can access OASAS resources and updates at: *https://oasas.ny.gov/*

Questions related to OASAS guidance should be directed to: *PICM@oasas.ny.gov*

Molina NY billing and claims guidance is available through the Provider Portal or Provider Manual.

Molina Healthcare remains committed to supporting providers in implementing these updates and ensuring accurate billing and claims submission.

New York Regulatory Communication: TOB Values Submitted on SUD Residential Habilitation

The New York State Department of Health (NYSDOH) is communicating expectations regarding the appropriate reporting of Type of Bill (TOB) values for substance use disorder (SUD) managed care encounters submitted to New York State Medicaid, in alignment with Centers for Medicare and Medicaid Services' (CMS) specifications. To meet CMS specifications and ensure accurate encounter reporting, NYSDOH is asking SUD providers to submit Facility Type Code values of '86' or '89' in loop 2300, in the Health Claim segment, for element 1331 (ref. CLM05-01) on claims for services using the following rate codes:

Program	Rate Code	Rate Code / Service Title
Withdrawal and Stabilization	4220	Article 32 Medically Supervised Inpatient Withdrawal
Inpatient Rehabilitation	4213	Article 32 Inpatient Rehabilitation
	4202	Article 32 State Operated Addiction Treatment Center
Residential Services	1144	Stabilization
	1145	Rehabilitation
	1146	Reintegration

NY Medicaid Article 29-I Billing and Appeals Requirements

Article 29-I Health Facilities and providers must follow all NY Medicaid billing guidelines when submitting claims and should use the formal appeals process when a claim is denied and an appeal is required. Submitting corrected or replacement claims instead of a filing an appeal may result in a denial for untimely filing.

All Article 29-I claims must be submitted accurately and completely, including correct rate codes, procedure codes, modifiers, dates of service, required documentation, and must comply with Medicaid timely filing limits. Providers are responsible for ensuring claims are correct at the time of original submission.

When a claim is denied, providers should review the denial reason to determine the appropriate action. Appeals are required for denials related to medical necessity, coverage or benefit determinations, authorization or eligibility issues, or payment decisions based on policy or guideline interpretation, and should be submitted within required contractual and NY Medicaid timeframes.

Corrected or replacement claims are only appropriate to fix clerical or data entry errors, such as incorrect codes, modifiers, member IDs, or dates of service, and do not replace the appeals process.

Providers with questions should contact Provider Services at (877) 872-4716 or email MHNYProviderServices@MolinaHealthcare.com before resubmitting a denied claim.

New York State Medicaid Telehealth Policy Update

Effective January 1, 2026, the New York State (NYS) Medicaid program released updates to the **Medicaid Telehealth Policy Manual**. These updates apply to all NYS Medicaid-enrolled providers and Medicaid Managed Care (MMC) Plans.

The updated manual includes the following changes:

- Updated information regarding Medicare telehealth waivers
- Addition of a teledentistry procedure code chart with expanded billing guidance
- A revised description for remote patient monitoring procedure code 99454, consistent with updates issued by the American Medical Association (AMA)
- A new format for Section 9.16: Clinic Billing by On-Site Presence, organized by clinic type
- Updated off-site billing guidance for School-Based Health Centers

Providers should review the updated Telehealth Policy Manual to confirm their telehealth services and billing practices comply with current NYS Medicaid requirements.
The full manual is available on the **NYS Department of Health – New York State Medicaid Telehealth** webpage:
https://www.health.ny.gov/health_care/medicaid/program/update/telehealth/

Claims Electronic Attachments (275) Now Accepted via SSI

Molina Healthcare now accepts standard electronic attachments (275) via The SSI Group (SSI), in addition to attachments submitted through the Availity Essentials Portal. This electronic option supports faster processing, improved accuracy, and reduced paper handling.

Providers must be registered with SSI—either directly or through their clearinghouse—to submit electronic attachments using the 275 transaction. Providers should confirm their clearinghouse has SSI connectivity or register directly with SSI if needed.

To support successful submission, Molina has published a Frequently Asked Questions (FAQ) resource that explains how attachments are matched to claims, how receipt is confirmed, registration options, and key submission requirements.

To view the full FAQ, visit the Molina Updates and Bulletins page:
https://www.molinahealthcare.com/providers/ny/medicaid/comm/bulletin.aspx

Under the Notices section, select "*FAQ – Claims Electronic Attachments Submission (275) via SSI*."

Reminders

Provider Memorandum: MCG 30th Edition Go-Live April 30, 2026

Molina Healthcare of New York would like to inform our provider partners that the MCG 30th Edition is scheduled to go live and will become effective on Thursday, April 30, 2026.

This update does not change providers' day-to-day operations. Molina is simply updating the MCG edition currently used to support utilization management review processes.

If you have any questions regarding this update, please contact your dedicated Provider Network Manager or email the Provider Network Management team at: MHNYProviderServices@MolinaHealthcare.com.

Primary Care Visits for Foster Care Members

For ongoing primary care visits, **children and youth should not be turned away** if there is a discrepancy with the assigned PCP listed on the MMC member ID card. Providers should **immediately contact Molina Healthcare of New York, Inc. at (877) 872-4716** to rectify the PCP assignment and ensure continuity of care.

Reminders

Behavioral Health Billing

This reminder is for Behavioral Health providers billing Office of Mental Health (OMH) and Office of Addiction Services and Supports (OASAS) services. Claims must be submitted in accordance with New York State Medicaid requirements. Submitting complete and accurate claims—using correct rate codes, procedure codes, modifiers, units, and allowable same-day service combinations—helps reduce avoidable denials and payment delays.

Key Billing Reminders

- **Use the correct rate code and procedure code** that matches the service, program, setting, and billing provider type per OMH and OASAS guidance.
- **Bill modifiers and units exactly as required** (follow unit definitions and any limits)
- **Ensure your documentation supports what you billed** and is submitted within timely filing limits.

Same-Day Billing and Service Combinations

- **Bill same-day services only when allowed** - confirm the combination is permitted by NY Medicaid policy for the member and date of service.
- **Avoid duplicate or overlapping billing** - do not bill services that duplicate or overlap; make sure dates of service (and times, when applicable) and documentation support each billed service.

Denials: Appeals vs. Corrected Claims

When a claim is denied, providers should carefully review the denial reason to determine the appropriate course of action. Appeals are required for denials related to medical necessity, coverage or benefit determinations, authorization or eligibility issues, or payment decisions based on policy or guideline interpretation. Appeals must be submitted within applicable contractual requirements and New York State Medicaid timeframes.

Corrected or replacement claims are only appropriate to address clerical or data entry errors, such as incorrect procedure codes, modifiers, member identification numbers, or dates of service. Corrected claims do not replace the appeals process and should not be submitted for denials that require an appeal.

For additional billing guidance, review the NYS resources listed below:

- **Billing Behavioral Health (BH) Services Under Managed Care**
- **OMH Medicaid Reimbursement Rates**
- **Reimbursement | Office of Addiction Services and Supports**

Please contact the Molina NY Provider Services team with any questions.

Reminders

Important Change – Tools Moved to Availity:

Access to Cultural Competency, Disability, & Language Services Resources

At Molina Healthcare, we are committed to helping our providers deliver care that is culturally and linguistically appropriate for every member.

You can now access a wide range of helpful resources and training materials on cultural competency, disability-related services, and language access services through the Availity Essentials portal or by visiting the Molina Healthcare website.

How to Access on Availity:

1. Log in to the **Availity 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**.

These tools are designed to support you in delivering respectful, inclusive, and person-centered care to all Molina members.

If you have questions or need more information about Molina's language access services or cultural competency resources, please reach out to your Provider Services representative. We're here to help.

Submit Itemized Bills for Accurate and Timely Claim Payment

Submitting itemized bills for inpatient claims helps ensure timely and accurate reimbursement, especially when dates of service extend beyond the approved authorization.

Why Itemized Bills Matter	Attachments in Availity
Validate Services Provided Every procedure, service, or supply is accurately recorded.	**When to Attach Documents** ◦ Initial claim submission ◦ Pending or in-process claim ◦ Corrected claim
Apply Correct Payment Methodology Ensures claims are reimbursed correctly.	**Attachment Guidelines** ◦ Max 64 MB per file; 640 MB total ◦ Up to 10 files per claim ◦ Accepted formats: jpg, tiff, gif, png, pdf ◦ File names must be 200 characters or less; can only contain letters, numbers, spaces, hyphens (-), and underscores (_)
Maintain Compliance Supports contractual and regulatory requirements.	**Tip for Smoother Processing** Whenever possible, attach your itemized bill **with the initial claim submission**. This simple step helps prevent delays and reduces additional requests—keeping your claim moving forward quickly.

Reminders

Provider Manual Updates

Molina Healthcare is committed to ensuring providers have access to accurate and up-to-date guidance that supports high-quality care for our members. The **Provider Manual** is reviewed annually and may also be updated more frequently as needed to reflect operational, regulatory, or program changes.

The most current version of the Provider Manual is available online at: **MolinaHealthcare.com/providers/ny/medicaid/manual/medical.aspx**

Availity Essentials Training

Access training anytime through the Availity Essentials Provider Portal at availity.com/providers. Select Help & Training for tutorials, webinars, and step-by-step guidance.

Most utilized courses include:

Training Area	Course
Authorizations	• Authorization Submission Training
Claims	• Claim Status Training • Quick Claims Training • Atypical Provider Training • Remittance Viewer Training
Eligibility & Benefits	• Eligibility and Benefits Inquiry Training
Recorded Webinars	• Availity Overview - Recorded Webinar • Claim Status - Recorded Webinar

Frequently Used Links

- 2026 Provider Quick Reference Guide
- **Molina Provider Website:**
  - Molina Healthcare.com
  - Molina Provider Communications - Updates and Bulletins
  - Molina Healthcare Provider Manual
  - Access and Availability Standards
- **Forms:**
  - New York Providers Home (MolinaHealthcare.com) under the Forms tab
- **Prior Authorization Lookup Tool:**
  - PA Lookup Tool
- **Provider Data Updates: Demographic Changes, Rosters, and Credentialing:**
  - MHNYNetworkOperations@Molinahealthcare.com
- **Provider Contracting:**
  - MHNYProviderContracting@MolinaHealthcare.com
- **General Inquiries - Provider Services:**
  - MHNYProviderServices@MolinaHealthCare.com