

<b>Subject:</b>	Non-Covered Codes – Medicaid Managed Care and Child Health Plus		
<b>Policy Number:</b>	PO-RE-156v1		
<b>Effective Date:</b>	02/01/2026	<b>Last Approval Date:</b>	10/20/2025

## I. Policy Description

This policy outlines the reimbursement guidelines for non-covered CPT® and HCPCS codes billed to Healthfirst for Medicaid Managed Care and Child Health Plus. The intent is to align with New York State Medicaid coding requirements and ensure consistency in claims adjudication and provider reimbursement practices.

Except as otherwise provided below, non-covered codes are defined as the absence of inclusion in the New York State Medicaid fee schedules and therefore not eligible for reimbursement by Healthfirst. Providers are expected to adhere to applicable coding guidelines and utilize appropriately covered procedure codes in accordance with current Medicaid billing standards.

The information below applies to the following lines of business:

- Child Health Plus (CHP)
- Medicaid Managed Care (MMC)
- Personal Wellness Plan (HARP)

### Reimbursement Guidelines

#### 1. Denial of Non-Covered Codes

- For MMC and HARP, Healthfirst will deny claims submitted with CPT® and HCPCS codes that are not included in the current New York State Medicaid fee schedules.
- For CHP services that are included in the Medicaid Managed Care benefit, Healthfirst will deny claims submitted with CPT® and HCPCS codes that are not included in the current New York State Medicaid fee schedules.
  - Instances where the CHP program covers services that are not included in the Medicaid Managed Care benefit, Healthfirst will continue to pay for these specific services as required by State defined CHP benefit requirements. Providers must verify members' specific coverage via the Healthfirst Provider Portal and review the following CHP resources:
    1. [Child Health Plus Information | NY State of Health](#)
    2. [NY Child Health Plus | Healthfirst](#)
    3. [Healthfirst-CHP Health Plan Documents](#)

- Non-covered codes are not eligible for separate reimbursement.
2. Definition of Non-Covered Codes
    - Non-covered codes are those CPT® or HCPCS codes not listed on the New York State Medicaid fee schedules. These codes are not recognized for separate payment.
      - For CHP, codes not listed in New York State Medicaid fee schedules may still be eligible for reimbursement if they are included in the CHP benefit package.
  3. Reference for Covered Codes
    - Providers must consult the official New York State Medicaid website for a list of codes that are covered:
      - [eMedNY](#)
      - [New York State Office of Mental Health](#)
      - [NYS Reimbursement Rate Reform](#)
    - For CHP, there are codes covered within the Managed Medicaid Care benefits that are not covered by the CHP program and therefore are not covered by Healthfirst. Please consult the CHP benefit site ([Healthfirst-CHP Health Plan Documents](#)) for more information.
    - It is the provider's responsibility to verify code coverage status prior to billing. For detailed verification of coverage, providers should consult: Member eligibility and benefit information via the Healthfirst Provider Portal
2. Correct Coding Requirement
    - Non-covered services should not be billed using ineligible codes.
    - Providers must:
      - Use a more appropriate, covered code, or
      - Bundle the service into a related, covered procedure code when applicable.
    - Unbundling of services that should be reported together under a single code is not permitted and may result in denial or recoupment.
  3. Provider Compliance
    - Claims submitted with non-covered codes may result in:
      - Claim denial
      - Rejection for resubmission with a valid code
      - No reimbursement to the provider
    - Repeated billing of non-covered codes may be subject to review under Healthfirst's provider compliance protocols.

## **Adjudication and Appeal Process**

1. Claims submitted by providers that do not adhere to this policy will be denied or rejected. It is the responsibility of the provider to ensure claims are coded accurately.
2. If the line of business (LOB) is not mentioned in this policy, the services are not covered and not eligible for reimbursement.

3. This policy is a provider resource for understanding Healthfirst’s reimbursement guidelines. It does not guarantee coverage or payment. Final reimbursement decisions depend on benefit coverage, state/federal mandates, medical necessity, and provider contract.
4. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17.6, “Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process” in this section.*

*For any questions or further clarification regarding this policy, providers are encouraged to reach out to their designated contact within our organization*

## II. Applicable Codes

Code	Description	Comment

## III. Definitions

Term	Meaning

## IV. Related Policies

Policy Number	Policy Description
N/A	N/A

Current Procedural Terminology © American Medical Association. All rights reserved.

*Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.*

## V. Reference Materials

<a href="https://www.emedny.org">https://www.emedny.org</a>
<a href="#">New York State Office of Mental Health</a>
<a href="#">NYS Reimbursement Rate Reform</a>
<a href="#">Child Health Plus Information   NY State of Health</a>
<a href="#">NY Child Health Plus   Healthfirst</a>
<a href="#">Healthfirst-CHP Health Plan Documents</a>

## VI. Revision History

Revision Date	Summary of Changes

### Disclaimer

Healthfirst’s claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst’s coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor’s revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for the services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider’s participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.