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

Presented by
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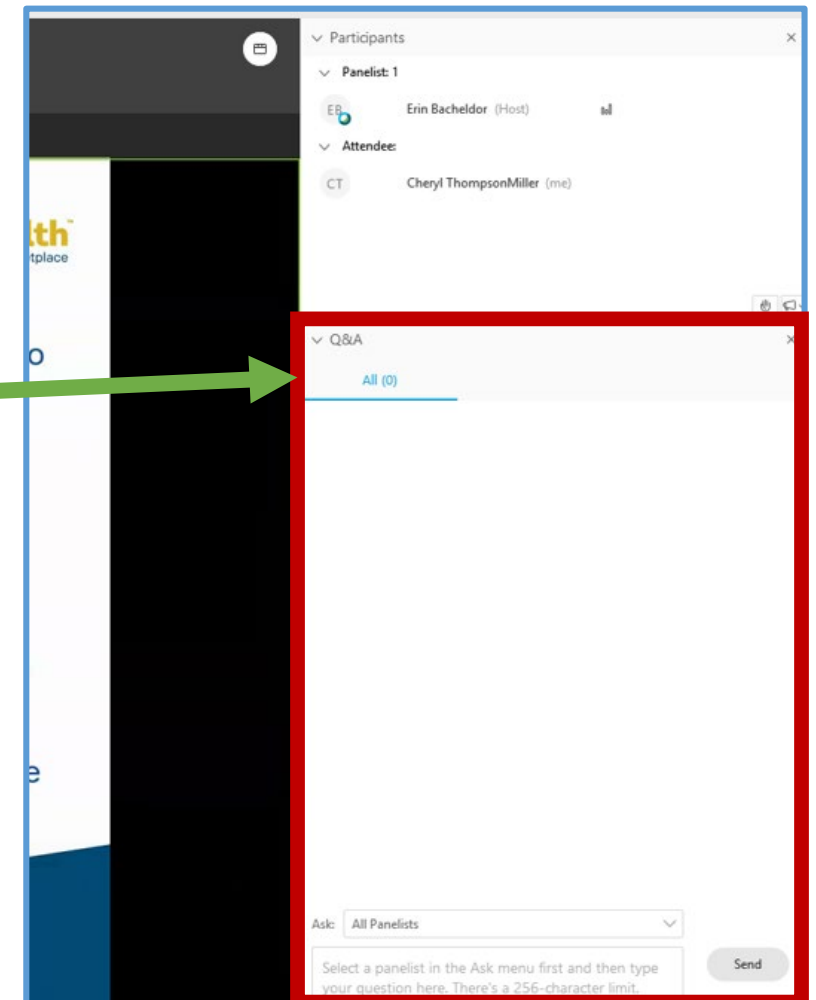
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Executive Order 202 – Disaster Emergency Declaration

- In response to the COVID-19 pandemic, Governor Cuomo has issued several Executive Orders to suspend or modify laws necessary to aid in coping with this emergency. www.governor.ny.gov/executiveorders

- The Emergency Medicaid Telehealth Guidance covered in this webinar is effective for dates of service on or after March 1, 2020 and shall remain in effect for the remainder of the disaster emergency declared by Executive Order No. 202, or until the issuance of subsequent guidance by the NYSDOH prior to the expiration of such state disaster emergency declaration.

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Overview

- New York State Medicaid will reimburse telephonic services provided to members in cases where face-to-face visits may not be recommended and it is appropriate for the member to receive the services by telephone.

- Applies to any qualified practitioner or service provider currently enrolled to serve Medicaid members.

- When providing services under this guidance, audio-visual services are always preferred.

- Telephonic services should be used only when audio-visual services are not possible.

- All other requirements in delivery of these services, unless specifically waived in applicable emergency policy statements, otherwise apply.

Overview

- Even prior to the COVID-19 public health emergency, the State enacted changes to the Public Health Law that significantly expanded telehealth services available under Medicaid, including Medicaid managed care.
  - expanding telehealth originating and distant sites (e.g., a member's residence recognized as a distant site)
  - permitting additional telehealth applications (store-and-forward technology, remote patient monitoring)
  - authorizing additional practitioner types (e.g., optometrists, dentists, certified diabetic and asthma educators)

Overview

- In order to ensure that the people who need services are able to get them, the Emergency Telehealth Guidance allows all providers to bill Medicaid for services that can be appropriately delivered remotely during the COVID-19 State of Emergency.
  - establishes payment pathways for all Medicaid providers, including those contracted with managed care plans, to bill for telephonic encounters
  - relaxes rules on distant and originating sites, and the types of clinicians, facilities, and services eligible for billing under telehealth rules.
  - allows for use of any non-public facing technology (e.g., Skype, FaceTime) with appropriate patient authorization.

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Privacy and Consents

- The Department of Health and Human Services (HHS) Office for Civil Rights (OCR) has issued a notice of enforcement discretion regarding telehealth:
  - Covered health care providers may communicate with patients, and provide telehealth services, through expanded remote communications technologies that may not fully comply with HIPAA requirements
  - Must be in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency.
  - https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html
- Providers regulated by OPWDD, OMH and OASAS should also refer to specific privacy and consent guidance from those state agencies.

Definitions

- **Originating Site** - Where the member is located at the time health care services are delivered to him/her by means of telehealth. During the State of Emergency, this can be anywhere the member is located **including the member's home.** There are no limits on originating sites during the State of Emergency.

- **Distant Site -** The distant site is the site where the telehealth provider is located while delivering health care services by means of telehealth. During the State of Emergency, any site within the fifty United States or United States' territories, is eligible to be a distant site for delivery and payment purposes, including Federally Qualified Health Centers and providers' homes, for all patients including patients dually eligible for Medicaid and Medicare.

Telehealth Definitions

- **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. Includes teledentistry.

  For Example, patient is assessed using FaceTime or Skype for a new medical condition, e.g., tendonitis, or monitored for an ongoing medical condition, e.g., hypertension.

- **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.

  For example, a primary care provider takes a digital photo of a skin lesion and forwards it to a dermatologist for assessment.

Telehealth Definitions

- **Remote Patient Monitoring -** 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 example, a patient with Type II diabetes has blood glucose levels monitored remotely by their primary care physician.

- **Telephonic -** use of two-way electronic audio-only communications over the telephone to deliver services to a patient at an originating site by a telehealth provider located at a distant site.

  For example, a patient has a 30 minute psychotherapy counseling session with their psychiatrist or psychologist.

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Medicaid Managed Care Plans (MMCP)

- MMCPs must follow FFS telehealth billing policy included in the March 2020 Medicaid Update Special Edition regarding Telehealth/Telephonic Services during the COVID-19 State of Emergency, and subsequent updates, but may follow separate reimbursement as highlighted on the next slide.

- MMCPs must cover telehealth/telephonic delivery of all Benefit Package services that are appropriate to deliver through telehealth/telephonic means to properly care for the member.

- MMCPs may not limit member access to telehealth/telephonic services to solely the MMCP's telehealth vendors, and must cover appropriate telehealth/telephonic services provided by other network providers.

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Medicaid Managed Care Reimbursement

- MMCPs may have separate detailed billing guidance from Medicaid FFS

- MMCPs must establish payment pathways for telephonic encounters, which may mirror the six payment pathways outlined in the Medicaid Update.

- MMCPs may use but are not required to use the telephonic encounter codes or payment pathways used by Medicaid FFS

- Absent negotiated rates for telehealth/telephonic services, the MMCP must reimburse network providers at the same rate that would be reimbursed for face-to-face encounters.

- Questions regarding MMC reimbursement and/or documentation requirements should be directed to the member's MMC plan.

Telephonic Reimbursement Overview

Billing Lane	Telephonic Service	Applicable Providers	Fee or Rate	Historical Setting	Rate Code or Procedure	POS Code	Modifier	Notes
Lane 1	Evaluation and Management Services	Physicians, NPs, PAs, Midwives, Dentists, RNs	Fee	**Practitioner's** Office	**Physicians, NPs, PAs, Midwives:** "99441", "99442", and "99443" **RNs on staff with a practitioner's office: "99211"** Dentists: "D9991"	POS should reflect the location where the service would have been provided face-to-face	**Append GQ modifier for "99211" only. Modifier GQ is for tracking purposes.**	New or established patients. **Only use "99211" for telephonic services delivered by an RN on staff with a practitioner and the practitioner bills Medicaid. Append the GQ modifier**
Lane 2	Assessment and Patient Management	All other practitioners billing fee schedule (e.g., Psychologist)	Fee	**Practitioner's** Office	Any existing Procedure Codes for services appropriate to be delivered by telephone.	POS should reflect the location where the service would have been provided face-to-face	**Append modifier GQ for tracking purposes.**	Billable by Medicaid enrolled providers. New or established patients.
Lane 3	Offsite E&M 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 **Report appropriate procedure code for service provided, e.g., "99201" – "99215".**	**POS N/A** **Service location zip code + 4 should reflect the location that describes where the service would have historically been provided face-to-face**	**Not required**	New or established patients. **All-inclusive payments. No professional claim is billed.**

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Billing Lane	Telephonic Service	Applicable Providers	Fee or Rate	Historical Setting	Rate Code or Procedure	POS Code	Modifier	Notes
Lane 4	**FQHC** Offsite **Licensed Practitioner** Services	Physicians, NPs, PAs, Midwives, **and Other Licensed Practitioners who have historically billed under these rate codes such as Social Workers and Psychologists.**	Rate	Clinic	Rate Code "4012" for non-SBHC Rate Code "4015" for SBHC **Report procedure code for service provided, e.g., "99201" – "99215".**	**POS N/A** **Service location zip code + 4 should reflect the location that describes where the service would have historically been provided face-to-face**	**Not required.**	New or established patients. **Wrap payments are available for these rate codes.**
Lane 5	Assessment and Patient Management	Other practitioners (e.g., Social Workers, Dieticians, **Dentists**, home care aides, RNs, therapists, and other home care workers)	Rate	Clinic or other Includes FQHCs **Non-Licensed Practitioners**, Day Programs, **ADHC programs,** and Home Care Providers **ADHC should bill if not meeting definition for Lane 6 comprehensive payment**	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)	**POS N/A.** **Service location zip code + 4 should reflect the location that describes where the service would have historically been provided face-to-face**	**Procedure code and modifier not required.** **However, correct procedure codes should be utilized in the claim, where applicable.**	**Billable by a wide range of providers including** 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, **School Supportive**, Hospice)	Rate	All other as appropriate	All appropriate rate codes as long as appropriate to delivery by telephone	**POS N/A.** **Service location zip code + 4 should reflect the location that describes where the service would have historically been provided face-to-face**	**Procedure Code and Modifier not required. However, correct procedure codes and the "GQ" modifier should be utilized in the claim, where applicable.**	Covers all Medicaid services not covered above. Includes LHCSA and CHHA assessments, evaluations and RN visits. **ADHC bills in Lane 6 if they meet minimum guidance standards.**

Telephonic Payment Pathways

The Payment Pathway chart has two basic sections.

- Lanes 1-2 are for use by fee schedule billers (primarily practitioners in office-based settings)
  - Practitioners that usually bill the fee schedule directly should bill for telephonic services using lane 1 and 2 based on practitioner types noted
- Lanes 3-6 are for all other billers that primarily bill rates for clinic and other services

Six Telephonic Payment Pathways

- 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:
  - Lane 1 – Practitioner's Office Evaluation and Management Services
  - Lane 2 – Practitioner's Office Assessment and Patient Management
  - Lane 3 – Non-FQHC Offsite Evaluation and Management Services
  - Lane 4 – FQHC Offsite Licensed Practitioner Services (Revised)
  - Lane 5 – All Clinic Assessment and Patient Management
  - Lane 6 – Other Services (not eligible to bill one of the above categories, or otherwise directed in guidance to bill this lane)

Telephonic Payment Pathways

- 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 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.

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Lane 1 – Evaluation and Management

- **Applicable Providers –** Physicians, NPs, PAs, Midwives, Dentists, RNs

- **Fee or Rate –** Fee Schedule

- **Historical Setting** – Office

- **CPT Codes – "**99211" for RNs; "99441", "99442", "99443 for Physician, NP, PA and Midwife Services; "D9991" for Dentists

- Available for new or established patients.

- Append "GQ" modifier for "99211" only

- POS should reflect the location where the service would have been provided face-to-face

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Lane 1 – Evaluation and Management Services – *Example 1*

Example 1: Patient has diabetes, notes elevated fingerstick glucose readings, and calls provider. Provider (**Phys, NPs, PAs**) is in their office or another location and able to speak to the patient over the telephone, reviews fingerstick readings and current medications, and adjusts insulin dosing (call is 11 to 20 minutes).

- **Place of Service** = Office (POS 11)
- **Bill CPT** = "99442"

Lane 1 – Evaluation and Management Services – *Example 2*

Example 2: Patient calls their provider complaining of COVID-19 like symptoms. **Registered Nurse** is in provider office or another location and able to speak to the patient over the telephone. Patient is screened for possible referral for COVID-19 lab test. RN refers patient for testing or provides follow-up guidance as appropriate.

- **Place of Service** = Office (POS 11)
- **CPT code** "99211", append with "GQ" modifier

Lane 1 – Evaluation and Management Services – *Example 3*

Example 3: Patient calls their **dentist** complaining of a toothache. Dentist is in their office or another location and able to speak to the patient over the telephone to address the toothache. Dentist sends in a prescription until patient can be seen in the office.

- **Place of Service** = Office (POS 11)
- **Bill CPT** = "D9991", no modifier

Lane 2 – Assessment and Patient Management

Applicable Providers – All other practitioners billing fee schedule (e.g., Psychologist)

Fee or Rate – Fee Schedule

Historical Setting – Office

Rate Code or Procedure – Any existing Procedure Codes for services appropriate to be delivered by telephone. Append modifier "GQ" for tracking purposes.

Billable for new or established patients

Lane 2 – Assessment and Patient Management – *Example*

Example: Patient calls their physical therapist to discuss pain management and whether exercise/therapy regime should be continued or modified. The physical therapist is able to counsel the patient over the phone for 15 minutes.

- Bill professional claim
- **Place of Service**= Office (POS 11)
- **CPT** = "97530", append "GQ" modifier

(GQ modifier is for tracking purposes only and does not affect reimbursement.)

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Lane 3 – Offsite Evaluation and Management Services (non-FQHC)

- **Applicable Providers –** Physicians, NPs, PAs, Midwives
- **Fee or Rate –** Rate
- **Historical Setting –** Clinic or Other (e.g., amb surg, day program)
- **Rate Codes**
  - Rate Code **"7961"** for non-SBHC
  - Rate Code **"7962"** for SBHC
- Report appropriate procedure codes for services provided
- For services provided to **New** or established patients

Lane 3 – Offsite Evaluation and Management Services (non-FQHC) – Example 1

Example 1: Practitioner at clinic, patient at home

Patient calls the clinic complaining of COVID
like symptoms. Practitioner (MD, NP, PA) is in the clinic (non-FQHC / non-SBHC) and able to speak to the patient over the telephone, screens patient initially for possible
referral for COVID-19 lab test. Provider refers patient for testing.

- **Bill Institutional Claim**
- **Rate Code "7961" for non-SBHC**
- **Place of Service** = N/A for Institutional Claims

Lane 3 – Offsite Evaluation and Management Services (non-FQHC) – Example 2

Example 2: Practitioner at home, patient at home

Patient calls the clinic complaining of muscle soreness after working in the garden over the weekend. Call is forwarded to a Practitioner (MD, NP, PA) who is currently home but is affiliated with the clinic (non-FQHC / SBHC) and able to speak to the patient over the telephone, assess symptoms, prescribe medication, and give follow-up instructions.

- **Bill Institutional Claim,**
- **Rate Code "7961" for Non-SBHC**
- **Place of Service** = N/A for Institutional Claims

Lane 4 – FQHC Offsite Licensed Practitioner Services

- **Applicable Providers** – Physicians, NPs, PAs, Midwives, and Other Licensed Practitioners who have historically billed under these rate codes (e.g., Social Workers and Psychologists)

- **Fee or Rate** – Rate

- **Historical Setting** – FQHC

- **Rate Code or Procedure – "**4012" (non-SBHC), "4015" (SBHC)

- Report appropriate procedure codes for services provided

- For services provided to **New** or established patients.

Lane 4 – FQHC Offsite Licensed Practitioner Services – *Example*

Physician, Nurse Practitioner, Physician Assistant

Patient recently had bloodwork done for chronic conditions. Practitioner is in the clinic (FQHC/non-SBHC) or another location and able to speak to the patient over the telephone, review their labs, make medication adjustments, and give follow-up instructions.

Institutional Claim, Rate Code "4012" for non-SBHC

Place of Service = N/A for Institutional Claims

Lane 4 – FQHC Offsite Licensed Practitioner Services – *Example*

Social Work or other Licensed Practitioner

Patient has a regular bi-weekly appointment with an LCSW. In lieu of the face-to-face appointment, the LCSW arranges for and conducts the appointment over the phone from the clinic (FQHC/non-SBHC) or another location and able to speak to the patient over the telephone. The call lasts 30 minutes.

- **Institutional Claim, Rate Code "4012" for non-SBHC**
- **Place of Service** = N/A for Institutional Claims

Lane 5 – Assessment and Patient Management

- **Applicable Providers** – Other practitioners (e.g., Social Workers, dieticians, home care aides, RNs, therapists and other home care workers). Non-Licensed FQHC Practitioners.

- **Fee or Rate** – Rate

- **Historical Setting** – Clinic or other

- Includes Non-Licensed FQHC practitioners, Day Programs and Home Care Providers

Lane 5 – Assessment and Patient Management Continued

- **Rate Codes**
  - **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)

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Lane 5 – Assessment and Patient Management Continued

- **Notes –** Broadly billable by a wide range of provider types including FQHCs (for Non-Licensed Practitioners), Day Programs and Home Care (e.g., aide supervision, aid orientation, medication adherence, patient check-ins).

- New or established patients.

- Report NPI of supervising physician as Attending.

Lane 5 – Assessment and Patient Management – *Example 1*

Non-FQHC SBHC LCSW

- Patient is referred to a Licensed Clinic Social Worker (LCSW) for brief counseling.
- LCSW is home, patient is home.
- The call lasts 25 minutes.
- Bill Institutional Claim, Rate Code "7968" for SBHC
- **Place of Service** = N/A for Institutional Claims

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Lane 5 – Assessment and Patient Management – *Example 2*

Dietician (Affiliated with an Article 28 FQHC or Non-FQHC)

- Diabetic patient is referred to a Dietician for a brief consultation.
- The call lasts 15 minutes.
- Dietician is home, patient is home.
- Bill Institutional Claim
- Rate Code "7967" for SBHC, "7964" for non-SBHC
- **Place of Service** = N/A for Institutional Claims

Lane 5 – Assessment and Patient Management – *Example 3*

Non-FQHC Clinic Dentist

- A patient calls their dentist about a toothache

- The call lasts 5-10 minutes

- The dentist is home, patient is home

- Bill institutional claim

- Rate code "7963" for non-SBHC, "7966" for SBHC

- **Place of Service** = N/A for Institutional Claims

Lane 6 – Other Services (not eligible to bill one of the above categories)

- **Applicable Providers** – All provider types not billing in previous 5 lanes (e.g., Home Care, ADHC programs, health home, HCBS, peers)

- **Historical Setting** – All other (i.e., not in lanes 1-5) as appropriate

- **Rate Code or Procedure –** All appropriate rate codes as long as appropriate to delivery by telephone

- **Notes –** Covers all Medicaid services not covered above. Includes LHCSA and CHHA assessments, evaluations and RN visits.

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Lane 6 – Other Services – Examples

Example 1: LHCSA/CHHA assessment by an RN at the agency conducted telephonically while member is at home would be billed by the agency under existing rate codes as if the assessment had been completed face-to-face.

Example 2: RN provides targeted case management service under the Nurse Family Partnership model to an enrolled member over the phone would bill Medicaid under rate code "5260", as if the service had been provided face-to-face.

Looking Ahead

- How will things evolve as distancing restrictions are lifted?
  - DOH will continue to monitor the lifting of restrictions and will, as applicable, update policy guidance accordingly.
  - DOH will consider adjustments to the policy to reflect the developing needs of each region of the state
  - Reminder – the telehealth policy states that telehealth/telephonic should only be used when clinically indicated for the treatment of the patient

State Agency Partner Guidance

- Please note that Other State Agencies have issued guidance on this topic, which can be found at the following links:
  - 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
  - NYS Office for Children and Family Services (OCFS): https://ocfs.ny.gov/main/news/COVID-19/
  - The Office for People With Developmental Disabilities (OPWDD): https://opwdd.ny.gov/news_and_publications/coronavirus-guidance-opwdd-service-providers

- Services delivered by agencies under the regulatory auspice of these agencies should follow their applicable guidance.

- Additional resource links are provided at the end of the webinar

Medicare Guidance

- CMS has previously and is continuing to expand allowable Telehealth benefits available to Medicare beneficiaries during the Emergency

- Updated Guidance Regarding
  - Provider Types
  - Originating Sites, Distant Sites
  - Telephonic Services

- Cross Over Billing Rules for Dual Eligible Medicaid Members are not impacted by this Emergency Telehealth Guidance

- For additional information visit https://www.cms.gov/newsroom

- Guidance is Frequently Updated

Useful Links – CMS Guidance

- March 17, 2020 – CMS Issues Medicare Telemedicine Face Sheet: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

- April 30, 2020: CMS Further Expands Telehealth in Medicare: https://www.cms.gov/newsroom/press-releases/trump-administration-issues-second-round-sweeping-changes-support-us-healthcare-system-during-covid

- CMS Provider-Specific Fact Sheets: https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers

Department of Health Guidance

- COVID-19 Guidance for Medicaid Providers
https://health.ny.gov/health_care/medicaid/covid19/index.htm

- COVID-19 Guidance for All Providers
https://coronavirus.health.ny.gov/information-providers

Q&A Panelists:

Jonathan Bick, Director, Division of Health Plan Contracting and Oversight, OHIP

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Questions? Contact:

- 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 via email at **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.

- Questions regarding OMH/OASAS/OPWDD specific policies or services should be directed to those Agencies for guidance.

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