New York State Department of Health
Medicaid Update
SPECIAL EDITION

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A Comprehensive Guidance Regarding Use of Telehealth including Telephonic Services After the Coronavirus Disease 2019 Public Health Emergency

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Comprehensive Guidance Regarding Use of Telehealth including Telephonic Services After the Coronavirus Disease 2019 Public Health Emergency

Updates are highlighted in yellow

This guidance is intended to clarify the New York State (NYS) Medicaid program's telehealth policies, including use of audio-only technology, following the federally declared Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE), which ends on May 11, 2023. Telehealth is a tool that can be used to supplement shifted traditional in person care in the delivery system, where possible. Although some barriers still exist and not all services are appropriate for remote delivery, telehealth has been largely beneficial in many service areas. Telehealth has proven to be a convenient and accessible access to specialists, reduced travel and transportation issues, and dependent care challenges. In recognition of the changing landscape of healthcare delivery and in preparation for the COVID-19 PHE unwind, the NYS Medicaid program has received recommendations from providers and NYS Medicaid Members on the experience with telehealth to inform our post PHE policy.

To support the use of telehealth services, the NYS Medicaid program has temporarily waived certain prior authorized audio-visual telehealth requirements, where appropriate, if such member chooses to receive telehealth services in lieu of an in-person visit. For those requirements that remain all elements of the billable procedure code or rate codes and all required documentation.

Audio-only services will also continue to be covered under audio-visual rates when audio-only is the choice of the member (choice audio-only services in lieu of audio-visual services). Providers will bill using the audio-only rate must consist of all elements of the billable procedure codes or rate codes and all required documentation. Telephonic (audio-only) services are a subset of the NYS Medicaid benefit and providers were used to the billing requirements.

This guidance does not change any other NYS Medicaid policy or billing requirements, such as those related to prior authorization, prior notification, or those requirements that expand authorization to bill NYS Medicaid beyond service providers who are licensed, certified, or approved bill Medicaid fee-for-service (FFS) or contracted managed care (MMC) providers.

I. General Information

Providers may use this guidance to prepare for upcoming policy changes tied to the end of the COVID-19 PHE as applies to state and federally-funded FFS in 2021 and 2022. This guidance supersedes guidance issued in June 2021. This guidance applies to all services (e.g., medical, behavioral, audiology, telehealth, remote patient monitoring (RPM), Store and Forward, virtual check-ins, virtual patient education, and eConsults) unless noted.

The information in this guidance applies to the following NYS Medicaid providers: Article 28 hospitals, Article 28 delivered via FFS or under contracted MMC Plans; Article 28 Ambulatory Surgery Centers; Skilled Nursing Facilities; including NYS DOH-licensed providers; Article 31 Clinics; Article 31 Federally Qualified Health Centers (FQHCs)-certified; and Article 31 Rural Health Clinic facilities;

- NYS Office of Mental Health (OMH)-licensed or designated providers and facilities; and Article 16 Clinics, Article 32 Certified Community Disabilities (OPWDD) Article 16 Clinic services (e.g., OT, PT, Speech, Psychology, etc.). This guidance does not include independent Medicaid providers for Individuals with Developmental Disabilities (IDD waiver).

Additional programmatic guidance may be published by NYS DOH that specifically allows or prohibits the use of telehealth by type of service.

II. Telehealth Definitions

"Telehealth" provider is defined in Public Health Law (PHL) § 2999-cc and per NYS regulation, 10 NYCRR Part 96. Per PHL § 2999-cc, Medicaid-enrolled providers, Article 28 Clinics, Article 31 Clinics, Rural Health Clinics, Federally Qualified Health Centers, Office of Mental Health (OCFS) and licensed pursuant to Article 29-i of PHL, as well as providers employed by those agencies. Providers licensed or certified by the Office of Mental Health, Licensed Independent Clinics and Behavioral Analysts (ABA) therapy.

- Providers licensed or certified by Article 131 of the Education Law and credentialed by the site from which the telehealth is provided.
- All NYS Medicaid providers and providers employed by NYS Medicaid facilities, or provider agencies who are authorized to provide telehealth services are required to meet the same standards of care regardless if such telehealth services are appropriate to meet the needs of the patient and are within the scope of practice of the provider.

IV. Confidentiality

Providers need to be aware of telehealth and be in compliance with HIPAA and all other relevant laws and regulations governing confidentiality, privacy and consent, including but not limited to 45 Code of Federal Regulations Parts 160 and 164 and 42 Code of Federal Regulations Part 2 and NYS Mental Hygiene Law Article 33 and 10 NYCRR Part 63 and NYS Public Health Law 2780 and 18 NYCRR 360-7.

Providers should monitor for guidance from the U.S. Department of Health and Human Services (HHS) related to HIPAA Enforcement Discretion. During the COVID-19 PHE, the Office for Civil Rights (OCR) at HHS has exercised its HIPAA enforcement discretion to waive certain HIPAA requirements in connection with the COVID-19 health emergency. OCR has issued guidance on how covered entities can exercise enforcement discretion and impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules when provided health care services in connection with the good faith provision of telehealth during the PHE.

V. Credentialing and Privileging

Registered Providers

NYS hospitals acting as originating sites are required to ensure that physicians who are providing consultations from a distant site are in the hospital's credentialing and privileging process. Telehealth providers are prohibited NYS DOH letter released September 27, 2006 and *Expanded Coverage of Telemedicine* article dated Fall 2006 from being credentialed and privileged by a hospital to provide services to patients at an originating site as a telehealth provider. Telehealth providers are required to be credentialed and privileged at all or part of the professional application and verification process (physician credentialing). This includes activities associated with the collection, verification, and review of the provider's qualifications to provide telehealth employment. A hospital originating site may therefore enter into a contract with the distant site to receive telehealth services provided by a credentialed and privileged provider. Hospitals may also rely on the credentialing and privileging process of other hospitals when contracting for telehealth services. However, the originating site and the distant consultations via telehealth. Such contracts must establish that the originating site hospital retains ultimate responsibility for the quality of care provided to its patients. Hospitals may also, in lieu of such a contract, their responsibility for peer review, quality assurance/quality improvement activities and credentialing activities. Hospitals may also rely on the credentialing and privileging process of other hospitals.

Certified Diabetes Educators/Certified Asthma Educators (Verification Requirements)

Certified Diabetes Educators (CDEs) and Certified Asthma Educators (CAEs) are required to be employed by a hospital, Diagnostic and Treatment Center, or Federally Qualified Health Center (FQHC) and are responsible for ensuring that the Certified Diabetes Educator (CDE)/Certified Asthma Educator (CAE) meets the requirements of the National Certification Board for Diabetes Educators (NCBDE) or the National Certification Board (NACB) or the Certification Board for Diabetes Educators (CBDE). NACB and CBDE educators are required to complete a minimum number of practice that is appropriate to their respective discipline, as defined by the NYSED Office of the Professions.

VI. Patient Rights and Consents

The practitioner shall confirm the identity of the NYS Medicaid member and provide the NYS Medicaid member with the name, address, and telephone number of the site at which the telehealth services will be provided. Prior to the provision of telehealth services, the NYS Medicaid member must provide informed consent to the distant site. Informed consent means that telehealth practitioners provide members with sufficient information and education about telehealth to assist them in making informed decisions about participating in care and treatment. This includes the following:

- The telehealth provider must confirm that the NYS Medicaid member is aware of the potential advantages and disadvantages of telehealth, be given the option of not participating in telehealth services, and be informed that there will be no loss of benefits or services if they do not consent to telehealth services or may withdraw their consent to receive telehealth services or services if they do not consent to telehealth devices or request to receive services in-person. Where the NYS Medicaid member is a minor, the consent must also be provided by the parent, legal guardian or person who has legal authority to consent to health care on behalf of the minor.

Informed consent shall be documented in writing or electronically before the telehealth service is provided. Providers and NYS Medicaid member. Although some providers may choose to document informed consent in the medical record of the member, it is not necessary to do so. Documents of informed consent processes should be specified in the policies and procedures of the provider.

VII. Billing Rules for Telehealth Services

A. Payment Parity with In-Person Services

Under NYS Law, Commonly Known as "Parity", HCPCS, healthcare services delivered by means of telehealth are entitled to reimbursement on the same basis, at the same rate, and to the same extent the equivalent healthcare service is reimbursed when delivered in person. Telehealth reimbursement shall be consistent with and not contrary to federal laws, regulations, and guidance. There is no prohibition against co-pays or other costs incurred in the provision of telehealth services because neither the originating nor the distant site occurring within the facility or in the home of the member. Telehealth services. This law is consistent with the Medicaid State Plan.

B. Modifiers to be Used When Billing for Telehealth, Store-and-Forward, and RPM

See "Table 1. Modifiers to be Used When Billing for Telehealth, Store-and-Forward, and RPM" provides modifiers to be used when billing.

C. POS Code to be Used when Billing for Telehealth, Store-and-Forward, and RPM Applicable When Billing Professional Claims)

See "Table 2. Telehealth Place of Service (POS) Codes" provides place of service codes.

D. Billing for Telephonic Services

Telephonic services are not telehealth, evaluations and telephonic services. For additional information, dental providers can refer to the Dental Fee Schedule, Dental Fee Schedule Addendum and Dental Billing Guidelines.

The types of telehealth (audio-visual) encounters are synchronous (real time) encounters and asynchronous (Store and Forward) encounters. Synchronous "**G0999**" encounters involve the transmission of recorded health information to a distant site to be viewed at a subsequent time without the patient present and in real time. Synchronous encounters occur between a patient or caregiver along with their dental provider and a specialist, such as an endodontist or oral surgeon. For example, a dentist may need to refer a patient to a specialist for a tooth extraction. The dental provider determines through radiographs and examination that the tooth in question requires extraction and sends the information to the specialist. The specialist then reviews the information and the patient receive the information at the time of the specialist's convenience. The specialist then calls the patient and provider along with the patient. This results in the patient scheduling an appointment for an extraction with the oral surgeon. Store-and-Forward services are used to support a physician consultation, or to allow providers to offer telehealth, and delaying in-person visit requirements prior to delivering mental health services via telehealth. When such telehealth Store-and-Forward services are provided, the provider must bill using the appropriate modifier. Additional information, providers can refer to the Congress Yields Committee Report Language Regarding Parity for Medicaid Services Under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the 2021 Medicaid Managed Care Model Contract, Section 4.0(b)(1)(xxxiii).

E. General Billing Guidelines for Dual Eligible Services

Pursuant to federal law, Medicare is the primary payer, except in the event, which means Medicaid will make payments only after all other sources of reimbursement have been exhausted. Therefore, potential third-party payments must be billed before billing NYS Medicaid. For Medicare Part B covered services, for additional information, providers can refer to the following NYS Medicaid billing guidance for other third party payers, including Medicare Part B crossover claims, Medicare deductibles and coinsurance:

- NYS Medicaid Crossover Claims Reimbursement Methodologies (Updated 2/2020)

For dually enrolled Medicare and NYS Medicaid members, if Medicare covers the telehealth encounter, NYS Medicaid will reimburse the Part B coinsurance and deductible to the extent permitted by NYS law. Medicaid does not cover the Part B telehealth deductible for services in 2021. For dually eligible members, providers should refer to the Medicare Part B Telehealth Services.

F. Telephonic (Audio-only) Reimbursement Overview

Following the COVID-19 PHE, the provision of audio-only telehealth is used in accordance with the policy outlined in "6. Telehealth Definitions", "IX. Telehealth Qualifications", providers may bill NYS Medicaid as they would for an in-person visit when the member is unable or choose not to use audio-visual telehealth. Services provided via audio-only visits shall contain all elements of the billable procedures or rate codes and all required documentation. Providers may use telehealth modifiers in the audio-only communications to deliver services to a patient at or originating site by a telehealth provider acting at a distant site. Telephonic (audio-only) services are a subset of the NYS Medicaid benefit. Providers were used to the billing requirements.

Distant telehealth services shall adhere to the standards of appropriate patient care with respect to distant patient care settings, including but not limited to, documentation of medical records, adherence to prescribing and dental history of the patient. For additional information, providers can refer to NYS Law Chapter 45 Article 29-b § 2999-cc.

G. General Billing Guidelines for Dual Eligible Services

Pursuant to federal law, Medicare is the primary payer, except in the event, which means Medicaid will make payments only after all other sources of reimbursement have been exhausted. Therefore, potential third-party payments must be billed before billing NYS Medicaid. For Medicare Part B covered services, for additional information, providers can refer to the following NYS Medicaid billing guidance for other third party payers, including Medicare Part B crossover claims, Medicare deductibles and coinsurance:

- NYS Medicaid Crossover Claims Reimbursement Methodologies (Updated 2/2020)

For dually enrolled Medicare and NYS Medicaid members, if Medicare covers the telehealth encounter, NYS Medicaid will reimburse the Part B coinsurance and deductible to the extent permitted by NYS law. Medicaid does not cover the Part B telehealth deductible for services in 2021. For dually eligible members, providers should refer to the Medicare Part B Telehealth Services.

The Performance Enhancement Reform Act, or ordinate budget for federal fiscal year (FY) 2023, included several provisions that extend telehealth flexibilities for federal programs through December 31, 2024. Several provisions in the bill include the ability for federally qualified health centers and rural health clinics to furnish telehealth services, improving telehealth for Medicare beneficiaries with end stage renal disease, allowing providers to offer telehealth, and delaying in-person visit requirements prior to delivering mental health services via telehealth. When such telehealth Store-and-Forward services are provided, the provider must bill using the appropriate modifier. Additional information, providers can refer to the Congress Yields Committee Report Language Regarding Parity for Medicaid Services Under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the 2021 Medicaid Managed Care Model Contract, Section 4.0(b)(1)(xxxiii).

H. RPM

1. Telehealth services provided by means of RPM should be billed using CPT code "**99091**" (collection and interpretation of physiologic data (e.g., Electrocardiography (ECG), blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the home care agency, home care or home care professional, qualified by education, training and transmission/gateway (when applicable) requiring a minimum of 30 minutes of clinical staff time per month.
2. Providers are not to bill "**99091**" more than once per member per month.
3. Medicaid RPM services are limited to:
   - In an effort to reduce inpatient and other medically avoidable emergency or ambulatory care, providers may provide RPM services to Medicaid members who are discharged from inpatient and postoperative NYS Medicaid members using CPT Codes and Medicaid Fee-for-Service Medicaid Administrative Rates and in the *New York State Medicaid Expansion of Remote Patient Monitoring for Maternal Care* article published in the September 2020 issue of the Medicaid Update.
   - **Please note: "99091" and "99454"** are both intended to be billed monthly. Providers may bill "99091" and "99454" in the same month. For more information on RPM, please refer to the September 2020 issue of the Medicaid Update that covered "CPT Code **"99454"** is billed along with CPT Codes "99091".
   - FQHCs that have opted out of Ambulatory Patient Groups (APGs) are unable to bill for RPM services at this time.

I. After Hours

An action payment is available for visits that occur on evenings, weekends, and holidays. An evening visit is one that is scheduled for and occurs after 6 p.m. A weekend visit is one that is scheduled for and occurs on Saturday or Sunday. A holiday visit is one that is scheduled for and occurs on a holiday. Although When the after hours visit is completed via telehealth, the appropriate modifier from the table below must be used. Providers should use the following CPT codes from the "Table 1. Telehealth Codes" as appropriate:

These CPT codes are popular if they are the only CPT procedure(s) listed on the claim. Providers should use the appropriate place of service (POS) code to indicate the place where the telehealth service is rendered. Services with CPT codes "99441" or "G2010" are reimbursed on a monthly basis. Providers should not be reported on the claim with the appropriate telehealth modifier (**95**, **96**, **97**, and **GQ**). Commercial insurance may require the use of modifier **95** for telehealth payment.

J. Virtual Check-In

A virtual check-in is defined as patient-initiated and allow patients to communicate with their provider in order to avoid an unnecessary office visit. Telehealth providers may need to inform and counsel beneficiaries on the availability of the service prior to patient initiation. A parent or caregiver may initiate a virtual check-in on behalf of a patient. The patient must consent to receive virtual check services and must provide or confirm verbally the consent of the patient in their chart at least once annually while the patient receives virtual check-in services. Providers may bill for a virtual check-in if the patient has not been seen in the provider's office within the preceding 24 hours, or if the patient is being seen in the provider's office on the same day, if the patient is being seen for a different medical condition, or service last messaging. Communication must be HIPAA-compliant and must originate from a member's home or other location and may be used by a related E&M visit within 24 hours.

Expanding on previous policy, NYS Medicaid-enrolled providers (physician or other qualified health care practitioner) may bill virtual check-in services using the CPT codes "**G2012**" or "**G2010**" for remote patient to provider check-ins. The virtual check-in must be reported on the claim with the appropriate telehealth modifier (**95**, **96**, **97**, and **GQ**). Commercial insurance may require the use of modifier **95** for telehealth payment.

Additional operational guidance may be available for specific populations. NYS OPWDD, OASAS, and OMH providers should review their respective guidance to ensure compliance.

K. Virtual Patient Education

Virtual patient education means education and training for patient self-management by a qualified health care professional to patients, their families, caregivers, and is reimbursable only for services that are otherwise reimbursable when delivered in person and meet the requirements of telehealth reimbursement.

Synchronous audio-visual telehealth may meet the definitions bound under CPT codes "**99490**" through "**99487**, specifically "**99484**" and "**99487**" for complex care management services. Providers should report on the claim with the appropriate telehealth **95** or **GT** modifier (see "Table 4. Virtual Patient Education").

Additional agency-issued guidance may be available for specific populations. NYS OPWDD, OASAS, and OMH providers should review their respective guidance to ensure compliance.

L. Virtual e-Visits

Virtual e-Visits occurring in place (as telehealth in response to 911 calls is allowable under the CMS E/M Guidelines. Providers may use the following CPT codes: Providers can refer to the *CMS Evaluation and Management Guidance*, *Telehealth Services*, *Telehealth Parity Bulletin* and *Telehealth Parity Bulletin* published in the September 2020 issue of the Medicaid Update.

M. FFS Billing for Telehealth by Site and Location

Telehealth services are provided at the distant site located at an originating site, the servicing provider should bill for the telemedicine encounter as if the provider saw the member **in-person** using the appropriate billing rules for services rendered. The CPT or HCPCS code should be reported with the appropriate place of service (POS) and the appropriate modifier (see "VII. Billing Rules for Telehealth Services"). "B. Modifiers to be Used When Billing for Telehealth, Store-and-Forward, and RPM" provides modifiers to be used when billing. Telehealth services are permissible. Providers should refer to agency-specific guidance to determine if telehealth services are permissible.

To view "Table 5. Telehealth Place of Service (POS) Codes" provides place of service codes.

N. Hospital Inpatient Billing for Audio-Visual Telehealth

When a telehealth consult is provided by a distant site telehealth physician to a NYS Medicaid member who is an inpatient in the hospital, payment for the telehealth encounter may be billed by the distant-site telehealth provider. The distant site provider bills the appropriate professional telehealth CPT code on the claim with the appropriate telehealth **95** or **GT** modifier (see "Table 4. Virtual Patient Education").

Additional agency-issued guidance may be available for specific populations. NYS OPWDD, OASAS, and OMH providers should review their respective guidance to ensure compliance.

O. Virtual Check-In

Providers may use the following place of telehealth encounters in 911 calls is allowable under the CMS E/M Guidelines. Providers may use the following CPT codes: Providers can refer to the *CMS Evaluation and Emergency Triage, Treat, and Transport Model (ETTM) Guidance* and *Telehealth Parity Bulletin* published in the September 2020 issue of the Medicaid Update.

P. MMC Considerations:

1. MMC Plans are required to cover, at a minimum, services that are covered by NYS Medicaid FFS and provided via telehealth, store-and-forward, and remote patient monitoring (RPM) to the extent such coverage is described in this guidance. **To allow DOH to adequately track telehealth services, MMC Plans must ensure claims** allow the use of the telehealth modifiers established in this guidance, and may establish additional requirements for providers to submit claims for telehealth services. Additionally, MMC Plans must adhere to the payment parity requirements outlined in "VII. Billing Rules for Telehealth Services" of this guidance when reimbursing for services.
2. MMC Plans are required to reimburse providers for services provided via telephonic services (audio-only) and must cover appropriate telehealth/telephonic services provided by providers within their networks. Cautious regard for reimbursement methodologies should be considered in the development of the Plan of the provider.

VIII. Options to Support NYS Medicaid Members with Limited or Lack of Access to Devices and Services

To view "X. Useful Links", providers should refer to this month's issue.

IX. Useful Links

To view "X. Useful Links", providers should refer to this month's issue.

X. Questions

- Medicaid FFS telehealth/telephonic/telehealth coverage and policy questions may be directed to the Office of Health Insurance Programs (OHIP) Bureau of Program Development and Management (DPDM) by telephone at (518) 473-2160 or by email at Telehealth.Policy@health.ny.gov.
- Questions regarding MMC telehealth coverage and reimbursement should be directed to the MMC Plan of the enrollee.
- Questions regarding FFS claiming should be directed to the eMedNY Call Center at (800) 343-9000.

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