SUMMARY OF EXPRESS TERMS

These proposed regulatory amendments are needed to ensure continuity of care provided to Medicaid enrollees during the transition from telehealth services provided during the public health emergency and after the public health emergency ends. During the public health emergency, all Medicaid providers were authorized to utilize telehealth, including audio-only telephone or other audio-only technology pursuant to Executive Orders and subsequently, pursuant to Emergency Regulations. This telehealth regulation is required to authorize Medicaid providers to continuously provide services pursuant to these flexibilities to ensure continuity of care. Specifically, the proposed telehealth regulation provides:

1. Expansion in the types of providers who can deliver care 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.
2. Addition of Audio-only, eConsult, Virtual Check-in, and Virtual Patient Education as telehealth modalities, as well as parameters for appropriately using those modalities and standards for reimbursement.

The revisions to radiology regulations are required to allow for the provision of teleradiology as well as remove outdated reimbursement processes. Specifically, the amendments provide:

1. Definitions for interventional and diagnostic radiology, which may be conducted without a physical encounter.
2. Reimbursement guidelines for physicians and hospitals billing for professional and technical and administrative components of a radiology service. References to an outdated fee schedule have been removed.

Pursuant to the authority vested in the Commissioner of Health by sections 2999-cc(2)(y) and (4), 2999-ee, and 201(1)(v) of the Public Health Law and section 365-a of the Social Services Law, sections 505.17 and 533.6 of Title 18 (Social Services) of the Official Compilation of Codes, Rules and Regulations of the State of New York are amended, and Part 538 is added, to be effective on publication of the Notice of Adoption in the State Register, to read as follows:

Paragraph (7) of subdivision (c) of section 505.17 is amended to read as follows:

(7) Radiology services means the provision of the following services to MA recipients:

(i) [diagnostic] interventional radiology;

(ii) screening and diagnostic radiology, including ultrasound and nuclear medicine; or

(iii) [nuclear medicine; or

(iv)] radiation oncology.

Subdivision (f) of section 505.17 is amended to read as follows:

(f) Limitations on payment for radiology services.

(1) In order to be paid for both the professional and the technical and administrative components of the radiology service or solely for the technical and administrative component, as defined in section 533.6(b) of this Title, qualified practitioners who provide radiology services in their offices must [perform the professional component of radiology services as set forth in section 533.6 of this Title and]:

(i) own or directly lease the equipment and must supervise and control the radiology technicians who perform the radiology procedures; or

(ii) be the employees of physicians who own or directly lease the equipment and must supervise and control the radiology technicians who perform the radiology procedures.

(2) In order to be paid for both the professional and the technical and administrative components of the radiology services or solely for the technical and administrative component, as defined in section 533.6(b) of this Title, qualified practitioners who provide radiology services in mobile settings must [perform the professional component of radiology services as set forth in section 533.6 of the Title and]:

(i) own or directly lease the equipment and must employ the radiology technicians who perform the radiology procedures; or

(ii) be the employees of physicians who own or directly lease the equipment and such physicians must employ the radiology technicians who perform the radiology procedures.

(3) A qualified practitioner who provides radiology services in a facility certified under Article 28 of the Public Health Law which owns or leases the equipment [and in which the professional component is not included in the facility's MA payment rate as established by the Department of Health and approved by the Director of the Budget] will be paid only the professional component of the radiology services as defined in section 533.6 of this Title. No payment will be made to a qualified practitioner solely for the technical and administrative component of radiology services provided in such a facility.

(4) If a qualified practitioner in private practice sends a film to a radiologist for professional review, [no payment will be made to the radiologist. The cost of such professional review is a cost of doing business to the qualified practitioner providing the radiology service] the

practitioner must comply with paragraph (1) or (2) of this subdivision and payment will be made solely for the technical and administrative component as defined in section 533.6 of this Title. The radiologist performing the read will be reimbursed solely for the professional component as defined in section 533.6 of this Title.

Subdivisions (a) through (e) of section 533.6 are amended to read as follows:

(a) Maximum payment for radiology services. The department will [pay] reimburse providers of radiology services according to the radiology fees listed in the relevant Radiology Fee Schedule [in subdivision (f) of this section] at https://www.emedny.org/ProviderManuals/Radiology/index.aspx or https://www.emedny.org/ProviderManuals/OrderedAmbulatory/index.aspx. Unless otherwise indicated, these fees are full payment for the radiology service provided.

(b) Radiology fee components. The fees listed in [the] each Radiology Fee Schedule set forth in subdivision (a) of this section include payment for the professional component [and for] and/or the technical and administrative component of radiology services.

(1) Professional component. [(i)] The professional component of radiology services refers to the various professional services performed by physicians, including:

[(a)] (i)(*a*) for interventional radiology services, determining the patient's problem, including interviewing the patient, obtaining the patient's medical history, and [physically] examining the patient to decide how to perform radiology procedures;

(*b*) for diagnostic radiology services, reviewing relevant clinical information as presented by the ordering or referring physician, including the basis for performing the radiology study;

[(b)] (ii) studying the results of diagnostic or therapeutic procedures, interpreting X-rays or radioisotope data and estimating treatment results;

[(c)] (iii) dictating examination or treatment reports; and

[(d) Consulting] (iv) consulting with and furnishing written reports to referring physicians regarding the results of diagnostic or therapeutic procedures.

[(ii) Physicians who render these services in hospitals are paid 40 percent of the appropriate fee listed in the Radiology Fee Schedule. The remaining 60 percent is applied to the technical and administrative component described in paragraph (2) of this subdivision.

(iii) Payments may be made only to physicians meeting the requirements of section 505.17 of this Title. Only physicians who are not paid by a hospital for patient care and who bill separately from a hospital may be paid under this section.]

(2) Technical and administrative component of radiology services. [(i)] The technical and administrative component of radiology services refers to [the] various services [provided to the physician by the hospital], including the following:

[(a)] (i) use of [hospital] personnel, such as technologists and clerical staff;

[(b)] (ii) use of [hospital] supplies such as film, opaques, radioactive substances, chemicals and drugs; and

[(c)] (iii) purchase, rental or maintenance of space, equipment, telephones or other [facilities or] related supplies.

[(ii) Sixty percent of the fee listed in the Radiology Fee Schedule is applicable to these technical and administrative services provided by the hospital.]

(3) Procedures not separable into professional and technical and administrative components. Injections of radiopaque media, fluoroscopy and consultations must be performed by the physician. Consequently, these procedures are not separated for billing into professional and technical and administrative components, and the total fee listed in the relevant Radiology Fee Schedule set forth in subdivision (a) of this section for such services is paid to the physician.

(c) Reimbursement. (1) Physicians who render both the professional and technical and administrative components of a radiology service must meet the requirements of section 505.17 of this Title and will be reimbursed the global fee listed in the relevant Radiology Fee Schedule set forth in subdivision (a) of this section.

(2) Physicians who render solely the professional component of a radiology service will be reimbursed the professional fee listed in the relevant Radiology Fee Schedule set forth in subdivision (a) of this section.

(3) Physicians who render solely the technical and administrative component of a radiology service must meet the requirements in section 505.17 of this Title and will be reimbursed the technical and administrative fee listed in the relevant Radiology Fee Schedule set forth in subdivision (a) of this section.

(4) Hospitals that render both the professional and technical component of a radiology service will be reimbursed the global fee listed in the relevant Radiology Fee Schedule set forth in subdivision (a) of this section.

(5) Hospitals that render solely the technical and administrative component of a radiology service will be reimbursed the technical and administrative fee listed in the relevant Radiology Fee Schedule set forth in subdivision (a) of this section.

(d) General rules. These rules apply to all procedure codes found in the Radiology Fee Schedule.

(1) What is included in radiology fees. Fees listed in the Radiology Fee Schedule include the following:

(i) the usual contrast media, equipment and materials. When the physician supplies special surgical trays or materials, an additional charge may be claimed from the department;

(ii) consultation with and written reports provided to the referring physician; and

(iii) payment for injection procedures, such as local anesthesia, needle or catheter placement or injection of contrast media as provided in the Radiology Fee Schedule, except for injection procedures which are identified by an asterisk before the [MMIS] code in the Radiology Fee Schedule.

(2) Payment for multiple or repeat radiology procedures. (i) When more than one radiology procedure is performed on different parts of the body during the same visit, the total payment is the sum of the fee for the more costly procedure plus 60 percent of the fee for the less costly procedure.

(ii) When a single radiology procedure is performed which shows more than one part of the body, payment will be made for only one procedure.

(iii) When repeat radiology procedures are performed on the same part of the body and for the same illness, payment for the repeat procedures will be made according to the fee listed in the Radiology Fee Schedule. However, no payment will be made for repeat procedures on the same part of the body and for the same illness when the reason for the repeat procedure is technical or professional error in the original procedure.

[(d)] (e) Outpatient and clinic services. No additional payment will be made for outpatient emergency and clinic services if the cost of providing radiology or radiotherapy services is included in the maximum reimbursement rate promulgated for the hospital by the Director of the Budget pursuant to section 2807 of the Public Health Law. When physicians refer patients for outpatient radiology or radiotherapy services, payment will be made according to the Radiology Fee Schedule except when radiology or radiotherapy services are provided in a facility that includes the cost of these services in its clinic rate calculation. In these cases, the recipient shall be registered as a clinic patient and the clinic rate shall be billed.

[(e)] (f) [Medicaid management information system (MMIS)] Current Procedural Terminology (CPT) code modifiers. Each radiology procedure listed in the Radiology Fee Schedules set forth in subdivision (a) of this section is preceded by a five-digit number identifying the specific procedure for which payment is claimed. Known as [the MMIS] a CPT procedure code, this number sometimes must be expanded by two additional digits, or modifiers, to describe more completely the particular procedure involved. The modifiers used in radiology are [described below:

(1) '-60' Professional component. When physicians provide radiology services in hospitals but are not paid for these services by the hospitals, the physicians' services are identified for billing purposes by adding the modifier '-60' to the MMIS procedure code.

(2) '-61' Technical and administrative component. When physicians provide radiology services in hospitals but are not paid for these services by the hospitals, the services, facilities and supplies furnished to the physicians by the hospitals are identified for billing purposes by adding the modifier '-61' to the MMIS procedure code.

(3) '-62' Multiple radiology procedures. When more than one radiology procedure is performed on different parts of the body during the same visit, the more costly procedure is identified for billing purposes by its MMIS procedure code, and the less costly procedure is identified by adding the modifier '-62' to its MMIS procedure code.

(4) '-65' Multiple vascular radiology procedures. When more than one vascular radiology procedure is performed at the same time, the more costly procedure is identified for billing purposes by its MMIS procedure code and the less costly procedure is identified by adding the modifier '-65' to its MMIS procedure code.

(5) '-66' Repeal radiology procedures. When radiology procedures are repeated for reasons other than technical or professional error in the original procedure, the repeat procedure is identified for billing purposes by adding the modifier, '-66' to the MMIS procedure code.

(6) '-19' Multiple modifiers. More than one modifier often may be needed to identify radiology procedures for which payment is sought. Add the modifier '-19' to the MMIS procedure code and

list the applicable modifiers in the procedure description] are found in the relevant Radiology Fee Schedule set forth in subdivision (a) of this section.

Subdivision (f) of section 533.6, Radiology Fee Schedule, is REPEALED.

Part 538 is added to read as follows:

PART 538 State Reimbursement for Telehealth Services

Section 538.1 Definitions. Telehealth has the meaning set forth in Public Health Law § 2999-cc and shall also include the following terms with the following meanings:

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

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

(c) "Telehealth provider" is defined in Public Health Law § 2999-cc(2) and 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.

(d) "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.

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

Section 538.2 Modalities and applicable standards. 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:

(a) 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.

(b) “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.

(c) “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.

(d) “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.

Section 538.3 Reimbursement. (a) 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.

(b) 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.

(c)(i) Subject to payment restrictions set forth in § 1842(n)(1) of the federal social security act and 42 C.F.R. § 414.50, 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.

(ii) 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.

REGULATORY IMPACT STATEMENT

Statutory Authority:

Public Health Law section 2999-cc(2)(y) provides the Commissioner of Health with the authority to determine, in consultation with the Commissioners of the Office of Mental Health, the Office of Addiction Services and Supports, or the Office for People with Developmental Disabilities, other categories of providers authorized to provide telehealth services.

Public Health Law section 2999-cc(4) requires promulgation of regulations to cover the modality of audio-only telephone communication as telehealth in the medical assistance and child health insurance programs.

Public Health Law section 2999-ee provides the Commissioner of Health with the authority to specify in regulation additional acceptable modalities for the delivery of health care services via telehealth, including audio-only telephone communications, in consultation with the Commissioners of the Office of Children and Family Services, the Office of Mental Health, the Office of Addiction Services and Supports, or the Office for People with Developmental Disabilities.

Public Health Law section 201(1)(v) requires the Department of Health (Department) to act as the single State agency for Medicaid with the responsibility to supervise the plan required by Title XIX of the federal Social Security Act and to adopt regulations as may be necessary to implement this plan.

Social Services Law section 365-a requires Medicaid coverage of certain medical care, services and supplies as authorized in regulations of the Department, including x-ray services.

Legislative Objectives:

The legislative objective is to provide the Commissioner of Health with authority to determine the appropriate providers and modalities of telehealth necessary to increase access to health care services for Medicaid enrollees, especially for behavioral health, oral health, maternity care, care management, services provided in emergency departments and services provided to certain high-need populations.

Needs and Benefits:

These regulatory amendments are needed to ensure continuity of care provided to Medicaid enrollees. During the public health emergency, pursuant to Executive Orders that waived certain New York State laws and regulatory requirements related to telehealth, all Medicaid providers were authorized to utilize telehealth, including audio-only telephone or other audio-only technology. When these Executive Orders expired on June 24, 2021, the Department promulgated emergency regulations to authorize Medicaid providers to continuously provide services pursuant to these flexibilities to ensure continuity of care. These regulations will establish this authority permanently.

During the course of the public health emergency, Medicaid providers have adopted widespread use of telehealth, including through audio-only telephonic modalities and other audio-only technologies, as a means of delivering services to Medicaid beneficiaries. Providers have reported that this expansion of telehealth has improved access to care, improved patient

experience, and improved provider satisfaction. Telehealth also has the potential to improve patient outcomes, although measurement of these outcomes requires further research. Furthermore, expanded use of telehealth during the pandemic has resulted in Medicaid program savings related to avoidance of emergency room and urgent care visits, and decreased utilization of Medicaid-covered non-emergency medical transportation services.

Telehealth mitigates provider access issues by connecting patients in rural areas with needed specialist care. Teleradiology, in particular, is needed to combat the lack of available radiologists. Teleradiology improves patient care by allowing radiologists to provide services remotely without having to be at the same location as the patient. Small rural hospitals often employ only one radiologist or no radiologist at all. In some cases, the interpretation of a radiological image may require input from a radiologist with a sub-specialty (e.g., MRI radiology, neuro-radiology, pediatric radiology, etc.). Professionals with sub-specialty expertise typically practice in large metropolitan facilities. Teleradiology allows for these trained specialists to fill a void by providing competent and timely professional radiology services, when a radiologist is not otherwise available, twenty-four hours a day, seven days a week.

Given that the Centers for Medicare and Medicaid Services has authorized continued use of telehealth through modalities that align with Article 29-G of the Public Health Law, the Department is issuing these regulations in order to ensure ongoing and continuous access to telehealth services for Medicaid members, during and after the COVID-19 pandemic. These regulations will expand the types of providers authorized to provide care via telehealth, define additional telehealth modalities, including audio-only, and allow for teleradiology. This

continuous access is particularly important for members of the Medicaid population who are unable to access services in person, or who continue to be at risk for COVID-19.

Costs to Regulated Parties:

There are no costs imposed on regulated parties by these regulations because the amendments provide reimbursement for health care services provided via telehealth.

Costs to the Administering Agencies, the State, and Local Governments:

Costs to administering agencies and the State associated with these amendments will be covered by existing State budget appropriations and anticipated federal financial participation. There are no costs imposed on local governments by these regulations because the amendments provide reimbursement for health care services provided via telehealth.

Local Government Mandates:

The proposed regulations do not impose any new programs, services, duties or responsibilities upon any county, city, town, village, school district, fire district or other special district.

Paperwork:

The proposed regulations impose minimal paperwork requirements on regulated parties to claim Medicaid reimbursement for telehealth services provided to Medicaid enrollees.

Duplication:

There are no other State or Federal requirements that duplicate, overlap, or conflict with the statute and the proposed regulations.

Alternatives:

The Department considered the option of not promulgating these regulations, which would create an abrupt halt to certain telehealth flexibilities authorized during the public health emergency and which have proven vital to Medicaid members. In consultation with the Office of Mental Health and Office of Addiction Services and Supports, the Department determined that providing continuity of care to Medicaid enrollees is a public health priority and as such, decided to move forward with these regulations.

Federal Standards:

There are no minimum Federal standards regarding this subject.

Compliance Schedule:

These amendments shall be effective on publication of the Notice of Adoption in the State Register.

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STATEMENT IN LIEU OF

REGULATORY FLEXIBILITY ANALYSIS

No regulatory flexibility analysis is required pursuant to section 202-b(3)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse economic impact on small businesses or local governments, and it does not impose any new reporting, record keeping or other compliance requirements on small businesses or local governments.

Cure Period:

Chapter 524 of the Laws of 2011 requires agencies to include a "cure period" or other opportunity for ameliorative action to prevent the imposition of penalties on the party or parties subject to enforcement when developing a regulation or explain in the Regulatory Flexibility Analysis why one was not included. This regulation creates no new penalty or sanction. Hence, a cure period is not necessary.

STATEMENT IN LIEU OF

RURAL AREA FLEXIBILITY ANALYSIS

No rural area flexibility analysis is required pursuant to section 202-bb(4)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse impact on rural areas, and it does not impose any new reporting, record keeping or other compliance requirements on public or private entities in rural areas.

STATEMENT IN LIEU OF JOB IMPACT STATEMENT

No job impact statement is required pursuant to section 201-a(2)(a) of the State Administrative Procedure Act. It is apparent, from the nature of the proposed amendment, that it will not have an adverse impact on jobs and employment opportunities.