Payor/Agency	Existing Telehealth Policy	COVID-19 New Services/Policies	Allowable Provider Location	Allowable Patient Location	Billing Information	Link to Guidance
Medicaid - DOH	NYS Medicaid currently covers telemedicine, which consists of two-way audio-visual communications to deliver clinical health care services from a distant site, remote patient monitoring, and store-and-forward technology. On 6/17/20, Governor Cuomo signed S.8416/A.10404A, which ensures audio-only and video-only telehealth and telemedicine services will be permanently eligible for reimbursement.	**NYS Medicaid will reimburse any covered service provided telephonically, as long as it is appropriate to be delivered by telephone.** Services may be provided to new or established patients. **Patient cost sharing is waived for all telehealth services.** All telehealth applications will be covered, including telephonic, telemedicine (including teledentistry), store-and-forward, and remote patient monitoring.	During the State of Emergency **all sites are eligible to be distant sites** for delivery and payment purposes. For Federally Qualified Health Centers, this includes all patients who are dually eligible for Medicaid and Medicare. Specifically, clinic providers may be working from their homes or any other location during the State of Emergency. DOH has now clarified that **Article 28 clinics may bill for telehealth (audio or video) services** when provided by **their employed practitioners who are at home.** Details about the types of staff who may bill for patient assessment and management were clarified in the FAQ.	During the State of Emergency, **there are no limits on originating sites.**	**For telephone services,** medical professionals should bill E&M codes: **99441** (5-10 mins), **99442** (11-20 mins), or **99443** (21-30 mins). RNs should use **99211** with GQ modifier. Other providers may use existing procedure code with GQ modifier. Clinics should use **7961.** FQHCs should use **4012.** FQHCs will now receive wrap payment. Non-fee schedule practitioners should use **7963** (5-10 mins), **7964** (11-20 mins), or **7965** (21-30 mins). Other providers not mentioned should use their existing rate codes for telephone services. **For telemedicine**, providers should bill FFS as if the service were delivered face-to-face, appending appropriate modifiers. Absent existing State-mandated rates or negotiated rates for such services, MMC plans must reimburse network providers at the same rate that would be reimbursed for providing the same service in-person.	DOH Guidance DOH FAQ DOH Coverage & Reimbursement
Medicaid - OASAS	Telepractice is a means of delivering services provided by an OASAS certified program subject to any other regulations applicable to the program's certified modality regarding evaluations, admissions, treatment/recovery plan development and review, discharge, etc. The program must have received an operating certificate "designation" from the OASAS to utilize this means of service delivery.	OASAS issued a waiver to allow current providers to more rapidly deliver services via telepractice (including telephonic) and **permits all providers to offer services via telepractice** for the duration of the COVID-19 emergency. Providers who do not already have approval for telepractice must self-attest that they will meet qualification standards, use a secure and credible technology system, maintain confidentiality, and use appropriate telehealth modifiers in billing, among other requirements. **Patient cost sharing is waived for all telehealth services.** Deliverable services include assessment, individual, group, medication management and collateral services.	OASAS has indicated that **it does not consider there to be restrictions on providers' physical locations**. Under current guidelines, services may be provided via telepractice by a practitioner from a site distant from the location of the patient, provided both practitioner and patient are in sites approved by OASAS. If the distant site is a hospital, the practitioner must be credentialed and privileged by such hospital.	As per current guidelines, the originating site may include OASAS licensed or designated provider locations or the recipient's place of residence.	There is no change in Medicaid reimbursement rates or methodology. Claim modifiers "95" or "GT" should be used for services delivered via telehealth and reimbursed by Medicaid.	OASAS Guidance OASAS Telepractice FAQs

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Payor/Agency	Existing Telehealth Policy	COVID-19 New Services/Policies	Allowable Provider Location	Allowable Patient Location	Billing Information	Link to Guidance
Medicaid - OPWDD	OPWDD recognizes all three applications of telehealth: telemedicine, store-and-forward technology, and remote patient monitoring. Health care services, which must include the assessment, diagnosis, consultation, treatment, education, care management, and/or self-management of a patient, may be provided via telehealth between qualifying providers. As such, clinic visits may be face-to-face or may be provided via telehealth for allowable services. IPSIDD services may not be delivered via telehealth.	OPWDD's interim guidance on the delivery of services via **telehealth "permits and encourages" all OPWDD programs to deliver services via telehealth "whenever possible."** This includes all nonresidential facilities and programs certified or operated by OPWDD. Health and habilitation services may be delivered via telehealth unless the service requires the physical presence of a staff member, such as residential habilitation and live-in caregivers. IPSIDD providers may deliver such services via telehealth and bill at the IPSIDD rate. Telephonic transmission is not permissible for respite services. Providers should document the reason for the encounter, name and credential of the provider, location of the provider, location of the patient, and other information. **Patient cost sharing is waived for all telehealth services.**	OPWDD guidance does not specifically waive current guidelines, but states that services are permitted for delivery by telehealth whenever "a provider exercising good clinical judgment determines a telehealth encounter is appropriate." Under current guidelines, Article 16 clinic services must only be delivered at sites that are specifically certified to provide those services.	OPWDD guidance does not specifically waive current guidelines, but states that services are permitted for delivery by telehealth whenever "a provider exercising good clinical judgment determines a telehealth encounter is appropriate." Under current guidelines, OPWDD permits certified clinic treatment facilities to serve individuals with I/DD and their collaterals when the individuals are in their residences or other temporary location via telehealth while the provider is located either at a main clinic site or at a certified satellite site.	Reimbursement will be made in accordance with existing Medicaid policy related to supervision and billing rules and requirements. Article 16 clinic providers should bill for the encounter using the appropriate billing rules for the services rendered and should include the telehealth modifier for the location code. Providers of HCBS waiver services should bill for the service as they normally do. **NEW 7/16:** OPWDD Day Service providers will no longer receive the retainer payment and may resume services in-person. Virtual care is still permitted under certain circumstances for Day Services.	OPWDD Guidance OPWDD Interim Billing Guidance for Day Services Providers **NEW 7/16** Interim Guidance on Reopening of Day Services
Medicaid - OMH	OMH allows for services to be provided via telemental health, which is the use of two-way real-time interactive audio and video equipment to provide and support mental health services at a distance.	**All Article 31 licensed programs may offer services via telehealth (including telephonic)** for the duration of the COVID-19 emergency. Providers, which may include paraprofessionals and unlicensed behavioral health staff, must self-attest that they will meet qualification standards, use a secure and credible technology system, maintain confidentiality, and use appropriate telehealth modifiers in billing, among other requirements. **Patient cost sharing is waived for all telehealth services.** This guidance applies to OMH designated, licensed, and funded services.	Any limitations and restrictions pertaining to the location of the telemental health practitioner while providing services via telemental health are waived.	As per current guidelines, the originating site may include OMH licensed or designated provider locations and the recipient's place of residence or another temporary location within or outside NYS. Limitations on the recipient's location (e.g., for PROS) are waived.	There is no change in Medicaid reimbursement rates or methodology. Claim modifiers "95" or "GT" should be used for services delivered via telehealth and reimbursed by Medicaid. For dual eligibles, Medicare-enrolled providers can crossover Medicare telehealth and telephonic claims to Medicaid using the Medicare-required codes. Providers not recognized by Medicare (LMSWs, LCATs, etc.) may bill Medicaid directly using the clinic APG codes with the telehealth modifier. OMH is allowing for temporary time reductions for certain clinic services (see clinic billing guidance)	**UPDATED 7/13** OMH COVID-19 FAQ on Telemental Health OMH Consolidated Guidance OMH Clinic Billing Guidance OMH Program Guidance

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Medicare	Current telehealth law only allows Medicare to pay practitioners for services like routine visits furnished through telehealth under certain circumstances. With a few exceptions, the beneficiary must generally be located in a rural area and in a medical facility. The beneficiary's home is generally not an eligible originating site.	Effective March 6th, **services delivered by telemedicine to a Medicare beneficiary are reimbursable regardless of geographic restrictions or originating site limitations**. This includes services delivered to beneficiaries in non-rural areas and/or located in their own homes. Providers may **choose to reduce or waive patient cost-sharing** for services delivered by telehealth. Patients no longer need to have a prior relationship with the telemedicine provider. CMS will now reimburse for many additional CPT codes by telehealth. Virtual check-ins and e-visits may be delivered to new patients. Virtual check-ins and remote patient monitoring may be offered by behavioral health and other therapists. Some services may be delivered by telephone (audio-only). CMS will now allow **anyone who is eligible to bill Medicare to bill by telehealth from a distant site**, including physical therapists, occupational therapists, and speech language pathologists.	Providers must be located in the United States. With the passage of the CARES Act, the restriction on FQHCs serving as the distant site for telehealth services has been removed. However, FQHCs will not receive the PPS rate; they will be paid at a rate comparable to the Medicare Physician Fee Schedule.	Under the waiver, **limitations on where Medicare patients are eligible for telehealth will be removed** during the emergency.	The telehealth visits are considered the same as in-person visits and will be paid at the same rate. Providers may also continue to provide the virtual check-in services and e-visits that they were previously able to offer. The claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site. Providers can provide **audio-only evaluation services** using CPT codes 99441-99443 (medical practitioners) and 98966-98968 (behavioral health therapists). CMS has **added new services that may be provided audio-only,** including psychotherapy (90832 & 90834), and has increased reimbursement for 99441-99443 to match in-person E/M services (CPT codes 99212-99214).	CMS Fact Sheet CMS FAQ CMS Info on New Rule and Waivers
Medicare Advantage	MA plans have the option to add telehealth services as part of their core benefits. It is not mandatory for MA plans to cover more services beyond what is required in original Medicare.	**MA plans have the option to increase access to telehealth** during the COVID-19 emergency. CMS will exercise its enforcement discretion regarding the administration of their benefit packages as approved by CMS until it is determined that the exercise of this discretion is no longer necessary in conjunction with the COVID-19 outbreak. **MA plans may choose to waive patient cost-sharing.**		MA plans may provide enrollees access to Medicare Part B services via telehealth in any geographic area and from a variety of places, including beneficiaries' homes.		CMS Guidance for MA Plans
Commercial	Federal regulation of commercial telehealth is limited. NYS has teleparity regulations, which require parity for telehealth coverage but not payment in the commercial market.	Individual commercial insurance plans are implementing different plans regarding telehealth during the COVID-19 emergency. Please see link for additional information on a selection of plans in NYS. **DFS is requiring regulated plans to eliminate cost-sharing for telehealth services.**				DFS Executive Order Health Insurance Provider Response to COVID-19

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