# August 2026 Provider Bulletin

## New Provider Network Management Portal Coming Soon: ProviderTrak!

### Programs Impacted:

MNY Medicaid and HARP
MNY Child Health Plus
MNY Essential Plan, SWHNY Medicaid Advantage Plus (MAP), SWHNY Managed Long Term Care (MLTC), SWHNY Medicare

### Summary:

Molina Healthcare of New York, Inc. and Senior Whole Health of New York, Inc is pleased to share a brand-new tool that will be available to providers as of **September 21, 2026: ProviderTrak!**

**ProviderTrak** is designed to make it easier for providers to submit and track network participation, onboarding, and initial credentialing requests in one secure location. At launch, self-service features will allow network providers and their delegates to complete many provider applications and credentialing activities electronically.

### Learn More:

For more details, join us at our next You Matter to Molina informational sessions. Click on the links below to register:

- **Thursday, August 27, 9-10:30 am**
- **Thursday, September 3, 9-10:30 am**
- **Wednesday, September 9, 12:30 - 2pm**
- **Wednesday, September 16, 12:30 - 2 pm**

## In this issue you can expect:


ProviderTrak

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Long-Term Nursing Facility Authorization Reviews

Children's HCBS Reminder

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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

**(Effective October 14, 2026)**

## 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.

(Continued on next page)

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

## 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.

## 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.

# Prior Authorization

*Updates and Automation*

## Availity Auto Authorization

Starting August 5, 2026, providers using the Availity Essentials Provider Portal will be able to receive faster, automated decisions for select behavioral health CPT codes 90867, 90868 and 90869.

This enhancement supports a smoother, faster and more consistent prior authorization process.

## 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 with these changes and will remain available online for your reference. If you have questions, contact the **Utilization Management team** at **1-877-872-4716**.

## Long-Term Nursing Facility Authorization Reviews

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.

## Children's HCBS Reminder

To support timely authorizations and continuity of care, providers are reminded that Children's Home and Community Based Services (HCBS) must be requested and authorized in accordance with New York State Department of Health (DOH) HCBS Service Definitions and Medical Necessity Criteria.

As part of the utilization review process, the Managed Care Plan evaluates the amount, duration, and scope of requested HCBS to ensure services are medically necessary, appropriate to the child's strengths and needs, and consistent with the Child and Family-Centered Plan of Care.

Please note that service limits represent standard utilization guidelines. Requests that approach or exceed these guidelines should include supporting clinical documentation demonstrating the child's individualized needs and the medical necessity for the requested level of service. Providing complete documentation at the time of request helps facilitate timely review and determination.

This reminder supports adherence to New York State HCBS requirements and promotes access to medically necessary services for enrolled children and families.

## 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

## 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.

## 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/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 | • **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
  - 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