

September 2026 Provider Bulletin

GB Collects Debt Collection Vendor

GB Collects is a nationwide debt collection vendor that Molina has contracted with to collect outstanding debts from providers due to overpaid claims. Molina has made all required notifications of overpayment and attempts to recoup the overpaid amounts.

Provider will receive a letter stating: "Your hospital/clinic/Doctors Group etc. was notified regarding Overpaid Claims paid by Molina. Molina attempted to recoup the money via adjustment and offsetting of the claim but was not successful in recovering the funds. The Overpaid Claims have not been resolved. Therefore, the matter is being managed by our Overpaid Claim Collection Vendor, GB Collects. Please contact them at 888-688-5700."

Frequently Asked Questions (FAQ):

- 1. Why was this matter sent to collection?** The Provider was Overpaid by Molina. Molina notified providers previously of overpayments and attempted to collect the overpayments via claim adjustment/recoupment but was unsuccessful. Molina was unable to automatically move the debt balance within its payment systems within state and federal guidelines. Therefore, the open payable amount due has been sent to GB Collects to outreach to providers and collect a refund check on Molina's behalf.
- 2. Will this impact our Organization's Credit Report?** No. GB Collects does not report to Credit Bureaus. However, unresolved matters may be referred to a lawyer in the provider's state for potential legal action.
- 3. Can we pay Molina directly?** Yes, the Provider can pay GB Collects or Molina. However, to ensure that the debt is properly accounted for, it is preferred that provider submit payment through GB Collects.
- 4. Can we pay in installments?** Yes, contact GB Collects at **888-688-5700** to arrange installment payments.
- 5. I dispute the balance amount. How can I resolve?** Yes, review the dispute by contacting **GB Collects** at **888-688-5700** for additional details regarding the debts.
- 6. What method(s) of payments are available to our organization?** Most common methods of payment are ACH payments, Check, and Credit cards

In this issue you can expect:

GB Collects
Debt Collection Vendor

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Need Quick Answers?

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

Reimbursement Clarification for High-Level Evaluation and Management (E/M) Services Reported with Preventive Medicine Services

Overview

This bulletin provides clarification regarding reimbursement of high-level Evaluation and Management (E/M) services billed on the same date of service as preventive medicine services for the same member, by the same provider, consistent with Molina Healthcare PI Payment Policy 37. **Effective October 14, 2026**, this guidance is intended to support accurate claim submission and help providers better understand reimbursement expectations for preventive medicine and high-level E/M services.

Background

Molina Healthcare recognizes that providers often address medical concerns identified during preventive medicine visits as part of comprehensive patient care.

Minor conditions or concerns addressed during a preventive examination are generally considered part of the preventive service and are included in reimbursement for the preventive medicine code.

While significant, separately identifiable medical issues may warrant submission of an E/M service with modifier 25, Molina recognizes substantial overlap between preventive medicine services and high-level E/M services, including:

- Comprehensive history requirements
- Physical examination components
- Review of systems
- Time spent during the encounter
- Administrative and nursing support activities
- Documentation requirements

Because of this overlap, encounters that fully support both a preventive medicine service and a high-level E/M service during the same visit are uncommon. In circumstances requiring significant time and medical decision making, the focus of the visit may shift from preventive care to problem-oriented management.

Billing and Reimbursement Guidance

When any of the following high-level E/M codes are billed on the same date of service as a preventive medicine code for the same member, by the same provider:

High-Level E/M Codes	Preventive Medicine Codes
99204	99385
99205	99386
99214	99387
99215	99395
	99396
	99397

Only the preventive medicine service will be reimbursed, regardless of modifier usage, including modifier 25.

FAQs

Can a high-level E/M service and preventive medicine service legitimately occur during the same visit?

Yes. While possible, Molina considers such situations uncommon and generally limited to encounters involving substantial time and highly complex medical management.

Do multiple chronic conditions and medications automatically justify billing both services?

No. The presence of multiple diagnoses or medications alone does not establish the high level of medical decision making required to support a high-level E/M service.

If a provider spends approximately one hour with a patient, can both services be reported?

Not necessarily. Molina notes that the time requirements for a high-level E/M service often leave insufficient time to perform and document all elements required for a preventive medicine service during the same encounter.

Would a separate follow-up visit for problem-oriented management be reimbursable?

Yes. A subsequent visit may be appropriate based on patient needs, the severity of active conditions, and clinical judgment regarding whether preventive services or problem-oriented management should be prioritized.

Reimbursement Clarification for High-Level E/M Services Reported with Preventive Medicine Services (continued)

Reminder

Providers should review current billing and documentation practices involving preventive medicine visits and high-level E/M services to ensure compliance with Molina Healthcare reimbursement policy.

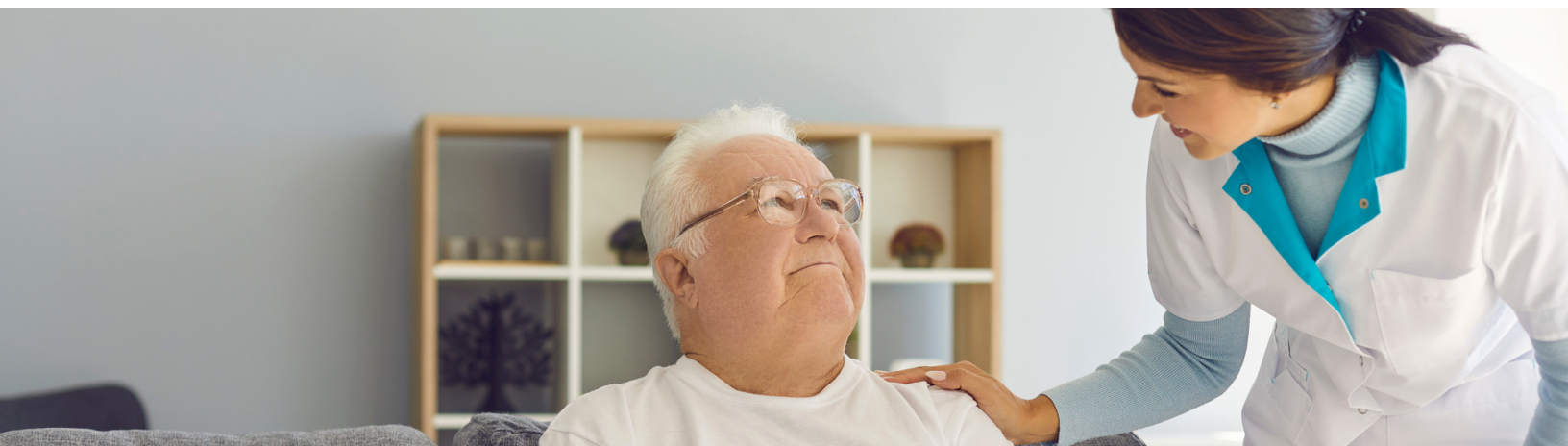
Claims submitted with the code combinations identified above may result in reimbursement of the preventive medicine service only.

Reference

Molina Healthcare PI Payment Policy 37: [High-Level E/M with Preventive Medicine](#) (Effective October 18, 2022).

Providers may access Molina Healthcare payment policies through the Molina Provider Website at

<https://www.molinahealthcare.com/providers/ny/medicaid/policies/payment.aspx> or through the [Availity](#) provider portal.



Long-Term Nursing Facility Authorization Reviews

Effective August 3, 2026, Molina is implementing a standardized review process for long-term nursing facility authorizations for Medicaid Managed Care (MMC) members to support the continued review of long-term placement requests.

To support the review process, facilities may be asked to provide documentation demonstrating Institutional Medicaid application submission, approval or pending status.

Supporting documentation may include:

- LDSS approval documentation
- Proof of Institutional Medicaid application submission
- Documentation demonstrating the application remains pending with LDSS

Timely submission of requested documentation will help prevent delays in authorization review and support continued processing of long-term nursing facility authorization requests.

If you have questions about this update, contact Molina Provider Services at (877) 872-4716.



Prior Authorization Updates Effective October 1, 2026

To help your team stay informed and prepared, Molina Healthcare is updating prior authorization (PA) requirements **effective October 1, 2026**. The summary below outlines which services will now require authorization and which will no longer need it.

Prior authorization **will be required** for the following CPT codes before the services are rendered.

Code	Description	Additional Information
J9053	Belantamab mafodotin-blmf injection, 0.1 mg	Healthcare Administered Drugs

Prior authorization will **not be required** for the following CPT codes, unless performed by an out of network provider.

Code	Description	Additional information
37292	Tibial/peroneal revascularization with stent and atherectomy, initial vessel	OP Hosp/Amb Surgery Center (ASC) procedures
37294	Tibial/peroneal revascularization with stent and atherectomy, complex lesion	
37296	Inframalleolar revascularization with angioplasty, initial vessel	
37298	Inframalleolar revascularization with angioplasty, complex lesion	
92930	Intracoronary stent placement for multiple lesions or coronary segments	
J9037	Belantamab mafodotin-blmf injection, 0.5 mg	Healthcare Administered Drugs

The Codification Matrix on our website has been updated and posted with the above referenced changes. In addition, this notification will be posted to our website for future reference. **Should you have any questions regarding the new prior authorization requirements, please contact Molina Healthcare's Utilization Management Department at 1-877-872-4716. Thank you for your continued cooperation.**

Lipectomy and Suction-Assisted Lipectomy Policy

Effective November 1, 2026

Lines of Business

Medicaid Managed Care (MMC); Essential Plan (EP); Child Health Plus (CHP)

Overview

Molina Healthcare of New York is implementing a new Utilization Management (UM) Clinical Policy to support the review of requests for Lipectomy and Suction-Assisted Lipectomy for Non-Cosmetic Indications.

Effective November 1, 2026, this policy will be utilized by Molina's Utilization Management (UM) team when reviewing prior authorization requests for lipectomy and suction-assisted lipectomy procedures performed for non-cosmetic indications.

The policy outlines the medical necessity criteria and documentation requirements used to support authorization determinations for applicable requests. The policy applies to New York Medicaid members.

Provider Action Required

Beginning **November 1, 2026**, providers are encouraged to review the policy prior to the effective date and ensure that requests include sufficient clinical documentation to support medical necessity and facilitate timely review.

Questions?

For additional information regarding this bulletin, please contact Molina Provider Services at (877) 872-4716.

Caring for Foster Care Members

As a Molina Healthcare of New York, Inc. network provider, you may provide trauma-informed care to Medicaid Managed Care (MMC) children and youth in foster care, including those in direct placement foster care and those receiving services through Voluntary Foster Care Agencies (VFCA).

Provision and coordination of services for children and youth in foster care must comply with the New York Medicaid Program 29-I Health Facility Billing Manual and the Transition of Children Placed in Foster Care and NYS Public Health Law Article 29-I Health Facility Services into Medicaid Managed Care guidance documents, available at:

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/vol_foster_trans.htm

Pharmacy benefit requirements for children and youth placed in foster care include, but are not limited to, rapid replacement of medically necessary prescriptions and transitional fills for children and youth newly placed in foster care.

Effective April 1, 2023, pharmacy benefits for Medicaid Managed Care (MMC) members, including children and youth in foster care, transitioned to NYRx, the Medicaid Pharmacy Program. Physician-administered drugs, durable medical equipment, prosthetics, orthotics and supplies remain covered by Molina Healthcare of New York, Inc. when billed as a medical or institutional claim. The Pharmacy Procedure Code Manual can be found here:

https://www.emedny.org/ProviderManuals/Pharmacy/PDFS/Pharmacy_Procedure_Codes.pdf

Upon placement into foster care, a child or youth is required to have an initial medical assessment within the first 30 days of placement. The child or youth may utilize any primary care physician (PCP) or qualified practitioner in the MMC plan's network for the purposes of this initial medical assessment.

For ongoing primary care visits, if there is a discrepancy with the assigned PCP on the MMC member ID card, the child or youth should not be turned away. Instead, please immediately call Molina Healthcare of New York, Inc. at (877) 872-4716 to resolve the issue or if you have questions regarding the information in this article.

Pharmacy Update: Blood Glucose Meters and Test Strips

The U.S. Food and Drug Administration (FDA) has issued a safety alert regarding Trividia Health's TRUE METRIX® Blood Glucose Monitoring Systems. Members using TRUE METRIX devices should be made aware of updated manufacturer guidance related to E-5 error messages. Providers are encouraged to review this information with affected members and caregivers.

To provide Molina members with alternative options for blood glucose monitoring, we are adding Roche Accu-Chek® blood glucose meters and corresponding test strips as preferred formulary options.

Roche Accu-Chek® Preferred Formulary Products

Blood Glucose Meters	
NDC	Product
65702-0729-10	Accu-Chek Guide Care Kit
65702-0731-10	Accu-Chek Guide Me Care Kit

Preferred Test Strips	
NDC	Product
65702-0711-10	Accu-Chek Guide Test Strips (50 count)
65702-0712-10	Accu-Chek Guide Test Strips (100 count)

Billing Information	
Field	Value
BIN	610524
RxPCN	1016
Issuer	80840
Group	40026479
ID#	373824350

Please submit and bill Accu-Chek® test strips to Molina Healthcare using the preferred NDCs listed above.

***If you need assistance, please contact the Roche Pharmacy Helpline at 1-800-657-7613.**

For More Information

For additional information, please refer to the FDA safety alert regarding TRUE METRIX® Blood Glucose Monitoring Systems: <https://www.fda.gov/medical-devices/medical-device-recalls-and-early-alerts/blood-glucose-monitor-recall-trividia-health-issues-correction-true-metrix-blood-glucose-monitoring>



Reminders

Looking for More Provider Updates?

Review the 2nd Quarter Provider
Newsletter at

<https://www.molinahealthcare.com/providers/ny/medicaid/comm/bulletin.aspx>

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

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/medical/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	• Remittance Viewer Training
Eligibility & Benefits	• Eligibility and Benefits Inquiry Training
Training Resources	• Availity Provider Help Center

Keep in Mind: You must be logged in to their Availity Essentials account to access training materials, tools, and resources available through the Availity Provider Help Center.

Frequently Used Links

- [2026 Provider Quick Reference Guide](#)
- **Molina Provider Website:**
 - [Molina Healthcare.com](https://MolinaHealthcare.com)
 - [Molina Provider Communications](#)
 - [Updates and Bulletins](#)
 - [Provider Newsletters](#)
 - [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
- **General Inquiries - Provider Services:**
 - MHNYProviderServices@MolinaHealthCare.com