Telehealth Policy Manual

New York State Medicaid Fee-for-Service
Provider Policy Manual
Version 2026-V1

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1 Links and Contacts

New York State (NYS) Department of Health's Office of Health Insurance Programs Bureau of Health Access, Policy, and Innovation

- 518-473-2160
- telehealth.policy@health.ny.gov
- For teledentistry inquiries: dentalpolicy@health.ny.gov

Other State Agency Contacts and Resources for Telehealth Guidance

Child Health Plus

- chplus@health.ny.gov
- Child Health Plus webpage

Office of Mental Health (OMH):

- telehealth@omh.ny.gov
- Telehealth Services Guide for OMH Providers

Office of Addiction Services and Supports (OASAS):

- PICM@oasas.ny.gov
- Telehealth Standards for OASAS Designated Providers

Office for People with Developmental Disabilities (OPWDD):

- OPWDD HCBS Telehealth Guidance
- Article 16 Clinic Guidance

Office of the Professions

- All Medicaid-enrolled providers must deliver care within their scope of practice for in-person and telehealth services. For details on licensing and scope of practice, please contact:
- https://www.op.nysed.gov/how-contact-us
- 518-474-3817

New York State Medicaid Updates
Medicaid Updates are published monthly. Updates to telehealth policy may be made periodically and posted on the Medicaid Update website.

eMedNY

- https://www.emedny.org
- (800) 343-9000
- eMedNY Contacts PDF

New York State Medicaid General Policy Manual – Information for All Providers
General Medicaid Policy information and billing guidance is available at:
https://www.emedny.org/ProviderManuals/AllProviders/index.aspx

New York Codes, Rules and Regulations, Title 18 (Social Services)
http://www.health.ny.gov/regulations/nycrr/title_18/

New York Codes, Rules and Regulations, Title 10 (Health)
http://www.health.ny.gov/regulations/nycrr/title_10/

Interactive Telehealth Trainings
Free educational videos developed by Care Compass.

- Telehealth NY
- Choose Your Journey
- Telehealth Talk Show

2 Document Control Properties

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3 Overview

The information in this guidance applies to services delivered via Fee-for-Service (FFS) or under contracted Medicaid Managed Care (MMC) Plans by:

- New York State (NYS) Medicaid-enrolled providers and facilities, including NYS Department of Health (Department) licensed providers;
- New York State Office of Addiction Services and Supports (OASAS)-certified or designated providers and facilities;
- New York State Office of Mental Health (OMH)-licensed or designated providers and facilities; and
- New York State Office for People with Developmental Disabilities (OPWDD) Article 16 Clinic services (e.g., occupational therapy, physical therapy, Speech, Psychology, etc.). This guidance does not include Independent Practitioner Services for Individuals with Developmental Disabilities (IPSIDD). This guidance also does not apply to services authorized pursuant to OPWDD's Section 1915(c) Comprehensive Home and Community-Based Services (HCBS) Waiver.

Please note: NYS OMH, OPWDD, and OASAS have issued, or may issue, separate guidance and/or regulations that may supersede or supplement the requirements for telehealth for NYS Medicaid members being served under the authority of those respective agencies and address

telehealth delivery for services certified by those agencies under the Mental Hygiene Law (MHL).

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

NYS Medicaid telehealth policy is distinct from Medicare telehealth policy. The Centers for Medicare & Medicaid Services (CMS) extended Medicare telehealth flexibilities until January 30, 2026, in accordance with the Continuing Appropriations Act, 2026. For benefits covered by Medicare, any telehealth restrictions set by Medicare apply to dually-enrolled members unless otherwise stated in policy, located on the CMS "List of Telehealth Services" webpage. More information can be found in the CMS Telehealth FAQ Calendar Year 2026 and HHS.gov Telehealth Policy Updates.

In accordance with The Americans with Disabilities Act (ADA), providers must provide communication aids for telehealth services. Providers may **not** charge the patient for communications aids. For more information, please visit the ADA telehealth webpage.

4 Definitions

4.1 Telehealth

Telehealth is defined as the use of electronic information and communication technologies to deliver health care to patients at a distance. NYS Medicaid covered services provided via telehealth include assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a NYS Medicaid member. Providers must meet all elements of the procedure code via telehealth and must adhere to the American Medical Association's guidelines for the procedure code to bill. This definition includes audio-only services when audio-visual is unavailable, or a member chooses audio-only.

4.2 Originating Site

The originating site is where the NYS Medicaid member is located at the time health care services are delivered to the individual by means of telehealth. On professional claims, place of service (POS) **"02"**, **"10"**, or **"11"** must be coded to document the location of the NYS Medicaid member during the telehealth visit. (See Section 9.3 for further guidance).

4.3 Distant Site

The distant site is the site where the telehealth provider is located while delivering health care services by means of telehealth. Any secure site within the fifty United States (U.S.) or U.S. territories, is eligible to be a distant site for delivery and payment purposes, including but not limited to, Federally Qualified Health Centers (FQHCs) and providers homes, for NYS Medicaid-enrolled patients. To receive reimbursement from NYS Medicaid, providers submitting telehealth claims or encounters must be NYS-licensed and enrolled in NYS Medicaid. The enrollment requirement is applicable only to enrollable provider types, including pharmacies and most licensed practitioners.

4.4 Telemedicine or Audio-Visual Telehealth

Telemedicine, or audio-visual telehealth, uses two-way synchronous 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.

4.5 Teledentistry

Teledentistry, an alternative method of delivering care, can provide a convenient and accessible platform for urgent dental problems, virtual consultations, monitoring of patients, and assistance in making referrals. By improving access to care using teledentistry, barriers to receiving care can be reduced and visits to urgent care facilities and emergency rooms for dental-related problems may be avoided. Teledentistry also makes in-office appointments more available for patients who need them.

See billing rules in Section 9.4 “Billing for Teledentistry Services.”

4.6 Store-and-Forward Technology

Store-and-forward technology involves the asynchronous, electronic transmission of health information of a NYS Medicaid member, 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. Store-and-forward technology aids in diagnoses when live video contact is not readily available or not necessary. Additionally, pre-recorded videos and/or static digital images (e.g., pictures) must be specific to the condition of the NYS Medicaid member, as well as be adequate for rendering or confirming a diagnosis or a plan of treatment.

See billing rules in Section 9.7 “Billing for Store-and-Forward Technology.”

4.7 Remote Patient Monitoring

Remote patient monitoring (RPM) uses digital technologies to collect medical data and other personal health information from the NYS Medicaid member 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 (COPD), wound care, polypharmacy, mental or behavioral problems, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition, or enteral feeding. RPM may be used during pregnancy and postpartum, as outlined in the September 2022 issue of the *Medicaid Update*.

See billing rules in Section 9.8 “Billing for Remote Patient Monitoring.”

4.8 Telephonic (Audio-only)

Telephonic service uses two-way electronic audio-only communications to deliver services to a patient at an originating site by a telehealth provider.

See billing rules in Section 9.6 “Billing for Telephonic (Audio-Only) Services”

4.9 Expanded 'After Hours' Access

An add-on payment is available for visits that occur on evenings, weekends, and holidays. An evening visit is one which 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 designated holiday. When the afterhours visit is completed via telehealth, the appropriate telehealth modifier must be used (see “Billing Rules for Telehealth Services” for specific guidance).

See billing rules in Section 9.9 “Billing for After Hours.”

4.10 Virtual Check-In

Virtual check-ins are brief medical interactions between a physician or other qualified health care professional and a patient. Virtual check-ins may be especially helpful for patients with ongoing chronic conditions that would benefit from recurring check-ins with their provider. A virtual check-in can be conducted via several technology-based modalities, including communication by telephone or by secure text-based messaging, such as electronic interactions via patient portal, secure email, or secure text messaging. Communication must be Health Insurance Portability and Accountability Act (HIPAA)-compliant and not relate to an Evaluation and Management (E&M) visit the patient had within the past seven days, nor lead to a related E&M visit within 24 hours (see “Billing Rules for Telehealth Services” for specific information on code and modifiers).

See billing rules in Section 9.10 “Billing for Virtual Check-In.”

4.11 eVisits

eVisits are patient-initiated communications with a medical provider through a text-based and HIPAA compliant digital platform, such as a patient portal. eVisits are a type of Virtual Check-In which occur through asynchronous communication; the exchange is neither real-time nor face-to-face. They are intended to remotely assess non-urgent conditions and prevent unnecessary in-person visits. Coverage of eVisits reimburses providers for the problem-focused communication and medical decision-making they do outside of an in person or other real time telehealth visits.

See billing rules in Section 9.11 “Billing for eVisits.”

4.12 Virtual Patient Education

Virtual patient education means education and training for patient self-management by a qualified health care professional via telehealth. Virtual patient education delivers health education to patients, their families, or caregivers, and is reimbursable only for services that are otherwise reimbursable when delivered in-person and when the provider meets certain billing requirements.

The National Diabetes Prevention Program (NDPP) is reimbursable when provided as a live/synchronous program (using code **"0403T"**) and is also reimbursable when provided as an on-demand/asynchronous program (using code **"0488T"**). NDPPs must first achieve recognition from the Centers for Disease Control and Prevention (CDC) based on its current NDPP Standards and Operating Procedures and adhere to previously published guidance.

NDPP may be delivered in any modality (in-person, online, distance learning, and combination) allowed under the Diabetes Prevention Recognition Program. The community-based organization (CBO) or individual practitioner rendering NDPP services to members must be enrolled in NYS Medicaid to be eligible to receive reimbursed.

See billing rules in Section 9.12 "Billing for Virtual Patient Education."

4.13 Virtual eTriage

Virtual eTriage is **not** covered by NYS Medicaid as of January 1, 2024. Virtual eTriage was previously covered under the CMS Emergency Triage, Treat, and Transport Model demonstration, as described in the November 2021 issue of the *Medicaid Update* authorized ambulance services responding to 911 calls to facilitate telehealth encounters where appropriate when providing "treatment in place". The visit was reported by both the ambulance service [as an Emergency Triage, Treat, and Transport (ET3) claim] and the telehealth provider (as a telehealth claim). Guidance will be published if eTriage becomes available for reimbursement in the future.

See billing rules in Section 9.13 "Billing for Virtual eTriage."

4.14 eConsults (Interprofessional Consultations)

eConsults, or interprofessional consultations between a treating/requesting provider and a consulting provider, are intended to improve access to specialty expertise by assisting the treating practitioner with the care of the patient without patient contact with the consulting practitioner.

See billing rules in Section 9.14 "Billing for eConsults (Interprofessional Consultations)."

4.15 Home Sleep Test

Home Sleep Tests (HST), also known as Unattended Sleep Studies or Home Sleep Apnea Tests (HSAT), are intended to help diagnose sleep disordered breathing conditions in the home setting when medically appropriate. A sleep technologist or qualified healthcare professional is not physically present with the patient during the recording session of an HST.

See billing rules in Section 9.15 "Billing for Home Sleep Tests."

5 Telehealth Providers

A "telehealth provider," as defined in Public Health Law (PHL) §2999-cc, may be a physician, physician assistant, dentist, nurse practitioner, registered professional nurse, podiatrist, optometrist, psychologist, social worker, speech language pathologist, physical therapist, occupational therapist, diabetes educator, asthma educator, genetic counselor, hospital, home cares services agency, hospice, alcoholism and substance abuse counselor, Early Intervention service coordinator, day and residential program, care manager, peer recovery advocate, mental health practitioner, or any other provider as determined by the Commissioner pursuant to regulation.

Per Title 18 of the New York Codes, Rules and Regulations (NYCRR) Part 538, additions to the "telehealth provider" definition include:

1. Voluntary foster care agencies certified by the NYS Office of Children and Family Services (OCFS) and licensed pursuant to Article 29-I of PHL, as well as providers employed by those agencies.
2. Providers licensed or certified by the New York State Education Department (NYSED) to provide Applied Behavioral Analysis (ABA) therapy.
3. Radiologists licensed pursuant to Article 131 of the Education Law and credentialed by the site from which the radiologist practices.
4. All NYS Medicaid providers and providers employed by NYS Medicaid facilities, or provider agencies who are authorized to provide in-person services, are authorized to provide such services via telehealth if such telehealth services are appropriate to meet the needs of the patient and are within the scope of practice of the provider.

Separate guidance and/or regulations may supersede or supplement these provider requirements.

5.1 Out of State Providers

Any secure site within the fifty United States (U.S.) or U.S. territories is eligible to be a distant site for delivery and payment purposes.

Providers located outside of New York State may provide telehealth services to New York Medicaid members if:

1. the services are allowable,
2. the provider is enrolled in New York State Medicaid, **and**
3. the provider possesses New York State licensure.

Out of state licensing is under the authority of The New York State Education Department, Office of the Professions.

Out of state providers should also consult the proper authorities in the state from which they are providing services for its requirements.

6 Confidentiality

Services provided by means of telehealth must 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 (CFR) Parts 160 and 164 [HIPAA Security Rules]; 42 CFR, Part 2; Public Health Law Article 27-F; and Mental Hygiene Law §33.13. All providers must take steps to reasonably ensure privacy during all patient-practitioner interactions.

The Notifications of Enforcement Discretion issued by the U.S. Department of Health and Human Services' Office for Civil Rights (OCR) expired with the end of the COVID-19 Public Health Emergency. OCR provided a 90-calendar day transition period for providers to comply with HIPAA rules in their provision of telehealth. The transition period expired on August 9, 2023. More information on HIPAA and telehealth can be found on the U.S. Department of Health and Human Services website.

7 Credentialing and Privileging

7.1 Physicians

NYS hospitals acting as originating sites are required to ensure that physicians who are providing consultations via telehealth at distant sites are appropriately credentialed and privileged. Pursuant to previously published letter released September 22, 2006 and *Expanded Coverage of Telemedicine* article published in the August 2011 issue of the *Medicaid Update*, a hospital facility, including one that is acting as a telehealth originating site, may enter into a contract with an outside entity to carry out all or part of the professional application and verification process (physician credentialing). This includes activities associated with the collection and verification of information specific to credentials and prior affiliations/employment. A hospital originating site may therefore enter into a contract with the distant site to receive and collect credentialing information, perform all required verification activities, and act on behalf of the originating site hospital for such credentialing purposes regarding those physicians who will be providing patient consultations via telehealth. Such contracts must establish that the originating site hospital retains ultimate responsibility for the physician credentialing. Distant site hospitals may not delegate, through a contract, their responsibility for peer review, quality assurance/quality improvement activities and decision-making authority for granting medical staff membership or professional privileges (physician privileging).

7.2 Certified Asthma Educators

The hospital outpatient department (OPD), Diagnostic and Treatment Center (D&TC), or private practice serving as the originating site is responsible for ensuring that the Certified Asthma Educator (CAE) providing self-management training services via telehealth, is a NYS licensed, registered, or certified health care professional, who is also certified as an educator by the National Asthma Educator Certification Board (NAECB).

7.3 Certified Diabetes Educators

Diabetes Self-Management Training (DSMT) services may be rendered in person or via telehealth by any NYS Medicaid-enrolled licensed, registered, or certified practitioner who is also affiliated with a DSMT program that has met the programmatic accreditation/recognition standards from a Centers for Medicare & Medicaid Services (CMS)-approved National Accreditation Organization

(NAO). Registered dieticians (RDs) are now recognized as independent practitioners within the Medicaid program and may render services within their defined scope of practice. Please see the January 2023 issue of the *Medicaid Update* for additional information on DSMT services.

8 Patient Rights and Consent

The practitioner shall confirm the identity of the NYS Medicaid member and provide the NYS Medicaid member with basic information about the services that they will be receiving via telehealth. Written consent by the NYS Medicaid member is not required, but the provider must document informed consent in the chart of the patient before or during the first visit in which telehealth services are provided. Telehealth sessions/services shall not be recorded without the consent of the NYS Medicaid member.

Informed consent means that telehealth practitioners provide members with sufficient information and education about telehealth to assist them in making an informed choice to receive telehealth services. This must include the following:

1. 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 information regarding their right to request a change in service delivery mode at any time.
2. The telehealth provider must inform NYS Medicaid members that they will not be denied services if they do not consent to telehealth devices or request to receive services in-person.
3. Where the NYS Medicaid member is a minor and the service requires parent/guardian consent, consent shall also be provided by the parent/guardian or other person who has legal authority to consent to health care on behalf of the minor.

Informed consent shall be obtained through a process of communication between the telehealth provider and NYS Medicaid member. Although some providers may choose to document informed consent to receive telehealth services using a form, it is not necessary to use a specific form. Informed consent processes should be specified in the policies and procedures of the provider.

9 Billing Rules for Telehealth Services

9.1 Payment Parity with In-Person Services

Under NYS Law Chapter 45 Article 29-G §2999-DD, 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 services, as may be defined in regulations promulgated by the commissioner, are reimbursed when delivered in person. Exceptions from payment parity exist for some facility types, including Article 28 licensed facilities. Such exceptions exclude certain costs, including facility fees when such costs were not incurred to deliver telehealth services because neither the patient nor the provider were located at the facility or clinic setting when the service was delivered. This law is effective until April 1, 2026.

9.2 Modifiers to be Used When Billing for Telehealth, Store-and-Forward, and Remote Patient Monitoring

Modifier	Description	Note/Example
95	Synchronous telemedicine service rendered via real-time interactive audio and video telecommunication system.	**Please note: 95** and **GT** indicate audio-visual telehealth. Both modifiers are allowable per NYS Medicaid FFS guidance, however other payors, programs, or agencies may issue further direction on their use. Per CMS, the **GT** modifier is allowed on institutional claims from Critical Access Hospitals (CAH).
GT	Via interactive audio and video telecommunication systems.	
GQ	Via asynchronous telecommunications system.	**Please note:** The **GQ** modifier is for use with Store-and-Forward technology.
25	Significant, separately identifiable 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 NYS Medicaid 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.
93	Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system.	**Please note: 93** and **FQ** indicate audio-only telehealth. Both modifiers are allowable per NYS Medicaid FFS guidance, however other payors, programs, or agencies may issue further direction on their use. For example, per the CMS 2023 Medicare Physician Fee Schedule, the **93** modifier must be used for mental health services provided via audio-only telecommunications. Providers can refer to the CMS "List of Telehealth Services" web page, for additional information relevant to Medicare enrollees or dually eligible individuals. **Effective July 1, 2025**, Office of Mental Health (OMH) providers should use modifier **93** for eligible telehealth audio-only mental health services. Refer to Updated Telehealth Modifier Use for OMH-Licensed/Designated Outpatient Programs Grid and Audio-Only Modifier Change for more detail.
FQ	A telehealth service was furnished using real-time audio-only communication technology.	
FR	A supervising practitioner was	

Modifier	Description	Note/Example
	present through a real-time two-way, audio/video communication technology.	

Claims allow multiple modifiers. If a claim represents multiple dates of services and modalities, such as a monthly component which included in-person and audio-visual service delivery, providers should indicate any and all telehealth modalities on the claim.

9.3 Place of Service Codes (Applicable to Professional Claims)

POS Code	Description (as of April 1, 2022)
02	Telehealth provided other than in the home of the patient.
10	Telehealth provided in the home of the patient (which is a location other than a hospital or other facility where the patient receives care in a private residence).
11	Telehealth provided in a private practice or office setting (other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF)). **Providers who would report POS 11 if the visit had been in person should report POS 11 on the telehealth claim to ensure proper reimbursement.**

Note: This guidance applies to all professional claims for telehealth services; place of service codes are not specific to certain modalities or procedure codes.

POS "**2"** and "**10"** are always allowable, although in many instances, POS "**11"** pays at the higher rate so we encourage providers to use that to ensure proper reimbursement per payment parity statute, as applicable.

9.4 Billing for Teledentistry Services

Teledentistry allows dentists and dental hygienists to deliver care from a distance; this includes performing evaluations and delivering services within scope of practice, using either synchronous or asynchronous means.

When services are provided via teledentistry (audio-visual telehealth) to a member 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. Required accompanying codes **"D9995"** or **"D9996"** will identify the encounter as synchronous or asynchronous.

Telephonic (audio only) dental encounters are intended to increase access to services when audio-visual telehealth is not available to the patient or audio-only is the preference of the patient. This service is billable utilizing Current Dental Terminology (CDT) code **"D9991"**. Providers must use professional judgment to determine whether audio-only services meet patient needs and whether an audio-only visit meets criteria for eligibility. The Department anticipates only rare

occasions when audio-only visits are appropriate for dental encounters.

Dental telehealth services shall adhere to the standards of appropriate patient care required in other dental health care settings, including but not limited to appropriate patient examination and review of the medical and dental history of the patient. For additional information, providers can refer to NYS Law Chapter 45 Article 29-G §2999-DD, located at: NYS Open Legislation | NYSenate.gov

Amendment to the Education Law allowing the Practice of Dental Hygiene Pursuant to Collaborative Arrangements in NYS was originally designed in 2016, independent of teledentistry, as a means to expand access by allowing independent care delivery by a dental hygienist in a formal relationship with a collaborating dentist, following criteria found at The Practice of Dental Hygiene Pursuant to Collaborative Arrangements. | Office of the Professions (nysed.gov). Please follow billing guidance found in Medicaid Update August 2016 Volume 32 Number 8 (ny.gov).

Access models exist in which a dental hygienist, providing services pursuant to a Collaborative Arrangement, delivers care in an originating Article 28 facility site and a dentist performs a subsequent evaluation at a distant site, through synchronous or asynchronous telehealth technology, using the information captured by the dental hygienist. In such models, the dental hygienist must work within the scope of their license, abiding by both collaborative practice and supervision requirements. **Billing follows teledental guidance in this model**.

For more information on NYS Education regulations, see Part 61, Dentistry, Dental Hygiene, and Registered Dental Assisting | Office of the Professions and the NYS Education Department's Teledentistry Guidelines. **Teledentistry is not a replacement for direct, personal supervision by a dentist**. For FQHC billing of bundled routine dental care services, one claim should be submitted, using the date information is captured at the originating site as the date of service for asynchronous evaluations when using this model (see Requirements and Expectations of Dental Clinics, bundling information).

Teledentistry Procedure Codes

Code	Description	Fee
D9311	**Consultation with a Medical Health Care Professional** Treating dentist consults with a medical health care professional concerning medical issues that may affect patient's planned dental treatment. May be billed by a dentist, either as the consultative or treating/requesting provider. See the October 2024 issue of the *Medicaid Update* for timing, record-keeping, and billing guidance.	$28.46
D9991	**Dental case management-addressing appointment compliance barriers** Limited to billing telephonic (audio-only) dental encounters.	$14.14
D9995	**Teledentistry – synchronous; real time encounter** Procedure code D9995 may be used by the provider at the distant site; Must be reported on claim line #1; Report all services rendered on subsequent lines; There is no reimbursement for procedure code D9995.	$0.00
D9996	**Teledentistry – asynchronous; information stored and forwarded** Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service.	$0.00

	• Procedure code D9996 may be used by the provider at the distant site; • Must be reported on claim line #1; • Report all services rendered on subsequent lines; • There is no reimbursement for procedure code D9996.	
Q3014	**Telehealth originating site facility fee** • Procedure code Q3014 may be used by the provider at the originating site; • Must be reported on claim line #1; • Report any additional services rendered on subsequent lines; • Q3014 is **not** reimbursable when off-site provider is employed, contractive, or a "collaborative" provider with the billing facility.	$26.02

When billing **"D9311," "D9991," "D9995," or "D9996,"** the attending provider must be a **Medicaid enrolled NYS licensed dental professional.**

Teledentistry Billing by Site and Location

Facility/Clinic Type	On-Site Presence	Example	Billing and Reimbursement Guidance
Article 28 Facility opting into Ambulatory Patient Groups (APGs)	Only the Dentist is on-site		Site may bill through APG per guidance[1]
	Only the NYS Medicaid Member is on-site (either at the facility or a host site)	e.g. a Dental Hygienist is working under General Supervision, gathering information/records for either asynchronous or synchronous evaluation by a Dentist	Site may bill through APG per guidance[1]
	Member: on-site (either at the facility or a host site) Dentist: on-site (at another facility site)	e.g. a Dental Hygienist is working under General Supervision, gathering information/records for either asynchronous or synchronous evaluation by a Dentist	Site may bill through APG per guidance[1]
	Neither the		Dentist can bill the

	provider nor the NYS Medicaid member is on site.		professional component only.
Article 28 Facility/FQHC that has not opted into APGs	Only the Dentist is on-site		Facility can bill at the Prospective Payment System (PPS) rate.
	Only the NYS Medicaid Member is on-site (either at the facility or a host site)	e.g. a Dental Hygienist is working under General Supervision, gathering information/records for either asynchronous or synchronous evaluation by a Dentist	Facility can bill visit at the PPS rate.
	Member: on-site (either at the facility or a host site) Dentist: on-site (at another facility site)	e.g. a Dental Hygienist is working under General Supervision, gathering information/records for either asynchronous or synchronous evaluation by a Dentist	Only one site can bill one visit at the PPS rate.
	Neither the provider nor the NYS Medicaid member is on site.		Facility can bill off-site (“4012”) rate
Private office, Urgent Care or Emergency Department facility seeking consultation	Only the NYS Medicaid Member is on-site Distant-site provider delivering service is not employed or contracted by the Originating Facility		If the Distant-site provider who is providing treatment to the member is not employed or contracted by the Originating Facility, Distant Site may bill Current Procedural Terminology (CPT)/Current Dental Terminology (CDT) code, APG, or PPS rate. The Originating-site practitioner may bill HCPCS code Q3014; and if 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[2]

[1] https://health.ny.gov/health_care/medicaid/rates/manual/docs/apg_provider_manual_december.pdf
[2] New York State Medicaid Update February 2019 Special Edition Volume 35 Number 2 (ny.gov)

9.5 General Billing Guidelines for Dual Eligible Enrollees

Pursuant to federal law, Medicaid is the payer of last resort, which means Medicaid will make payments only after all other sources of reimbursement have been exhausted. Therefore, potential third-party reimbursement sources including Medicare, must be billed prior to billing Medicaid. For additional information, providers can refer to the following NYS Medicaid billing guidance for dual enrollees:

- NYS DOH, OMH, and OASAS "Duals Reimbursement in MMC" memorandum
- NYS DOH, OMH, and OASAS "Medicaid Managed Care Billing Guidance for Dual Eligible Enrollees" policy guidance

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. For benefits covered by Medicare, any telehealth restrictions set by Medicare apply to dually-enrolled members unless otherwise stated in policy, located on the CMS "List of Telehealth Services" webpage.

NYS Medicaid telehealth policy is distinct from Medicare telehealth policy. CMS extended Medicare telehealth flexibilities until January 30, 2026, in accordance with the Continuing Appropriations Act, 2026. For benefits covered by Medicare, any telehealth restrictions set by Medicare apply to dually enrolled member unless otherwise stated in policy, located on the CMS "Listed of Telehealth Services" webpage. More information can be found in the CMS Telehealth FAQ Calendar Year 2026 and HHS.gov Telehealth Policy Updates.

9.6 Billing for Telephonic (Audio-Only) Services

NYS Medicaid expanded coverage of remote services to include audio-only visits, to increase access to services, eliminate barriers, supplement oversight of chronic conditions, and improve outcomes. Decisions on what type of visit the NYS Medicaid member receives should be based on their choice and best interest. Provider preference or convenience are not relevant. Providers must use professional judgment to determine whether audio-only services meet patient needs and whether a visit is eligible for audio-only based on criteria below. The Department anticipates limited occasions when audio-only visits are appropriate for medical visits (non-behavioral health (BH) or community health worker (CHW) services). For example, during weather emergencies when the patient is unable to use audio-visual technologies or when the visit could not occur unless provided via audio-only telehealth. NYS DOH will monitor audio-only billing and take steps

to limit overuse and prevent misuse of audio-only services.

NYS Medicaid covers audio-only visits for NYS Medicaid members when all the following conditions are met:

- audio-visual telehealth is not available to the patient due to lack of patient equipment or connectivity;
- audio-only is the preference of the patient;
- the provider must make either audio-visual or in-person appointments available at the request of the patient;
- the service can be effectively delivered without a visual or in-person component, unless otherwise stated in guidance issued by the NYS DOH (this is a clinical decision made by the provider); ***and***
- the service provided via audio-only visits contains all elements of the billable procedures or rate codes and meets all documentation requirements as if provided in person or via an audio-visual visit.

Additional programmatic guidance may be published that specifically allows or prohibits the use of audio-only telehealth by type of service. Additional agency-issued guidance outlines the appropriateness of audio-only visits for their specific populations.

The American Medical Association deleted the telephonic (audio-only) E/M procedure codes "99441" through "99443" effective January 1, 2025.

When audio-only telehealth is used in accordance with the conditions outlined above, providers may bill NYS Medicaid as they would for an in-person or audio-visual telehealth visit (using the appropriate procedure or rate code) with the addition of a telehealth modifier to indicate delivery by audio-only.

Services provided via audio-only visits shall contain all elements of the billable procedures or rate codes and must meet all documentation requirements as if provided in person or via an audio-visual visit.

The telephonic rate codes **"7961"** through **"7968"** were retired effective November 1, 2023. FQHCs can bill the Prospective Payment System (PPS) rate code **"4013"** or off-site rate code "**4012**," depending on on-site presence as outlined in Section 9.16 "Clinic Billing by On-Site Presence." Wrap payments are available for any telehealth services, including telephonic services reimbursed by an MMC Plan, under qualifying PPS and off-site rate codes.

All audio-only claims and encounters must include the "**93"** or "**FQ"** modifier unless modifiers are not allowable (e.g., teledentistry). The "**UA"** modifier should no longer be used to indicate the service as delivered via audio-only.

When a POS is allowable on a claim or encounter, providers should report POS **"02"** for telehealth provided other than in patient's home**, "10"** for telehealth provided in the home of the patient, except in cases where **POS "11" is typically submitted (**private practice or office setting); **POS "11" providers should continue to report POS "11" and use telehealth modifiers on the claim or encounter to identify it as telehealth.**

The Department does not prescribe a list of services deemed appropriate or prohibited for audio-only telehealth, but other payors, programs, or agencies may issue additional guidance that supplements or supersedes this policy (see Section 10 "Restrictions for Specific Services or Populations"). For example, CMS publishes a List of Telehealth Services which includes services allowable via audio-only for **Medicare** claims. Further, providers must meet all elements of the procedure code via audio-only telehealth and must adhere to the American Medical Association's guidelines for the procedure code to bill.

MMC Plans may have separate detailed billing guidance that supplements the billing guidance outlined in this issue, but must cover all services appropriate to deliver through telehealth, **including audio-only telehealth**. Further detail on FFS code coverage is provided in specialized guidance for mental health, substance use, and NYS OPWDD services.

9.7 Billing for Store-and-Forward Technology

1. Reimbursement will be made to the consulting distant-site practitioner when billed with an appropriate procedure code.
2. 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.

The consulting practitioner should bill the Current Procedural Terminology (CPT) code for the professional service appended with the telehealth "**GQ"** modifier.

9.8 Billing for Remote Patient Monitoring

Remote patient monitoring (RPM) uses digital technologies to collect medical data and other personal health information from the NYS Medicaid member in one location and electronically transmit that information to health care providers in a different location for assessment and recommendations.

To report RPM, the device used must be a medical device as defined by the FDA and the service must be ordered by a physician or other qualified health care professional.

FQHCs that have opted out of Ambulatory Patient Groups (APGs) are unable to bill for RPM services at this time.

Coverage is **not** available for services provided solely by a technician or for technical support of device interrogation at this time.

Patient Consent
The provider shall provide the Medicaid member with information about remote patient monitoring and obtain consent from the patient prior to each episode of care for remote patient monitoring.

Documentation and Records
The following information must be documented in the medical record by the provider:

- The patient's written or verbal consent for remote patient monitoring, and
- The provider's clinical interpretation of the collected data.

Billing

RPM Delivered by a Physician or Other Qualified Health Care Professional

Physicians and other qualified health care professionals (Nurse Practitioners, Certified Midwives) may bill for RPM using CPT code **"99091."**

Providers are not to bill **"99091"** more than one time per member per 30-day period. **"99091"** includes the time involved with data accession, review and interpretation, modification of care plan as necessary (including communication to patient and/or caregiver), and associated documentation.

RPM Delivered by Clinical Staff

Effective January 1, 2025, NYS Medicaid will reimburse RPM Current Procedural Terminology (CPT) code "**99457**". Medicaid Managed Care (MMC) Plans must comply with this coverage, by March 1, 2025.

This service may be delivered by clinical staff; however, the service must be ordered by a physician or other qualified health care professional. Clinical staff includes individuals under the direction of a physician or qualified health care professional who do not independently bill professional services, such as pharmacists and some registered dieticians. Providers delivering RPM must confirm that they operate within their scope of practice. Clinical staff may not order nor modify prescriptions. This service is not intended for retail pharmacists.

CPT code **"99457"** requires a live, interactive communication with the patient/caregiver. The interactive communication contributes to the cumulative time, but it does not need to represent the entire cumulative reported time of the treatment management services. Providers are not to bill **"99457"** more than one time per member per 30-day period.

Prenatal and Postpartum RPM Services

In an effort to reduce maternal and infant morbidity and mortality, an additional allowance may be reimbursable for RPM equipment provided by enrolled providers to pregnant and postpartum NYS Medicaid members using CPT codes "**99453"** and "**99454"** with **"HD"** modifier. Additional information can be found in the *New York State Medicaid Expansion of Remote Patient Monitoring for Maternal Care* article published in the September 2022 issue of the *Medicaid Update*.

Please note: "99091" and **"99454"** are both intended to be billed once monthly but cannot be billed on the same day. This replaces the guidance for billing these codes that was included in the September 2022 issue of the *Medicaid Update* that stated, "CPT Code **"99454"** is billed along with CPT Code **"99091"**.

CPT Code	Description	NYS Medicaid Rate
99091	Collection and interpretation of physiologic data [e.g., electrocardiogram (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, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days. *Do not report in conjunction with "**99457."***	$48.84
99453 (Prenatal and postpartum services only)	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment. *One-time billing. To be billed with **HD** modifier. May be billed with "**99091**" or "**99457"** for an episode of care, however **"99454"** may not be billed on the same date as **"99091"** or **"99457."***	$16.98
99454 (Prenatal and postpartum services only)	Device(s) supply with daily recording(s) or programmed alert(s) transmission,16-30 days in a 30-day period. *To be billed with **HD** modifier. May be billed with "**99091**" or "**99457"** for an episode of care, however **"99454"** may not be billed on the same date as **"99091"** or **"99457."***	$49.40
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes. *May be billed once each 30 days, regardless of the number of parameters monitored. Do not report for services less than 20 minutes. Do not report in conjunction with "**99091**."*	$41.80

Codes **"99453"** and **"99454"** may be reported if monitoring occurs for at least 16 days of the 30-day period.

Ambulatory Patient Group (APG) Reimbursement

Hospital Outpatient Departments (OPDs), freestanding Diagnostic and Treatment Centers (D&TCs), and Federally Qualified Health Centers (FQHCs) that have opted into the Ambulatory Patient Group (APG) reimbursement methodology are eligible for reimbursement of the remote patient monitoring (RPM) Current Procedural Terminology (CPT) codes "**99091**," "**99453**," and "**99454**" through the APG fee schedule in an outpatient clinic setting.

Effective July 1, 2025, CPT code "**99457**" will also be eligible for reimbursement through the APG fee schedule in an outpatient clinic setting.

9.9 Billing for After Hours

An add-on 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 designated holiday. 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 as appropriate:

Procedure Codes	Procedure Description	Appropriate Telehealth Modifiers	NYS Medicaid Rate
99050	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday, or Sunday), in addition to basic service.	**95**, **GT**, **93**, or **FQ**	$7.07
99051	Services provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service.	**95**, **GT**, **93**, or **FQ**	$7.07

Note: **"99050"** and **"99051"** can be used in conjunction with E&M codes only.

These CPT codes are not payable if they are the only CPT procedure(s) listed on the claim. They are reimbursed only when accompanied by a valid CPT code that represents an in-office or remote medical service/procedure. The entire visit must occur outside of normal hours. Services occurring after hours due to office/provider delays are not eligible for this supplemental payment.

Additional information on after hours billing can be found in the October 2008 issue of the *Medicaid Update*.

9.10 Billing for Virtual Check-In

Virtual check-ins must be patient-initiated and allow patients to communicate with their provider in order to avoid an unnecessary visit; however, practitioners may need to inform and educate 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-in services and the provider must document the consent of the patient in their chart at least once annually while the patient receives virtual check-in services. A virtual check-in can be conducted via several technology-based modalities, including communication by telephone or by secure text-based messaging, such as electronic interactions via patient portal, secure email, or secure text messaging. Communication must be HIPAA-compliant and must not originate from a related E&M visit within seven days, nor lead to a related E&M visit within 24 hours.

Expanding on previous policy, NYS Medicaid-enrolled providers (physician or other qualified health care professional who report E&M services) can bill CPT codes **"98016"** or **"G2252"** for reimbursement for virtual check-ins. The virtual check-in must be reported on the claim with the

appropriate telehealth modifier ("**93"**, "**95"**, "**FQ"**, "**GT"**, and "**GQ"**). Communications reported with a virtual check-in CPT code must meet the criteria outlined below.

The American Medical Association replaced HCPCS code "G2012" with CPT code "98016" effective January 1, 2025.

CPT Code	Description	Appropriate Telehealth Modifiers	NYS Medicaid Rate
98016	Brief communication technology-based service by a physician or other qualified healthcare professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion.	**93**, **95**, **FQ**, **GT**, and **GQ**	$17.30
G2252	Brief communication technology-based service by a physician or other qualified health care professional who can report E&M services, not originating from a related E&M service provided within the previous seven days nor leading to a E&M service or procedure within the next 24 hours or soonest available appointment; 11 to 20 minutes of medical discussion.	**93**, **95**, **FQ**, **GT**, and **GQ**	$24.30

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

9.11 Billing for eVisits

Providers who can independently bill for evaluation and management codes (physicians, nurse practitioners, midwives) may bill CPT codes "**99421"**, "**99422"**, and "**99423"**. Providers who may not independently bill for evaluation and management codes (e.g., licensed clinical social workers, clinical psychologists, speech language pathologists, physical therapists, occupational therapists) may bill CPT codes "**98970"**, "**98971"**, and "**98972"**.

eVisits are billed via time-based codes. The service time is cumulative up to a seven-day period. The seven-day period starts upon the provider's review the initial patient communication. The provider must begin their review within three business days of the patient inquiry. For example, if a patient initiates an eVisit on Monday, the provider must begin review on or before Thursday. Service time may include review of pertinent patient records, interaction with clinical

staff about the presenting problem, and subsequent communications which are not included in a separately reported service.

eVisit CPT codes may be billed once per seven-day period (using the last date of communication within the seven-day period as the date of service). eVisits may not be billed if the patient inquiry is related to a visit within the previous seven days of the initial digital communication. If the eVisit leads to an Evaluation and Management (E&M) visit, the eVisit should not be billed, but the time spent on the communication can be incorporated into the separately billed E&M visit.

CPT Code	Description	NYS Medicaid Rate
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes	$12.18
99422	Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 11– 20 minutes	$23.81
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	$38.76
98970	Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes	$9.42
98971	Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11–20 minutes	$16.61
98972	Qualified non-physician healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes	$25.74

To bill the above procedure codes, providers must meet all elements of the code and must adhere to the American Medical Association's guidelines related to frequency of billing these codes, as well as billing restrictions when the eVisit leads to a face-to-face encounter.

When billed by an Article 28 clinic via APGs, eVisit codes are payable to the clinic only. The provider may **not** also bill a professional component.

FQHCs may not bill for eVisits at this time.

9.12 Billing for Virtual Patient Education

Virtual patient education means education and training for patient self-management by a qualified health care professional via telehealth. Virtual patient education delivers health education to patients, their families, or caregivers, and is reimbursable only for services that are otherwise

reimbursable when delivered in person and when the provider meets certain billing requirements.

CPT codes "**98960**" through "**98962**" are limited to Community Health Worker (CHW) services and Asthma Self-Management Training (ASMT) services. CPT codes "**98960**" through "**98962**" may **not** be billed for general patient education that does not meet the provider or service definitions for CHWs or ASMT. Synchronous telehealth may meet the definitions found under CPT codes **"98960"** through **"98962"**, specifying "face-to-face" education and training. For Virtual Patient Education, "Face-to-face" means the provider directly interacting with the Medicaid member (i.e. not a service organization or other provider) for CHW and ASMT services billed via CPT codes "**98960**" through "**98962**." Audio-visual delivery is preferred, however audio-only is allowable when the conditions listed in Section 9.6 "Billing for Telephonic (Audio-Only) Services" are met. Additional information about CHW services is in the December 2023 issue of the *Medicaid Update*. Additional information about ASMT is in April 2021 issue of the *Medicaid Update*.

All virtual patient education codes must be reported on the claim with the appropriate telehealth modifier (see Section 9.2 "Modifiers to be Used When Billing for Telehealth, Store-and-Forward, and Remote Patient Monitoring").

CPT Code	Modifier (CHW only)	Description	Appropriate Telehealth Modifiers	NYS Medicaid Rate
98960*	**U1, U3**	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	**95**, **GT**, **93**, or **FQ**	$35.00
98961*	**U1, U3**	Two to four patients	**95**, **GT**, **93**, or **FQ**	$16.45
98962*	**U1, U3**	Five to eight patients	**95**, **GT**, **93**, or **FQ**	$12.25
0403T		Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day	**95** and **GT**	$22.22
0488T		Preventive behavior change, online/electronic structured intensive program for prevention of diabetes using a standardized diabetes prevention program curriculum, provided to an individual, per 30 days. Coaches must be able to track participant progress through online modules. To bill, the patient must complete a minimum of three sessions per month	Not applicable	$49.00

		and adhere to the CDC guidelines regarding coaching support (no less than once per week first six months and no less than once per month next six months)		
G0108		Diabetes outpatient self-management training services, individual, per 30 minutes.	**95** and **GT**	$48.37
G0109		Diabetes outpatient self-management training services, group (two to eight patients), per 30 minutes.	**95** and **GT**	$13.68
99406		Intermediate Smoking Cessation Counseling (SCC), three to ten minutes (billable only as an individual session).	**95** and **GT**	$13.54
99407		Intensive SCC, greater than 10 minutes (billable as an individual or group session; using the **HQ** modifier to indicate a group SCC session, up to eight patients in a group).	**95** and **GT**	$24.91
D1320		Tobacco counseling for the control and prevention of oral disease. Billable only as an individual session, greater than three minutes.	**95** and **GT**	$10.10

*Limited to CHW and ASMT services.

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

9.13 Billing for Virtual eTriage

Virtual eTriage is **not** covered by NYS Medicaid as of January 1, 2024. Virtual eTriage was previously covered under the CMS Emergency Triage, Treat, and Transport Model demonstration and providers billed as described in the November 2021 issue of the *Medicaid Update*. Guidance will be published if eTriage becomes available for reimbursement in the future.

9.14 Billing for eConsults (Interprofessional Consultations)

eConsults, also known as electronic consultations or interprofessional consultations between a treating/requesting provider and a consultative provider (physicians [including psychiatrists/addiction psychiatrists], physician assistants, nurse practitioners, midwives), are intended to improve access to specialty expertise by assisting the treating/requesting provider with the care of the patient without patient contact with the consultative provider.

The purpose of an eConsult is to answer patient-specific treatment questions that a consultative provider can reasonably answer from information in the request for consultation and the electronic

health record without an in-person visit. The consultative provider should respond to the eConsult request within 3 business days. The response should include recommendations, rationale, and contingencies that warrant a re-consult or referral. eConsults may not be appropriate for cases that involve complex decision-making nor for urgent medical decision making.

eConsults **cannot** be used for the purpose of arranging a referral for an in-person visit. They may be used for patients with or without an existing relationship with the consultative provider. For patients with a pre-existing relationship with the consultative provider, eConsults may be used upon presentation of a new problem where management of the patient can be reasonably carried out by the practitioner seeking the consultation.

The eConsult must be performed through electronic communication between the treating/requesting provider and the consultative provider. The complete record of the consult must be documented in the patient chart. Both the treating/requesting provider and the consultative provider can bill for the eConsult. To bill NYS Medicaid for eConsults the provider must be enrolled in NYS Medicaid.

The treating/requesting provider shall provide the NYS Medicaid member with information about the eConsult and obtain consent from the patient prior to each eConsult. A single instance of patient consent cannot apply to multiple eConsults across different specialties. Written consent is not required; however, the provider must document informed consent in the chart of the patient before the eConsult. Patients have the right to refuse an eConsult and see a consultative provider in-person if they wish to do so.

The following information must be documented in the medical record by the treating/requesting provider:

- the written or verbal consent made by the patient for the eConsult;
- the request made by the treating/requesting provider; and
- the recommendation and rationale from the consultative provider.

Both the treating/requesting provider and the consultative provider are required to follow all state and federal privacy laws regarding the exchange of patient information.

Please note: In addition to Title 18 of the NYCRR §504.3(a), providers may be subject to other record retention requirements (e.g., contractual requirements under the MMC program).

The eConsult codes appear on the fee schedules for physicians, nurse practitioners, and midwives. The codes are billable by providers eligible to bill those fee schedules. Both the treating/requesting provider and the consultative provider can bill for an eConsult through independent claims; one code may be billed without a corresponding claim for the other. eConsults should be billed using the following CPT codes:

CPT Code	Billed By	Description	NYS Medicaid Rate
99451	Consultative Provider	Interprofessional telephone/internet/electronic health record assessment and management	$28.46

		service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time.	
99452	Treating/Requesting Provider	Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes.	$26.56

To bill either of the above procedure codes, providers must meet all elements of the code, and must adhere to the American Medical Association's guidelines related to frequency of billing these codes, as well as billing restrictions when the eConsult leads to a face-to-face encounter.

All Medicaid billing guidelines, including for practitioner types, apply.

FQHCs that have not opted into APGs may not bill for eConsults at this time.

Ambulatory Patient Group (APG) Reimbursement

Effective January 1, 2025, for New York State (NYS) Medicaid fee-for-service (FFS) providers, and March 1, 2025, for Medicaid Managed Care (MMC) plans, Hospital Outpatient Departments (OPDs), freestanding Diagnostic and Treatment Centers (D&TCs), and Federally Qualified Health Centers (FQHCs) that have opted into the Ambulatory Patient Group (APG) reimbursement methodology will be eligible for reimbursement of eConsult Current Procedural Terminology (CPT) codes "**99451**" and "**99452**" through the APG fee schedule in an outpatient clinic setting.

An Article 16, Article 28, Article 31, or Article 32 OPD or D&TC may submit an APG claim to Medicaid for eConsult services, provided that either the treating/requesting provider or the consulting provider is an eligible practitioner employed by the clinic. Claims for eConsult services should utilize one of the designated CPT codes referenced above to ensure appropriate billing and reimbursement.

eConsults in the Dental Setting

Effective January 1, 2025, the New York State (NYS) Medicaid fee-for-service (FFS) program and Medicaid Managed Care (MMC) Plans will reimburse for eConsults in the dental setting. eConsults, also known as electronic consultations or interprofessional consultations between a dentist and another medical health care professional [physician, physician assistant (PA), nurse practitioner (NP), midwife (MW], are intended to improve access to specialty expertise by assisting the treating/requesting provider with the care of the patient, without patient contact, with the consultative provider on medical issues that may affect patient's planned dental treatment. Please see January 2024 Medicaid Update for additional information on reimbursement of eConsults.

The consultative provider should respond to the eConsult request within three business days. The

response should include recommendations, rationale and contingencies that warrant a re-consult or referral. To bill NYS Medicaid for CDT code "**D9311"**, there is an expectation that the requesting or consultative dentist will spend 15 minutes or more of dental consultative time. eConsults must not be used for the purpose of arranging a referral for an in-person visit. They may be used for patients with or without an existing relationship with the consultative provider.

The complete record of the consult must be documented in the patient chart. Both the treating/requesting provider and the consultative provider can bill for the eConsult. This includes any consultation required for dental services that are integral to the clinical success of a primary medical service. To bill NYS Medicaid for eConsults, the provider must be enrolled in NYS Medicaid.

For individuals enrolled in MMC, providers should check with the individual´s MMC Plan for implementation details, reimbursement fees, and billing instructions.

Current Dental Terminology (CDT) Code	Billed By	Description	NYS Medicaid Rate
D9311	Dentist, either as consultative or requesting provider	Consultation with a Medical Health Care Professional Treating dentist consults with a medical health care professional concerning medical issues that may affect patient's planned dental treatment.	$28.46

Rate Enhancement for Integrated eConsults

Effective June 1, 2025, New York State (NYS) will enhance reimbursement rates for a period of five years for eConsultations between eligible physical health and behavioral health practitioners. For instance, a primary care physician may seek a consultation with a psychiatrist to determine the most suitable antidepressant medication for a patient diagnosed with major depressive disorder, who also has complex comorbidities including heart disease, hypertension, and diabetes. This collaborative approach ensures a comprehensive evaluation of treatment options that address both the mental health needs and the medical complexities of the patient, promoting safer, more effective care.

The following practitioners may engage in eConsults: physicians (including psychiatrists), physician assistants, nurse practitioners (NPs) (including psychiatric NPs), and midwives. Eligible eConsults will be reimbursed at 200 percent for the initial two years of the enhanced reimbursement period and both providers engaged in the eConsult will be entitled to the enhanced rate. Following this initial period, reimbursement will adjust according to a scheduled reduction as outlined in the following table.

CPT Code	Provider Type	Established Rate Effective January 1, 2025	Enhancement Rate Effective June 1, 2025 through December 31, 2026 (*200 percent*)	Enhancement Rate Effective January 1, 2027 through December 31, 2028 (*150 percent*)	Enhancement Rate Effective January 1, 2029 through December 31, 2029 (*125 percent*)
99451	Consultative Provider	$28.46	$56.92	$42.69	$35.58
99452	Treating/Requesting Provider	$26.56	$53.12	$39.84	$33.20

Article 16, Article 28, Article 31, or Article 32 Hospital Outpatient Departments or freestanding Diagnostic and Treatment Centers, and Federally Qualified Health Centers that have opted into the Ambulatory Patient Group (APG) reimbursement methodology may submit an APG claim to NYS Medicaid for eConsult services, provided that either the treating/requesting provider and/or the consulting provider is an eligible practitioner employed by the clinic. Claims for eConsult services should utilize one of the designated CPT codes referenced above with the modifier outlined in this guidance to ensure appropriate billing and reimbursement. **To identify these collaborative eConsult visits, a new modifier combination, "U1, U1", has been established. This combination must be appended to the claim line to qualify for the enhanced reimbursement rate. This modifier must also be appended to claims submitted by private practice providers to eMedNY in order to receive the enhanced reimbursement for integrated eConsultations.**

Please note: Medicaid Managed Care (MMC) Plans are required to pay the government rate for eConsults collaborations involving Article 31 and 32 clinics.

9.15 Billing for Home Sleep Tests

Effective October 1, 2024, the New York State (NYS) Medicaid fee-for-service (FFS) program will reimburse for an at Home Sleep Test (HST) if a NYS Medicaid member meets the coverage criteria. NYS Medicaid Managed Care (MMC) Plans must comply, at a minimum, with this coverage, effective December 1, 2024. HSTs, also known as Unattended Sleep Studies or Home Sleep Apnea Tests (HSAT), are intended to help diagnose sleep disordered breathing conditions in the home-setting when medically appropriate. A sleep technologist or qualified healthcare professional is not physically present with the patient during the recording session of an HST.

NYS Medicaid FFS coverage for HST is limited to NYS Medicaid members with mobility impairments who are unable to travel to a sleep lab for a lab-based sleep test (polysomnography) [e.g., NYS Medicaid members who need assistance with ambulation or use a Durable Medical

Equipment (DME) to ambulate, such as a wheelchair or a walker]. HST can only be used when the member's clinician deems it a medically appropriate alternative to polysomnography for the NYS Medicaid member.

For NYS members who meet the above coverage criteria, healthcare providers should use their clinical judgement to determine if a HST is a medically appropriate alternative to a lab-based sleep test (polysomnography). Additionally, HST raw data must be reviewed and interpreted by a Sleep Medicine specialist who is either board-certified or board-eligible in Sleep Medicine.

Age
Adults 18 years of age and over who meet the NYS Medicaid FFS coverage criteria for HST. The American Academy of Sleep Medicine (AASM) does not recommend the use of HST for the diagnosis of Obstructive Sleep Apnea (OSA) in children because of insufficient evidence indicating its validity to identify OSA in children at this time.

NYS Medicaid HST Access
A Sleep Medicine specialist evaluates the NYS Medicaid member and orders a HST if medically appropriate and if needed. The Sleep Medicine specialist or Sleep Lab then provides the prescribed HST equipment and counsels the NYS Medicaid member on how to compete the HST.

Limitations
HST is not medically appropriate for everyone. HST can only be used to diagnose sleep disordered breathing conditions, such as OSA, and cannot be used to diagnose other sleep disorders. HST results may sometimes be inaccurate due to multiple factors relating to the inherent nature of home-based sleep testing and may sometimes underdiagnose the severity of OSA. It is imperative that healthcare providers use good clinical judgement when determining if a HST is a medically appropriate alternative to a lab-based sleep test (polysomnography).

Frequency
Should providers exceed the frequency limit, they must resubmit the claim on paper with supporting documentation showing the medical necessity for a repeat study. Repeat studies may be indicated for the following situations:

1. If the first study was technically inadequate due to equipment failure.
2. If the NYS Medicaid member did not know how to operate the HST equipment correctly or did not sleep for a sufficient amount of time to allow a clinical diagnosis.

For positive test results and prescribing of positive airway pressure equipment (PAP therapy), providers should refer to the *eMedNY New York State Medicaid Provider Procedure Code Manual – Physician Medicine, Drugs and Drug Administration Procedure Code*, located at: https://www.emedny.org/ProviderManuals/Physician/PDFS/Physician_Procedure_Codes_Sect2.pdf.

Patient Rights and Consent
The treating healthcare provider shall provide the member with information about HST and obtain consent from the patient. Written consent is not required, but the healthcare provider must document informed consent in the chart of the patient.

Documentation

The following must be documented in the medical records of the patient;

1. Documentation of informed consent by the patient.
2. Documentation supporting the medical necessity for sleep testing must be maintained in the clinical file of the ordering physician.
3. Documentation of patient history, physical exam, and healthcare provider assessment that prompted the need for an HST.
4. Documentation of the HST outcome/test results.

Billing

Orders for sleep testing are limited to physician specialists in pulmonology, otolaryngology, and neurology. Physician specialists should refer to the table below when billing, as well as the following orders:

- Do not report Current Procedure Code (CPT) code **"95800"**, in conjunction with CPT codes **"93041" through "93227"**, **"93228"**, **"93229"**, **"93268" through "93272"**, **"95801"**, **"95803"**, and **"95806"**.
- Watchpat must be billed as CPT code **"95800"**.
- If a sleep study is performed for less than six hours, it should be billed with **modifier "52"**.
- Bundled under the one rate includes cost of equipment, the assessment, and interpreting results.

CPT Code	Modifier	Description	NYS Medicaid Rate
95800	**N/A**	Sleep Study, unattended, simultaneous recordings; heart rate, oxygen saturation, respiratory analysis (e.g., by airflow or peripheral arterial tone), and sleep time.	$117.08
95800	**TC**	Physician provides the test only.	$84.68
95800	**26**	Physician only interprets the results.	$32.40

9.16 Clinic Billing by On-Site Presence

9.16.1 Article 16 (OPWDD-Licensed) Clinics

Clinic Type	On-Site Presence	Billing Instructions
Article 16 Clinic	Only the provider is on-site.	APGs (+Capital Component), if and as appropriate.
	Only the NYS Medicaid member is on-site.	APGs (+Capital Component), if and as appropriate.
	Neither the provider nor the NYS Medicaid member is onsite.	Not billable [with exception for dual enrollees when Medicare Part B covers the service when delivered via telehealth].[1]

[1] 42 CFR §440.90 defines clinic services as those occurring within the clinic's four walls. NYS Medicaid does not currently have a mechanism to allow Article 16 clinics to bill when there is no on-site presence at the clinic.

9.16.2 Article 28 (DOH-Licensed) Facilities

Clinic Type	On-Site Presence	Billing Instructions
Article 28 (Non-FQHC) Hospital OPDs, EDs, and ASCs	Only the provider is on-site.	Provider submits APG claim for services provided. Physician professional services may be billed separately per the Physician Fee Schedule.
	Only the NYS Medicaid member is on-site.	Provider submits APG claim for services provided. If the off-site provider delivering the service is **not** employed or contracted by the originating site facility, the facility may submit an APG claim for CPT code "**Q3014**" as the originating site fee. Physician professional services may be billed separately per the Physician Fee Schedule.
	Neither the provider nor the NYS Medicaid member is on-site.	Physician professional services may be billed per the Physician Fee Schedule. [1]
Article 28 (Non-FQHC) D&TCs	Only the provider is on-site.	Provider submits APG claim for services provided.
	Only the NYS Medicaid member is on-site.	Provider submits APG claim for services provided. If the off-site provider delivering the service is **not** employed or contracted by the originating site facility, the facility may submit an APG

		claim for CPT code "**Q3014**" as the originating site fee.
	Neither the provider nor the NYS Medicaid member is on-site.	Not billable.[1]
Article 28 FQHCs opted into APGs	Only the provider is on-site.	Provider submits APG claim for services provided.
	Only the NYS Medicaid member is on-site.	Provider submits APG claim for services provided. If the off-site provider delivering the service is **not** employed or contracted by the originating site facility, the facility may submit an APG claim for CPT code "**Q3014**" as the originating site fee.
	Neither the provider nor the NYS Medicaid member is on-site.	Off-site ("**4012**") rate[3] (in place of "**4013**"). For group psychotherapy, bill "**4011**."
Article 28 FQHCs that have not opted into APGs	Only the provider is on-site.	PPS Rate[2]
	Only the NYS Medicaid member is on-site.	PPS Rate[2]
	Neither the provider nor the NYS Medicaid member is on-site.	Off-site ("**4012**") rate[3] (in place of "**4013**"). For group psychotherapy, bill "**4011**."[4]

[1] 42 CFR §440.90 defines clinic services as those occurring within the clinic's four walls. NYS Medicaid does not currently have a mechanism to allow freestanding clinics / diagnostic and treatment centers to bill when there is no on-

site presence at the clinic. FQHCs operate under separate regulatory authority and are not subject to the four walls rule.

[2] Article 28 FQHCs should refer to the March 2024 issue of the *Medicaid Update* for detail about services which qualify as an eligible threshold visit.

[3] Refer to New York Codes, Rules, and Regulations Section 86-4.9 for more detail on how the off-site rate code can be used.

[4] Article 28 FQHCs should bill group psychotherapy sessions using the group rate code ("4011") regardless of on-site presence.

9.16.3 Article 28 School-Based Health Centers (SBHCs)

Clinic Type	On-Site Presence	Billing Instructions
Article 28 SBHCs (non-FQHC) opted into APGs	Only the provider is on-site (at an SBHC).	If the provider is located **at an SBHC**, the provider must bill SBHC rate codes "**1444**", "**1450**", "**1447**", "**1453**", "**3257**", "**3258**" or "**3259**".
	Only the NYS Medicaid member is on-site (at an SBHC)	If the provider is located **at a different SBHC than the student**, the provider must bill SBHC rate codes "**1444**", "**1450**", "**1447**", "**1453**", "**3257**", "**3258**" or "**3259**". If the provider is located at the **operator's facility**, bill under the operator's facility type guidance and rate codes.
	Neither the provider nor the NYS Medicaid member is on-site (at an SBHC).	Not billable.[1]
Article 28 FQHC SBHCs that have not opted into APGs	Only the provider is on-site (at an SBHC).	If the provider is located **at an SBHC,** bill FQHC SBHC rate code ("**4014**" or "**4016**").
	Only the NYS Medicaid member is on-site (at an SBHC).	If the provider is located **at a different SBHC than the student,** bill FQHC SBHC rate code ("**4014**" or "**4016**"). If the provider is located at the **operator's facility,** bill under the operator's facility type guidance and rate codes.
	Neither the provider nor the NYS Medicaid member is on-site (at an SBHC).	Not billable as an SBHC visit.

Article 28 FQHC SBHCs opted into APGs	Only the provider is on-site (at an SBHC)	If the provider is located **at an SBHC**, the provider must bill SBHC rate codes "**1444**", "**1450**", "**1447**", "**1453**", "**3257**", "**3258**" or "**3259**".
	Only the NYS Medicaid member is on-site (at an SBHC).	If the provider is located **at a different SBHC than the student**, the provider must bill SBHC rate codes "**1444**", "**1450**", "**1447**", "**1453**", "**3257**", "**3258**" or "**3259**". If the provider is located at the **operator's facility**, bill under the operator's facility type guidance and rate codes.
	Neither the provider nor the NYS Medicaid member is on-site (at an SBHC).	Not billable as an SBHC visit.

[1] 42 CFR §440.90 defines clinic services as those occurring within the clinic's four walls. NYS Medicaid does not currently have a mechanism to allow freestanding clinics / diagnostic and treatment centers to bill when there is no on-site presence at the clinic. FQHCs operate under separate regulatory authority and are not subject to the four walls rule.

9.16.4 Article 31 (OMH-Licensed) Clinics

Clinic Type	On-Site Presence	Billing Instructions
Article 31 OMH Part 599 Clinic	Only the provider is on-site.	Provider submits APG claim for services provided. No facility fee. No professional component.
	Only the NYS Medicaid member is on-site.	Provider submits APG claim for services provided. If the off-site provider delivering the service is **not** employed or contracted by the originating site facility, the facility may submit an APG claim for CPT code "**Q3014**" as the originating site fee.
	Neither the provider nor the NYS Medicaid member is on-site.	Provider submits APG claim for services provided. No facility fee. No professional component.
Article 31 FQHCs that have not opted into APGs[1]	Only the provider is on-site.	Provider submits Article 31 rate coded claim for PPS rate (e.g., "**4301**", "**4303**") with appropriate telehealth modifier (i.e., **95**, **GT**, **93**).
	Only the NYS Medicaid member is on-site.	Provider submits Article 31 rate coded claim for PPS rate (e.g., "**4301**", "**4303**") with appropriate telehealth modifier (i.e., **95**, **GT**, **93**).
	Neither the provider nor the NYS Medicaid member is on-site.	Provider submits Article 31 rate coded claim for PPS rate (e.g., "**4301**", "**4303**") with appropriate telehealth modifier (i.e., **95**, **GT**, **93**).

[1] Article 31 facilities operated by FQHCs should follow guidance from OMH and should bill according to the guidance above.

9.16.5 Article 32 (OASAS-Licensed) Clinics

Clinic Type	On-Site Presence	Billing Instructions
Article 32 OASAS Clinic	Only the provider is on-site.	Provider submits APG claim for services provided.
	Only the NYS Medicaid member is on-site.	Provider submits APG claim for services provided.
	Neither the provider nor the NYS Medicaid member is on-site.	Provider submits APG claim for services provided.
Article 32 FQHCs that have not opted into APGs[1]	Only the provider is on-site.	Provider submits Article 32 rate coded claim for PPS rate (e.g., "**4273**" through "**4275**", "**4214**" through "**4216**") with appropriate telehealth modifier (i.e., **95**, **GT**, **93**).
	Only the NYS Medicaid member is on-site.	Provider submits Article 32 rate coded claim for PPS rate (e.g., "**4275**", "**4214**" through "**4216**") with appropriate telehealth modifier (i.e., **95**, **GT**, **93**).
	Neither the provider nor the NYS Medicaid member is on-site.	Provider submits Article 32 rate coded claim for PPS rate (e.g., "**4275**", "**4214**" through "**4216**") with appropriate telehealth modifier (i.e., **95**, **GT**, **93**).

[1] Article 32 facilities operated by FQHCs should follow guidance from OASAS and should bill according to the guidance above.

9.17 Hospital Inpatient Billing for Audio-Visual Telehealth

When a telehealth consult is being provided by a distant-site 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 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.

9.18 Skilled Nursing Facility Billing for Audio-Visual Telehealth

When the services of the telehealth practitioner are included in the nursing home rate, the telehealth practitioner must bill the nursing home. If the services of the telehealth practitioner are not included in the nursing home rate, the telehealth practitioner should bill NYS Medicaid as if practitioner saw the NYS Medicaid member in-person. The CPT code billed should be appended with the applicable telehealth modifier. Practitioners providing services via telehealth should confirm with the nursing facility whether their services are in the nursing home rate.

Skilled nursing facilities may **not** bill for the "**Q3014**" originating site fee.

9.19 Medicaid Managed Care (MMC) Considerations

MMC Plans are required to cover, at a minimum, services that are covered by NYS Medicaid FFS and included in the MMC benefit package, when determined medically necessary and must provide telehealth coverage as described in this guidance. To allow the Department to adequately track telehealth use, MMC Plans must ensure claims allow the use of the telehealth modifiers in this guidance and may establish additional claiming requirements beyond those set out in the FFS billing instructions in this guidance.

MMC Plans must adhere to the payment parity requirements outlined in "Billing Rules for Telehealth Services", "Payment Parity with In-Person Services".

MMC Plans may not limit enrollee access to telehealth/telephonic services to solely the MMC Plan telehealth vendors and must cover appropriate telehealth/telephonic services provided by other network providers.

Questions regarding MMC reimbursement or documentation requirements should be directed to the MMC Plan of the enrollee.

10 Restrictions for Specific Services and Populations

Other payors, programs, and agencies beyond NYS FFS Medicaid may issue additional guidance that supplements or supersedes this guidance, such as restrictions on the use of telehealth for specific services or populations.

Below is a list of current restrictions as of the date of this manual. It is not a comprehensive list and other restrictions may apply. Please contact the issuing entity for more detail.

10.1 Restrictions for Adult Day Health Care, Home Health Care, and Hospice

Telehealth is not acceptable:

- For in-person initial medical, clinical, mental health, or dental assessments;
- To perform the Functional Supplement component of the Uniform Assessment System-New York (UAS-NY);
- At any time when the patient is not able to access a secure location; or
- As a substitute for in-person delivery of any personal care services by a provider licensed under Article 36 of the Public Health Law, or for the delivery of meals or congregate or rehabilitative activities or for required resident/patient supervision services in any setting.

Sources: DAL 23-27 and DHCBS 24-03

10.2 Restrictions for OMH

Licensed programs may use Telehealth Technologies, including Audio-visual or Audio-only modalities for the provision of all Clinic CPT procedure codes, except:

- Injectable Medication Administration with Monitoring and Education (H2010) and Injection
- Only (96372) is restricted to in-person only.
- Health Physical (99382-99387) (New Patient) and 99392-99397 (Established Patient) – is restricted to in-person or Audio-visual only.
- Developmental (96110, 96111) and Psychological Testing (96101, 96116, 96118) is restricted to in-person or Audio-visual for testing administration.

Source: April 2023 Telehealth Services Guidance for OMH Providers

10.3 Restrictions for OPWDD

Independent Practitioner Services for Individuals with Developmental Disabilities (IPSIDD) services are prohibited from being delivered via telehealth. This guidance also does not apply to services authorized pursuant to OPWDD's Section 1915(c) Comprehensive Home and Community-Based Services (HCBS) Waiver.

Source: OPWDD Regulation: 14 CRR-NY 635-13.4(c)

10.4 Restrictions for School Based Health Centers (SBHCs)

The SBHC vaccine administration rate codes 1381, 1382, and 1383 are not allowable via telehealth. See Section 9.16 "Clinic Billing by On-Site Presence" for additional guidance on billing SBHC rate codes.

10.5 Restrictions for Opioid Treatment Programs (OTPs)

Per the Substance Abuse and Mental Health Services Administration (SAMHSA) Final Rule published February 2, 2024:

- Screenings can be undertaken by non-OTP practitioners who work outside of the OTP and telehealth is permitted.
- Telehealth screenings and full examinations for methadone must be audio-visual.
- Telehealth screenings and full examinations for buprenorphine can be audio-visual or audio only.

Source: Medications for the Treatment of Opioid Use Disorder, 89 FR 7528, (Feb. 2, 2024).

10.6 Restrictions for 1915(c) Children's Home and Community-Based Services Waiver

1915(c) waiver services may not be delivered via telehealth without explicit authority in the waiver.

10.7 Restrictions for Doula Services

Labor and delivery doula services must be provided to the Medicaid member in-person except in extenuating circumstances, such as illness, emergency or precipitous birth, in which case the current telehealth policy will apply.' See the Doula Services Benefit Policy Manual for additional details on the provision on doula services.

Source: Doula Services Benefit Policy Manual

10.8 Restrictions for Physician Administered Drugs

Costs associated with shipping physician administered medications to Medicaid members is not a reimbursable expense. There are no telehealth allowances for shipping costs. More information on Physician Administered Drugs, please refer to the Physician Medicine, Drugs, and Drug Administration Manual.

11 Appendix A – Change Log

Date	Summary of Changes
January 26, 2026	-Section 3: Updated information about Medicare's telehealth waivers. -Section 9.4: Added a teledentistry procedure code chart and more detailed billing guidance. -Section 9.5: Updated information about Medicare's telehealth waivers. -Section 9.8: Revised the description for remote patient monitoring procedure code 99454 in accordance with the American Medical Association's revision. -Section 9.16: Reformatted the table by clinic type and clarified billing guidance. -Section 9.16.3: Updated off-site billing guidance for School-Based Health Centers.
July 1, 2025	-Section 3: Revised the end date for Medicare flexibilities and emphasized that duals are subject to Medicare's rules. -Section 4.1: Added that providers must meet all elements of a procedure code to bill. -Section 4.5: Revised teledentistry definition. -Section 9.2: Added OMH guidance for audio-only modifier. -Section 9.4: Updated teledentistry billing guidance. -Section 9.6: Added that providers must meet all elements of a procedure code to bill. -Section 9.8: Clarified RPM billing guidance and added information about APG reimbursement. -Section 9.14: Added integrated eConsult rate enhancement guidance. -Section 10.1: Added link to OALTC's latest DAL.
December 20, 2024	-Section 4.8: Clarified when audio-only telehealth is appropriate. -Section 9.6: Edited audio-only billing guidance. -Section 9.8: Clarified RPM policy and added guidance for RPM delivered by clinical staff. -Section 9.10: Updated procedure code for virtual check-ins. -Section 9.12: Clarified virtual patient education billing guidance for CHW and ASMT services. -Section 9.14: Clarified eConsult policy, added guidance for eConsults in the dental setting, and added guidance for APG reimbursement. -Section 9.15: Added guidance for Home Sleep Tests. -Section 9.16: Clarified Article 28 FQHC billing. -Section 10.7: Added restriction for doula services via telehealth. -Section 10.8: Added restriction for shipment of physician administered drugs.
May 13, 2024	Initial publication of this manual.