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New York State Medicaid Expansion of Telehealth

OVERVIEW

The New York State (NYS) Department of Health (DOH) has released a special edition of the Medicaid Update to announce expanded coverage of telehealth services for DOH-regulated providers and practitioners. Coverage is being extended to include:

- Additional originating and distant sites;
- Additional telehealth applications (store-and-forward technology); and
- Additional practitioner types.

The update also provides billing rules and guidelines, including CPT codes and rates, for various situations and settings. These updates are effective January 1, 2019 for Medicaid fee-for-service (FFS) and March 1, 2019 for Medicaid Managed Care (MMC) plans.

This guidance applies to DOH-regulated providers. The Office of Mental Health (OMH), the Office for People with Developmental Disabilities (OPWDD), and the Office of Alcoholism and Substance Abuse Services (OASAS) have published, and are expected to publish further, separate guidance on telehealth regulations, including additional guidance on specialty consultations for individuals served by OMH, OPWDD, and OASAS. SPG expects further clarifications on how these rules will be aligned in interagency situations.

The Medicaid Update is available here. A summary of the update is provided below.

TELEHEALTH SITES

The originating site is where a member receiving services is located at the time of telehealth service delivery. Previously, originating sites could only be one of the following:

- Facilities licensed under Article 28 of the Public Health Law (PHL)
- Private physician or dentist's offices located within NYS;
- Federally qualified health centers (FQHCs); and
- Non-FQHC school-based health centers (SBHCs).

DOH has now expanded the range of permissible originating sites to include:

- Facilities licensed under Article 40 of the PHL (i.e., hospice programs);
- Clinics certified under Articles 16, 31, and 32 of the Mental Hygiene Law (MHL);
- Certified and non-certified day and residential programs funded or operated by OPWDD;
- Any type of adult care facility licensed under Title 2 of Article 7 of the SSL;
- Public, private, and charter elementary and secondary schools located within NYS;
- School-age child care programs located within NYS;
- Child daycare centers located within NYS; and
- The member's place of residence located within NYS or other temporary location within or outside of NYS.

The distant site is where the provider who is delivering a health care service by telehealth is physically located. Distant sites may include any secure location within the United States or its territories. The provider at the distant site must be capable of complying with the Health Insurance Portability and Accountability Act (HIPAA) and any other relevant privacy, confidentiality, and consent laws.

TELEHEALTH APPLICATIONS

Previously, NYS Medicaid has covered two telehealth applications:

- Telemedicine, which consists of two-way audio-visual communications to deliver clinical health care services from a distant site; and
- Remote patient monitoring (RPM) when provided by certified home health agencies (CHHAs), which consists of (a) the collection of medical data or other personal health information (PHI), (b) secure transmission of this data to a different location, and (c) assessment and follow-up.

DOH is now expanding the scope of RPM to include a wider array of providers and services, as well as adding coverage for store-and-forward technology.

Remote Patient Monitoring

RPM may be used to treat or monitor a variety of medical conditions, including, but 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, or enteral feeding.

RPM must be ordered and billed by a physician, nurse practitioner or midwife who has an ongoing relationship with the patient. It may also be provided and billed by an Article 28 clinic (when ordered by one of the above practitioners). Practitioners must provide follow-up care in person as needed. RPM must be medically necessary and shall be discontinued when the member's condition is determined to be stable or controlled.

When a patient receives RPM services, the provider at the distant site (i.e., receiving the patient's data) may bill using CPT code 99091. This code will pay a fee of $48 per month, and may only be billed one time per member month, on the last day of the month. To bill for RPM, the provider must spend a minimum of 30 minutes per month collecting and interpreting the member's RPM data.

FQHCs may not bill the PPS rate for RPM. FQHCs that have opted out of APGs are unable to bill for RPM services at this time.

CHHAs will continue to provide and bill for RPM pursuant to the existing demonstration program. Payments for RPM while a member is receiving home health services from a CHHA may only be made to that same CHHA.

Store-and-Forward

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

Store-and-forward technology may be used as a diagnostic aid when live video (i.e., telemedicine) or in-person contact is unavailable or unnecessary. The videos and pictures sent using store-and-forward technology, excluding radiology, must be specific to the member's condition and must be adequate for rendering or confirming a diagnosis or a plan of treatment.

When store-and-forward technology is used to service a patient, reimbursement will be made to the consulting (distant site) practitioner. The distant site practitioner will be paid 75 percent of the Medicaid fee that would have been paid if the consultation were face-to-face. To receive payment, the distant site practitioner distant-site practitioner must provide the requesting originating-site practitioner with a written report of the consultation.

TELEHEALTH PROVIDERS

Telehealth payment policies described in this update apply to DOH-regulated facilities and practitioners, including the following provider types:

- Physicians;
- Physician assistants;
- Dentists;
- Nurse practitioners;
- Registered professional nurses (for RPM only);
- Podiatrists;
- Optometrists;
- Psychologists;
- Social workers;
- Speech language pathologists;
- Audiologists;
- Midwives;
- Physical therapists;
- Occupational therapists;
- Certified diabetes educators;
- Certified asthma educators;
- Genetic counselors;
- Credentialed alcoholism and substance abuse counselors (CASACs);
- Service providers and coordinators in the Early Intervention (EI) Program[1];
- Licensed Article 28 hospitals, including residential health care facilities serving special needs populations;
- Licensed Article 36 home care services agencies; and
- Article 40 hospice programs.

Forthcoming regulations will address telehealth payment policy for the following provider types:

- Article 16 licensed or certified clinics;
- OPWDD certified and non-certified day and residential programs; and
- Any other provider as determined by DOH in consultation with OMH, OPWDD, and/or OASAS.

All practitioners providing services through telehealth must be licensed, registered in accordance with NYS Education Law or other applicable State law, and enrolled in NYS Medicaid. Reimbursement for services provided through telehealth will be made in accordance with existing Medicaid policy related to

[1] DOH intends to issue EI-specific guidance on telehealth in the near future.

supervision and billing rules and requirements. When services are provided by an Article 28 facility, the telehealth practitioner must be credentialed and privileged at both the originating and distant sites.

TELEHEALTH BILLING GUIDELINES

General Billing Guidelines

When the originating site and distant site are both part of the same billing entity, only the originating site should bill NYS Medicaid for a telehealth encounter. Only one payment will be made in such cases. If the originating site and distant site are not part of the same billing entity, both entities may be able to bill certain components, as detailed below.

For dual eligible individuals, if telehealth services are covered by Medicare, NYS Medicaid will reimburse the Part B coinsurance and deductible as usual. If the service is within Medicare's scope of benefits but Medicare does not cover the service when provided via telehealth, NYS Medicaid will currently not cover the encounter either.

Fee-for-Service (FFS) Billing for Telemedicine

In general, for Medicaid FFS members, the servicing (distant site) provider should bill as if the visit was performed face-to-face in their setting. The originating site provider may bill an originating site fee. If the originating site provider performs a separate service unrelated to the telemedicine encounter, it may typically bill that service as well. Other setting-specific billing rules will typically continue to apply (e.g., the professional component for all providers and settings, except physicians, are included in APG payments). For example:

- If an FQHC is serving as the originating site, it may bill the FQHC offsite services rate code as an originating site fee.
- If an originating site FQHC performs a separate and unrelated procedure during the visit, it may bill its PPS rate.
- If a provider onsite at an FQHC is providing a telemedicine consult to a patient's home or other temporary location, the FQHC may bill the FQHC offsite services rate code, with the appropriate modifier code.
- If an FQHC is serving as a distant site provider (i.e., when a separate provider initiates the service as the originating site), the FQHC may bill its PPS rate.

For members who are in a nursing home, practitioners should verify whether their services are included in the nursing home's rate. If so, they should bill the nursing home. If not, they may bill Medicaid as if the visit occurred face-to-face. Further detail on various settings is included in the update.

Medicaid Managed Care (MMC)

At minimum, MMC plans are required to cover any services that are covered by Medicaid FFS and also included in the MMC benefit package, when determined medically necessary. Questions regarding MMC reimbursement and/or billing requirements should be directed to individual MMC plans.

MMC plans are encouraged to work with providers to include telehealth services into value-based payment (VBP) contracts as a way to add flexibility in such arrangements.