

Medicaid Update

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Comprehensive Guidance Regarding Use of Telehealth including Telephonic Services During the COVID-19 State of Emergency

The intent of this guidance is to provide broad expansion for the ability of all Medicaid providers in all situations to use a wide variety of communication methods to deliver services remotely during the COVID-19 State of Emergency, to the extent it is appropriate for the care of the member.

Telehealth services will be reimbursed at parity with existing off-site visit payments (clinics) or face-to-face visits (i.e., 100% of Medicaid payment rates). This guidance relaxes rules on the types of clinicians, facilities, and services eligible for billing under telehealth rules.

This guidance additionally addresses some technological barriers to telehealth by allowing clinicians and health care organizations to bill for telephonic services if they cannot provide the audiovisual technology traditionally referred to as “telemedicine.”

This guidance replaces previously issued guidance regarding telehealth and telephonic communication services during the COVID-19 State of Emergency (Medicaid Update March 2020 Vol 36, Numbers 3 and 4).

This guidance does not change any other Medicaid program requirements with respect to authorized services or provider enrollment and does not expand authorization to bill Medicaid beyond service providers who are currently enrolled to bill Medicaid Fee for Service (FFS) or contracted with a Medicaid Managed Care Plan.

I. General Information

Effective for dates of service on or after March 1, 2020, for the duration of the State Disaster Emergency declared under Executive Order 202, herein referred to as the “State of Emergency”, New York State Medicaid will reimburse telephonic assessment, monitoring, and evaluation and management services provided to members in cases where face-to-face visits may not be recommended and it is appropriate for the member to be evaluated and managed by telephone. This guidance is to support the policy that members should be treated through telehealth provided by all Medicaid qualified practitioners and service providers, including telephonically, wherever possible to avoid member congregation with potentially sick patients. Telephonic communication will be covered when provided by any qualified practitioner or service provider. All telephonic encounters documented as appropriate by the provider would be considered medically necessary for payment purposes in Medicaid FFS or Medicaid Managed Care. All other requirements in delivery of these services otherwise apply.

The following information applies to all Medicaid providers and providers contracted to serve Medicaid members under Medicaid managed care plans. However, the Office of Mental Health (OMH), the Office for People with Developmental Disabilities (OPWDD), and the Office of Addiction Services and Supports (OASAS) have issued separate guidance on telehealth and regulations that will align with state law and Medicaid payment policy for Medicaid members being served under their authority. Links are provided at the end of this document.

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II. Telephonic Reimbursement Overview

Payment for telephonic encounters for health care and health care support services will be supported in six different payment pathways utilizing the usual provider billing structure. See the table below for the billing pathways available for telephonic encounters during the COVID-19 State of Emergency by both FFS and Managed Care*: **Chart Changes in Bold 3/23/20**

Billing Lane	Telephonic Service	Applicable Providers	Fee or Rate	Historical Setting	Rate Code or Procedure	Notes:
Lane 1	Evaluation and Management Services	Physicians, NPs, PAs, Midwives, Dentists, RNs	Fee Schedule	Office	CPT Procedure Codes “99211”, “99441”, “99442”, and “99443” “D9991” - Dentists	New or established patients. Append GQ modifier for 99211 only
Lane 2	Assessment and Patient Management	All other practitioners billing fee schedule (e.g., Psychologist)	Fee Schedule	Office	Any existing Procedure Codes for services appropriate to be delivered by telephone. Append modifier GQ for tracking purposes.	Billable by Medicaid enrolled providers. New or established patients.
Lane 3	Offsite Evaluation and Management Services (non-FQHC)	Physicians, NPs, PAs, Midwives	Rate	Clinic or Other (e.g., amb surg, day program)	Rate Code “7961” for non-SBHC Rate Code “7962” for SBHC	New or established patients.
Lane 4	Offsite Evaluation and Management Services (FQHC)	Physicians, NPs, PAs, Midwives	Rate	Clinic	Rate Code “4012” for non-SBHC Rate Code “4015” for SBHC	New or established patients.
Lane 5	Assessment and Patient Management	Other practitioners (e.g., Social Workers, dietitians, home care aides, RNs, therapists and other home care workers)	Rate	Clinic or other Includes FQHCs, Day Programs and Home Care Providers	Non-SBHC: - Rate Code “7963” (for telephone 5 – 10 minutes) - Rate Code “7964” (for telephonic 11 – 20 minutes) - Rate Code “7965” (for telephonic 21 – 30 minutes) SBHC: - Rate code “7966” (for telephone 5 – 10 minutes) - Rate code “7967” (for telephonic 11 – 20 minutes) - Rate code “7968” (for telephonic 21 – 30 minutes)	Broadly billable by a wide range of provider types including FQHCs, Day Programs and Home Care (e.g., aide supervision, aid orientation, medication adherence, patient check-ins). However, see LHCSA/CHHA assessments and RN visits which get billed under existing rates in Lane 6). New or established patients. Report NPI of supervising physician as Attending.
Lane 6	Other Services (not eligible to bill one of the above categories)	All provider types (e.g., Home Care , ADHC programs, health home, HCBS , peers)	Rate	All other as appropriate	All appropriate rate codes as long as appropriate to delivery by telephone	Covers all Medicaid services not covered above. Includes LHCSA and CHHA assessments, evaluations and RN visits.

*Managed care plans may have separate detailed billing guidance but will cover all services appropriate to deliver through telehealth/telephonic means to properly care for the member during the State of Emergency. Further detail on FFS code coverage is provided below including links to specialized guidance for mental health, substance abuse and OPWDD services.

Telephonic Payment Chart Explained

The chart has two basic sections. Lanes 1-2 are for use by fee schedule billers (primarily practitioners in office-based settings) and lanes 3-6 are for all other billers that primarily bill rates for clinic and other services. Practitioners that usually bill the fee schedule directly should bill for telephonic services using lane 1 and 2 based on practitioner types noted. Clinics should bill using lanes 3, 4 and 5 depending on FQHC status and practitioner type. Lane 5 is for clinics and other programs to use for the noted practitioners and should be used for any and all patient assessment and management services that are appropriate to be billed telephonically unless otherwise noted. Lane 6 is reserved for all other services that do not fit into the first 5 lanes. More guidance will be issued on lane 6 adding to the noted services but it is expected that over 90 percent of all Medicaid telephonic billing should fall into lanes 1-5.

III. Telehealth

A. Definition of Telehealth

Telehealth is defined as the use of electronic information and communication technologies to deliver health care to patients at a distance. Medicaid covered services provided via telehealth include assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a Medicaid member. For purposes of the State of Emergency, this definition is expanded to include telephone conversations.

B. Originating Site

The **originating site** is where the member is located at the time health care services are delivered to him/her by means of telehealth. Originating sites during the State of Emergency can be anywhere the member is located. There are no limits on originating sites during the State of Emergency.

C. Distant Site

The **distant site** is any location including the provider's home that is within the fifty United States or United States' territories. The distant is the site where the telehealth provider is located while delivering health care services by means of telehealth. During the State of Emergency all sites are eligible to be distant sites for delivery and payment purposes including Federally Qualified Health Centers for all patients including patients dually eligible for Medicaid and Medicare. This includes clinic providers working from their homes or any other location during the State of Emergency.

D. Telehealth Applications (Telemedicine, Store-and-Forward, Remote Patient Monitoring)

NYS Medicaid has covered both remote patient monitoring provided by Certified Home Health Agencies (CHHAs) for their patients and telemedicine for a number of years. NYS Medicaid has recently expanded coverage of telehealth to include store-and-forward technology, additional originating sites and additional practitioners. During the State of Emergency, all telehealth

applications will be covered at all originating and distant sites as appropriate to properly care for the patient.

E. Telemedicine

Telemedicine uses two-way electronic audio-visual communications to deliver clinical health care services to a patient at an originating site by a telehealth provider located at a distant site.

F. Store-and-Forward Technology

Store-and-forward technology involves the asynchronous, electronic transmission of a member's health information in the form of patient-specific pre-recorded videos and/or digital images from a provider at an originating site to a telehealth provider at a distant site.

1. Store-and-forward technology aids in diagnoses when live video or face-to-face contact is not readily available or not necessary or in the case of the State of Emergency is imprudent.
2. Pre-recorded videos and/or static digital images (e.g., pictures), excluding radiology, must be specific to the member's condition as well as be adequate for rendering or confirming a diagnosis or a plan of treatment.

G. Remote Patient Monitoring during the State of Emergency

Remote patient monitoring (RPM) uses digital technologies to collect medical data and other personal health information from members in one location and electronically transmit that information to health care providers in a different location for assessment and recommendations. Monitoring programs can collect a wide range of health data from the point of care, such as vital signs, blood pressure, heart rate, weight, blood sugar, blood oxygen levels and electrocardiogram readings. RPM may include follow-up on previously transmitted data conducted through communication technologies or by telephone.

Medical conditions that may be treated/monitored by means of RPM include, but are not limited to, congestive heart failure, diabetes, chronic obstructive pulmonary disease, wound care, polypharmacy, mental or behavioral problems, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding.

IV. Telehealth Providers

During the State of Emergency, all Medicaid provider types are eligible to provide telehealth but services should be appropriate for telehealth and should be within the provider's scope of practice.

V. Confidentiality

Services provided by means of telehealth must be in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and all other relevant laws and regulations governing confidentiality, privacy, and consent (including, but not limited to 45 CFR Parts 160 and 164 [HIPAA Security Rules]; 42 CFR, Part 2; PHL Article 27-F; and MHL Section 33.13).

However, during the COVID-19 nationwide public health emergency, the Department of Health and Human Services Office for Civil Rights (OCR) has issued a Notification of Enforcement Discretion for telehealth remote communications. OCR will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the emergency. <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html>

All providers must take steps to reasonably ensure privacy during all patient-practitioner interactions.

VI. Patient Rights and Consents

The practitioner shall confirm the member's identity and provide the member with basic information about the services that he/she will be receiving via telehealth/telephone. Written consent by the member is not required. Telehealth/telephonic sessions/services shall not be recorded without the member's consent.

VII. Billing Rules for Telehealth Services

Modifiers to be Used When Billing for Telehealth Services

Modifier	Description	Note/Example
"95"	Synchronous telemedicine service rendered via real-time interactive audio and video telecommunication system	Note: Modifier "95" may only be appended to the specific services covered by Medicaid and listed in Appendix P of the AMA's CPT Professional Edition 2018 Codebook. The CPT codes listed in Appendix P are for services that are typically performed face-to-face but may be rendered via a real-time (synchronous) interactive audio-visual telecommunication system.
"GT"	Via interactive audio and video telecommunication systems	Note: Modifier "GT" is only for use with those services provided via synchronous telemedicine for which modifier 95 cannot be used.
"GQ"	Via asynchronous telecommunications system	Note: Modifier "GQ" is for use with Store-and-Forward technology
"25"	Significant, separately identifiable evaluation & management (E&M) service by the same physician or other qualified health care professional on the same day as a procedure or other service	Example: The member has a psychiatric consultation via telemedicine on the same day as a primary care E&M service at the originating site. The E&M service should be appended with the "25" modifier.

Place of Service (POS) Code to be Used when Billing for Telehealth Services

POS Code	Description
"02"	The location where health services and health-related services are provided or received, through telehealth telecommunication technology. When billing telehealth services, providers must bill with place of service code "02" and continue to bill modifier "95", "GT" or "GQ".

A. Billing for Teledentistry Services

When billing for teledentistry services, modifiers cannot be used by dentists. Additional guidance was issued in the January 2020 Medicaid update (see link below) which allows for two dental codes "D9995" and "D9996" to be used in place of modifiers. Both dental codes "D9995" and "D9996" along with "Q3014" were added to the dental fee schedule.

https://www.health.ny.gov/health_care/medicaid/program/update/2020/2020-01.htm

B. General Billing Guidelines

For individuals with Medicare and Medicaid, if Medicare covers the telehealth encounter, Medicaid will reimburse the Part B coinsurance and deductible to the extent permitted by state law.

C. Fee-for-Service Billing for Telemedicine by Site and Location (not telephonic)

When services are provided via telemedicine to a member located at an originating site, the servicing provider should bill for the telemedicine encounter as if the provider saw the member face-to-face using the appropriate billing rules for services rendered. The CPT code for the encounter must be appended with the applicable modifier ("95" or "GT").

Article 28 Clinic Originating Sites Billing Under Ambulatory Patient Groups (APGs) for Telemedicine (not telephonic)

1. Institutional Component (Originating Site)

1. When services are provided via telemedicine to a member located at an Article 28 originating site (outpatient department/clinic, emergency room), the originating site may bill only CPT code "Q3014" (telehealth originating-site facility fee) through APGs to recoup administrative expenses associated with the telemedicine encounter.
2. When a separate and distinct medical service, unrelated to the telemedicine encounter, is provided by a qualified practitioner at the originating site, the originating site may bill for the medical service provided in addition to "Q3014". The CPT code billed for the separate and distinct service must be appended with the "25" modifier.

2. Practitioner (Professional) Component (Originating Site)

1. When the originating site is an Article 28 hospital (outpatient department/clinic, emergency room) **or Article 28 D&TC** and a physician is onsite assisting or

attending to the member during a telemedicine encounter, a physician claim cannot be billed to Medicaid.

2. When a separate and distinct medical service, unrelated to the reason for the telemedicine encounter, is provided by a physician at the originating site **including Article 28 hospitals or D&TCs**, the physician, **nurse practitioner, physician assistant, or midwife** may bill for the medical service provided. The CPT code billed for the separate and distinct service must be appended with the “25” modifier.

Article 28 Distant Sites Billing Under APGs for Telemedicine (not telephonic)

1. Institutional Component (Distant Site)

1. When the distant-site practitioner is physically located at the Article 28 distant site, the distant site may bill Medicaid under APGs for the telemedicine encounter using the appropriate CPT code for the service provided. The CPT code must be appended with the applicable modifier (“95” or “GT”).

2. Practitioner (Professional) Component (Distant Site)

1. When the distant site is an Article 28 hospital outpatient department/clinic **or an Article 28 Freestanding clinic or the practitioners home** and telemedicine services are being provided by a **physician, nurse practitioner, physician assistant or midwife**, the **practitioner** should bill Medicaid using the appropriate CPT code appended with the applicable modifier (“95”).

Office Setting or Other Secure Location – Billing by Originating and/or Distant-Site Practitioner for Telemedicine (not telephonic)

1. Practitioner (Professional) Component (Originating Site)

1. When a telemedicine service is being provided by a distant-site practitioner to a member located in a private practitioner's office (originating site), the originating-site practitioner may bill CPT code “Q3014” to recoup administrative expenses associated with the telemedicine encounter.
2. When a telemedicine service is being provided by a distant-site practitioner to a member located in a private practitioner's office (originating site) and the originating-site practitioner provides a separate and distinct medical service unrelated to the telemedicine encounter, the originating-site practitioner may bill for the medical service provided in addition to “Q3014”. The CPT code billed for the separate and distinct medical service must be appended with the “25” modifier.

2. Practitioner (Professional) Component (Distant Site):

1. If the distant-site practitioner is providing services via telemedicine from his/her private office or other secure location **including the practitioner's home**, the practitioner should bill the appropriate CPT code for the service provided. The CPT code should be appended with the applicable modifier (“95” or “GT”).

Hospital Inpatient Billing for Telemedicine (not telephonic)

When a telemedicine consult is being provided by a distant-site physician to a member who is an inpatient in the hospital, payment for the telemedicine encounter may be billed by the distant-site physician. Other than physician services, all other practitioner services are included in the All Patient Revised - Diagnosis Related Group (APR-DRG) payment to the facility.

Skilled Nursing Facility Billing for Telemedicine (not telephonic)

When the telehealth practitioner's services are included in the nursing home's rate, the telehealth practitioner must bill the nursing home. If the telehealth practitioner's services are not included in the nursing home's rate, the telehealth practitioner should bill Medicaid as if he/she saw the member face-to-face. The CPT code billed should be appended with the applicable modifier (“95” or “GT”). Practitioners providing services via telehealth should confirm with the nursing facility whether their services are in the nursing home rate.

Federally Qualified Health Centers (FQHCs) Billing for Telemedicine (not telephonic)

1. **FQHCs That Have "Opted Into" APGs:** FQHCs that have "opted into" APGs should follow the billing guidance outlined above for sites billing under APGs.
2. **FQHCs That Have Not "Opted Into" APGs - FQHC Originating Sites:**
 1. When services are provided via telemedicine to a patient located at an FQHC originating site, the originating site may bill only the FQHC offsite services rate code (“4012”) to recoup administrative expenses associated with the telemedicine encounter.
 2. When a separate and distinct medical service, unrelated to the telemedicine encounter, is provided by a qualified practitioner at the FQHC originating site, the originating site may bill the Prospective Payment System (PPS) rate in addition to the FQHC offsite services rate code (“4012”).
 3. If a provider who is onsite at an FQHC is providing services via telemedicine to a member who is in their place of residence or other temporary location, the FQHC should bill the FQHC off-site services rate code (“4012”) and report the applicable modifier (“95” or “GT”) on the procedure code line.
 4. If the FQHC is providing services as a distant-site provider, the FQHC may bill their PPS rate.

D. Application-Specific Telehealth Billing Rules

Telephonic

See preceding guidance.

Store-and-Forward Technology

1. Reimbursement will be made to the consulting distant-site practitioner.

2. Reimbursement for consultations provided via store-and-forward technology will be paid at 75 percent of the Medicaid fee for the service provided.
3. The consulting distant-site practitioner must provide the requesting originating-site practitioner with a written report of the consultation in order for payment to be made.
4. The consulting practitioner should bill the CPT code for the professional service appended with the telehealth modifier **"GQ."**

Remote Patient Monitoring (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 physician or other qualified health care professional, qualified by education, training and licensure/regulation (when applicable) requiring a minimum of 30 minutes of time).
2. A fee of \$48.00 per month will be paid for RPM.
3. Providers are not to bill **"99091"** more than one time per member per month.

E. Medicaid Managed Care Considerations

1. Medicaid Managed Care (MMC) plans are required to cover, at a minimum, services that are covered by Medicaid fee-for-service and also included in the MMC benefit package, when determined medically necessary. Managed care plans should follow FFS telehealth billing policy included in this guidance.
2. Questions regarding MMC reimbursement and/or documentation requirements should be directed to the member's MMC plan.

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

The following is a listing of helpful resources compiled for emergency assistance:

- **Free Wifi/internet**
 - Charter Communications (Spectrum) and Comcast are giving households with K-12 and college students, and those who qualify as low-income complimentary Wifi for 60 days
 - Families who do not have the service will also receive free installation of the service
 - Both companies are expanding Wifi hotspots to the public within the company's available regions
 - Call **(844) 488-8395** (Charter) or **(855) 846-8376** (Comcast) to enroll
 - Individuals must call company after 60 days, or they will be automatically billed

- **Unlimited data**
 - Charter, Comcast, AT&T, and Verizon are offering unlimited data plans to customers until May 13 for no additional charge
- **Safelink Wireless**
 - Eligibility requirements must be met, which are set by each State where the service is provided
 - To qualify for Lifeline, subscribers must either have an income that is at or below 135% of the federal Poverty Guidelines, or participate in one of the following assistance programs:
 - Medicaid
 - Supplemental Nutrition Assistance Program (SNAP) Food Stamps
 - Supplemental Security Income (SSI)
 - Federal Public Housing Assistance (Section 8)
 - Veterans and Survivors Pension Benefit
 - Service is limited to one person per household
 - Call **1-800-SafeLink (723-3546)** for enrollment and plan changes support
 - Subscribers can use their own phones:
 - SafeLink Keep Your Own Smartphone plan requires a compatible or unlocked Smartphone. Most GSM Smartphones are compatible.
 - Subscribers can get up to 350 minutes and 3GB of data, which includes voice minutes and unlimited texts, voicemail, nationwide coverage and 4G LTE on 4G LTE compatible devices

IX. Useful Links:

- Department of Health COVID-19 Guidance for Medicaid Providers
https://health.ny.gov/health_care/medicaid/covid19/index.htm
- Department of Health COVID-19 Guidance for Providers:
<https://coronavirus.health.ny.gov/information-providers>
- CMS Telehealth Toolkit for General Practitioners:
<https://www.cms.gov/files/document/general-telemedicine-toolkit.pdf>
- CMS Guidance re Medicaid State Plan Fee-for-Service Payments for Services Delivered Via Telehealth
<https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-telehealth-services.pdf>
- General CMS Medicaid.gov Telemedicine Guidance:
<https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html>

- HHS Office for Civil Rights Guidance Regarding HIPAA and Telehealth:
<https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html>
- Medicare Guidance
Medicare Telemedicine Fact Sheet: <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet>
- Health Homes:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/covid19_guidance_health_homes.pdf
- Children's HCBS Providers:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/docs/covid19_guidance_health_homes.pdf
- Children and Family Treatment and Support Services' (CFTSS) Providers:
https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/covid19_cftss_guidance.pdf
- Homeless Shelters and Supportive Housing:
https://coronavirus.health.ny.gov/system/files/documents/2020/03/guidance_homeless_shelters_supportive_housing.pdf
- Home Care:
https://coronavirus.health.ny.gov/system/files/documents/2020/03/03-16-20_home_care_services.pdf
- Adult Care Facilities:
https://coronavirus.health.ny.gov/system/files/documents/2020/03/adult_care_guidance.pdf
- NYS Office of Mental Health (OMH):
<https://omh.ny.gov/omhweb/guidance>
- NYS Office of Addiction Services and Supports (OASAS):
https://oasas.ny.gov/system/files/documents/2020/03/telepractice_waiver-update.pdf
- The Office for People With Developmental Disabilities (OPWDD):
https://opwdd.ny.gov/news_and_publications/coronavirus-guidance-opwdd-service-providers

X. Questions:

- **Medicaid FFS telehealth/telephonic coverage and policy questions may be directed to the Office of Health Insurance Programs (OHIP) Division of Program**

**Development and Management at (518) 473–2160 or
Telehealth.Policy@health.ny.gov.**

- Medicaid FFS coverage and policy questions may be directed to the Office of Health Insurance Programs (OHIP) Division of Program Development and Management at (518) 473–2160 or FFSMedicaidPolicy@health.ny.gov.
- Questions regarding MMC reimbursement and/or documentation requirements should be directed to the enrollee's MMC plan.
- Questions regarding FFS claiming should be directed to the eMedNY Call Center at (800) 343–9000