Medicaid FFS coverage and policy questions should be directed to the Office of Health Insurance Programs (OHIP) Division of Program Development. MMC reimbursement, billing, and/or documentation requirement questions should be directed to the enrollee's MMC Plan. MMC general coverage questions should be directed to the OHIP Division of Health Plan Contracting and Oversight (DHPCO) by email at: providerenrollment@health.ny.gov or by telephone at (518) 473-1134.

Please note:

- Providers should always ask a Medicaid member if they have other third-party coverage to ensure the member's bill will be reimbursed properly.
- MMC Plans will provide coders with the corresponding CPT/HCPCS codes for each Medicaid NIPS test.
- Effective September 1, 2022, Out-of-Network and Non-Enrolled Providers are not allowed to bill Medicaid directly without first receiving denials for items. The exception to this policy is for items that are statutorily exempt from prior authorization. Medicaid will provide the appropriate codes to allow correct calculation of Medicaid reimbursement amounts. The Explanation of Benefits (EOB), along with other documentation supporting Medicare coverage, will be provided to allow proper coordination of benefits.

- Providers must contact their MMC Plan to determine if a test is covered under a specific agreement between the MMC Plan and a product manufacturer.
- The FDA recommends that pregnant women be administered a quantitative test for G6PD deficiency. Instead, the law, pursuant to New York Social Services Law §365-a(4)(f), directs providers to exhaust applicable coverage before seeking reimbursement from Medicaid. Independent of this policy, providers are required to ask Medicaid enrollees about other third-party coverage.
- Genetic counseling must also be provided to those who test positive for a fetal chromosomal abnormality.
- The interpretation of results with non-invasive prenatal screening tests is outside the scope of this policy, per their communication, "[t]he FDA recommends that..."

- The commissioner directed providers to exhaust applicable coverage before seeking reimbursement from Medicaid. Independent of this policy, providers are required to ask Medicaid enrollees about other third-party coverage.
- Genetic counseling must also be provided to those who test positive for a fetal chromosomal abnormality.
- The interpretation of results with non-invasive prenatal screening tests is outside the scope of this policy, per their communication, "[t]he FDA recommends that..."

- For additional information, providers and families may visit the NYS Department of Health (DOH) Wadsworth Center web page, titled "Newborn Screening" or go directly to the Clinical Criteria Worksheet.

- Ambulette Providers (Category of Service 0602) Performing Covered Services: Ambulette providers, including those billing through an MMC Plan, must be performing services in vehicles inspected semi-annually by the DOT and by drivers certified under Article 19A of Vehicle and Traffic Law. Ambulette providers are also required to be certified in accordance with Article 19-A of the New York State Motor Vehicle Law. Ambulette Providers (Category of Service 0602) must be listed in the Provider Directory to allow correct calculation of reimbursement amounts. The Corresponding Resource Code (CRC) and Financial Action Code (FAC) can be found on the eMedNY "Provider Directory" web page.

- The Ambulette Service Codes are: J7326 Hyaluronan or derivative, SynviscOne®, for intra-articular injection, per dose
- J7327 Hyaluronan or derivative, Monovisc, for intra-articular injection, per dose
- J7321 Hyaluronan or derivative, Hyalgan, Supartz, or Visco-3 for intra-articular injection, per dose
- J7328 Hyaluronan or derivative, GelSyn-3, for intra-articular injection, 0.1 mg

- For a number of services, including: change of address, updating an enrollment file due to an ownership change, enrolling another NPI, or any other service requiring an enrollment update, the MMC Program recommends that providers contact the Medicaid Member Services (MMS) Call Center at (518) 473-1134.

- Providers must review all insurance coverage information, including eligibility verification, benefits summary, and any applicable prior authorization requirements, before billing the NYS Medicaid program. Providers should always ask a Medicaid member if they have other third-party coverage to ensure the member's bill will be reimbursed properly.

- Effective September 1, 2022, Out-of-Network and Non-Enrolled Providers are not allowed to bill Medicaid directly without first receiving denials for items that are statutorily exempt from prior authorization. Medicaid will provide the appropriate codes to allow correct calculation of Medicaid reimbursement amounts. The Explanation of Benefits (EOB), along with other documentation supporting Medicare coverage, will be provided to allow proper coordination of benefits.

- For current information on best practices in pharmacotherapy, please visit the following websites:
  - Medicaid Prescriber Education Program:
  - Medicaid Pharmacy Policy Unit:
  - NYS Department of Health (DOH) Wadsworth Center web page, titled "Newborn Screening"