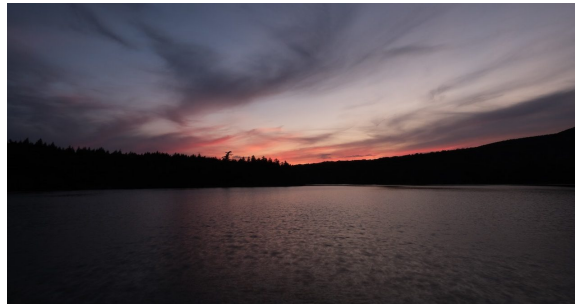


New York



At A Glance

MEDICAID REIMBURSEMENT

- Live Video: Yes
- Store-and-Forward: Yes
- Remote Patient Monitoring: Yes
- Audio Only: Yes

PRIVATE PAYER LAW

- Law Exists: Yes
- Payment Parity: Yes

PROFESSIONAL REQUIREMENTS

- Licensure Compacts: None
- Consent Requirements: Yes

STATE RESOURCES

1. Medicaid Program: New York Medicaid
2. Administrator: New York State Dept. of Health
3. Regional Telehealth Resource Center: Northeast Telehealth Resource Center

Private Payer

DEFINITIONS

Last updated 04/27/2025

Telehealth means the use of electronic information and communications technologies by a health care provider to deliver health services to an insured individual while such individual is located at a site that is different from the site where the health care provider is located.

SOURCE: NY Insurance Law Article 32 Section 3217-h & Article 43 Section 4306-g. (Accessed Apr. 2025).

Telehealth means the use of electronic information and communication technologies, including the telephone, by a health care provider to deliver health care services to an insured while such insured is located at a site that is different from the site where the health care provider is located, pursuant to Insurance Law sections 3217-h and 4306-g.

SOURCE: NY Codes, Rules, & Regs. Title 11, Sec. 52.16 (q)(3). (Accessed Apr. 2025).

Workers' Compensation

Telehealth shall mean treatment by physicians, podiatrists, psychologists, nurse practitioners, physician assistants, and licensed clinical social workers authorized by the Chair to provide treatment and care under the Workers' Compensation Law using two-way audio and visual electronic communication, or audio only.

SOURCE: Title 12 NYCRR Section. 325-1.26 as proposed to be added by Notice Of Adoption. (Accessed Apr. 2025).

REQUIREMENTS

Last updated 04/27/2025

An insurer or corporation shall not exclude from coverage a service that is otherwise covered under a policy or contract that provides comprehensive coverage for hospital, medical or surgical care because the service is delivered via telehealth. Provided, however, that an insurer or corporation may exclude from coverage a service by a health care provider where the provider is not otherwise covered under the policy or contract.

An insurer or corporation may subject the coverage of a service delivered via telehealth to co-payments, coinsurance or deductibles provided that they are at least as favorable

to the insured as those established for the same service when not delivered via telehealth.

An insurer or corporation may subject the coverage of a service delivered via telehealth to reasonable utilization management and quality assurance requirements that are consistent with those established for the same service when not delivered via telehealth.

Effective until April 1, 2026:

An insurer or corporation that provides comprehensive coverage for hospital, medical, or surgical care with a network of health care providers shall ensure that such network is adequate to meet the telehealth needs of insured individuals for services covered under the policy when medically appropriate.

SOURCE: NY Insurance Law Article 32 Section 3217-h & NY Insurance Law Article 43 Section 4306-g, as amended by A 9007 (2022 Session) and extended by S 8307 (2024 Session). (Accessed Apr. 2025).

No policy or contract delivered or issued for delivery in this State that provides comprehensive coverage for hospital, surgical, or medical care shall impose, and no insured shall be required to pay, copayments, coinsurance, or annual deductibles for in-network services delivered via telehealth when such service would have been covered under the policy if it had been delivered in person.

SOURCE: NY Codes, Rules, & Regs. Title 11, Sec. 52.16 (q). (Accessed Apr. 2025).

Network Adequacy – Effective July 1, 2025

Recently adopted regulations set forth appointment wait time standards for behavioral health services. If an insured cannot access behavioral health services from an in-network provider who can treat the insured's behavioral health condition and is available within the appointment wait time standards, the regulation gives the health care plan three business days from receipt of an access complaint to provide the insured or the insured's designee with the contact information for an in-network provider who can treat the insured's behavioral health condition and is available within the appointment wait time standards. If the insured requests an in-person visit rather than a telehealth visit, the in-network provider also must be located within a reasonable distance.

The regulations also require health care plans to verify information in their provider directories and to include information in the directories on any restrictions concerning the conditions or ages treated by network providers, languages spoken by a health care

professional, whether the provider offers services via telehealth, and, if the provider is a facility, the level of care offered by the facility.

SOURCE: Title 11 NYCRR Section 38 as proposed to be added by Notice of Adoption. (Accessed Apr. 2025).

Recently adopted regulations specific to managed care organizations (MCOs) also added similar network adequacy and access standards for behavioral health services. Standards reference that an MCO may meet the appointment wait times through the use of telehealth unless the enrollee specifically requests an in-person appointment to treat the enrollee's behavioral health condition. Standards relative to provider directories also reference including whether the behavioral health provider offers services via telehealth. Additionally, regulations state that an MCO shall have an access plan that establishes a protocol for monitoring and ensuring access to behavioral health services, including addressing the role of telehealth in providing access to behavioral health services.

SOURCE: Title 10 NYCRR Section 98-5 as proposed to be added by Notice of Adoption. (Accessed Apr. 2025).

Workers' Compensation

When rendering medical treatment or care via telehealth, an Authorized Medical Provider must be available for an in-person clinical encounter with the claimant should such in-person encounter be medically necessary. This means the Authorized Medical Provider must be able to meet the claimant at the Authorized Medical Provider's office within a reasonable travel time and distance from the claimant's residence. Telehealth must be used in accordance with this section and any applicable New York State Medical Treatment Guideline incorporated by reference under section 324.2 of this Title.

See regulations for billing and coding requirements.

SOURCE: Title 12 NYCRR Section. 325-1.26 as proposed to be added by Notice Of Adoption. (Accessed Apr. 2025).

PARITY

Last updated 04/27/2025

SERVICE PARITY

An insurer or corporation shall not exclude from coverage a service that is otherwise covered under a policy or contract that provides comprehensive coverage for hospital,

medical or surgical care because the service is delivered via telehealth; provided, however, that an insurer or corporation may exclude from coverage a service by a health care provider where the provider is not otherwise covered under the policy or contract.

SOURCE: NY Insurance Law Article 32 Section 3217-h & NY Insurance Law Article 43 Section 4306-g. (Accessed Apr. 2025).

PAYMENT PARITY

Effective until April 1, 2026:

An insurer or corporation that provides comprehensive coverage for hospital, medical or surgical care shall reimburse covered services delivered by means of telehealth on the same basis, at the same rate, and to the same extent that such services are reimbursed when delivered in person; provided that reimbursement of covered services delivered via telehealth shall not require reimbursement of costs not actually incurred in the provision of the telehealth services, including charges related to the use of a clinic or other facility when neither the originating site nor distant site occur within the clinic or other facility.

SOURCE: NY Insurance Law Article 32 Section 3217-h & NY Insurance Law Article 43 Section 4306-g, as amended by A 9007 (2022 Session) and extended by S 8307 (2024 Session). (Accessed Apr. 2025).

Medicaid

OVERVIEW

Last updated 04/25/2025

New York Medicaid offers live video, store-and-forward, and remote patient monitoring reimbursement. Both the Department of Health and Office of Mental Health adopted final rules making many emergency Medicaid telehealth expansions permanent, including allowances for audio-only coverage. In addition, recently effective legislation requires telehealth reimbursement parity until April 1, 2026. See NY Medicaid Telehealth website for an overview of policies and the Medicaid Telehealth Policy Manual for the most current guidance.

DEFINITIONS

Last updated 04/25/2025

“Telehealth” means the use of electronic information and communication technologies by telehealth providers to deliver health care services, which shall include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a patient. Telehealth shall not include delivery of health care services by means of facsimile machines, or electronic messaging alone, though use of these technologies is not precluded if used in conjunction with telemedicine, store and forward technology, or remote patient monitoring. For purposes of this section, telehealth shall be limited to telemedicine, store and forward technology, remote patient monitoring and audio-only telephone communication, except that with respect to the medical assistance program established under section three hundred sixty-six of the social services law, and the child health insurance plan under title one-A of article twenty-five of this chapter, telehealth shall include audio-only telephone communication only to the extent defined in regulations as may be promulgated by the commissioner. This subdivision shall not preclude the delivery of health care services by means of “home telehealth” as used in section thirty-six hundred fourteen of this chapter.

“Telemedicine” means the use of synchronous, two-way electronic audio visual communications to deliver clinical health care services, which shall include the assessment, diagnosis, and treatment of a patient, while such patient is at the originating site and a telehealth provider is at a distant site.

SOURCE: NY Public Health Law Article 29 – G Section 2999-cc. (Accessed Apr. 2025).

Telehealth is defined as the use of electronic information and communication technologies to deliver health care to patients at a distance. Medicaid covered services provided via telehealth include assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a Medicaid member. This definition includes audio-only services when audio-visual is unavailable, or a member chooses audio-only.

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. Telemedicine includes teledentistry.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 6. (Accessed Apr. 2025).

“Telehealth” means the use of electronic information and communication technologies by a health care provider to deliver health care services to an enrollee while such enrollee is located at a site that is different from the site where the health care provider is located.

SOURCE: NY Public Health Law Article 44 – G Section 4406-g (2). (Accessed Apr. 2025).

Telehealth and telepsychiatry are both defined as the use of interactive audio and video technology to support interactive patient care and consultations between healthcare practitioners and patients at a distance.

SOURCE: Article 29-I VFCA Health Facilities License Guidelines, p. 56 (Dec. 2024). (Accessed Apr. 2025).

Telehealth Services means the use of Telehealth Technologies by Telehealth Practitioners to provide mental health services at a distance. Such services do not currently include an electronic mail message, text message, or facsimile transmission between a practitioner and an individual receiving services, services provided where the originating and distant sites are the same location, or a consultation between two (2) physicians or nurse practitioners, or other staff, although these activities may support Telehealth Services. Telehealth Services must be synchronous. Where program regulations or guidance define an individual’s service provider as a collateral, a discussion or consultation between the Telehealth Practitioner and the individual’s other provider is considered a collateral contact, therefore is considered a Telehealth Service.

Telehealth Technologies means a dedicated, secure, and interactive Audio-only or Audiovisual linkage system approved by the Office to transmit data between an originating/spoke site and distant/hub site for purposes of providing Telehealth Services.

SOURCE: NY Office of Mental Health, Telehealth Services Guidance for OMH Providers, 2023, pg. 5. (Accessed Apr. 2025).

Telehealth Services means the use of telehealth technologies by telehealth practitioners to provide and support mental health services at a distance. Such services do not include an electronic mail message, text message, or facsimile transmission between a provider and a recipient, services provided where the originating and distant sites are the same location, or a consultation between two physicians or nurse practitioners, or other staff, although these activities may support telehealth services.

SOURCE: NY Code of Rules and Regs. Title 14, Sec. 596.4, as amended by OMH final rule and Notice Of Adoption. (Accessed Apr. 2025).

Telehealth (formerly referred to as telepractice) as defined in 14 NYCRR Part 830 is the delivery of addiction treatment services via audio and video telecommunication, audio-only or video-only telecommunication.

SOURCE: OASAS Telehealth Standards for OASAS Designated Providers, p. 3, Aug. 2023. (Accessed Apr. 2025).

Teledentistry

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.

Telehealth is defined as “the use of electronic information and communication technologies to deliver health care to patients at a distance, which shall include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a patient (Medicaid member)”.

SOURCE: NY Dental Policy and Procedure Code Manual, 2025, page 71 (Accessed Apr. 2025).

Caregiver Guide

Telehealth is the use of electronic technology to deliver health care to patients from a distance. Telehealth may take many forms including a video call with a doctor to discuss symptoms or treatment options; or the use of technology to remotely monitor and collect health data. Health and medical data collected remotely may include vital signs, blood pressure, heart rate, or blood oxygen levels.

SOURCE: NY State Caregiver Guide (2021), p. 36. (Accessed Apr. 2025).

LIVE VIDEO

Last updated 04/25/2025

POLICY

Reimbursement policy applies to fee-for-service and Medicaid Managed Care plans.

NYS Medicaid covered services provided via telehealth include assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a NYS Medicaid member. This definition includes audio-only services when audio-visual is unavailable, or a member chooses audio-only. 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.

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.

See manual for modifiers and place of service codes to be used when billing for telehealth modalities, as well as billing instructions for telehealth by site and location.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 5-7, 12-13. (Accessed Apr. 2025).

Payment for telehealth services shall be made in accordance with section 538.3 of this Part only if the provision of such services appropriately reduces the need for on-site or in-office visits and certain modality-specific standards are met. As required by Social Services Law § 367-u and, except for services paid by State only funds, contingent upon federal financial participation, reimbursement shall be made in accordance with fees determined by the commissioner based on and benchmarked to in-person fees for equivalent or similar services. Reimbursement shall not be made for services that do not warrant separate reimbursement as identified by the department during fraud, waste and abuse detection efforts. The department reserves the right to request additional documentation and deny payment for services deemed duplicative or included in a primary service. Any potential fraud, waste, or abuse, identified through claims monitoring or any other source, will be referred to the Office of Medicaid Inspector General.

SOURCE: NY Code of Rules and Regs. Title 18, Sec. 538, as added by Final rule per Notice Of Adoption. (Accessed Apr. 2025).

Recent Legislation Effective until April 1, 2026

Health care services delivered by means of telehealth shall be 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; provided, however, that health care services delivered by means of telehealth shall not require reimbursement to a telehealth provider for certain costs, including but not limited to facility fees or costs reimbursed through ambulatory patient groups or other clinic reimbursement methodologies, if such costs were not incurred in the provision of telehealth services due to neither the originating site nor the distant site occurring within a facility or other clinic setting.

For services licensed, certified or otherwise authorized, such services provided by telehealth, as deemed appropriate by the relevant commissioner, shall be reimbursed at the applicable in person rates or fees established by law, or otherwise established or certified by the office for people with developmental disabilities, office of mental health, or the office of addiction services and supports.

Both temporary and permanent statute state that while services delivered by means of telehealth shall be entitled to reimbursement, reimbursement for additional modalities, provider categories, originating sites and audio-only telephone communication defined in regulations shall be contingent upon federal financial participation.

SOURCE: NY Public Health Law Article 29 – G Section 2999-dd, as amended by A 9007 (2022 Session) and extended by S 8307 (2024 Session). (Accessed Apr. 2025).

Mental Health

A program applying for use of Telehealth Services must complete a “Telehealth Services Standards Compliance Attestation” form (AppendixA) and append it to the administrative action. The attestation assures OMH that the Provider’s plan for the use of telehealth conforms to the technological and clinical standards prescribed by 14 NYCRR Part 596 and applicable guidance. The “Technical Guidelines Checklist for Local Providers” (Appendix B) may be used as a guide to assist the program in purchasing equipment or choosing a telehealth platform.

SOURCE: NY Office of Mental Health, Telehealth Services Guidance for OMH Providers, 2023, pg. 44. (Accessed Apr. 2025).

ELIGIBLE SERVICES/SPECIALTIES

Teledentistry

Services provided by means of telehealth must be in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and all other relevant laws and regulations governing confidentiality, privacy, and consent.

Reimbursement for teledentistry be made in accordance with existing Medicaid policy related to supervision and billing rules and requirements. See manual for billing procedures.

The acquisition, installation and maintenance of telecommunication devices or systems is not reimbursable. Providers should bill using the claim format appropriate to their category of service.

SOURCE: NY Dental Policy and Procedure Code Manual 2025, page 71-75 (Accessed Apr. 2025).

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. For billing of bundled routine dental care services, one claim should be submitted, using the date information is captured as the date of service for asynchronous evaluations. For bundling information, see pages 8-10 of the Dental Policy and Procedure Manual at NEW YORK STATE DENTAL POLICY AND PROCEDURE MANUAL (emedny.org).

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.

Teledentistry may be employed during encounters delivered under a collaborative practice arrangement, as determined by the dentist or dental hygienist.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 14-15. (Accessed Apr. 2025).

Teleradiology

Reimbursement for professional services delivered via teleradiology shall be made only for the final radiology read and must be billed separately from the technical and

administrative component as specified by the commissioner in administrative guidance.

Hospitals and physicians shall bill the professional and technical and administrative components separately in accordance with the relevant Radiology Fee Schedule set forth in subdivision (a) of section 533.6 of this Title.

SOURCE: NY Code of Rules and Regs. Title 18, Sec. 538.3(c), as added by Final rule per Notice Of Adoption. (Accessed Apr. 2025).

Telemental Health

Telemental Health Services may be authorized by the office for licensed, designated or otherwise approved services provided by telehealth practitioners.

Under the Medicaid program, Telemental Health Services are covered when medically necessary and under the following circumstances:

- The person receiving services is located at the originating/spoke site and the telehealth practitioner is located at the distant/hub site and is employed by or contracted with a program licensed or designated by the Office;
- The person receiving services is present during the encounter;
- The request for telehealth services and the rationale for the request are documented in the individual's clinical record;
- The clinical record includes documentation that the encounter occurred; and
- The telehealth practitioner at the distant/hub site is (1) authorized in New York State; (2) practicing within his/her scope of specialty practice; and (3) if the originating/spoke site is a hospital, credentialed and privileged at the originating/spoke site facility.

SOURCE: NY Code of Rules and Regs. Title 14, Sec. 596.5 & 596.7, as proposed to be amended by Final Rule and Notice Of Adoption. (Accessed Apr. 2025).

Telehealth services may be used to satisfy specific statutory examination, evaluation, or assessment requirement necessary for the involuntary removal from the community, or involuntary retention in a hospital, pursuant to section 9.27 of the Mental Hygiene Law, and for the immediate observation, care and treatment in a hospital, pursuant to section 9.39 of the Mental Hygiene Law, if such services are utilized in compliance with regulations. See Final Rule for additional details.

SOURCE: NY Code of Rules and Regs. Title 14, Sec. 596.6(12-13), as proposed to be amended by Final Rule and Notice Of Adoption. (Accessed Apr. 2025).

Restrictions for Office of Mental Health

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.

See April 2023 Telehealth Services Guidance for OMH Providers for more information.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 34. (Accessed Apr. 2025).

Office of Alcoholism and Substance Abuse Services

Telepractice services, as defined in this Part, may be authorized by the office for the delivery of certain addiction services provided by practitioners employed by, or pursuant to a contract or memorandum of understanding (MOU) with a program certified by the office.

For purposes of billing for Medicaid reimbursement, both the practitioner and/or facility employing the practitioner, and the designated program must be Medicaid enrolled and in good standing. For Medicaid reimbursement the practitioner, as defined in this Part, must be defined as a telehealth provider in subdivision two of Public Health Law section 2999-cc. For purposes of this subdivision, telepractice services shall be considered face-to-face contacts.

To be eligible for Medicaid reimbursement, telepractice services must meet all requirements applicable to assessment and treatment services of Part 841 and the part pursuant to which the designated program operating certificate is issued and must exercise the same standard of care as services delivered on-site or in-community.

Telepractice services will be reimbursed at the same rates for identical procedures provided by practitioners on-site or in-community; an additional administrative fee for transmission may be billed pursuant to applicable rules or directives issued by the NYS Department of Health. The designated program is the primary billing entity; reimbursement for practitioners at a distant/hub site must be pursuant to a contract or MOU. Delivery of services via telepractice are covered when medically necessary and under the following circumstances:

- the patient is located at an originating/spoke site and the practitioner is located at a distant/hub site;
- the patient is located at another designated program, an additional location of a designated program or at an in-community location approved by the office; and the practitioner is located in another designated program;
- the patient is present during the telepractice session;
- the request for a telepractice session and the rationale for the request are documented in the patient's case record; or
- the case record includes documentation that the telepractice session occurred and the results and findings were communicated to the designated provider.

If the person receiving services is not present during the telepractice service, the service is not eligible for third party reimbursement and any incurred costs may remain the responsibility of the designated provider. Telepractice services may only be delivered via technological means approved by the Federal Center for Medicaid and Medicare Services (CMS), provided such means are compliant with Federal confidentiality requirements. If all or part of a telepractice service is undeliverable due to a failure of transmission or other technical difficulty, reimbursement shall not be provided.

SOURCE: NY Compilation of Codes, Rules and Regulations, Title 14, Chapter XXI, Part 830.5(d). (Accessed Apr. 2025).

Gambling Disorder Treatment

Effective January 1, 2023, New York State (NYS) Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC) Plans will begin covering Gambling Disorder treatment provided to individuals receiving services from the Office of Addiction Services and Supports (OASAS) certified programs. These services may be delivered face to face on-site at the certified location, via telehealth, and in the community. See Medicaid Update for billing guidance.

SOURCE: NY Dept. of Health, Medicaid Update, Vol. 38, Number 10, September 2022 (Accessed Apr. 2025)

Office for People with Developmental Disabilities (OPWDD) Services

OPWDD will continue to allow the use of Remote Technologies, where appropriate, to remotely deliver the following services authorized under OPWDD's Comprehensive HCBS 1915(c) Waiver: Day Habilitation, Community Habilitation, Prevocational Services, Supported Employment, Pathway to Employment, Support Broker, and Respite Services. Remote technology cannot be an exclusive, long-term service delivery option. Additional

requirements and information for the delivery of remote services is available in 21-ADM-03 Ability to use Technology to Remotely Deliver Home and Community-Based Services available at https://opwdd.ny.gov/system/files/documents/2021/07/21-adm-03-hcbs-remote-technology_final.pdf.

SOURCE: OPWDD Post-PHE Memo, Apr. 2023. (Accessed Apr. 2025).

Effective May 12, 2023, with the end of the Public Health Emergency (PHE), the State of New York will continue to allow the remote delivery of CSIDD through telephonic or other technology in accordance with State, Federal, and Health Insurance Portability and Accountability Act (HIPAA) requirements. Other technology means any two-way, real-time communication technology that meets HIPAA requirements. See Telehealth Allowance Attachment which will serve as an addendum to CSIDD ADM #2021-04R and outlines the allowance of the remote delivery of Crisis Services for Individuals with Intellectual and/or Developmental Disabilities (CSIDD).

SOURCE: OPWDD ADM#2021-04R Telehealth Allowance Attachment, Jul. 2024. (Accessed Apr. 2025).

Office for People with Developmental Disabilities (OPWDD) Article 16 Clinics – Individuals with Intellectual/Developmental Disabilities (I/DD)

Various procedure codes are approved by OPWDD for use in Article 16 clinics via telehealth, designated as allowed for either or both live video and audio-only. See Article 16 APG Crosswalk for codes.

SOURCE: OPWDD A16 APG Crosswalk 2024. (Accessed Apr. 2025).

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.

See OPWDD Regulation: 14 CRR-NY 635-13.4(c) for more information.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 34. (Accessed Apr. 2025).

Doula Services for Pregnant and Postpartum People

Effective March 1, 2024, New York State (NYS) Medicaid will reimburse for doula services for all pregnant and postpartum NYS Medicaid members needing the service. Between March 1, 2024, through September 30, 2024, doula services will be carved out of the

Medicaid Managed Care (MMC) benefit package. NYS Medicaid-enrolled doula providers may bill Medicaid fee-for-service (FFS) for covered doula services, including doula services provided to MMC enrollees during this period. Effective October 1, 2024, doula services will be covered by MMC Plans [inclusive of mainstream MMC Plans, Human Immunodeficiency Virus-Special Needs Plans (HIV-SNPs), as well as Health and Recovery Plans (HARPs)]. Doula services provided to MMC enrollees between March 1, 2024 and September 30, 2024 will be billed to Medicaid FFS. Doula services provided on or after October 1, 2024, will be billed to the MMC Plan of the enrollee. Doula services are provided on an individual basis with the NYS Medicaid member.

To qualify for NYS Medicaid reimbursement for perinatal doula services, the service:

- must involve a direct interaction with the NYS Medicaid member;
- must meet the minimum time frame for the doula service; and
- can be administered in-person or via telehealth, in accordance with NYS Medicaid telehealth policy (providers should refer to the NYS Department of Health “NYS Medicaid Telehealth” web page.)

SOURCE: New York State Medicaid Update – March 2024 Volume 40 – Number 3. (Accessed Apr. 2025).

Perinatal visits can occur in-person or via telehealth.

Current NYS Medicaid Telehealth policy will apply to reimbursable perinatal services.

To qualify for Medicaid reimbursement for perinatal doula services, the service...

- Can be administered in-person or via telehealth according to current Medicaid telehealth policy.

To qualify for Medicaid reimbursement for labor and delivery doula services, the service...

- 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

Labor & Delivery doula services are to be provided in-person except in extenuating circumstances such as illness or precipitous birth, in which case the current NYS Medicaid Telehealth policy will apply.

SOURCE: New York State Medicaid Program, Doula Services Benefit Policy Manual, Apr. 2025. (Accessed Apr. 2025).

Coverage of doula services by Medicaid Managed Care (MMC) Plans is delayed until January 1, 2025. Doula services provided to MMC enrollees between March 1, 2024, and December 31, 2024, will continue to be billed to Medicaid fee-for-service (FFS). Effective January 1, 2025, doula services will be covered by MMC Plans [inclusive of mainstream MMC Plans, Human Immunodeficiency Virus-Special Needs Plans (HIV-SNPs), as well as Health and Recovery Plans (HARPs)].

Doula services are provided on an individual basis with the NYS Medicaid member. To qualify for NYS Medicaid reimbursement for perinatal doula services, the service:

- must involve a direct interaction with the NYS Medicaid member;
- must meet the minimum time frame for the doula service; and
- can be administered in-person or via telehealth, in accordance with NYS Medicaid telehealth policy, which can be found on the NYS Department of Health (DOH) “NYS Medicaid Telehealth” web page.

To qualify for NYS Medicaid reimbursement for labor and delivery doula services, the service:

- must involve a direct interaction with the NYS Medicaid member;
- must be provided to the NYS Medicaid member in-person except in extenuating circumstances, such as illness, emergency, or precipitous birth, in which case the current telehealth policy will apply; and
- must be in attendance by a licensed perinatal services provider in order for the doula to be reimbursed for the labor and delivery encounter.

SOURCE: New York State Medicaid Update – August 2024 Volume 40 – Number 8. (Accessed Apr. 2025).

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.

See Doula Services Benefit Policy Manual for more information.

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.

For more information on Physician Administered Drugs, please refer to the Physician Medicine, Drugs, and Drug Administration Manual.

Restrictions for Adult Day Health Care and Home Health Care

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.

See DAL 23-27 for more information.

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.

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.

See Medications for the Treatment of Opioid Use Disorder, 89 FR 7528, (Feb. 2, 2024) for more information.

Restrictions for School Based Health Centers (SBHCs)

The SBHC vaccine administration rate codes 1381, 1382, and 1383 are not allowable via telehealth. See Section 9.15 of the Medicaid Telehealth Manual for additional guidance on billing SBHC rate codes.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 33-35. (Accessed Apr. 2025).

Genetic Counseling

Genetic counseling services may be provided in a practitioner's office or in an Article 28 hospital outpatient department (OPD) or diagnostic and treatment center (D&TC) or via telemedicine.

SOURCE: New York State Medicaid Program, Fee for Services Laboratory Manual Policy Guidelines, Version 2021-1, pg. 17. (Accessed Apr. 2025).

Homeless Healthcare Services

The New York State (NYS) Department of Health (DOH) Office of Health Insurance Programs (OHIP) is implementing new policy and billing guidance for providing services to NYS Medicaid members experiencing homelessness. Effective February 1, 2025, NYS Medicaid Managed Care (MMC) Plans must reimburse credentialed, in-network Homeless Healthcare providers for primary care services provided to an MMC Plan enrollee experiencing homelessness, regardless of whether the provider is the assigned primary care provider (PCP) of the enrollee. The MMC Plan must reimburse such services at the agreed upon contracted PCP rates. For purposes of the policy and billing guidance, Homeless Healthcare provider includes any licensed medical provider or any licensed dental provider who conducts patient visits with homeless individuals in a sheltered or unsheltered location. POS code "10" (Telehealth Provided in Home of Patient) is listed as one of the appropriate POS codes for services provided. See Medicaid Update for additional details.

SOURCE: New York State Medicaid Update – December 2024 Volume 40 – Number 13. (Accessed Apr. 2025).

New York State Medicaid Chronic Disease Self-Management Program

Reimbursement for the Chronic Disease Self-Management Program (CDSMP), as outlined by the Self-Management Resource Center (SMRC), for New York State (NYS) Medicaid members who are 18 years and older with a diagnosis of arthritis, will be available for claims submitted for dates of service on or after March 1, 2025, for New York State (NYS) Medicaid fee-for-service (FFS), and June 1, 2025, for Medicaid Managed Care (MMC). CDSMP is an evidence-based, self-management interactive program for adults that focuses on disease management skills. Its purpose is to increase confidence, physical and psychological well-being, knowledge to manage chronic conditions, and the motivation to manage challenges associated with chronic diseases including

arthritis. Providers interested in assisting NYS Medicaid members with skills including decision making, problem-solving, and action planning to promote health, can become a NYS Medicaid CDSMP provider. CDSMP providers assist NYS Medicaid members with making lasting behavior changes through group-based training and individual support. CDSMP services may be rendered as in-person group-based sessions, or virtually via telehealth. Policy and billing guidelines pertaining to NYS Medicaid coverage of CDSMP are located on the eMedNY “Provider Enrollment & Maintenance – Chronic Disease Self-Management Program (CDSMP)” web page.

SOURCE: New York State Medicaid Update – January 2025 Volume 41 – Number 1. (Accessed Apr. 2025).

ELIGIBLE PROVIDERS

For purposes of medical assistance reimbursement, all Medicaid providers authorized to provide in-person services are authorized to provide such services via telehealth, as long as such telehealth services are appropriate to meet a patient’s health care needs and are within a provider’s scope of practice.

SOURCE: NY Code of Rules and Regs. Title 18, Sec. 538.1, as added by Final rule per Notice Of Adoption. (Accessed Apr. 2025).

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.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 6. (Accessed Apr. 2025).

Providers who may deliver telehealth services include:

- Licensed physician
- Licensed physician assistant
- Licensed dentist
- Licensed nurse practitioner
- Licensed registered professional nurse (only when such nurse is receiving patient-specific health information or medical data at a distant site by means of RPM)
- Licensed podiatrist

- Licensed optometrist
- Licensed psychologist
- Licensed social worker
- Licensed speech language pathologist or audiologist
- Licensed midwife
- Physical Therapists
- Occupational Therapists
- Certified diabetes educator
- Certified asthma educator
- Certified genetic counselor
- Hospital (including residential health care facilities serving special needs populations)
- Home care services agency
- Hospice
- Credentialed alcoholism and substance abuse counselor
- Providers authorized to provide services and service coordination under the early intervention program
- Clinics licensed or certified under Article 16 of the MHL
- Certified and Non-certified day and residential programs funded or operated by the OPWDD
- Care manager employed by or under contract to a health home program, patient centered medical home, office for people with developmental disabilities Care Coordination Organization (CCO), hospice or a voluntary foster care agency certified by the office of children and family services. (in Public Health Law only)
- Certified peer recovery advocate services providers certified by the commissioner of addiction services and supports pursuant to section 19.18-b of the mental hygiene law, peer providers credentialed by the commissioner of addiction services and supports and peers certified or credentialed by the office of mental health (in Public Health Law only)
- Or any other provider as determined by the Commissioner of Health pursuant to regulation or in consultation with the Commissioner, by the Commissioner of OMH, the Commissioner of OASAS, or the Commissioner of OPWDD pursuant to regulation.

SOURCE: NY Public Health Law Article 29 – G Section 2999-cc; NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 10. (Accessed Apr. 2025).

Telehealth provider shall also include:

1. Voluntary foster care agencies certified by the New York State Office of Children and Family Services and licensed pursuant to article twenty-nine-I of Public Health Law, and providers employed by those agencies.
2. Providers licensed or certified by the New York State Department of Education to provide Applied Behavioral Analysis therapy.
3. Radiologists licensed pursuant to Article 131 of the Education Law and credentialed by the site from which the radiologist practices;
4. All Medicaid providers and providers employed by Medicaid facilities or provider agencies who are authorized to provide in-person services are authorized to provide such services via telehealth as long as such telehealth services are appropriate to meet a patient's needs and are within a provider's scope of practice.

SOURCE: NY Code of Rules and Regs. Title 18, Sec. 538.1, as added by Final rule per Notice Of Adoption & NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 10. (Accessed Apr. 2025).

Effective until April 1, 2026

Additional providers who may deliver telemedicine services include mental health practitioners licensed pursuant to article one hundred sixty-three of the education law.

SOURCE: NY Public Health Law Article 29 – G Section 2999-cc, as amended by A 9007 (2022 Session) and extended by S 8307 (2024 Session). (Accessed Apr. 2025).

Telemental Health

Telehealth services may be authorized by the office for licensed, designated, or otherwise approved services provided by telehealth practitioners, as defined in section 596.4 of this Part, from a site distant from the location of a recipient, where the recipient is physically located at a provider site licensed by the office, or the recipient's place of residence, other identified location, or other temporary location out-of-state. Services may be delivered via telehealth unless otherwise specified by guidelines established by the Office.

‘Telehealth practitioner’ means (i) a prescribing professional eligible to prescribe medications pursuant to federal regulations; or (ii) staff authorized by OMH to provide in-person services are authorized to provide behavioral health services via telehealth consistent with their scope of practice where applicable, and in accordance with guidelines established by the Office.

SOURCE: NY Code of Rules and Regs. Title 14, Sec. 596.4(i) & 596.5(a), as proposed to be amended by Final Rule and Notice Of Adoption. (Accessed Apr. 2025).

Distant or “hub” site means the distant secure location, as defined in Section 596.6(a)(1) (vi[i]) of this Part, at which the practitioner rendering the service using telehealth

services is located. The distant/hub site telehealth practitioner must possess a current, valid license, permit, or limited permit to practice in New York State, or is designated or approved by the Office to provide services, amongst other requirements. Telehealth practitioners may deliver services from a site located within the United States or its territories, which may include the practitioner's place of residence, office, or other identified space approved by the Office and in accordance with Office guidelines.

SOURCE: NY Code of Rules and Regs. Title 14, Sec. 596.4(b) & Sec. 596.6(a), as proposed to be amended by Final Rule and Notice Of Adoption. (Accessed Apr. 2025).

Home Telehealth

Subject to the approval of the state director of the budget, the commissioner may authorize the payment of medical assistance funds for demonstration rates or fees established for home telehealth services and subject to federal financial participation shall not exclude from the payment of medical assistance funds the delivery of health care services through telehealth as defined in Section 2999-cc.

SOURCE: NY Statute, Social Services Law SOS §367-u. (Accessed Apr. 2025).

Teledentistry

Dentists providing services via telehealth must be licensed and currently registered in accordance with NYS Education Law or other applicable law and enrolled in NYS Medicaid. Telehealth services must be delivered by providers acting within their scope of practice.

All dental telehealth providers shall identify themselves to patients, including providing the professional's New York state license number. 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.

SOURCE: NY Dental Policy and Procedure Code Manual 2025, page 71-72. (Accessed Apr. 2025).

Federally Qualified Health Centers (FQHCs)

FQHCs can bill the Prospective Payment System (PPS) rate code "4012" or "4013", depending on on-site presence as outlined in "Billing Rules for Telehealth Services", "FFS Billing for Telehealth by Site and Location" in the Medicaid Telehealth Manual. Wrap payments are available for any telehealth services, including telephonic services reimbursed by an MMC Plan, under qualifying PPS and off-site rate codes.

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.

See Manual for additional billing instructions for Telehealth by Site and Location.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 18. (Accessed Apr. 2025).

An eligible threshold visit is defined as a medically necessary, face-to-face (either in person or via telehealth), medical or behavioral health service rendered by specified practitioners. See Medicaid Comprehensive Guidance for NY FQHCs and RHCs article in the March 2024 Medicaid Update for more information.

SOURCE: New York State Medicaid Update – March 2024 Volume 40 – Number 3. (Accessed Apr. 2025).

Community Health Workers

Current NYS Medicaid telehealth service policy applies to coverage of CHW services as indicated in the telehealth service policy.

SOURCE: New York State Medicaid Program, Community Health Worker Services Manual, Apr. 2025, pg. 10. (Accessed Apr. 2025).

ELIGIBLE SITES

“Originating site” means a site at which a patient is located at the time health care services are delivered to him or her by means of telehealth

“Distant site” means a site at which a telehealth provider is located while delivering health care services by means of telehealth. Any site within the United States or United States’ territories is eligible to be a distant site for delivery and payment purposes.

SOURCE: NY Public Health Law Article 29 – G Section 2999- cc. (Accessed Apr. 2025).

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.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 6. (Accessed Apr. 2025).

The commissioner may specify in regulation acceptable modalities for the delivery of health care services via telehealth, including but not limited to audio-only or video-only telephone communications, online portals and survey applications, and may specify additional categories of originating sites at which a patient may be located at the time health care services are delivered to the extent such additional modalities and originating sites are deemed appropriate for the populations served.

SOURCE: NY Public Health Law Article 29 – G Section 2999-ee. (Accessed Apr. 2025).

Teledentistry

Most health care facilities and health care settings can be originating sites, as well as a Medicaid Member's place of residence in NYS or temporary location out of state.

Place of Service (POS) code: Use 02 on professional claims to specify the location teledentistry associated services were provided.

When services are provided by an Article 28 facility, the telehealth dentist must be credentialed and privileged at both the originating and distant sites in accordance with Section 2805-u of PHL

SOURCE: Dental Procedure Manual. 2025. P. 71-72. (Accessed Apr. 2025).

Telemental Health

The recipient can be physically located at a provider site licensed by the office, or the recipient's place of residence, other identified location, or other temporary location out-of-state.

Originating or "spoke" site means a site where the recipient is physically located at the time mental health services are delivered to them by means of telehealth services, which may include the recipient's place of residence, other identified location, or other temporary location out-of-state.

Distant or "hub" site means the distant secure location, as defined in Section 596.6(a)(1) (vi[i]) of this Part, at which the practitioner rendering the service using telehealth services is located. The distant/hub site telehealth practitioner must possess a current, valid license, permit, or limited permit to practice in New York State, or is designated or approved by the Office to provide services, amongst other requirements. Telehealth practitioners may deliver services from a site located within the United States or its territories, which may include the practitioner's place of residence, office, or other identified space approved by the Office and in accordance with Office guidelines.

SOURCE: NY Code of Rules and Regs. Title 14, Sec. 596.4(b)(e), Sec. 596.5(a), & Sec. 596.6(a) as proposed to be amended by Final Rule and Notice Of Adoption. (Accessed Apr. 2025).

Upon receipt of the application for use of Telehealth Services, OMH Field Office licensing staff may conduct a remote readiness review to either or both the originating and/or distant sites to review the use of Telehealth Services as part of the routine certification process. This review may be achieved by having the Field Office licensing staff log on to the hub and/or spoke site's telecommunication system to ascertain the quality of the transmission. See guidance for details.

SOURCE: NY Office of Mental Health, Telehealth Services Guidance for OMH Providers, 2023, pg. 44. (Accessed Apr. 2025).

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.

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.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 32-33. (Accessed Apr. 2025).

GEOGRAPHIC LIMITS

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.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 6. (Accessed Apr. 2025).

FACILITY/TRANSMISSION FEE

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.

Private office, Urgent care or Emergency Department facility seeking consultation: The Originating-site practitioner may bill CPT 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.

See Medicaid Telehealth Manual for further site and location billing instructions.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 13, 16. (Accessed Apr. 2025).

Skilled nursing facilities may not bill for the “Q3014” originating site fee.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 33. (Accessed Apr. 2025).

Teledentistry

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.

SOURCE: Dental Procedure Manual. 2025. P.72. (Accessed Apr. 2025).

See Medicaid Telehealth Manual for when the originating site practitioner may bill CPT code Q3014.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 15-16. (Accessed Apr. 2025).

STORE-AND-FORWARD

Last updated 04/25/2025

POLICY

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

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

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 7. (Accessed Apr. 2025).

Reimbursement will be made to the consulting distant-site practitioner when billed with an appropriate procedure code. 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 CPT code for the professional service appended with the telehealth GQ modifier.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 18. (Accessed Apr. 2025).

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

SOURCE: NY Public Health Law Article 29 – G Section 2999-cc. (Accessed Apr. 2025).

"eConsults" means the asynchronous or synchronous, consultative, provider-to-provider assessment and management services conducted through telephone, internet, or electronic health records.

"Virtual Check-in" means a brief communication via a secure, technology-based service initiated by the patient or patient's guardian/caregiver, e.g., virtual check-in by a physician or other qualified healthcare professional.

"Virtual Patient Education" means education and training for patient self-management by a qualified health care professional via telehealth.

Payment for telehealth services shall be made in accordance with section 538.3 of this Part only if the provision of such services appropriately reduces the need for on-site or in-office visits and the following standards are met:

- “eConsults” are intended to improve access to specialty expertise through consultations between consulting providers and treating providers. eConsults are reimbursable when the providers meet minimum time and billing requirements, as determined and specified by the commissioner in administrative guidance.
- “Virtual Check-in” visits are intended to be used for brief medical discussions or electronic communications between a provider and a new or established patient, at the patient’s request. Virtual check-ins are reimbursable when the provider meets certain billing requirements, as determined and specified by the commissioner in administrative guidance.
- “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, as determined and specified by the commissioner in administrative guidance

As required by Social Services Law § 367-u and, except for services paid by State only funds, contingent upon federal financial participation, reimbursement shall be made in accordance with fees determined by the commissioner based on and benchmarked to in-person fees for equivalent or similar services. Reimbursement shall not be made for services that do not warrant separate reimbursement as identified by the department during fraud, waste and abuse detection efforts. The department reserves the right to request additional documentation and deny payment for services deemed duplicative or included in a primary service. Any potential fraud, waste, or abuse, identified through claims monitoring or any other source, will be referred to the Office of Medicaid Inspector General.

SOURCE: NY Code of Rules and Regs. Title 18, Sec. 538, as added by Final rule per Notice Of Adoption. (Accessed Apr. 2025).

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).

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 “G2012”^{*} 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 in the Medicaid Telehealth Policy Manual under section 9.10, Billing for Virtual Check-In.

^{*}The American Medical Association replaced HCPCS code “G2012” with CPT code “98016” effective January 1, 2025.

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 now 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.

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 4.8 “Telephonic (Audio-Only)” 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). See additional billing information and Medicaid rates in the Medicaid Telehealth Policy Manual under section 9.12, Billing for Virtual Patient Education. Additional agency-issued guidance may be available for specific populations. NYS OPWDD, OASAS, and OMH providers should review their respective guidance to ensure compliance.

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.

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.

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).

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.

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. See additional billing information and Medicaid rates in the Medicaid Telehealth Policy Manual under section 9.11, Billing for eVisits.

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.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 8-9, 21-26. (Accessed Apr. 2025).

Effective October 1, 2023, the New York State (NYS) Medicaid Fee-for-Service (FFS) program will reimburse for eVisits. eVisits are a type of Virtual Check-In involving patient-initiated communications with a medical provider through a text-based and Health Insurance Portability and Accountability Act (HIPAA)-compliant digital platform, such as a patient portal. eVisits occur through asynchronous communication; the exchange is neither real-time nor face-to-face. Additional detail on telehealth modalities can be found in the February 2023 Comprehensive Guidance Regarding Use of Telehealth including Telephonic Services After the Coronavirus Disease 2019 Public Health Emergency Special Edition issue of the Medicaid Update. 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 normal visits.

eVisits may be provided to established patients only (though the presenting problem may be new). The patient must initiate the communication and the problem must require a physician or other qualified practitioner's professional's evaluation, assessment, and management. Claims for eVisits may not be submitted for contact initiated by the provider, whether individualized or as part of an outreach program. Communication of test results, scheduling appointments, medication refills, and any other communications outside the scope of evaluation and management are not considered eVisits.

Billing for eVisits is based on cumulative time spent with a single patient within a seven-day period. For example, if five to ten minutes are spent with a single patient for an eVisit over a seven-day period, procedure code "99421" may be billed (see table in Medicaid Update). For an encounter to qualify as an eVisit, the patient must not have been seen for the same clinical issue within the previous seven days.

See NY Medicaid Update for additional billing information, patient consent and documentation requirements and rates.

SOURCE: Medicaid Update Vol. 39, No. 13, Aug. 2023. (Accessed Apr. 2025).

eConsults

Effective April 1, 2024, the New York State (NYS) Medicaid fee-for-service (FFS) program will reimburse for eConsults. Medicaid Managed Care (MMC) Plans must comply with this coverage, effective June 1, 2024. eConsults, also known as electronic consultations or interprofessional consultations between a treating/requesting provider and a consultative provider [physicians (including psychiatrists), physician assistants (PAs), nurse practitioners (NPs), midwives (MWs)], 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 in which a consultative provider can reasonably answer from information in the request for consultation and the electronic health record, without an inperson visit. The consultative provider should respond to the eConsult request within three business days. The response should include recommendations, rationale and may include contingencies

that warrant a re-consult or referral. eConsults may not be appropriate for cases that involve complex decision-making and urgent medical decision-making.

eConsults cannot be used to arrange 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 an 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.

eConsults 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 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:

- **99451** Consultative Provider Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, 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.

To bill the above CPT codes, providers must meet all elements of the code, adhere to the American Medical Association (AMA) guidelines related to frequency of billing these codes, as well as follow billing restrictions when the eConsult leads to a face-to-face encounter. All NYS Medicaid billing guidelines, including those for practitioner types, apply.

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

SOURCE: NY State Medicaid Update January 2024 Volume 40, Number 1; NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 25-27. (Accessed Apr. 2025).

eConsult Expansion: New Reimbursement in an Outpatient Setting

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.

SOURCE: New York State Medicaid Update – December 2024 Volume 40 – Number 13; NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 27 (Accessed Apr. 2025).

Enhanced Reimbursement for Integrated eConsultations, Physical Health and Behavioral Health 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 table below.

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.

Providers should refer to the *eConsults* article published in the January 2024 issue of the *Medicaid Update*, including as to consent, record and documentation requirements. Additional information regarding eConsults in APGs can be found in the *eConsult Expansion: New Reimbursement in an Outpatient Setting* article published in the December 2024 issue of the *Medicaid Update*.

SOURCE: New York State Medicaid Update – February 2025 Volume 41 – Number 2. (Accessed Apr. 2025).

Teledentistry

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

SOURCE: NY Dental Policy and Procedure Code Manual 2025, page 72 (Accessed Apr. 2025).

eConsults in the Dental Setting

Effective January 1, 2025, for New York State (NYS) Medicaid fee-for-service (FFS) members and Medicaid Managed Care (MMC) enrollees, providers can be reimbursed 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 the planned dental treatment of the patient. Providers should refer to the *eConsults* article published in the January 2024 issue of the *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 and rationale that warrant a re-consult or referral. To bill NYS Medicaid for Current Dental Terminology (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 eConsult 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 refer to the individual MMC Plan for implementation details, reimbursement fees and billing instructions.

SOURCE: New York State Medicaid Update – October Volume 40 – Number 11; NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 27-28. (Accessed Apr. 2025).

ELIGIBLE SERVICES/SPECIALTIES

Store-and-forward services may be reimbursed, based on the definition of telehealth.

SOURCE: NY Public Health Law Article 29 – G Section 2999-cc. (Accessed Apr. 2025).

Teledentistry

Pre-recorded videos and/or static digital images (e.g., pictures), excluding radiology, must be specific to the member’s condition as well as be adequate for rendering or confirming a diagnosis or a plan of treatment.

SOURCE: NY Dental Policy and Procedure Code Manual 2025, page 72 (Accessed Apr. 2025).

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.

Required accompanying codes “D9995” or “D9996” will identify the encounter as synchronous or asynchronous. For billing of bundled routine dental care services, one claim should be submitted, using the date information is captured as the date of service for asynchronous evaluations. For bundling information, see pages 8-10 of the Dental Policy and Procedure Manual at NEW YORK STATE DENTAL POLICY AND PROCEDURE MANUAL (emedny.org).

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.

Teledentistry may be employed during encounters delivered under a collaborative practice arrangement, as determined by the dentist or dental hygienist.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 14-15. (Accessed Apr. 2025).

Telemental Health

The definition of telehealth services excludes store-and-forward since it states that telehealth services must be synchronous.

SOURCE: NY OMH Telehealth Services Guidance for OMH Providers. April 2023, page 5. (Accessed Apr. 2025).

GEOGRAPHIC LIMITS

No Reference Found

TRANSMISSION FEE

Teledentistry

Procedure code Q3014 may be used by the provider at the originating site.

SOURCE: NY Dental Policy and Procedure Code Manual 2025, page 72. (Accessed Apr. 2025).

REMOTE PATIENT MONITORING

Last updated 04/26/2025

POLICY

“Remote patient monitoring” means the use of synchronous or asynchronous electronic information and communication technologies to collect personal health information and medical data from a patient at an originating site that is transmitted to a telehealth provider at a distant site for use in the treatment and management of medical conditions that require frequent monitoring. Such technologies may include additional interaction triggered by previous transmissions, such as interactive queries conducted through communication technologies or by telephone.

RPM included within definition of “telehealth” in statute requiring Medicaid Reimburse telehealth delivery of services.

Subject to the approval of the state director of the budget, the commissioner may authorize the payment of medical assistance funds for demonstration rates or fees established for home telehealth services provided pursuant to subdivision three-c of section thirty-six hundred fourteen of the public health law.

Subject to federal financial participation and the approval of the director of the budget, the commissioner shall not exclude from the payment of medical assistance funds the delivery of health care services through telehealth, as defined in subdivision four of section two thousand nine hundred ninety-nine-cc of the public health law.

SOURCE: Social Services Law Title 11, Article 367-u & NY Public Health Law Article 29 – G Section 2999-cc. (Accessed Apr. 2025).

Remote patient monitoring (RPM) uses digital technologies to collect medical data and other personal health information from members in one location and electronically transmit that information securely 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.

Telehealth services provided by means of RPM should be billed using CPT code “99091” [collection and interpretation of physiologic data (e.g., Electrocardiography (ECG), blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training and licensure/regulation (when applicable) requiring a minimum of 30 minutes of time].

A fee of \$48.84 per month will be paid for RPM.

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.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 7, 19. (Accessed Apr. 2025).

CONDITIONS

Medical conditions that may be treated/monitored by means of RPM include, but are not limited to:

- Congestive heart failure
- Diabetes
- Chronic obstructive pulmonary disease
- Wound care
- Polypharmacy
- Mental or behavioral problems
- Technology-dependent care, such as continuous oxygen, ventilator care, total parenteral nutrition, or enteral feeding.

SOURCE: NY Public Health Law Article 29 – G Section 2999-cc; NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 7.(Accessed Apr. 2025).

RPM may be used during pregnancy and postpartum, as outlined in the September 2022 issue of the Medicaid Update.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 7. (Accessed Apr. 2025).

Maternal Care RPM Coverage

Effective October 1, 2022, for fee-for-service (FFS), and December 1, 2022, for Medicaid Managed Care (MMC) Plans, New York State (NYS) Medicaid is expanding coverage for remote patient monitoring (RPM) during pregnancy and up to 84 days postpartum to further improve and expand access to prenatal and postpartum care. This expansion of coverage includes an additional monthly fee to cover the cost of RPM devices/equipment. See Medicaid Update for additional billing guidance.

SOURCE: NY Dept. of Health, Medicaid Update, Vol. 38, Number 10, September 2022 (Accessed Apr. 2025)

The additional allowance that may be reimbursable for maternity RPM equipment provided by enrolled providers to pregnant and postpartum NYS Medicaid members calls for using CPT codes “99453” and “99454” with HD modifier. 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”.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 20. (Accessed Apr. 2025).

Continuous Glucose Monitoring (CGM)

NYS Medicaid covers continuous glucose monitoring for:

1. Members with a diagnosis of gestational diabetes; or
2. Members with a diagnosis of type 1 or type 2 diabetes, who meet all the following criteria:
 - Are under the care of an endocrinologist, or an enrolled Medicaid provider with experience in diabetes treatment, who orders the device.
 - Are compliant with regular visits to review CGM data with their provider.
 - Are on an insulin treatment plan or an insulin pump.
 - Are able, or have a caregiver who is able, to hear and view CGM alerts and respond appropriately

SOURCE: NY Dept. of Health, Provider Communication, Updated Continuous Glucose Monitoring Criteria, Oct. 2023. (Accessed Apr. 2025).

PROVIDER LIMITATIONS

Remote patient monitoring shall be ordered by a physician licensed pursuant to article one hundred thirty-one of the education law, a nurse practitioner licensed pursuant to article one hundred thirty-nine of the education law, or a midwife licensed pursuant to article one hundred forty of the education law, with which the patient has a substantial and ongoing relationship.

SOURCE: NY Public Health Law Article 29 – G Section 2999-cc. (Accessed Apr. 2025)

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.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 19. (Accessed Apr. 2025).

Expansion of Remote Patient Monitoring Coverage to Clinical Staff

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

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 dietitians. 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.

Providers should refer to the *Telehealth Policy Manual – New York State Medicaid Fee-for-Service Provider Policy Manual*, for additional details on RPM CPT codes and billing guidance.

SOURCE: New York State Medicaid Update – October Volume 40 – Number 11; NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 19. (Accessed Apr. 2025).

OTHER RESTRICTIONS

No Reference Found

EMAIL, PHONE & FAX

Last updated 04/26/2025

“Audio-only visits” means the use of telephone and other audio-only technologies to deliver services.

“eConsults” means the asynchronous or synchronous, consultative, provider-to-provider assessment and management services conducted through telephone, internet, or electronic health records.

“Virtual Check-in” means a brief communication via a secure, technology-based service initiated by the patient or patient’s guardian/caregiver, e.g., virtual check-in by a physician or other qualified healthcare professional.

Payment for telehealth services shall be made in accordance with section 538.3 of this Part only if the provision of such services appropriately reduces the need for on-site or in-office visits and the following standards are met:

- An “audio-only visit” is reimbursable when the service can be effectively delivered without a visual or in-person component; and it is the only available modality or is the patient’s preferred method of service delivery; and the patient consents to an audio-only visit; and it is determined clinically appropriate by the ordering or furnishing provider; and the provider meets billing requirements, as determined and specified by the commissioner in administrative guidance. 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.
- “eConsults” are intended to improve access to specialty expertise through consultations between consulting providers and treating providers. eConsults are reimbursable when the providers meet minimum time and billing requirements, as determined and specified by the commissioner in administrative guidance.
- “Virtual Check-in” visits are intended to be used for brief medical discussions or electronic communications between a provider and a new or established patient, at the patient’s

request. Virtual check-ins are reimbursable when the provider meets certain billing requirements, as determined and specified by the commissioner in administrative guidance.

As required by Social Services Law § 367-u and, except for services paid by State only funds, contingent upon federal financial participation, reimbursement shall be made in accordance with fees determined by the commissioner based on and benchmarked to in-person fees for equivalent or similar services.

SOURCE: NY Code of Rules and Regs. Title 18, Sec. 538.1-3, as proposed by Final rule per Notice Of Adoption. (Accessed Apr. 2025).

Telehealth shall not include delivery of health care services by means of facsimile machines, or electronic messaging alone, though use of these technologies is not precluded if used in conjunction with telemedicine, store and forward technology, or remote patient monitoring. For purposes of this section, telehealth shall be limited to telemedicine, store and forward technology, remote patient monitoring and audio-only telephone communication, except that with respect to the medical assistance program shall include audio-only telephone communication only to the extent defined in regulations as may be promulgated by the commissioner.

SOURCE: NY Public Health Law Article 29 – G Section 2999-cc, (Accessed Apr. 2025).

The commissioner may specify in regulation additional acceptable modalities for the delivery of health care services via telehealth, including but not limited to audio-only or video-only telephone communications, online portals and survey applications, and may specify additional categories of originating sites at which a patient may be located at the time health care services are delivered to the extent such additional modalities and originating sites are deemed appropriate for the populations served.

SOURCE: NY Public Health Law Article 29 – G Section 2999-ee. (Accessed Apr. 2025).

Legislation Effective until April 1, 2026 – Health care services delivered by means of telehealth shall be 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; provided, however, that health care services delivered by means of telehealth shall not require reimbursement to a telehealth provider for certain costs, including but not limited to facility fees or costs reimbursed through ambulatory patient groups or other clinic reimbursement methodologies, if such costs were not incurred in the provision of telehealth services due to neither the originating site nor the distant site occurring within a facility or other clinic setting. For services licensed, certified or otherwise

authorized, such services provided by telehealth, as deemed appropriate by the relevant commissioner, shall be reimbursed at the applicable in person rates or fees established by law, or otherwise established or certified by the office for people with developmental disabilities, office of mental health, or the office of addiction services and supports.

Both temporary and permanent statute state that while services delivered by means of telehealth shall be entitled to reimbursement, reimbursement for additional modalities, provider categories, originating sites and audio-only telephone communication defined in regulations shall be contingent upon federal financial participation.

SOURCE: NY Public Health Law Article 29 – G Section 2999-dd, as amended by A 9007 (2022 Session) and extended by S 8307 (2024 Session). (Accessed Apr. 2025).

Reimbursement policy applies to fee-for-service and Medicaid Managed Care plans.

NYS Medicaid covered services provided via telehealth include assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a NYS Medicaid member. This definition includes audio-only services when audio-visual is unavailable, or a member chooses audio-only.

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.

See manual for modifiers and place of service codes to be used when billing for telehealth modalities, as well as billing instructions for telehealth by site and location.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 5-6, 12-15. (Accessed Apr. 2025).

Telephonic service uses two-way electronic audio-only communications to deliver services to a patient at an originating site by a telehealth provider. For complete billing instructions for telephonic services, providers can refer to the “Billing Rules for Telehealth Services”, “Telephonic (Audio-only) Reimbursement Overview” section of the Medicaid Telehealth Provider Manual.

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 or 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. See billing rules in Section 9.6 “Telephonic (Audio-Only) Reimbursement Review.”

When audio-only telehealth is used in accordance with the policy outlined in “Telehealth Definitions”, “Telephonic (Audio-only),” 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. The American Medical Association deleted the telephonic (audio-only) E/M procedure codes “99441” through “99443” effective January 1, 2025.

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 audiovisual visit.

The telephonic rate codes “7961” through “7968” were retired effective November 1, 2023. FQHCs can bill the Prospective Payment System (PPS) rate code “4012” or “4013”, depending on on-site presence as outlined in “Billing Rules for Telehealth Services”, “FFS Billing for Telehealth by Site and Location.” 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.

NYS Medicaid 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 “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. 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.

Virtual Check-Ins

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 don't 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).

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 checkin 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.

Expanding on previous policy, NYS Medicaid-enrolled providers (physician or other qualified health care professional who report E&M services) can bill CPT codes "G2012"* 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 in the Medicaid Telehealth Provider Manual.

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

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

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 7-8, 17-18, 21-22. (Accessed Apr. 2025).

Telemental Health

Audio-only or audio-video communication is an acceptable option only when determined appropriate by the provider of service, in accordance with guidelines established by the Office, and with informed consent from the recipient. Where the recipient is a minor, 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.

Audio-only or audio-video communication is covered by Medicaid and the Child Health Insurance Plan to the extent consistent with regulations promulgated by the New York State Commissioner of Health pursuant to Section 2999-cc of the Public Health Law.

Telehealth services do not include an electronic mail message, text message, or facsimile transmission between a provider and a recipient, services provided where the originating and distant sites are the same location, or a consultation between two physicians or nurse practitioners, or other staff, although these activities may support telehealth services.

SOURCE: NY Code of Rules and Regs. Title 14, Sec. 596.1(d)(e) & 596.4(r), as amended by Final Rule and Notice Of Adoption. (Accessed Apr. 2025).

Telehealth Services means the use of Telehealth Technologies by Telehealth Practitioners to provide mental health services at a distance. Such services do not currently include an electronic mail message, text message, or facsimile transmission between a practitioner and an individual receiving services, services provided where the originating and distant sites are the same location, or a consultation between two (2) physicians or nurse practitioners, or other staff, although these activities may support Telehealth Services. Telehealth Services must be synchronous. Where program regulations or guidance define an individual's service provider as a collateral, a discussion or consultation between the Telehealth Practitioner and the individual's other provider is considered a collateral contact, therefore is considered a Telehealth Service.

OMH's position is that in-person and Audio-visual telehealth are the preferred methods for service delivery, while recognizing that Audio-only service delivery, where appropriate, has an important role to play in increasing access to care. OMH expects providers to use their judgment and respect individual and, as applicable, family preference in deciding which services and in which circumstances to utilize the appropriate telehealth modality to best meet the individual's needs.

Telehealth Services must include all elements of the billable procedure code or rate codes and all required documentation, and the provider must decide that services can be effective using Telehealth Technologies and without an in-person component. Additionally, for Audio-only Telehealth Services, pursuant to Department of Health (DOH) regulation 18 NYCRR § 538.2, providers must decide that services can be effectively delivered without a visual or in-person component.

For individuals without the developmental capacity to participate meaningfully telephonically, the Audio-only modality is not recommended.

- Children 0-5 do not have the developmental capacity to participate meaningfully telephonically. Audio-only telehealth is not permissible for individual sessions with children 0-5 or dyadic sessions with a child 0-5 and parent. Audio-only telehealth is permissible for collateral sessions with parent/guardian of a child 0-5.

For all Telehealth Services including children/youth, Audio-visual is strongly encouraged.

- All services for children/youth (up to age 18 or 21, based on regulation and program guidance) must include visualization of the individual (using Audio-visual Telehealth Services or in-person) in the initial assessment period and every 12 months thereafter at minimum. When this does not occur, reasons should be documented.
- Audio-visual options should be fully explored with parents/guardians prior to considering Audio-only services.

For Audio-only Telehealth Services, DOH Medicaid guidance requires that providers document why Audio-only services were used for each encounter, i.e., Audio-only Telehealth Services are the individual's preference or Audio-visual Telehealth Services are not available due to lack of equipment or connectivity.

See OMH Guidance for additional OMH program-specific audio-only considerations.

When clinically appropriate, prescribers may provide medication treatment services using Audio-only telehealth.

SOURCE: NY State Office of Mental Health Telehealth Services Guidance for OMH Providers (April 2023), p. 4-6, 8, 12. (Accessed Apr. 2025).

Crisis Services for Individuals with Intellectual and/or Developmental Disabilities (CSIDD)

Effective May 12, 2023, with the end of the Public Health Emergency (PHE), the State of New York will continue to allow the remote delivery of CSIDD through telephonic or other technology in accordance with State, Federal, and Health Insurance Portability and Accountability Act (HIPAA) requirements. Other technology means any two-way, real-time communication technology that meets HIPAA requirements. See Telehealth Allowance Attachment which will serve as an addendum to CSIDD ADM #2021-04R and outlines the allowance of the remote delivery of Crisis Services for Individuals with Intellectual and/or Developmental Disabilities (CSIDD).

SOURCE: OPWDD ADM#2021-04R Telehealth Allowance Attachment, Jul. 2024. (Accessed Apr. 2025).

Office for People with Developmental Disabilities (OPWDD) Article 16 Clinics – Individuals with Intellectual/Developmental Disabilities (I/DD)

Various procedure codes are approved by OPWDD for use in Article 16 clinics via telehealth, designated as allowed for either or both live video and audio-only. See Article 16 APG Crosswalk for codes.

SOURCE: OPWDD A16 APG Crosswalk 2024. (Accessed Apr. 2025).

Teledentistry

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. NYS DOH 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.

Teledentistry may be employed during encounters delivered under a collaborative practice arrangement, as determined by the dentist or dental hygienist.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 14-15. (Accessed Apr. 2025).

Physicians

Medicaid payment is based upon the direct provision of a personal and identifiable service to the enrollee. Payment is not appropriate for appointments for medical care, which are not kept, or for services rendered by a physician to a patient over the telephone.

SOURCE: NY State Medicaid Program, Policy Guidelines: Physicians Manual, Feb. 2025, (Accessed Apr. 2025).

Nurse Practitioners

Reimbursement will not be made for appointments for medical care which are not kept, or for services rendered to a client over the telephone.

SOURCE: NY State Medicaid Program, Policy Guidelines: Nurse Practitioner Manual, Version 2022-1, pg. 25. (Accessed Apr. 2025).

CONSENT REQUIREMENTS

Last updated 04/27/2025

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 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.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 11-12. (Accessed Apr. 2025).

eVisits

The provider shall obtain verbal or written consent for communication-based technology services (CBTS) annually. Written consent is not required, but the provider must document informed consent for CBTS in the chart of the patient before an eVisit can occur.

SOURCE: Medicaid Update Vol. 39, No. 13, Aug. 2023. (Accessed Apr. 2025).

Remote Patient Monitoring

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. 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.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 19. (Accessed Apr. 2025).

Virtual Check-Ins

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.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 21. (Accessed Apr. 2025).

eConsults

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.

SOURCE: NY State Medicaid Update January 2024 Volume 40, Number 1, NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 26. (Accessed Apr. 2025).

Home Sleep Test (HST)

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. 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.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 29. (Accessed Apr. 2025).

Mental Health

Telehealth services may be provided only where clinically appropriate and with informed consent by the recipient. Where the recipient is a minor 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. The recipient may withdraw consent at any time. A provider may not deny services to an individual who has a preference to receive services in-person.

SOURCE: NY Code of Rules and Regs. Title 14, Sec. 596.1(b), as amended by Final Rule and Notice Of Adoption. (Accessed Apr. 2025).

Part of obtaining approval for telehealth services is obtaining informed consent and may be incorporated into the informed consent process for in-person care. See regulation for specific requirements.

SOURCE: NY Code of Rules and Regs. Title 14, Sec. 596.5(b)(c) & 596.6., as amended by Final Rule and Notice Of Adoption. (Accessed Apr. 2025).

Mental health services guidance requires the same informed consent process as above and additionally states that:

- Informed consent must be obtained before or during the first visit in which Telehealth Services are provided and documented in the case record

- Individuals, or a minor individual's parent or guardian, should be informed how to verify a Telehealth Practitioner's professional license.

SOURCE: NY Office of Mental Health. Telehealth Services Guidance for OMH Providers. April 2023, p. 11. (Accessed Apr. 2025).

Teledentistry

Services provided by means of telehealth must be in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and all other relevant laws and regulations governing confidentiality, privacy, and consent.

SOURCE: NY Dental Policy and Procedure Code Manual 2025, page 71. (Accessed Apr. 2025).

OUT OF STATE PROVIDERS

Last updated 04/27/2025

“Distant site” means a site at which a telehealth provider is located while delivering health care services by means of telehealth. Any site within the United States or United States’ territories is eligible to be a distant site for delivery and payment purposes.

SOURCE: NY Public Health Law Article 29 – G Section 2999-cc, (Accessed Apr. 2025).

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.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 10-11. (Accessed Apr. 2025).

Telemental Health

Part 596 of Title 14 NYCRR permits the provision of Telehealth Services by the New York State (NYS) Office of Mental Health (OMH) programs licensed or designated pursuant to

Article 31 of the NYS Mental Hygiene Law, if approved to do so by OMH. Approval shall be based upon review of policies and procedures that satisfactorily address a series of standards and procedures. For example, the policies and procedures must confirm that:

- Telehealth Practitioners meet standards established in Part 596.6(a)(1)(i), including that they possess a current, valid license, permit, or limited permit to practice in New York State, or are designated or approved by the Office to provide services.

SOURCE: New York State Office of Mental Health, Telehealth Services Guidance for OMH Providers (Apr. 2023) p. 45. (Accessed Apr. 2025).

The recipient can be physically located at a provider site licensed by the office, or the recipient's place of residence, other identified location, or other temporary location out-of-state.

Telehealth practitioners may deliver services from a site located within the United States or its territories, which may include the practitioner's place of residence, office, or other identified space approved by the Office and in accordance with Office guidelines.

SOURCE: NY Code of Rules and Regs. Title 14, Sec. 596.4(b)(e), Sec. 596.5(a), & Sec. 596.6(a) as amended by Final Rule and Notice Of Adoption. (Accessed Apr. 2025).

MISCELLANEOUS

Last updated 04/27/2025

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.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 6. (Accessed Apr. 2025).

Subject to federal financial participation and the approval of the director of the budget, the commissioner shall not exclude from the payment of medical assistance funds the delivery of health care services through telehealth, as defined in section 2999-cc(4) of the public health law.

SOURCE: Social Services Law Article 367-u. (Accessed Apr. 2025).

The superintendent of financial services, in collaboration with the commissioner of health, shall report on the impact of reimbursement for telehealth services that, pursuant to the insurance law and public health law, will be reimbursed by an accident and health insurer and a corporation subject to article 43 of the insurance law, including a health maintenance organization, on the same basis, at the same rate, and to the

same extent the equivalent services are reimbursed when delivered in person. The report shall, at a minimum, and to the extent possible, contain information regarding the use of telehealth services broken down by: social service district or county; age and gender of patients; procedure codes, diagnosis codes, and associated descriptions or modifiers; claims paid amount totals; claims information such as categories of services, specialty or type codes; and trends in the types of telehealth services used such as primary care, behavioral and mental health care, and the number of telehealth visits by provider type. The report shall include such utilization information dating from the effective date of this act and ending on the one-year anniversary of such effective date, and shall be submitted to the governor, the temporary president of the senate, and the speaker of the assembly by December 31, 2023.

See the NYSDOH and NYSDFS 2023 Telehealth Report for more information.

SOURCE: A 9007 (2022 Session), part V, p. 28. (Accessed Apr. 2025).

Demonstration rates of payment or fees shall be established for telehealth services provided by a certified home health agency, a long term home health care program or AIDS home care program, or for telehealth services by a licensed home care services agency under contract with such an agency or program, in order to ensure the availability of technology-based patient monitoring, communication and health management. Reimbursement is provided only in connection with Federal Food and Drug Administration-approved and interoperable devices that are incorporated as part of the patient's plan of care.

SOURCE: NY Public Health Law Article 36 Section 3614(3-c). (Accessed Apr. 2025).

Independent Practitioner Services for Individuals with Developmental Disabilities (IPSIDD) are prohibited from being delivered via telehealth.

SOURCE: NY Code of Rules and Regs. Title 14, Sec. 635-13.4(c). (Accessed Apr. 2025).

Each agency that operates a clinic treatment facility shall provide the Office for People with Developmental Disabilities (OPWDD) information it requests, including but not limited to the following: services provided by CPT/HCPSCS and/or CDT codes, where such services were delivered, including the location of both the provider and the individual when services are delivered via telehealth, (i.e., on-site or at a certified satellite site, or, prior to April 1, 2016, off-site) and revenues by funding SOURCE or payee. These data shall correspond to the identical time period of the cost report.

SOURCE: NY Code of Rules and Regs. Title 14, Sec. 679.6(b). (Accessed Apr. 2025).

Medicaid Managed Care (MMC) Considerations

1. 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 DOH 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.
2. MMC Plans must adhere to the payment parity requirements outlined in “Billing Rules for Telehealth Services”, “Payment Parity with In-Person Services”.
3. 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.
4. Questions regarding MMC reimbursement or documentation requirements should be directed to the MMC Plan of the enrollee.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 33. (Accessed Apr. 2025).

Credentialing and Privileging

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 NYS DOH 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).

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).

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 dietitians (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.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 11-12. (Accessed Apr. 2025).

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.

The Performance Enhancement Reform Act, or omnibus budget for federal fiscal year (FY) 2023, included several provisions that extend telehealth flexibilities for federal programs through December 31, 2024. Several flexibilities apply to Medicare’s coverage

of telehealth, including suspending geography-based telehealth requirements, allowing audio-only telehealth, patient homes as originating sites, FQHCs and RHCs to continue to offer telehealth, and delaying inperson visit requirements prior to delivering mental health services via telehealth. When such flexibilities end, NYS Medicaid coverage of some services via telehealth for those dually enrolled may be impacted. For additional information, providers can refer to the Congress “House Committee Print 117-59 – RULES COMMITTEE PRINT 117-59 TEXT OF H.R. 4040, THE ADVANCING TELEHEALTH BEYOND COVID-19 ACT OF 2021 [Showing the text of H.R. 4040, as introduced, with modifications.]” web page, located at: <https://www.congress.gov/committeeprint/117th-congress/house-committee-print/48141>.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 17. (Accessed Apr. 2025).

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 must be used. See Medicaid Telehealth Provider Manual for appropriate modifiers and codes. The 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.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 8, 20. (Accessed Apr. 2025).

eConsults

Documentation and Records

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).

SOURCE: NY State Medicaid Update January 2024 Volume 40, Number 1; NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 26. (Accessed Apr. 2025).

Home Sleep Test

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 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 complete the HST. 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 18 years of age and over 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).

Orders for sleep testing are limited to physician specialists in pulmonology, otolaryngology, and neurology. 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.

See Telehealth Provider Manual, section 9.15, for billing codes and additional requirements related to home sleep tests.

SOURCE: NY Dept. of Health Medicaid Telehealth Policy Manual (Dec. 2024), p. 9-10, 28-29. (Accessed Apr. 2025).

Telemental Health

See clinical and program-specific guidance for telemental health services in guidance document. Also includes billing guidelines, managed care reimbursement, technology and telecommunications guidance, and guidance for contracting with telemedicine companies.

SOURCE: NY Office of Mental Health, Telehealth Services Guidance for OMH Providers, 2023. (Accessed Apr. 2025).

Office of Alcoholism and Substance Abuse Services (OASAS)

Telepractice services, as defined in this Part, may be authorized by the office for the delivery of certain addiction services provided by practitioners employed by, or pursuant to a contract or memorandum of understanding (MOU) with a program certified by the office. See regulation for details.

SOURCE: NY Codes, Rules and Regulations, Title 14, Chapter XXI, Part 830.5. (Accessed Apr. 2025).

Community-Based Paramedicine Demonstration Program

Legislation requires the Department to establish a community paramedicine demonstration program to evaluate the role of emergency medical services personnel in the delivery of health care services in the community in non-emergent settings. The program shall authorize mobile integrated and community paramedicine programs operating under COVID emergency policies to continue in the same manner and capacity as currently approved for a period of two years. The program shall include authorizing emergency medical service personnel to provide community paramedicine, use alternative destinations, telemedicine to facilitate treatment in place, and other services as approved by the Commissioner.

SOURCE: NY Public Health Law Sec. 3018 as added by S 6749 (2023 Session). (Accessed Apr. 2025).

Professional Requirements

DEFINITIONS

Last updated 04/27/2025

Related to Credentialing and Privileging health care practitioners providing telemedicine

“Telemedicine means the delivery of clinical health care services by means of real time two-way electronic audio-visual communications which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care, while such patient is at the originating site and the health care provider is at a distant site.”

SOURCE: NY Public Health Law Article 28 – Section 2805-u. (Accessed Apr. 2025).

Office of Addiction Services and Supports

Telehealth (formerly referred to as telepractice) as defined in 14 NYCRR Part 830 is the delivery of addiction treatment services via audio and video telecommunication, audioonly or video-only telecommunication.

SOURCE: OASAS Telehealth Standards for OASAS Designated Providers, p. 3, Aug. 2023. (Accessed Apr. 2025).

Applied Behavior Analysis, Mental Health Practitioners, Psychology Practice & Social Work

Telepractice includes the use of telecommunications and web-based applications to provide assessment, diagnosis, intervention, consultation, supervision, education and information across distance. It may include providing non-face-to-face applied behavior analysis (ABA), psychological, mental health, marriage and family, creative arts, psychoanalytic, psychotherapy and social work services via technology such as telephone, e-mail, chat and videoconferencing.

SOURCE: NY Office of the Professions, Applied Behavior Analysis, Practice Guidelines; Mental Health Practitioners, Telepractice; Psychology Practice, Telepractice Guidelines; Social Work, Telepractice Guidelines, (Accessed Apr. 2025).

Speech Language Pathology and Audiology

“Telepractice” is providing service that is not “in person” and is delivered through the use of technology. Such technology may include, but is not limited to: telephone, telefax, email, internet, or videoconference. It is considered a mode of practice and the same standards that apply to all forms of practice in the speech-language pathology and audiology professions would apply to telepractice. With reference to speech-language

pathology and audiology, telepractice is the use of technology for the application of speech language pathology and audiology services over a distance by connecting a qualified and licensed clinician to a client or one clinician to another for assessment, treatment, and/or consultation.

SOURCE: NY Office of the Professions, Speech Language Pathology and Audiology, Practice Guidelines. (Accessed Apr. 2025).

Physical Therapy

“Telepractice” is providing service that is not “in person” and is facilitated through the use of technology. Such technology may include, but is not limited to, telephone, telefax, e-mail, internet, or videoconference.

SOURCE: NY Office of the Professions, Physical Therapy. Practice Guidelines, (Accessed Apr. 2025).

CONSENT REQUIREMENTS

Last updated 04/27/2025

Office of Alcoholism and Substance Abuse Services

Consent: a patient or potential patient’s acknowledgment that the benefits, limitations, and risks associated with services delivered via telehealth have been explained; and they have approved receipt of services via this modality either verbally or in writing. Providers are required to obtain informed consent prior to delivering services via telehealth. Informed consent may be in writing or verbal and noted in the patient record for each encounter.

SOURCE: OASAS Telehealth Standards for OASAS Designated Providers, p. 3, 8. Aug. 2023. (Accessed Apr. 2025).

Telepractice sessions shall not be recorded without the patient’s written consent.

SOURCE: NY Codes, Rules and Regulations, Title 14, Chapter XXI, Part 830.5. (Accessed Apr. 2025).

Applied Behavior Analysis, Mental Health Practitioners, Psychology Practice & Social Work

Licensed behavior analysts (LBAs) and certified behavior analyst assistants (CBAAAs)/Mental Health Practitioners/Psychologists/Social Workers should develop procedures for and obtain informed consent prior to providing remote services and ensure that informed consent includes both benefits and risks.

SOURCE: NY Office of the Professions, Applied Behavioral Analysis, Practice Alerts – Telepractice; Mental Health Practitioner, Practice Alerts – Telepractice; Psychology Practice Alerts – Telepractice; Social Work Practice Alerts – Telepractice. (Accessed Apr. 2025).

Speech Language Pathology and Audiology

Should maintain appropriate documentation, including informed consent (risks and benefits) for use of telepractice which includes a client agreement to use a private environment with a secure connection, and documentation of the telepractice encounter.

SOURCE: NY Office of the Professions, Speech Language Pathology and Audiology Practice Guidelines. (Accessed Apr. 2025).

ONLINE PRESCRIBING

Last updated 04/27/2025

Office of Alcoholism and Substance Abuse Services (OASAS)

Buprenorphine is a controlled substance and requires appropriate evaluation for use and ongoing monitoring. As such, buprenorphine initiation must include an evaluation by a practitioner with a valid DEA registration prior to issuance of a buprenorphine prescription; this visit may be done in person or via telehealth (an audio and video visit or an audio-only visit); all follow up visits may be done via telehealth.

SOURCE: OASAS Telehealth Standards for OASAS Designated Providers, p. 9. Aug. 2023. (Accessed Apr. 2025).

Induction and prescribing of addiction medications must be done in accordance any and all applicable Federal rules and regulations; guidance may be found in the Telepractice Standards for OASAS Designated Providers posted on the OASAS website.

SOURCE: NY Codes, Rules and Regulations, Title 14, Chapter XXI, Part 830.5. (Accessed Apr. 2025).

Mental Health

OMH Telehealth Standards outline various considerations and program-specific requirements related to prescribing medications via telehealth.

SOURCE: NY Office of Mental Health. Telehealth Services Guidance for OMH Providers. (Apr. 2023). (Accessed Apr. 2025).

Workers' Compensation

When rendering medical treatment or care via telehealth, an Authorized Medical Provider must be available for an in-person clinical encounter with the claimant should such in-person encounter be medically necessary. This means the Authorized Medical Provider must be able to meet the claimant at the Authorized Medical Provider's office within a reasonable travel time and distance from the claimant's residence. Telehealth must be used in accordance with this section and any applicable New York State Medical Treatment Guideline incorporated by reference under section 324.2 of this Title.

See regulations for additional rules related to when telehealth may be rendered following an initial in-person clinical encounter and related restrictions.

SOURCE: Title 12 NYCRR Section. 325-1.26 as proposed to be added by Notice Of Adoption. (Accessed Apr. 2025).

CROSS-STATE LICENSING

Last updated 04/27/2025

Applied Behavioral Analysis, Mental Health Practitioners, Psychologists, Social Workers

In New York State, a practitioner must hold a New York license, or be otherwise authorized to practice, when providing professional services to a patient/client located in New York or when the practitioner is located in New York.

SOURCE: NY Office of the Professions, Applied Behavioral Analysis, Practice Alerts – Telepractice; Mental Health Practitioner, Practice Alerts – Telepractice; Psychology Practice Alerts – Telepractice; Social Work Practice Alerts – Telepractice. (Accessed Apr. 2025).

Speech Language Pathologists and Audiologists

If you intend to provide telepractice services to a resident of New York State, you must hold a New York State license and be in compliance with the relevant law, rules and regulations.

New York State law permits a person from another state to perform speech-language pathology or audiology services in this State, as long as such services are performed for no more than thirty (30) days in any calendar year and provided that such services are performed in conjunction with and/or under the supervision of Speech-Language Pathologist or Audiologist licensed under Article 159 of the New York State Education Law.

SOURCE: NY Office of the Professions, Speech-Language Pathologists, Practice Guidelines, (Accessed Apr. 2025).

LICENSURE COMPACTS

Last updated 04/27/2025

No Reference Found

PROFESSIONAL BOARDS STANDARDS

Last updated 04/27/2025

Profession-Specific Telepractice Guidance is available for:

- Applied Behavior Analysis
- Audiology
- Mental Health Practitioners
- Physical Therapy
- Psychology
- Social Work
- Speech-Language Pathology

SOURCE: NY Office of the Professions, Applied Behavioral Analysis, Practice Alerts – Telepractice; Audiology, Practice Alerts – Telepractice; Mental Health Practitioner, Practice Alerts – Telepractice; Physical Therapy, Practice Alerts – Telepractice; Psychology Practice Alerts – Telepractice; Social Work Practice Alerts – Telepractice; Speech Language Pathology Practice Alerts – Telepractice. (Accessed Apr. 2025).

Workers' Compensation

See regulations for related provider practice requirements.

SOURCE: Title 12 NYCRR Section. 325-1.26 as proposed to be added by Notice Of Adoption. (Accessed Apr. 2025).

MISCELLANEOUS

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Services may be provided by OASAS certified, approved or otherwise authorized programs. OASAS programs must apply in accordance with these Telehealth Standards for OASAS Designated Providers (hereinafter Standards) for approval to deliver services via telehealth. OASAS certified programs are required to submit the Attestation for Telehealth (attached herein as Appendix B) requesting a designation be added to their

operating certificate prior to service delivery via this method. The purpose of this document is to provide guidance to programs seeking to deliver services via telehealth.

OASAS has specific telepractice standards for its providers. See regulation for details.

SOURCE: OASAS Telehealth Standards for OASAS Designated Providers, p. 3. Aug. 2023. (Accessed Apr. 2025).

Adverse action against legal reproductive health care or gender affirming care

Every insurer that issues or renews medical malpractice insurance covering a health care provider licensed to practice in this state shall be prohibited from taking any adverse action against a health care provider solely on the basis that the health care provider performs an abortion or provides reproductive health care or gender affirming care that is legal in this state on someone who is from out of the state. Such policy shall include health care providers who legally prescribe abortion medication to out-of-state patients by means of telehealth.

As used in this section, “adverse action” shall mean but not be limited to: (1) refusing to renew or execute a contract or agreement with a health care provider; (2) making a report or commenting to an appropriate private or governmental entity regarding practices of such provider which may violate abortion laws in other states; and (3) increasing in any charge for, or a reduction or other adverse or unfavorable change in the terms of coverage or amount for, any medical malpractice insurance contract or agreement with a health care provider.

SOURCE: NY Insurance Law Article 34 Section 3436*2-a, as added by S 9080 (2022 Session) and amended by S 4007 (2023 Session) and S 8058 (2024 Session). (Accessed Apr. 2025).