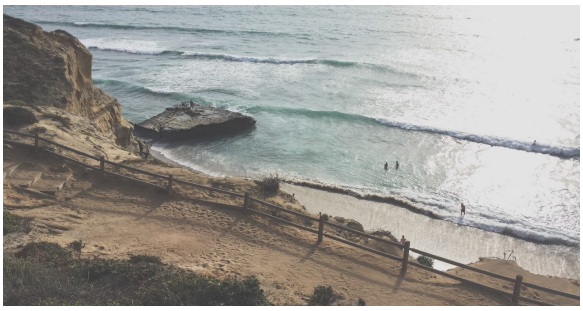
California



At A Glance

MEDICAID REIMBURSEMENT

- Live Video: Yes
- Store-and-Forward: Yes
- Remote Patient Monitoring: Yes* (CMS RPM codes)
- Audio Only: Yes

PRIVATE PAYER LAW

- Law Exists: Yes
- Payment Parity: Yes

PROFESSIONAL REQUIREMENTS

- Licensure Compacts: None
- Consent Requirements: Yes

FQHCs

- Originating sites explicitly allowed for Live Video: Yes
- Distant sites explicitly allowed for Live Video: Yes
- Store and forward explicitly reimbursed: Yes
- Audio-only explicitly reimbursed: Yes
- Allowed to collect PPS rate for telehealth: Yes

STATE RESOURCES

1. Medicaid Program: Medi-Cal
2. Program Administrator: California Dept. of Health Care Services (DHCS)
3. Regional Telehealth Resource Center: California Telehealth Resource Center

Private Payer

DEFINITIONS

Last updated 04/02/2024

"Telehealth means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store-and-forward transfers."

SOURCE: CA Business & Professions Code Sec. 2290.5. (Accessed Apr. 2024).

REQUIREMENTS

Last updated 04/02/2024

A health care service plan and health insurer shall not require that in-person contact occur between a health care provider and a patient before payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee or subscriber and the health care service plan or insurer, and between the health care service plan or insurer and its participating providers or provider groups, and pursuant to Health & Safety Code Section 1374.14 & Insurance Code Section 10123.855.

A health care service plan and health insurer shall not limit the type of setting where services are provided for the patient or by the health care provider before payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee or subscriber and the health care service plan or insurer, and between the health care service plan or insurer and its participating providers or provider groups, and pursuant to Health & Safety Code Section 1374.14 & Insurance Code Section 10123.855.

Applies to Medi-Cal Managed Care.

SOURCE: CA Health & Safety Code Sec. 1374.13 & Insurance Code Sec. 10123.85. (Accessed Apr. 2024).

Coverage shall not be limited only to services delivered by select third-party corporate telehealth providers. Insurers are not required to cover telehealth services provided by

an out-of-network provider, unless coverage is required under other provisions of law. Does not apply to Medi-Cal managed care.

SOURCE: CA Health & Safety Code Sec. 1374.14 & Insurance Code 10123.855. (Accessed Apr. 2024).

If a health care service plan or insurer offers a service via telehealth to an enrollee through a third-party corporate telehealth provider, all of the following conditions shall be met:

- The health care service plan or insurer shall disclose to the enrollee in any promotion or coordination of the service both of the following:
  - The availability of receiving the service on an in-person basis or via telehealth, if available, from the patients' primary care provider, treating specialist, or from another contracting individual health professional, contracting clinic, or contracting health facility consistent with the service and existing timeliness and geographic access standards in Sections 1367 and 1367.03 and regulations promulgated thereunder.
  - If the patient has coverage for out-of-network benefits, a reminder of the availability of receiving the service either via telehealth or on an in-person basis using the enrollee's out-of-network benefits, and the cost sharing obligation for out-of-network benefits compared to in-network benefits and balance billing protections for services received from contracted providers.
- After being notified pursuant to paragraph (1), the patient chooses to receive the service via telehealth through a third-party corporate telehealth provider.
- The patient consents to the service consistent with Section 2290.5 of the Business and Professions Code.
- If the patient is currently receiving specialty telehealth services for a mental or behavioral health condition, the enrollee is given the option of continuing to receive that service with the contracting individual health professional, a contracting clinic, or a contracting health facility.

If services are provided to an enrollee through a third-party corporate telehealth provider, a health care service plan or insurer shall comply with all of the following:

- Notify the patient of their right to access their medical records.
- Notify the patient that the record of any services provided to the enrollee through a third-party corporate telehealth provider shall be shared with their primary care provider, unless the patient objects.
- Ensure that the records are entered into a patient record system shared with the patient's primary care provider or are otherwise provided to the patient's primary care provider, unless the patent objects, in a manner consistent with state and federal law.
- Notify the patient that all services received through the third-party corporate telehealth provider are available at in-network cost-sharing and out-of-pocket costs shall accrue to any

applicable deductible or out-of-pocket maximum.

A health care service plan or insurer shall include in its reports submitted to the department all of the following for each product type:

- By specialty, the total number of services delivered via telehealth by third-party corporate telehealth providers.
- The names of each third-party corporate telehealth provider contracted with the plan or insurer and, for each, the number of services provided by specialty.
- For each third-party corporate telehealth provider with which it contracts, the percentage of the third-party corporate telehealth provider's contracted providers available to the plan's patients that are also contracting individual health professionals.
- For each third-party corporate telehealth provider with which it contracts, the types of telehealth services utilized by patients, including frequency of use, gender, age, and any other information as determined by the department.
- For each patient that has accessed services for a third-party corporate telehealth provider, patient demographic data, including gender and age, and any other information as determined by the department.

This section shall not apply when an enrollee seeks services directly from a third-party corporate telehealth provider or to Medicaid.

SOURCE: CA Health & Safety Code Sec. 1374.141 & Insurance Code 10123.856. (Accessed Apr. 2024).

A health care service plan or insurer that issues, sells, renews, or offers a plan contract covering dental services, including a specialized health care service plan contract covering dental services that offers a service via telehealth to an enrollee through a third-party corporate telehealth provider shall report to the department, in a manner specified by the department, all of the following for each product type:

1. The total number of services delivered via telehealth by a third-party corporate telehealth provider.
2. For each third-party corporate telehealth provider with which it contracts, the percentage of the third-party telehealth provider's contracted providers available to the plan's enrollees that are also network providers.
3. For each third-party corporate telehealth provider with which it contracts, the types of telehealth services utilized by enrollees, including information on the gender and age of the enrollee, and any other information as determined by the department.

A health care service plan or insurer that issues, sells, renews, or offers a plan contract covering dental services, including a specialized health care service plan contract

covering dental services that offers a service via telehealth to an enrollee through a third-party corporate telehealth provider, shall disclose to the enrollee the impact of third-party telehealth visits on the enrollee's benefit limitations, including frequency limitations and the enrollee's annual maximum.

For the purposes of this section, "third-party corporate telehealth provider" means a corporation that provides dental services exclusively through a telehealth technology platform and has no physical location at which a patient can receive services, and is directly contracted with a health care service plan, including a specialized health care service plan, that issues, sells, renews, or offers a plan contract covering dental services.

SOURCE: CA Health & Safety Code Sec. 1374.142 & Insurance Code 10123.857, as added by AB 1982 (2022 Session). (Accessed Apr. 2024).

PARITY

Last updated 04/02/2024

SERVICE PARITY

A health care service plan or insurer shall not require that in-person contact occur between a health care provider and a patient before payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee or subscriber and the health care service plan or insurer, and between the health care service plan or insurer and its participating providers or provider groups, and pursuant to Health and Safety Code Section 1374.14 and Insurance Code Section 10123.855.

A health care service plan or insurer shall not limit the type of setting where services are provided for the patient or by the health care provider before payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee or subscriber and the health care service plan or insurer, and between the health care service plan or insurer and its participating providers or provider groups, and pursuant to Health and Safety Code Section 1374.14 and Insurance Code Section 10123.855.

Applies to Medi-Cal Managed Care.

SOURCE: CA Health & Safety Code Sec. 1374.13 & Insurance Code Sec. 10123.85. (Accessed Apr. 2024).

A health care service plan or health insurer contract shall specify that the health care service plan or insurer shall provide coverage for health care services appropriately

delivered through telehealth services on the same basis and to the same extent that the health care service plan or insurer is responsible for coverage for the same service through in-person diagnosis, consultation, or treatment. Coverage shall not be limited only to services delivered by select third-party corporate telehealth providers. Does not apply to Medi-Cal managed care.

SOURCE: CA Health & Safety Code Sec. 1374.14 & Insurance Code 10123.855. (Accessed Apr. 2024).

PAYMENT PARITY

A contract between a health care service plan or insurer and a health care provider for the provision of health care services to an enrollee or subscriber shall specify that the health care service plan or insurer shall reimburse the treating or consulting health care provider for the diagnosis, consultation, or treatment of an enrollee or subscriber appropriately delivered through telehealth services on the same basis and to the same extent that the health care service plan or insurer is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment.

Services that are the same, as determined by the provider's description of the service on the claim, shall be reimbursed at the same rate whether provided in person or through telehealth. When negotiating a rate of reimbursement for telehealth services for which no in-person equivalent exists, a health care service plan or insurer and the provider shall ensure the rate is consistent with subdivision (h) of Section 1367.

Does not apply to Medi-Cal managed care.

SOURCE: CA Health & Safety Code Sec. 1374.14 & Insurance Code 10123.855. (Accessed Apr. 2024).

Medicaid

OVERVIEW

Last updated 04/02/2024

Medi-Cal allows providers to decide what modality, live video, store-and-forward, or audio-only, will be used to deliver eligible services to a Medi-Cal enrollee as long as the service is covered by Medi-Cal and meets all other Medi-Cal guidelines and policies, can be properly provided via telehealth, and meets the procedural and definition

components of the appropriate CPT or HCPCS code. Additional requirements apply for specific programs (such as FQHCs/RHCs and Indian Health Services). Medi-Cal also reimburses Medicare CTBS remote patient monitoring codes and one specific e-consult code.

DEFINITIONS

Last updated 04/02/2024

"Telehealth" means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a patient's health care. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store-and-forward transfers.

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth (Jan. 2023). Pg. 1. (Accessed Apr. 2024).

"Telehealth" means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a patient's health care. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous, real-time interactions between a patient and a health care provider located at a distant site.

SOURCE: CA Department of Health Care Services. Medi-Cal LEA Telehealth Manual. Jun. 2023. Pg. 1. (Accessed Apr. 2024).

LIVE VIDEO

Last updated 04/02/2024

POLICY

Synchronous Interaction

"Synchronous interaction" means a real-time interaction between a patient and a health care provider located at a distant site.

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth (Aug. 2020). Pg. 2. (Accessed Apr. 2024).

Medi-Cal covered benefits or services, identified by CPT or HCPCS codes and subject to all existing Medi-Cal coverage and reimbursement policies, including any treatment

authorization request requirements, may be provided via a telehealth modality, as outlined in this section, only if all of the following are satisfied:

- The treating health care provider at the distant site believes that the benefits or services being provided are clinically appropriate based upon evidence-based medicine and/or best practices to be delivered via telehealth;
- The benefits or services delivered via telehealth meet the procedural definition and components of the CPT or HCPCS code(s), as defined by the American Medical Association (AMA), associated with the Medi-Cal covered service or benefit, as well as any extended guidelines as described in this section of the Medi-Cal provider manual;
- The benefits or services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to his or her medical information.

Covered benefits or services provided via a telehealth modality are reimbursable when billed in one of two ways:

- For services or benefits provided via synchronous, interactive audio and visual telecommunications systems, the health care provider bills with modifier 95.
- For services or benefits provided via asynchronous store and forward telecommunications systems, the health care provider bills with modifier GQ.
- For services or benefits provided via synchronous telephone or other real-time interactive audio-only telecommunications systems, the health care provider bills with modifier 93.

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth (Mar. 2024). Pg. 8. (Accessed Apr. 2024).

CA Medicaid and Medi-Cal managed care plans are required to reimburse health care providers of applicable health care services delivered via video synchronous interaction, synchronous audio-only modality, or asynchronous store and forward, as applicable, at payment amounts that are not less than the amounts the provider would receive if the services were delivered via in-person, face-to-face contact, so long as the services or settings meet the applicable standard of care and meet the requirements of the service code being billed.

In-person, face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for covered health care services and provider types designated by the department, when provided by video synchronous interaction, asynchronous store and forward, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, when those

services and settings meet the applicable standard of care and meet the requirements of the service code being billed.

Applicable health care services appropriately provided through video synchronous interaction, asynchronous store and forward, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities are subject to billing, reimbursement, and utilization management policies imposed by the department. Utilization management protocols adopted by the department pursuant to this section shall be consistent with, and no more restrictive than, those authorized for health care service plans pursuant to Section 1374.13 of the Health and Safety Code.

Pursuant to an effective date designated by the department that is no sooner than January 1, 2024, a provider furnishing services through video synchronous interaction or audio-only synchronous interaction shall also maintain and follow protocols to do one of the following:

- Offer those services via in-person, face-to-face contact.
- Arrange for a referral to, and a facilitation of, in-person care that does not require a patient to independently contact a different provider to arrange for that care. (This clause does not require a provider to schedule an appointment with a different provider on behalf of a patient.)

In implementing this subdivision, the department shall consider additional recommendations from affected stakeholders regarding the need to maintain access to in-person services without unduly restricting access to telehealth services.

SOURCE: Welfare and Institutions Code 14132.725, as amended by SB 184 (2022 Session) and AB 1241 (2023 Session). (Accessed Apr. 2024).

In-person contact between a health care provider and a patient shall not be required under the Medi-Cal program for services appropriately provided through telehealth, subject to reimbursement policies adopted by the department to compensate a licensed health care provider who provides health care services through telehealth that are otherwise reimbursed pursuant to the Medi-Cal program.

SOURCE: Sec. 14132.72 of the Welfare and Institutions Code. (Accessed Apr. 2024).

Providers may establish a relationship with new patients via synchronous video telehealth visits.

SOURCE: Welfare and Institutions Code 14132.725; CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth (Mar. 2024). Pg. 3. (Accessed Apr. 2024).

Patient Choice of Telehealth Modality

Medi-Cal providers can offer a variety of telehealth modalities for covered Medi-Cal services to the extent that the service can be appropriately rendered via the allowable telehealth modalities. For Medi-Cal providers who do offer telehealth modalities, they are required to offer Medi-Cal recipients the ability to choose whether they want to receive covered Medi-Cal services via:

- Synchronous, interactive audio/visual telecommunication systems (for example, video) or
- Synchronous, telephone or other interactive audio-only telecommunications systems.

While Medi-Cal providers are required to offer both video and telephone telehealth modalities, Medi-Cal recipients may freely choose, and change at any time, their desired telehealth modalities, which includes the ability to decline video modalities and select audio-only (telephone) modalities if preferred and/or necessary given the recipient's needs. For example, if the visit is related to sensitive services as defined in subsection (s) of Section 56.05 of the Civil Code, then the Medi-Cal recipient may prefer to utilize an audio-only (telephone) modality. Medi-Cal recipients shall be given the choice of how they receive their covered Medi-Cal services.

Exception to Telehealth Modalities Provider Requirement

Since broadband is necessary to ensure quality and effective communication between Medi-Cal providers and recipients, Medi-Cal providers are exempt from the requirement to offer both telehealth modalities if the Medi-Cal provider does not have access to broadband. Note: Broadband refers to high-speed internet access that is always on and faster than traditional dial-up access. Broadband includes several high-speed transmission technologies, such as fiber, wireless, satellite, digital subscriber line, and cable. For the purposes of delivering telehealth services to patients, DHCS uses the Federal Communications Commission's (FCC) definition of broadband and the FCC minimum mbps upload/download speeds. Medi-Cal providers claiming this exception must maintain appropriate supporting documentation, which should be made available to DHCS upon request. For example, supporting documentation might include confirmation from an internet services provider regarding the lack of broadband service in a particular coverage area.

Right to In-person Services

Medi-Cal providers furnishing services to Medi-Cal recipients through telehealth modalities must also either offer services in-person or have a documented process in place to link Medi-Cal recipients to in-person care within a reasonable time if in-person services are unavailable from the provider.

If the Medi-Cal provider chooses to link the Medi-Cal recipient to in-person care to satisfy this requirement, then they must provide a referral to and facilitation of in-person care that does not require a recipient to independently contact a different Medi-Cal provider to arrange for such care. The Medi-Cal provider may initiate a process by which a different Medi-Cal provider in their office or an affiliated in-person care site contacts the Medi-Cal recipient directly to schedule an in-person visit. T

he referring Medi-Cal provider or a member of their staff must confirm the referred Medi-Cal provider has at least attempted to contact the recipient to schedule an in-person appointment. However, the Medi-Cal referring provider is not required to schedule an appointment with a different provider on behalf of the Medi-Cal recipient. The Medi-Cal provider must offer referral and facilitation support that is minimally burdensome to the Medi-Cal recipient. Medi-Cal providers must maintain documentation of their process to link Medi-Cal recipients to in-person care, which should be made available to DHCS upon request.›

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth (Mar. 2024). Pg. 6-7. (Accessed Apr. 2024).

Brief Virtual Communications and Check-ins

Virtual or telephonic communication includes a brief communication with an established patient not physically present (face-to-face). Medi-Cal providers may be reimbursed using HCPCS codes G2010 and G2012 for brief virtual communications.

HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5 to 10 minutes of medical discussion. G2012 can be billed when the virtual communication via a telephone call.

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth (Mar. 2024). Pg. 12. (Accessed Apr. 2024).

Federally Qualified Health Center (FQHC) & Rural Health Clinic (RHC)

Telehealth services must meet all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter with a billable provider and meet the applicable standard of care.

Services rendered via telehealth must be FQHC or RHC covered services. Synchronous interaction means a real-time audio-visual, two-way interaction between a new or established patient and an FQHC or RHC billable provider at a distant site. Medi-Cal benefits or services being provided are clinically appropriate and meet the procedural and billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter. An FQHC patient who receives telehealth services shall otherwise be eligible to receive in-person services from the FQHC pursuant to the federal Health Resources Services Administration requirements. A patient may be "established" via synchronous interaction if all of the conditions of the "New Patient" requirements in this manual section are met.

See manual for billing examples.

In regard to patient choice of telehealth modality and right to in-person services requirements, FQHC/RHC providers are directed to refer to the policies found in more detail in the Telehealth Manual.

SOURCE: CA Dept. of Health Care Services, Part 2 Manual, Medi-Cal Rural Health Clinics and Federally Qualified Health Centers (Mar. 2024), p. 12-13, 15-16. (Accessed Apr. 2024).

Visits shall also include an encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and family therapist using video synchronous interaction, when services delivered through that interaction meet the applicable standard of care. A visit described in this clause shall be reimbursed at the applicable FQHC's or RHC's per-visit PPS rate to the extent the department determines that the FQHC or RHC has met all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter.

An FQHC or RHC is not precluded from establishing a new patient relationship through video synchronous interaction.

Effective on a date designated by the department that is no sooner than January 1, 2024, an FQHC or RHC furnishing services through video synchronous interaction or audio-only synchronous interaction shall also do one of the following:

- Offer those services via in-person, face-to-face contact.
- Arrange for a referral to, and a facilitation of, in-person care that does not require a patient to independently contact a different provider to arrange for that care.

SOURCE: Welfare and Institutions Code 14132.100, as amended by SB 184 (2022 Session) and AB 32 (2022 Session). (Accessed Apr. 2024).

Family PACT

Family PACT providers must ensure that the covered Family PACT service or benefit being delivered via telehealth meets the procedural definition and components of the CPT or HCPCS code(s) associated with the Family PACT covered service or benefit, as well as any other requirements described in this manual. In addition, Family PACT services rendered by the use of a telehealth modality must follow ICD-10-CM diagnosis code billing policy as noted in this manual. All healthcare practitioners rendering Family PACT covered benefits or services under this policy must comply with all applicable state and federal laws.

SOURCE: CA Department of Health Care Services. Family Planning, Access, Care and Treatment Program. Benefits Manual. Jun. 2023, Pg. 6. (Accessed Apr. 2024).

A Family PACT provider may enroll and recertify clients through synchronous video or audio-only synchronous telehealth modalities. See manual for more information.

SOURCE: CA Department of Health Care Services. Family PACT Client Eligibility Manual. Apr. 2023. Pg. 1. (Accessed Apr. 2024).

Managed Care

To ensure proper payment and record of Covered Services provided via Telehealth, all Providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered through both synchronous interactions and asynchronous store and forward telecommunications. Regarding the rate of reimbursement, unless otherwise agreed to by the MCP and Provider, MCPs must reimburse Network Providers at the same rate, whether a Covered Service is provided in-person or through Telehealth, if the service is the same regardless of the modality of delivery, as determined by the Provider's description of the service on the claim.

SOURCE: CA Department of Health Care Services (DHCS). All Plan Letter 23-007: Telehealth Services Policy. Apr. 10, 2023. (Accessed Apr. 2024).

Indian Health Services, Memorandum of Understanding Agreement (IHS-MOA)

Services rendered via telehealth must be IHS-MOA covered services.

Services provided through synchronous telehealth for an established patient are subject to the same program restrictions, limitations and coverage that exist when the service is

provided in-person.

- IHS-MOA clinics must submit claims for telehealth services using the appropriate per visit IHS-MOA billing codes, modifiers and related claims submission requirements. Providers may refer to the Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics: Billing Codes section in the appropriate Part 2 manual.
- IHS-MOA clinics are not eligible to bill an originating site fee or transmission charges. The costs of these services should be included in the IHS-MOA rate.

See manual for billing examples.

SOURCE: CA Department of Health Care Services (DHCS). Indian Health Services, Memorandum of Agreement (MOA) 638, Clinics Manual. Jan. 2023. Pg. 8. (Accessed Apr. 2024).

Local Educational Agency (LEA)

For dates of service on or after May 12, 2023, LEAs may bill for covered direct medical services under the LEA Medi-Cal Billing Option Program according to the following guidelines. All LEA services covered under the LEA Medi-Cal Billing Option Program may be billed by participating LEAs when performed via telehealth, except for services that preclude a telehealth modality, such as specialized medical transportation services. Services delivered via telehealth must meet the requirements described in the Medi-Cal provider manual.

Practitioners must use the "LEA Services Billing Codes Chart" in the Local Educational Agency (LEA) Billing Codes and Reimbursement Rates provider manual section to find LEA services that are reimbursable when rendered by telehealth. The first column of the chart indicates "Add modifier 95 if via telehealth" when the telehealth service is reimbursable under the LEA Medi-Cal Billing Option Program.

SOURCE: CA Department of Health Care Services (DHCS). Local Education Agency (LEA) Telehealth. Jun. 2023. Pg. 1, 5. (Accessed Apr. 2024).

Dental Services

The Department of Health Care Services has opted to permit the use of teledentistry (including live video) as an alternative modality for the provision of select dental services.

Synchronous interaction, or live transmission, is a real-time interaction between a member and a provider located at a distant site. Live transmissions are limited to 90 minutes per member per provider, per day. Please note, live transmissions may be

provided at the member's request or if the health care provider believes the service is clinically appropriate. See manual for billing codes.

SOURCE: CA Department of Health Care Services (DHCS). Dental Provider Handbook. (2023) Pg. 4-22 – 4-24 (Accessed Apr. 2024).

Drug Medi-Cal Treatment Program

A county that enters into a Drug Medi-Cal Treatment Program contract with the department shall reimburse Drug Medi-Cal certified providers for medically necessary Drug Medi-Cal reimbursable services, as defined in Section 14124.24, provided by a licensed practitioner of the healing arts, or a registered or certified alcohol or other drug counselor or other individual authorized by the department to provide Drug Medi-Cal reimbursable services when those services meet the standard of care, meet the requirements of the service code being billed, and are delivered through video synchronous interaction or audio-only synchronous interaction.

SOURCE: Welfare and Institutions Code 14132.731, as amended by SB 184 (2022 Session). (Accessed Apr. 2024).

ELIGIBLE SERVICES/SPECIALTIES

Medi-Cal covered benefits or services, identified by CPT or HCPCS codes and subject to all existing Medi-Cal coverage and reimbursement policies, including any treatment authorization request requirements, may be provided via a telehealth modality if all of the following are satisfied:

- The treating health care provider at the distant site believes that the benefits or services being provided are clinically appropriate based upon evidence-based medicine and/or best practices to be delivered via telehealth;
- The benefits or services delivered via telehealth meet the procedural definition and components of the CPT or HCPCS code(s), as defined by the American Medical Association, associated with the Medi-Cal covered service or benefit, as well as any extended guidelines as described in this section of the Medi-Cal provider manual; and
- The benefits or services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to his or her medical information.

Covered benefits or services provided via a telehealth modality are reimbursable when billed in one of two ways:

- For services or benefits provided via synchronous, interactive audio and visual telecommunications systems, the health care provider bills with modifier 95.
- For services or benefits provided via asynchronous store and forward telecommunications systems, the health care provider bills with modifier GQ.
- For services or benefits provided via synchronous telephone or other real-time interactive audio-only telecommunications systems, the health care provider bills with modifier 93.

Certain types of benefits or services that would not be expected to be appropriately delivered via telehealth include, but are not limited to, benefits or services that are performed in an operating room or while the patient is under anesthesia, require direct visualization or instrumentation of bodily structures, involve sampling of tissue or insertion/removal of medical devices and/or otherwise require the in-person presence of the patient for any reason.

The amount paid by DHCS and Medi-Cal managed care plans for a service rendered via telehealth is the same as the amount paid for the applicable service when rendered in-person.

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth (Mar. 2024). Pg. 4, 8. (Accessed Apr. 2024).

Medi-Cal covers an 'e-visit' which are communications between a patient and their provider through an online patient portal.

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth (Aug. 2020). Pg. 2. (Accessed Apr. 2024).

Evaluation and management services may be delivered via telehealth when Medi-Cal requirements are met.

SOURCE: Department of Health Care Services. Evaluation & Management Manual. Page 27. Dec 2022. (Accessed Apr. 2024).

Modifier 95 must be used for Medi-Cal covered benefits or services delivered via synchronous, interactive audio/visual, telecommunications systems. Only the portion(s) of the telehealth service rendered at the distant site are billed with modifier 95. The use of modifier 95 does not alter reimbursement for the CPT or HCPCS code.

See manual for telecommunications system requirements.

See Telehealth Modifier Reference Sheet- Organized by Delivery System for more information on modifiers.

Evaluation and Management (E&M) and all other covered Medi-Cal services provided at the originating site (in-person with the patient) during a telehealth transmission are billed according to standard Medi-Cal policies (without modifier 95). The E&M service must be in real-time or near real-time (delay in seconds or minutes) to qualify as an interactive two-way transfer of medical data and information between the patient and health care provider.

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth (Mar. 2024). Pg. 10. (Accessed Apr. 2024).

Federally Qualified Health Center (FQHC) & Rural Health Clinic (RHC)

Synchronous interaction means a real-time audio-visual, two-way interaction between a new or established patient and an FQHC or RHC billable provider at a distant site.

Medi-Cal benefits or services being provided are clinically appropriate and meet the procedural and billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter.

SOURCE: CA Department of Health Care Services (DHCS). Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHC) Outpatient Services Manual. Mar. 2024. Pg. 16. (Accessed Apr. 2024).

Indian Health Services, Memorandum of Understanding Agreement (IHS-MOA)

Services provided through synchronous telehealth for an established patient are subject to the same program restrictions, limitations and coverage that exist when the service is provided in-person.

- IHS-MOA clinics must submit claims for telehealth services using the appropriate per visit IHS-MOA billing codes, modifiers and related claims submission requirements. Providers may refer to the Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics: Billing Codes section in the appropriate Part 2 manual.

SOURCE: CA Department of Health Care Services (DHCS). Indian Health Services, Memorandum of Agreement (MOA) 638, Clinics Manual. Jan. 2023. Pg. 7-8. (Accessed Apr. 2024).

Dental Services

Synchronous interaction, or live transmission, is a real-time interaction between a member and a provider located at a distant site. Live transmissions are limited to 90 minutes per member per provider, per day. Please note, live transmissions may be provided at the member's request or if the health care provider believes the service is clinically appropriate. All dental information transmitted during the delivery of Medi-Cal

covered benefits or services via a telehealth modality must become part of the patient's dental record maintained by the Medi-Cal provider at the distant site.

SOURCE: CA Department of Health Care Services (DHCS). Denti-Cal Manual. 2023. Pg. 4-24. (Accessed Apr. 2024).

Home Health & Durable Medical Equipment

Telehealth may be used to deliver a face-to-face encounter related to the primary reason a recipient requires home health services or a durable medical equipment item.

SOURCE: Department of Health Care Services. Home Health Agencies (HHA) Provider Handbook. (Feb. 2021), Pg. 3. & Department of Health Care Services. Durable Medical Equipment (DME): An Overview. (July 2021), Pg. 6. (Accessed Apr. 2024).

CA Children's Services (CCS)

CA Children's Services Program lists eligible CPT/HCPCS codes in Numbered Letters 16-1217 & 09-0718. Codes specifically include tele-speech, tele-auditory verbal therapy, tele-auditory habilitation and tele-auditory rehabilitation services in the home, with the parent or guardian working with the speech therapist at the distant site.

SOURCE: Number Letter 09-0718 to CA Children's Services Program. Jul. 10, 2018. (Accessed Apr. 2024).

CCS providers must request prior authorization services from CCS paneled physicians (22, CCR Section 41412) who are available to provide telehealth services. Prior authorization requests are also authorized to CCS-approved hospitals and outpatient special care centers. GHPP providers must be Medi-Cal enrolled providers.

Physical and Occupational Therapy may be offered through appropriate telehealth modalities. Medical Therapy Unit therapists may offer remote/virtual teletherapy services as an alternative to in-person visits, as appropriate and directed by the Medical Therapy Conference and directing physicians. CCS clients receiving services through a Special Care Center and/or Medical Therapy Program Medical Therapy Conference must have an annual in-person evaluation by a CCS-paneled physician. GHPP clients require an annual evaluation to ensure continued program coverage.

Billing for telehealth services is contingent upon the CCS Program or GHPP clients meeting all eligibility criteria, with an approved CCS Program/GHPP SAR, and in conformance with required Medi-Cal claims submission procedures as outlined in the DHCS Medi-Cal Telehealth Policy.

- When submitting a SAR for synchronous telemedicine services, the provider must use codes provided in the American Medical Association (AMA's) CPT Manual, Appendix P.
- Telehealth modifiers (93, 95 or GQ) are required on SARs to differentiate the telehealth service from the equivalent in-person service.
- For services or benefits provided via synchronous, interactive audio, and telecommunications systems, the health care provider bills with modifier 95.
- For services or benefits provided via synchronous, telephone or other interactive audio-only telecommunications systems, the health care provider bills with modifier 93.
- For services or benefits provided via asynchronous store-and-forward telecommunications systems, the health care provider bills with modifier GQ.

For Whole Child Model (WCM) counties, the client's managed care plan (MCP) shall be responsible for authorizing, coordinating, and covering CCS telehealth services.

SOURCE: Department of Health Care Services. Numbered letter 03-0723 to the Children's Services Program and Genetically Handicapped Persons Program (GHPP). Jul. 7, 2023 – supersedes Department of Health Care Services. Numbered letter 16-1217 to the CA Children's Services Program and Genetically Handicapped Persons Program (GHPP). Dec. 22, 2017. (Accessed Apr. 2024).

Opioid Use Disorder Treatment Services

Outpatient treatment services for opioid use disorder (OUD), which include management, care coordination, psychotherapy and counseling are reimbursable using HCPCS codes G2086, G2087 and G2088. At least one psychotherapy service must be furnished in order to bill for HCPCS codes G2086 thru G2088. Although the descriptions for these codes refer to "office-based treatment," these services may be delivered via telehealth when they meet Medi-Cal requirements. See Medi-Cal Telehealth Provider Manual.

HCPCS codes G2086 thru G2088 are not reimbursable for treatment in state-licensed Opioid Treatment Programs as defined in Health and Safety Code Section 11875. HCPCS codes G2086 and G2087 each have a frequency limit of once per calendar month, per recipient, any provider and G2088 has a frequency limit of two per calendar month, per recipient, any provider. Only one provider can be reimbursed for HCPCS code G2086, G2087 or G2088 per calendar month.

SOURCE: Department of Health Care Services. Evaluation & Management Manual. Page 47-48. Dec. 2022. (Accessed Apr. 2024).

The Program for All Inclusive Care for the Elderly (PACE)

A PACE organization approved by the department pursuant to Chapter 8.75 (commencing with Section 14591) may use video telehealth to conduct initial assessments and annual re-assessments for eligibility for enrollment in the PACE program.

SOURCE: Welfare and Institutions Code 14132.725, as amended by SB 184 (2022 Session). (Accessed Apr. 2024).

Multipurpose Senior Services Program

Providers are required to report revenue code 0780 with each MSSP procedure code that is rendered via telehealth.

SOURCE: DHCS Provider Bulletin, Multipurpose Senior Services Program Transitions to HIPAA-Compliant Code Sets. Dec. 2023. & Multipurpose Senior Services Program (MSSP) Billing Codes, p. 15. Dec. 2023. (Accessed Apr. 2024).

Doula, Community Health Worker (CHW) and Asthma Preventive Services

Doulas may provide services described in the Doula Services manual via telehealth.

Community Health Workers (CHWs) may provide services described in the Community Health Worker (CHW) Preventive Services manual via telehealth

Asthma preventive education and training services described in the Asthma Preventive Services (APS) manual may be provided via telehealth by unlicensed asthma preventive service providers. In-home environmental trigger assessments for asthma may not be conducted via telehealth and must be conducted in-person.

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth (Jan 2023). Pg. 4. (Accessed Apr. 2024).

Doula Services

IHS-MOA and Tribal FQHC providers may bill for doula services provided via telehealth using either modifier 93 for synchronous audio-only or modifier 95 for synchronous video.

SOURCE: CA Dept. of Health Care Services (DHCS) Provider Bulletin, Doula Services Now a Benefit for IHS-MOA and Tribal FQHC Providers. Jul. 2023. (Accessed Apr. 2024).

Doulas may bill for services provided by telehealth using either modifier 93 for synchronous audio-only or modifier 95 for synchronous video. Doulas should refer to the Medicine: Telehealth section in Part 2 of the Provider Manual for guidance regarding

providing services via telehealth for prenatal or postpartum visits, labor and delivery support, and for abortion and miscarriage support.

SOURCE: CA Dept. of Health Care Services (DHCS) Doula Services Manual, p. 5-6. (Dec. 2022). (Accessed Apr. 2024).

Family PACT

Family PACT covered benefits or services, identified by CPT or HCPCS codes and subject to all existing Family PACT coverage and reimbursement policies, including any Treatment Authorization Request (TAR) requirements, may be provided via a telehealth modality, as outlined in this section, only if all of the following are satisfied:

- The provider at the distant site believes that the benefits or services being provided are clinically appropriate based upon evidence-based medicine and/or best practices to be delivered via telehealth.
- The benefits or services delivered via telehealth meet the procedural definition and components of the CPT or HCPCS code(s), as defined by the American Medical Association (AMA), associated with the Family PACT covered service or benefit, as well as any extended guidelines as described in this section and the Medicine: Telehealth section in the appropriate Part 2 Medi-Cal manual.
- The benefits or services provided via telehealth meet all laws regarding confidentiality of health care information and a client's right to his or her medical information.

SOURCE: CA Department of Health Care Services. Family Planning, Access, Care and Treatment Program. Benefits Manual. Jun. 2023, Pg. 8. (Accessed Apr. 2024).

Medication Abortion

The COVID-19 PHE ended May 11, 2023, but DHCS will continue to allow flexibilities granted during the PHE for services billed under HCPCS code S0199. The following policies are effective July 1, 2023:

- Medication abortion policy allows for 77 days gestational age and continues the COVID-19 PHE policies regarding in-person visits and ultrasounds without payment reduction.
- When determined clinically appropriate based on a provider's clinical judgement, services may be provided through telehealth. Confirmation of pregnancy must be documented.
- Ultrasound to confirm gestational age and/or intrauterine pregnancy, and ultrasound to confirm completion of abortion, must be provided when clinically indicated, but is not required in all cases.
- Providers may bill S0199 without providing a pre-abortion ultrasound when a pre-abortion ultrasound is not clinically indicated.

- Providers may bill S0199 without providing a post-abortion ultrasound when a post-abortion ultrasound is not clinically indicated.
- Providers may bill S0199 when a post-abortion assessment is provided via telehealth, if clinically appropriate and if patient prefers assessment via telehealth. An in-person visit must be offered but is not required to bill S0199.
- For recipients who do not show up for follow-up visits, HCPCS code S0199 must be billed using the "from-through" method with the "no show" date as the "through" date and modifier 52 is not required.

In addition, as specified in DHCS telehealth guidance, services may be provided via telehealth when:

- The treating health care practitioner at the distant site believes that the Medi-Cal benefits or services being provided are clinically appropriate based upon evidence-based medicine and/or best practices to be delivered via telehealth, subject to oral or written consent by the member.
- The benefits or services delivered via telehealth meet the procedural definition and components of the CPT or HCPCS code(s), as defined by the American Medical Association (AMA), associated with the Medi-Cal covered service or benefit, as well as any extended guidelines as described in this section of the Medi-Cal provider manual.
- The benefits or services provided via telehealth satisfies all laws regarding confidentiality of health care information and a patient's right to their medical information.

As specified in the above telehealth guidance, delivery of benefits or services that require the in-person presence of the patient for any reason are not appropriate for delivery via a telehealth modality.

SOURCE: DHCS Provider Bulletin, Post-PHE Policy Clarification for Medication Abortion. (Sept. 2023). (Accessed Apr. 2024).

Managed Care

Existing Covered Services, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing treatment authorization requirements, may be provided via a Telehealth modality only if all of the following criteria are satisfied:

- The treating Provider at the distant site believes the Covered Services being provided are clinically appropriate to be delivered via Telehealth based upon evidence-based medicine and/or best clinical judgment.
- The Member has provided verbal or written consent.
- The Medical Record documentation substantiates that the Covered Services delivered via Telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s)

associated with the Covered Service. Providers are not required to:

- Document a barrier to an in-person visit for Covered Services provided via Telehealth (WIC section 14132.72(d)); or
- Document the cost effectiveness of Telehealth to be reimbursed for Covered Services provided via a Telehealth modality.

- The Covered Services provided via Telehealth meet all state and federal laws regarding confidentiality of health care information and a Member's right to their own medical information.

SOURCE: CA Department of Health Care Services (DHCS). All Plan Letter 23-007: Telehealth Services Policy. Apr. 10, 2023. (Accessed Apr. 2024).

Behavioral Health Services

Medi-Cal covered services delivered via telehealth (synchronous audio-only and synchronous video interactions) are reimbursable in Medi-Cal Specialty Mental Health Services (SMHS), the Drug Medi-Cal Organized Delivery System (DMC-ODS), and the Drug Medi-Cal (DMC) programs (including initial assessments, only as set forth in this BHIN). Patient choice must be preserved; therefore, patients have the right to request and receive in-person services. See Behavioral Health Information Notice No.: 23-018 for program specific telehealth reimbursement requirements. Behavioral Health Information Notice No.: 21-075 has additional program specific information related to telehealth services.

The use of telehealth modifiers on SMHS, DMC, and DMC-ODS claims is mandatory and necessary for accurate tracking of telehealth usage in behavioral health. Billing codes must be consistent with the level of care provided. The following codes shall be used in SMHS, DMC, and DMC-ODS:

- Synchronous video interaction service: GT
- Synchronous audio-only interaction service: SC
- Asynchronous store and forward (e-consult in DMC-ODS only): GQ

Effective July 1, 2023, additional modifiers will be required for Current Procedural Terminology (CPT) codes after DHCS implements a successor payment methodology and transitions from Healthcare Common Procedure Coding System (HCPCS) codes to a combination of HCPCS and CPT codes. See BHIN 22-046 for more information and the MEDCCC Library for the version of the billing manuals that will take effect in 2023. If a telehealth modifier is used for outpatient services on or after July 1, 2023, the place of service must be "02" or "10" unless the service is Mobile Crisis Services.

SOURCE: CA Department of Health Care Service (DHCS). Behavioral Health Information Notice No.: 23-018. Apr. 25, 2023. Pg. 2, 8. (Accessed Apr. 2024).

Managed Care & Behavioral Health

Effective no sooner than January 1, 2024, to preserve a beneficiary's right to access covered services in person, a provider furnishing services through telehealth must do one of the following:

- Offer those same services via in-person, face-to-face contact; or
- Arrange for a referral to, and a facilitation of, in-person care that does not require a beneficiary to independently contact a different provider to arrange for that care.

SOURCE: CA Department of Health Care Services (DHCS). All Plan Letter 23-007: Telehealth Services Policy. Apr. 10, 2023, p. 3.; CA Department of Health Care Service (DHCS). Behavioral Health Information Notice No.: 23-018. Apr. 25, 2023. Pg. 3-5, 8 (Accessed Apr. 2024).

Diabetes Prevention Program (DPP)

The Medi-Cal DPP can be offered through telehealth where trained peer coaches deliver sessions via remote classroom or telehealth where the peer coach is present in one location and participants are calling or video-conferencing in from another location. DPP providers that offer online, virtual, or distance learning programs may bill one of the fourteen HCPCS codes in conjunction with an appropriate telehealth modifier when all requirements for billing the HCPCS code have been met.

SOURCE: CA Dept. of Health Care Services. Medi-Cal's Diabetes Prevention Program (DPP) Policy Preview. Pg. 3, 8. (Accessed Apr. 2024).

ELIGIBLE PROVIDERS

The health care provider rendering Medi-Cal covered benefits or services provided via a telehealth modality must meet the requirements of Business and Professions Code (B&P Code), Section 2290.5(a)(3), or must be otherwise designated by the Department of Health Care Services (DHCS) pursuant to Welfare and Institutions Code (WIC) 14132.725 (b)(2)(A).

A licensed health care provider rendering Medi-Cal covered benefits or services via a telehealth modality must be licensed in California, enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal provider group.

The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community.

For purposes of telehealth [the distant site] can be different from the administrative location.

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth (Mar. 2024). Pg. 2-3. (Accessed Apr. 2024).

Federally Qualified Health Center (FQHC) & Rural Health Clinic (RHC)

Billable providers are eligible to deliver covered FQHC/RHC services. Providers may refer to "RHC/FQHC Covered Services" in this manual section.

SOURCE: CA Department of Health Care Services (DHCS). Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHC) Outpatient Services Manual. Mar. 2024. Pg. 12. (Accessed Apr. 2024).

Indian Health Services, Memorandum of Understanding Agreement (IHS-MOA)

Billable providers are eligible to deliver available services offered under IHS-MOA services.

SOURCE: CA Department of Health Care Services (DHCS). Indian Health Services, Memorandum of Agreement (MOA) 638, Clinics Manual. Jan. 2023. Pg. 7-8. (Accessed Apr. 2024).

Dental Professionals

For Medi-Cal dental benefits or services, Medi-Cal enrolled dentists and allied dental professionals (under the supervision of a dentist) may render limited services via synchronous/live transmission teledentistry, so long as such services are within their scope of practice, when billed using CDT code D9995 for dates of service on or after May 16, 2020.

SOURCE: CA Department of Health Care Services (DHCS). Denti-Cal Manual. Jan. 2023. Pg. 4-24-26. (Accessed Apr. 2024).

Psychiatrists

Psychiatrists may bill for services delivered through telehealth in accordance with the Medicaid state plan.

SOURCE: Sec. 14132.73 of the Welfare and Institutions Code. (Accessed Apr. 2024).

Doula, Community Health Worker (CHW) and Asthma Preventive Services

Doulas may provide services described in the Doula Services manual via telehealth.

Community Health Workers (CHWs) may provide services described in the Community Health Worker (CHW) Preventive Services manual via telehealth

Asthma preventive education and training services described in the Asthma Preventive Services (APS) manual may be provided via telehealth by unlicensed asthma preventive service providers. In-home environmental trigger assessments for asthma may not be conducted via telehealth and must be conducted in-person.

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth (Jan. 2023). Pg. 4. (Accessed Apr. 2024).

ELIGIBLE SITES

For purposes of reimbursement for covered treatment or services provided through telehealth, the type of setting where services are provided for the patient or by the health care provider is not limited (Welfare and Institutions Code [WIC] Section 14132.72(e)). This may include, but is not limited to, a hospital, medical office, community clinic, or the patient's home.

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth (Aug. 2020). Pg. 2. (Accessed Apr. 2024).

Federally Qualified Health Center (FQHC) & Rural Health Clinic (RHC)

The billable provider, employed or under direct contract with an FQHC or RHC can respond from any location, including their home, during a time that they are scheduled to work for the FQHC or RHC.

For the purposes of payment for covered treatment or services provided through telehealth, the department shall not limit the type of setting where services are provided for the patient or by the health care provider.

SOURCE: CA Department of Health Care Services (DHCS). Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHC) Outpatient Services Manual. Mar. 2024. Pg. 17. (Accessed Apr. 2024).

Indian Health Services, Memorandum of Understanding Agreement (IHS-MOA)

Refers to fee-for-service policy for the definition of an 'originating site' and 'distant site'.

SOURCE: CA Department of Health Care Services (DHCS). Indian Health Services, Memorandum of Agreement (MOA) 638, Clinics Manual. Jan. 2023. Pg. 7. (Accessed Apr. 2024).

Family PACT

Family PACT telehealth policy follows Medi-Cal telehealth policy to the extent it is applicable to the Family PACT Program and covered services. Exceptions include the definition for distant site:

- For Family PACT, the distant site must be the enrolled service site. In Medi-Cal, the distant site can be different than the administrative location, as stated in the *Medicine: Telehealth* section of the appropriate Part 2 Medi-Cal provider manual.

SOURCE: CA Department of Health Care Services. Medi-Cal Provider Bulletin. Family PACT Update. Jun. 2023. (Accessed Apr. 2024).

GEOGRAPHIC LIMITS

No Reference Found

FACILITY/TRANSMISSION FEE

The originating site facility fee is reimbursable only to the originating site when billed with HCPCS code Q3014 (telehealth originating site facility fee). Transmission costs incurred from providing telehealth services via audio/video communication is reimbursable when billed with HCPCS code T1014 (telehealth transmission, per minute, professional services bill separately).

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth (Mar. 2024). Pg. 13. (Accessed Apr. 2024).

FQHC & RHC/IHS-MOA

FQHCs/RHCs/IHS-MOA are not eligible to bill an originating site fee or transmission charges. The costs of these services should be included in the PPS/AIR/IHS-MOA rates, as applicable.

SOURCE: CA Department of Health Care Services (DHCS). Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHC) Outpatient Services Manual. Mar. 2024. Pg. 13; CA Department of Health Care Services (DHCS). Indian Health Services, Memorandum of Agreement (MOA) 638, Clinics Manual. Jan. 2023. Pg. 8. (Accessed Apr. 2024).

Local Education Agency

Ancillary costs, such as equipment, technical support, facility fee, and transmission charges incurred while providing telehealth services via audio/video communication are

not reimbursable.

SOURCE: CA Department of Health Care Services (DHCS). Local Education Agency (LEA) Telehealth. Jun. 2023. Pg. 5 (Accessed Apr. 2024).

Every Woman Counts Program

Effective retroactively for dates of service on or after November 1, 2013, HCPCS codes Q3014 (telehealth originating site facility fee) and T1014 (telehealth transmission, per minute, professional services bill separately) are benefits of the *Every Woman Counts* (EWC) program.

SOURCE: Department of Health Care Services. Every Woman Counts Program Manual. Pgs. 41-42. Nov. 2023. (Accessed Apr. 2024).

STORE-AND-FORWARD

Last updated 04/02/2024

POLICY

"Asynchronous store-and-forward" means the transmission of a patient's medical information from an originating site to the health care provider at a distant site. Consultations via asynchronous electronic transmission initiated directly by patients, including through mobile phone applications, are not covered under this policy.

"E-consults" fall under the auspice of store-and-forward. E-consults are asynchronous health record consultation services that provide an assessment and management service in which the patient's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the patient's health care needs without patient face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers.

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth (Jan. 2023). Pg. 1. (Accessed Apr. 2024).

CA Medicaid and Medi-Cal managed care plans are required to reimburse health care providers of applicable health care services delivered via video synchronous interaction, synchronous audio-only modality, or asynchronous store and forward, as applicable, at payment amounts that are not less than the amounts the provider would receive if the

services were delivered via in-person, face-to-face contact, so long as the services or settings meet the applicable standard of care and meet the requirements of the service code being billed.

A health care provider shall not establish a new patient relationship with a Medi-Cal beneficiary via asynchronous store and forward, telephonic (audio-only) synchronous interaction, remote patient monitoring, or other virtual communication modalities. The department may provide for specific exceptions to this prohibition, which shall be developed in consultation with affected stakeholders and published in departmental guidance. Additional exceptions apply for audio-only in particular as well. See Email, Phone & Fax Section for audio-only exception information.

In-person, face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for covered health care services and provider types designated by the department, when provided by video synchronous interaction, asynchronous store and forward, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, when those services and settings meet the applicable standard of care and meet the requirements of the service code being billed.

Applicable health care services appropriately provided through video synchronous interaction, asynchronous store and forward, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities are subject to billing, reimbursement, and utilization management policies imposed by the department. Utilization management protocols adopted by the department pursuant to this section shall be consistent with, and no more restrictive than, those authorized for health care service plans pursuant to Section 1374.13 of the Health and Safety Code.

SOURCE: Welfare and Institutions Code 14132.725, as amended by SB 184 (2022 Session) and AB 32 (2022 Session). (Accessed Apr. 2024).

Brief Virtual Communications and Check-ins

Virtual or telephonic communication includes a brief communication with an established patient not physically present (face-to-face). Medi-Cal providers may be reimbursed using HCPCS codes G2010 and G2012 for brief virtual communications.

HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 hours, not originating from a related evaluation and

management (E/M) service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth (Mar. 2024). Pg. 12. (Accessed Apr. 2024).

FQHCs/RHCs

Asynchronous store and forward means the transmission of a patient's medical information from an originating site to the billable provider at a distant site.

Medi-Cal benefits or services being provided are clinically appropriate and meet the procedural and billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter.

A patient may be "established" on an asynchronous store and forward service, if all of the conditions of the "New Patient" requirements in this manual section are met.

Only one visit or store and forward service may be billed at the PPS rate when there is a service payment contract with a non-FQHC/RHC, contractor, or another FQHC or RHC. Conversely, the non-FQHC/RHC or contractor may request fee-for-service reimbursement for a visit or store and forward service directly from the appropriate managed care plan or the Medi-Cal Fiscal Intermediary if no service payment contract exists with the FQHC or RHC.

FQHCs and RHCs must use the appropriate telehealth modifier when billing for the covered service.

RHCs and FQHCs cannot use billing codes G2010 and G2017, which are for Fee-For-Service (FFS) providers. Likewise, effective the end of the COVID-19 public health emergency, code G0071 may not be billed to Medi-Cal.

An e-consult, e-visit, or remote patient monitoring is not a reimbursable telehealth service for FQHCs or RHCs.

SOURCE: CA Department of Health Care Services (DHCS). Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHC) Outpatient Services Manual. Mar. 2024. Pg. 16-17. (Accessed Apr. 2024).

Visits shall also include an encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and

family therapist using an asynchronous store and forward modality, when services delivered through that modality meet the applicable standard of care. A visit described in this clause shall be reimbursed at the applicable FQHC's or RHC's per-visit PPS rate to the extent the department determines that the FQHC or RHC has met all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter.

An FQHC or RHC is not precluded from establishing a new patient relationship through an asynchronous store and forward modality, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, if the visit meets all of the following conditions:

- The patient is physically present at the FQHC or RHC, or at an intermittent site of the FQHC or RHC, at the time the service is performed.
- The individual who creates the patient records at the originating site is an employee or contractor of the FQHC or RHC, or other person lawfully authorized by the FQHC or RHC to create a patient record.
- The FQHC or RHC determines that the billing provider is able to meet the applicable standard of care.

SOURCE: Welfare and Institutions Code 14132.100, as amended by SB 184 (2022 Session) and AB 32 (2022 Session). (Accessed Apr. 2024).

Family PACT

Family PACT telehealth policy mirrors the fee-for-service policy.

SOURCE: CA Department of Health Care Services. Family Planning, Access, Care and Treatment Program. Benefits Manual. Jun. 2023, Pg. 6. (Accessed Apr. 2024).

Managed Care

To ensure proper payment and record of Covered Services provided via Telehealth, all Providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered through both synchronous interactions and asynchronous store and forward telecommunications. Regarding the rate of reimbursement, unless otherwise agreed to by the MCP and Provider, MCPs must reimburse Network Providers at the same rate, whether a Covered Service is provided in-person or through Telehealth, if the service is the same regardless of the modality of delivery, as determined by the Provider's description of the service on the claim.

SOURCE: CA Department of Health Care Services (DHCS). All Plan Letter 23-007: Telehealth Services Policy. Apr. 10, 2023, Pg. 5. (Accessed Apr. 2024).

Indian Health Services, Memorandum of Understanding Agreement (IHS-MOA)

A patient may not be "established" on an asynchronous store and forward service with the exception of a homeless patient. Reimbursement is permitted for an established patient by a billable provider at the distant site.

SOURCE: CA Department of Health Care Services (DHCS). Indian Health Services, Memorandum of Agreement (MOA) 638, Clinics Manual. May 2023. Pg. 9. (Accessed Apr. 2024).

Local Education Agency

For purposes of LEA policy, the telehealth definition only includes synchronous, real-time interactions between a patient and a health care provider located at a distant site.

SOURCE: CA Department of Health Care Services (DHCS). Local Education Agency (LEA) Telehealth. Jun. 2023. Pg. 1. (Accessed Apr. 2024).

Dental Services

The Department of Health Care Services has opted to permit the use of teledentistry (includes store-and-forward) as an alternative modality for the provision of select dental services. See manual for codes and requirements.

DHCS has expanded its teledentistry policy to allow Medi-Cal dental Fee-for-Service (FFS) and Dental Managed Care (DMC) providers the ability to establish new patient relationships through an asynchronous store and forward modality, consistent with Federally Qualified Health Center/Rural health Clinic (FQHC/RHC) providers.

SOURCE: CA Department of Health Care Services (DHCS). Medi-Cal Dental Provider Handbook. Jan. 2023 Pg. 4-22 – 4-23. (Accessed Apr. 2024).

ELIGIBLE SERVICES/SPECIALTIES

Modifier GQ must be used for Medi-Cal covered benefits or services, including, but not limited to, teleophthalmology, teledermatology, teledentistry and teleradiology, delivered via asynchronous store and forward telecommunications systems, including e-consults. Only the service(s) rendered from the distant site must be billed with modifier GQ.

The use of modifier GQ does not alter reimbursement for the CPT or HCPCS code billed. For additional information about policy and billing requirements relating to

teledentistry, providers may refer to “Teledentistry” in the Medi-Cal Dental Provider Handbook.

For billing purposes, health care providers must ensure that the documentation, typically images, sent via store and forward be specific to the patient’s condition and adequate for meeting the procedural definition and components of the CPT or HCPCS code that is billed. In addition, all services billed via store and forward, including e-consult, are subject to all existing Medi-Cal coverage and reimbursement policies.

E-Consults

A health care provider at the distant site may bill for an e-consult with the CPT code listed below when the benefits or services delivered meet the procedural definition and components of the CPT code as defined by the AMA as well as any requirements described in this section of the Medi-Cal provider manual.

When billing for e-consults, health care providers at the originating and distant sites must clearly document the following information relating to previous and/or pertinent health care services, maintain this information in the patient’s medical record and make it available to DHCS upon request:

- A health care provider at the originating site must create and maintain the following: A record that the e-consult is the result of patient care that has occurred or will occur and relates to ongoing patient management; and A record of a request for an e-consult by the health care provider at the originating site.
- In order to bill for e-consults, the health care provider at the distant site must create and maintain the following: A record of the review and analysis of the transmitted medical information with written documentation of date of service and time spent; and A written report of case findings and recommendations with conveyance to the originating site.

To bill for e-consults, the health care provider at the distant site (consultant) may use CPT code 99451 in conjunction with the modifier GQ. In accordance with the AMA requirements, CPT code 99451 is not separately reportable or reimbursable if any of the following are true:

- The distant site provider (consultant) saw the patient within the last 14 days.
- The e-consult results in a transfer of care or other face-to-face service with the distant site provider (consultant) within the next 14 days or next available appointment date of the consultant.
- The distant site provider did not spend at least five minutes of medical consultative time, and it did not result in a written report.

If more than one contact or encounter is required to complete the e-consult request, the entirety of the service and cumulative discussion and information review time should be reported only once using CPT code 99451. CPT code 99451 is not reimbursable more than once in a seven-day period for the same patient and health care practitioner. Medi-Cal covered benefits or services provided at the originating site (in-person) with the patient in connection with an e-consult are billed according to standard Medi-Cal policies (without modifier GQ).

E-consults are not applicable for FQHCs, RHCs, or IHS-MOA clinics.

See Telehealth Modifier Reference Sheet- Organized by Delivery System for more information on modifiers.

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth (Mar. 2024), Pg. 10-12. (Accessed Apr. 2024).

Medi-Cal covers an 'e-visit' which are communications between a patient and their provider through an online patient portal.

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth (Aug. 2020). Pg. 2. (Accessed Apr. 2024).

Managed Care

All Providers, with the exception of Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Tribal Health Providers (THPs), are allowed to be reimbursed for consultations provided via a Telehealth modality. These electronic consultations (e-consults) are permissible using the appropriate CPT-4 code, modifier(s), and Medical Record documentation defined in the Medi-Cal Provider Manual. Members cannot initiate e-consults as they are interprofessional interactions, and therefore only permissible between Providers. Providers are permitted to be reimbursed for brief virtual communications that consist of a brief communication with a Member who is not physically present (face-to-face) at the FFS rate. Virtual communications reimbursement for FQHCs, RHCs, and THPs is no longer allowed consistent with the end of the COVID-19 Public Health Emergency on May 11, 2023.

SOURCE: CA Department of Health Care Services (DHCS). All Plan Letter 23-007: Telehealth Services Policy. Apr. 10, 2023. Pg. 3. (Accessed Apr. 2024).

Indian Health Services, Memorandum of Understanding Agreement (IHS-MOA)

A patient may not be "established" on an asynchronous store and forward service with the exception of a homeless patient. Reimbursement is permitted for an established

patient by a billable provider at the distant site.

SOURCE: CA Department of Health Care Services (DHCS). Indian Health Services, Memorandum of Agreement (MOA) 638, Clinics Manual. May 2023. Pg. 9. (Accessed Apr. 2024).

Vision Care

Teleophthalmology by store-and-forward is covered for three specific CPT codes. Information can be reviewed by a physician or optometrist at a distant site. If the reviewing optometrist identifies a disease or condition requiring consultation or referral pursuant to Section 3041 of the Business and Professions Code, a referral must be made with an appropriate physician and surgeon or ophthalmologist, as required. Teleophthalmology services by store and forward must be billed with modifier GQ (service rendered by store and forward telecommunications system). Only the portion(s) rendered from the distant site (hub) are billed with modifier GQ. The use of modifier GQ does not alter reimbursement for the CPT or HCPCS code billed.

SOURCE: CA Department of Health Care Services, Vision Care: Professional Services Manual. (Dec. 2022), Pg. 5-6. (Accessed Apr. 2024).

Dental Services

Reimburses for specific teledentistry codes via store-and-forward (see manual).

SOURCE: CA Department of Health Care Services (DHCS). Medi-Cal Dental Provider Manual. Jan. 2023. Pg. 4-23 – 4-24. (Accessed Apr. 2024).

Opioid Use Disorder Treatment Services

Outpatient treatment services for opioid use disorder (OUD), which include management, care coordination, psychotherapy and counseling are reimbursable using HCPCS codes G2086, G2087 and G2088. At least one psychotherapy service must be furnished in order to bill for HCPCS codes G2086 thru G2088. Although the descriptions for these codes refer to “office-based treatment,” these services may be delivered via telehealth when they meet Medi-Cal requirements. See Medi-Cal Telehealth Provider Manual.

HCPCS codes G2086 thru G2088 are not reimbursable for treatment in state-licensed Opioid Treatment Programs as defined in Health and Safety Code Section 11875. HCPCS codes G2086 and G2087 each have a frequency limit of once per calendar month, per recipient, any provider and G2088 has a frequency limit of two per calendar month, per recipient, any provider. Only one provider can be reimbursed for HCPCS code G2086, G2087 or G2088 per calendar month.

SOURCE: Department of Health Care Services. Evaluation & Management Manual. Page 47-48 Dec. 2022. (Accessed Apr. 2024).

Drug Medi-Cal Providers

A Drug Medi-Cal certified provider shall not establish a new patient relationship with a Medi-Cal beneficiary via asynchronous store and forward, audio-only synchronous interaction, remote patient monitoring, or other virtual communication modalities. The department may provide for specific exceptions to this prohibition, which shall be developed in consultation with affected stakeholders and published in departmental guidance.

SOURCE: Welfare and Institutions Code 14132.731, as amended by SB 184 (2022 Session). (Accessed Apr. 2024).

Behavioral Health Services

For purposes of Medi-Cal Specialty Mental Health Services (SMHS), the Drug Medi-Cal Organized Delivery System (DMC-ODS), and the Drug Medi-Cal (DMC) programs (including initial assessments, only as set forth in this BHIN), telehealth coverage is only specified for synchronous audio-only and synchronous video interactions. However, the following asynchronous code is covered and directed to be used as follows:

- Asynchronous store and forward (e-consult in DMC-ODS only): GQ

As a general rule, State law prohibits the use of asynchronous store and forward, synchronous audio-only interaction, or remote patient monitoring when providers establish new patient relationships with Medi-Cal beneficiaries.

SOURCE: CA Department of Health Care Service (DHCS). Behavioral Health Information Notice No.: 23-018. Apr. 25, 2023. Pg. 2, 4, 8. (Accessed Apr. 2024).

Children's Services Program

CCS providers must request prior authorization services from CCS paneled physicians (22, CCR Section 41412) who are available to provide telehealth services. Prior authorization requests are also authorized to CCS-approved hospitals and outpatient special care centers. GHPP providers must be Medi-Cal enrolled providers.

Physical and Occupational Therapy may be offered through appropriate telehealth modalities. Medical Therapy Unit therapists may offer remote/virtual teletherapy services as an alternative to in-person visits, as appropriate and directed by the Medical Therapy Conference and directing physicians. CCS clients receiving services through a Special Care Center and/or Medical Therapy Program Medical Therapy Conference must

have an annual in-person evaluation by a CCS-paneled physician. GHPP clients require an annual evaluation to ensure continued program coverage.

Billing for telehealth services is contingent upon the CCS Program or GHPP clients meeting all eligibility criteria, with an approved CCS Program/GHPP SAR, and in conformance with required Medi-Cal claims submission procedures as outlined in the DHCS Medi-Cal Telehealth Policy.

- When submitting a SAR for synchronous telemedicine services, the provider must use codes provided in the American Medical Association (AMA's) CPT Manual, Appendix P.
- Telehealth modifiers (93, 95 or GQ) are required on SARs to differentiate the telehealth service from the equivalent in-person service.
- For services or benefits provided via asynchronous store-and-forward telecommunications systems, the health care provider bills with modifier GQ.

For Whole Child Model (WCM) counties, the client's managed care plan (MCP) shall be responsible for authorizing, coordinating, and covering CCS telehealth services.

SOURCE: Department of Health Care Services. Numbered letter 03-0723 to the Children's Services Program and Genetically Handicapped Persons Program (GHPP). Jul. 7, 2023 – supersedes Department of Health Care Services. Numbered letter 16-1217 to the CA Children's Services Program and Genetically Handicapped Persons Program (GHPP). Dec. 22, 2017. (Accessed Apr. 2024).

GEOGRAPHIC LIMITS

No Reference Found

TRANSMISSION FEE

If billing store and forward, including e-consult, providers at the originating site may bill the originating site fee with HCPCS code Q3014, but may not bill for the transmission fee.

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth. (Mar. 2024), Pg. 13. (Accessed Apr. 2024).

FQHC & RHC/IHS-MOA

These sites are not eligible for the facility or transmission fee.

SOURCE: CA Department of Health Care Services (DHCS). Indian Health Services, Memorandum of Agreement (MOA) 638, Clinics Manual. Jan. 2023. Pg. 8 & Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHC) Outpatient Services Manual. Mar. 2024. Pg. 13. (Accessed Apr. 2024).

Vision Care

The facility fee is reimbursable to the originating site when billed with HCPCS code Q3014. Transmission costs incurred from providing telehealth services via audio/video communication is also reimbursable for the original site and the consulting provider when billed with HCPCS code T1014. Expenses involving telehealth equipment and telecommunications and transmission costs by Internet service providers will not be reimbursed by Medi-Cal.

SOURCE: CA Department of Health Care Services, Vision Care: Professional Services Manual. (Oct. 2022), Pg. 5. (Accessed Apr. 2024).

Dental Care

The originating site and transmission fee and billing rules are not applicable to Safety Net Clinics (Federally Qualified Health Centers, Rural Health Clinics, Indian Health Services Memorandum of Agreement 683 Clinics). For policy and billing information specific to Safety Net Clinics, please refer to those sections of the Medi-Cal Provider Manual (Rural and Ind Health).

Transmission costs associated with store and forward are not payable.

SOURCE: CA Department of Health Care Services (DHCS). Denti-Cal Manual. Jan. 2023. Pg. 4-24-25. (Accessed Apr. 2024).

REMOTE PATIENT MONITORING

Last updated 04/02/2024

POLICY

Principal care management (PCM) services are provided when medical and/or psychological needs manifested by a single, complex chronic condition are expected to last at least three months. CPT codes 99424 and 99426 each have a frequency limit of once per calendar month, any provider and 99427 has a frequency limit of two per calendar month, any provider.

Remote physiologic monitoring (RPM) services for established patients ages 21 and older are reimbursable when ordered by and billed by physicians or other qualified health professionals (QHP). RPM services may be delivered by auxiliary personnel including

contracted employees, when under the supervision of the billing physician or qualified health professional. See manual for codes.

Prior to or at the time RPM services are furnished, the patient must give consent to receive the services. Consent may be verbal (written consent is not required) but must be documented in the medical record, along with justification for the use of RPM services.

SOURCE: CA DHCS Evaluation and Management Manual (Dec. 2022), p. 39-42. (Accessed Apr. 2024).

The department may authorize the use of remote patient monitoring as an allowable telehealth modality for covered health care services and provider types it deems appropriate for dates of service on or after July 1, 2021. The department may establish a fee schedule for applicable health care services delivered via remote patient monitoring.

SOURCE: Sec. 14124.12 (f)(1)(B) of the Welfare and Institutions Code. As amended by AB 133, Sec. 380 (2021 Session). (Accessed Apr. 2024).

Remote Physiologic Monitoring

Medi-Cal reimburses for 5 remote physiologic monitoring codes (99091, 99453, 99454, 99457, 99458), consistent with Medicare Communication Technology Based Services (CTBS) .

SOURCE: Medi-Cal Rates Information. (Accessed Apr. 2024).

Continuous Glucose Monitoring

Effective for dates of service on or after May 1, 2023, CPT® codes 95250 (ambulatory continuous glucose monitoring [CGM] of interstitial fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified health care professional [office] provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of a sensor, and printout of recording) and 95251 (ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report) are added as Medi-Cal benefits.

SOURCE: CA Dept. of Health Care Services. Medi-Cal Update Bulletin. April 2023. & Durable Medical Equipment (DME): Billing Codes Manual, Nov. 2023, p. 52. (Accessed Apr. 2024).

Continuous Glucose Monitoring (CGM) is a covered benefit for California Children's Services (CCS) and the Genetically Handicapped Persons Program (GHPP). CGM systems are minimally invasive devices that measure subcutaneous interstitial fluid glucose. The availability of real-time CGM data allows the individual or caregiver to monitor glucose

levels, receive alerts for dangerously high or low blood glucose levels, and adjust diet and medications to avert adverse hypoglycemic or hyperglycemic events.

Effective October 1, 2022, non-therapeutic CGMs are also processed through Medi-Cal Rx according to the Medi-Cal Rx integrated coverage policy. Prior Authorization is required on all CGM requests through Medi-Cal Rx.

- Section 13.4 of the Medi-Cal Rx Provider Manual
- Under Covered continuous Glucose Monitoring (CGM) Systems Medi-Cal Providers | Forms and Information

SOURCE: CA Dept. of Health Care Services. California Children's Services Numbered Letter 15-1222. CGM as a CCS and GHPP Program Benefit. Dec. 23, 2022. (Accessed Apr. 2024).

CONDITIONS

Continuous Glucose Monitoring

The CCS Program or GHPP client must meet all of the following:

- The client has a diagnosis of type 1 diabetes mellitus, cystic fibrosis (CF) related diabetes, insulin-dependent type 2 diabetes, or sequelae of a CCS Program-eligible condition that requires ongoing insulin use.
- The client requires glucose testing by finger stick or CGM at least three times per day.
- The client requires analog insulin injections at least three times per day or uses an insulin pump.
- The client's insulin regimen requires frequent adjustment on the basis of finger stick or CGM blood glucose readings.

SOURCE: CA Dept. of Health Care Services. California Children's Services Numbered Letter 15-1222. CGM as a CCS and GHPP Program Benefit. Dec. 23, 2022. (Accessed Apr. 2024).

PROVIDER LIMITATIONS

Remote Physiologic Monitoring

Remote physiologic monitoring (RPM) services for established patients ages 21 and older are reimbursable when ordered by and billed by physicians or other qualified health professionals (QHP). RPM services may be delivered by auxiliary personnel including

contracted employees, when under the supervision of the billing physician or qualified health professional. See manual for codes.

SOURCE: Department of Health Care Services. Evaluation & Management Manual. Page 41. Dec. 2022. (Accessed Apr. 2024).

Continuous Glucose Monitoring

CCS/CHPP – Therapeutic and non-therapeutic CGMs may be prescribed by one of the following:

- A CCS Program-paneled endocrinologist affiliated with an Endocrine Special Care Center (SCC) or SCC nurse practitioner if the physician has ordered CGM for the client, as documented in the medical record.
- A CCS-paneled community pediatric endocrinologist if the client meets certain conditions.
- For GHPP clients, an adult endocrinologist at an approved Endocrine SCC or an adult endocrinologist or internal medicine specialist with an active MediCal provider number treating the GHPP-eligible condition.

SOURCE: CA Dept. of Health Care Services. California Children's Services Numbered Letter 15-1222. CGM as a CCS and GHPP Program Benefit. Dec. 23, 2022. (Accessed Apr. 2024).

OTHER RESTRICTIONS

Principle Care Management Services

CPT codes 99424 and 99426 each have a frequency limit of once per calendar month, any provider and 99427 has a frequency limit of two per calendar month, any provider.

Remote Physiologic Monitoring

Remote physiologic monitoring (RPM) services are reimbursable for established patients ages 21 and older.

CPT code 99453 is reimbursable once per episode of care but cannot be used for monitoring fewer than 16 days during a 30-day billing period. The interactive communication required for 99457 must be real-time synchronous with two-way audio with a minimum of 20 minutes per month and the patient must have a treatment plan for chronic care management. For additional information regarding minimum duration of service and definition of episode care, refer to the CPT book.

The frequency limit for 99453, 99454 and 99091 is one per 30 days, any provider. The frequency limit for 99457 is one per calendar month, any provider. The frequency limit for 99458 is three per interactive communication session.

Prior to or at the time RPM services are furnished, the patient must give consent to receive the services. Consent may be verbal (written consent is not required) but must be documented in the medical record, along with justification for the use of RPM services.

SOURCE: Department of Health Care Services. Evaluation & Management Manual. Page 39-42. Dec. 2022. (Accessed Apr. 2024).

The department may establish separate fee schedules for applicable health care services delivered via remote patient monitoring or other permissible virtual communication modalities.

SOURCE: Welfare and Institutions Code 14132.725, as amended by SB 184 (2022 Session). (Accessed Apr. 2024).

Continuous Glucose Monitoring

CPT codes 95250 and 95251 cannot be reported more than once per month per patient, any provider, regardless of the duration of professional CGM or the number of times CGM is provided in a single month. CPT 95251 cannot be reported in conjunction with CPT 99091. For prior authorization requirements for CGM systems, see Medi-Cal Rx Provider Manual, Section 13.4.

SOURCE: CA Dept. of Health Care Services. Medi-Cal Update Bulletin. April 2023. & Durable Medical Equipment (DME): Billing Codes Manual, Nov. 2023, p. 52. (Accessed Apr. 2024).

CCS/CHPP – Specific documentation containing certain information must be submitted by the Endocrine SCC or provider to Medi-Cal Rx. See notice for additional information and requirements.

SOURCE: CA Dept. of Health Care Services. California Children's Services Numbered Letter 15-1222. CGM as a CCS and GHPP Program Benefit. Dec. 23, 2022. (Accessed Apr. 2024).

EMAIL, PHONE & FAX

Last updated 04/02/2024

For services or benefits provided via synchronous telephone or other real-time interactive audio-only telecommunications systems, the health care provider bills with modifier 93.

Modifier 93 must be used for Medi-Cal covered benefits or services delivered via synchronous, telephone or other interactive audio-only telecommunications systems. Only the portion(s) of the telehealth service rendered at the distant site are billed with modifier 93. The use of modifier 93 does not alter reimbursement for the CPT or HCPCS code.

Health care providers must use an interactive audio-only telecommunications system that permits real-time communication between the provider at the distant site and the patient at the originating site. The audio telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through telehealth. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

The totality of the communication of information exchanged between the provider and the patient during the audio-only service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.

Providers must document in the patient's medical file that the patient has given a written or verbal consent to the audio-only telehealth encounter.

See Telehealth Modifier Reference Sheet- Organized by Delivery System for more information on modifiers.

Brief Virtual Communications and Check-ins

Virtual or telephonic communication includes a brief communication with an established patient not physically present (face-to-face). Medi-Cal providers may be reimbursed using HCPCS codes G2010 and G2012 for brief virtual communications.

HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5 to 10 minutes of medical discussion. G2012 can be billed when the virtual communication via a telephone call.

Establishing a Relationship

Providers may establish a relationship with new patients via audio-only synchronous interaction only if one or more of the following applies:

- The visit is related to sensitive services as defined in subsection (n) or Section 56.06 of the Civil Code. Section 56.06 of the Civil Code defines "sensitive services" as all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender-affirming care, and intimate partner violence, and includes services described in Sections 6924 through 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.
- The patient requests an audio-only modality.
- The patient attests they do not have access to video.

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth (Mar. 2024). Pg. 3, 8-9, 12. (Accessed Apr. 2024).

The department shall reimburse health care providers of applicable health care services delivered via synchronous audio-only modality at payment amounts that are not less than the amounts the provider would receive if the services were delivered via in-person, face-to-face contact, so long as the services or settings meet the applicable standard of care and meet the requirements of the service code being billed.

Pursuant to an effective date designated by the department that is no sooner than January 1, 2024, a Medi-Cal provider furnishing applicable health care services via audio-only synchronous interaction shall also offer those same health care services via video synchronous interaction to preserve beneficiary choice. The department may provide specific exceptions to this requirement specified in subparagraph based on a Medi-Cal provider's access to requisite technologies, which shall be developed in consultation with affected stakeholders and published in departmental guidance.

Pursuant to an effective date designated by the department that is no sooner than January 1, 2024, a provider furnishing services through video synchronous interaction or audio-only synchronous interaction shall also maintain and follow protocols to do one of the following:

- Offer those services via in-person, face-to-face contact.
- Arrange for a referral to, and a facilitation of, in-person care that does not require a patient to independently contact a different provider to arrange for that care. (This clause does not require a provider to schedule an appointment with a different provider on behalf of the patient.)

- In implementing this subdivision, the department shall consider additional recommendations from affected stakeholders regarding the need to maintain access to in-person services without unduly restricting access to telehealth services.

A health care provider shall not establish a new patient relationship with a Medi-Cal beneficiary via telephonic (audio-only) synchronous interaction except:

- when the visit is related to sensitive services, as defined in subdivision (n) of Section 56.05 of the Civil Code, and when established in accordance with department specific requirements and consistent with federal and state law, regulations and guidance
- when the patient requests an audio-only modality or attests they do not have access to video, and when established in accordance with department specific requirements and consistent with federal and state laws, regulations and guidance.

SOURCE: Welfare and Institutions Code 14132.725, as amended by SB 184 (2022 Session) and AB 1241 (2023 Session). (Accessed Apr. 2024).

Patient Choice of Telehealth Modality

Medi-Cal providers can offer a variety of telehealth modalities for covered Medi-Cal services to the extent that the service can be appropriately rendered via the allowable telehealth modalities. For Medi-Cal providers who do offer telehealth modalities, they are required to offer Medi-Cal recipients the ability to choose whether they want to receive covered Medi-Cal services via:

- Synchronous, interactive audio/visual telecommunication systems (for example, video) or
- Synchronous, telephone or other interactive audio-only telecommunications systems.

While Medi-Cal providers are required to offer both video and telephone telehealth modalities, Medi-Cal recipients may freely choose, and change at any time, their desired telehealth modalities, which includes the ability to decline video modalities and select audio-only (telephone) modalities if preferred and/or necessary given the recipient's needs. For example, if the visit is related to sensitive services as defined in subsection (s) of Section 56.05 of the Civil Code, then the Medi-Cal recipient may prefer to utilize an audio-only (telephone) modality. Medi-Cal recipients shall be given the choice of how they receive their covered Medi-Cal services.

Exception to Telehealth Modalities Provider Requirement

Since broadband is necessary to ensure quality and effective communication between Medi-Cal providers and recipients, Medi-Cal providers are exempt from the requirement to offer both telehealth modalities if the Medi-Cal provider does not have access to broadband. Note: Broadband refers to high-speed internet access that is always on and

faster than traditional dial-up access. Broadband includes several high-speed transmission technologies, such as fiber, wireless, satellite, digital subscriber line, and cable. For the purposes of delivering telehealth services to patients, DHCS uses the Federal Communications Commission's (FCC) definition of broadband and the FCC minimum mbps upload/download speeds. Medi-Cal providers claiming this exception must maintain appropriate supporting documentation, which should be made available to DHCS upon request. For example, supporting documentation might include confirmation from an internet services provider regarding the lack of broadband service in a particular coverage area.

Right to In-person Services

Medi-Cal providers furnishing services to Medi-Cal recipients through telehealth modalities must also either offer services in-person or have a documented process in place to link Medi-Cal recipients to in-person care within a reasonable time if in-person services are unavailable from the provider.

If the Medi-Cal provider chooses to link the Medi-Cal recipient to in-person care to satisfy this requirement, then they must provide a referral to and facilitation of in-person care that does not require a recipient to independently contact a different Medi-Cal provider to arrange for such care. The Medi-Cal provider may initiate a process by which a different Medi-Cal provider in their office or an affiliated in-person care site contacts the Medi-Cal recipient directly to schedule an in-person visit.

The referring Medi-Cal provider or a member of their staff must confirm the referred Medi-Cal provider has at least attempted to contact the recipient to schedule an in-person appointment. However, the Medi-Cal referring provider is not required to schedule an appointment with a different provider on behalf of the Medi-Cal recipient. The Medi-Cal provider must offer referral and facilitation support that is minimally burdensome to the Medi-Cal recipient. Medi-Cal providers must maintain documentation of their process to link Medi-Cal recipients to in-person care, which should be made available to DHCS upon request.›

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth (Mar. 2024). Pg. 6-7. (Accessed Apr. 2024).

FQHCs/RHCs

An audio-only synchronous interaction is eligible for reimbursement if provided by a billable provider and FQHC or RHC patient.

Medi-Cal benefits or services being provided are clinically appropriate and meet the procedural and billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter.

A patient may not be "established" using an audio-only synchronous interaction unless the visit is related to a "sensitive service", as defined in the California Civil Code, section 56.05, subdivision (n), or if the patient requests "audio only" or does not have access to video.

SOURCE: CA Dept. Health Care Services, Medi-Cal Part 2 RHCs and FQHCs Manual, (Mar. 2024), p 16. (Accessed Apr. 2024).

Visits shall also include an encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and family therapist using audio-only synchronous interaction, when services delivered through that modality meet the applicable standard of care. A visit described in this clause shall be reimbursed at the applicable FQHC's or RHC's per-visit PPS rate to the extent the department determines that the FQHC or RHC has met all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter.

An FQHC or RHC may not establish a new patient relationship using an audio-only synchronous interaction. Notwithstanding this prohibition, the department may provide for specific exceptions to this prohibition, which shall be developed in consultation with affected stakeholders and published in departmental guidance. Exceptions shall include but not be limited to:

- An FQHC or RHC may establish a new patient relationship using an audio-only synchronous interaction when the visit is related to sensitive services, as defined in subdivision (n) of Section 56.05 of the Civil Code, or when the patient requests an audio-only modality or attests they do not have access to video – in accordance with department-specific requirements and consistent with federal and state laws, regulations, and guidance.

Pursuant to an effective date designated by the department that is no sooner than January 1, 2024, an FQHC or RHC furnishing applicable health care services via audio-only synchronous interaction shall also offer those same health care services via video synchronous interaction to preserve beneficiary choice. The department may provide specific exceptions to the requirement based on an FQHC's or RHC's access to requisite

technologies, which shall be developed in consultation with affected stakeholders and published in departmental guidance.

Effective on the date designated by the department pursuant to above, an FQHC or RHC furnishing services through video synchronous interaction or audio-only synchronous interaction shall also do one of the following:

- Offer those services via in-person, face-to-face contact.
- Arrange for a referral to, and a facilitation of, in-person care that does not require a patient to independently contact a different provider to arrange for that care.

SOURCE: Welfare and Institutions Code 14132.100, as amended by SB 184 (2022 Session) and AB 32 (2022 Session). (Accessed Apr. 2024).

In regard to patient choice of telehealth modality and right to in-person services requirements, FQHC/RHC providers are directed to refer to the policies found in more detail in the Telehealth Manual.

SOURCE: CA Dept. of Health Care Services, Part 2 Manual, Medi-Cal Rural Health Clinics and Federally Qualified Health Centers (Mar. 2024), p. 15. (Accessed Apr. 2024).

Telehealth services, telephonic services and other specified services must be reimbursed when provided by specific entities during or immediately following an emergency, subject to the Department obtaining federal approval and matching funds and Department guidance.

SOURCE: Welfare and Institutions Code Sec. 14132.723. (Accessed Apr. 2024).

The department shall seek any federal approvals it deems necessary to extend the approved waiver or flexibility implemented pursuant to subdivision (a), as of July 1, 2021, that are related to the delivery and reimbursement of services via telehealth modalities in the Medi-Cal program, including audio-only. The department shall implement those extended waivers or flexibilities for which federal approval is obtained, to commence on the first calendar day immediately following the last calendar day of the federal COVID-19 public health emergency period, and through December 31, 2022.

For purposes of informing the 2022–23 proposed Governor's Budget, released in January 2022, the department shall convene an advisory group consisting of consultants, subject matter experts, and other affected stakeholders to provide recommendations to inform the department in establishing and adopting billing and utilization management protocols for telehealth modalities to increase access and equity and reduce disparities in the Medi-Cal program. The advisory group shall analyze the impact

of telehealth in increased access for patients, changes in health quality outcomes and utilization, best practices for the appropriate mix of in-person visits and telehealth, and the benefits or liabilities of any practice or care model changes that have resulted from telephonic visits.

SOURCE: AB 133, Sec. 380 (2021 Session). (Accessed Apr. 2024).

IHS-MOA

An audio-only visit is eligible for reimbursement if provided by a billable provider, regardless of the location of the patient or provider.

SOURCE: DHCS IHS Manual. May 2023. Pg. 9. (Accessed Apr. 2024).

Vision Services

Asynchronous telecommunications system (store and forward telehealth) in single media format does not include telephone calls, images transmitted via facsimile machine, and text messages without visualization of the patient (electronic mail).

SOURCE: CA Department of Health Care Services. Medi-Cal Professional Services Manual. Page 6. (Dec. 2022). (Accessed Apr. 2024).

LEA Services

Allowable services delivered via telehealth must be synchronous telehealth service rendered via a real-time interactive audio and video telecommunications system only.

SOURCE: CA Department of Health Care Services. Medi-Cal Local Educational Agency (LEA) Telehealth Manual. Page 3. (Jun. 2023). (Accessed Apr. 2024).

Drug Medi-Cal Treatment Program

A county that enters into a Drug Medi-Cal Treatment Program contract with the department shall reimburse Drug Medi-Cal certified providers for medically necessary Drug Medi-Cal reimbursable services, as defined in Section 14124.24, provided by a licensed practitioner of the healing arts, or a registered or certified alcohol or other drug counselor or other individual authorized by the department to provide Drug Medi-Cal reimbursable services when those services meet the standard of care, meet the requirements of the service code being billed, and are delivered through video synchronous interaction or audio-only synchronous interaction.

A Drug Medi-Cal certified provider shall not establish a new patient relationship with a Medi-Cal beneficiary via asynchronous store and forward, audio-only synchronous

interaction, remote patient monitoring, or other virtual communication modalities. The department may provide for specific exceptions to this prohibition, which shall be developed in consultation with affected stakeholders and published in departmental guidance.

SOURCE:Welfare and Institutions Code 14132.731, as amended bySB 184 (2022 Session). (Accessed Apr. 2024).

Managed Care

MCPs must reimburse Providers for a Covered Service rendered via telephone or video at the same rate for in-person visits, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the Member.

SOURCE: CA Department of Health Care Services (DHCS). All Plan Letter 23-007: Telehealth Services Policy. Apr. 10, 2023. (Accessed Apr. 2024).

Managed Care & Behavioral Health

Effective no sooner than January 1, 2024, all providers furnishing applicable covered services via synchronous audio-only interaction must also offer those same services via synchronous video interaction to preserve beneficiary choice. Also, effective no sooner than January 1, 2024, to preserve a beneficiary's right to access covered services in person, a provider furnishing services through telehealth must do one of the following:

- Offer those same services via in-person, face-to-face contact; or
- Arrange for a referral to, and a facilitation of, in-person care that does not require a beneficiary to independently contact a different provider to arrange for that care.

SOURCE: CA Department of Health Care Services (DHCS). All Plan Letter 23-007: Telehealth Services Policy. Apr. 10, 2023, p. 3.; CA Department of Health Care Service (DHCS). Behavioral Health Information Notice No.: 23-018. Apr. 25, 2023. Pg. 3-5, 8 (Accessed Apr. 2024).

Behavioral Health

As a general rule, State law prohibits the use of asynchronous store and forward, synchronous audio-only interaction, or remote patient monitoring when providers establish new patient relationships with Medi-Cal beneficiaries. SMHS, DMC, and DMC-ODS providers may establish a relationship with new patients via synchronous audio-only interaction in the following instances:

- When the visit is related to sensitive services as defined in subsection (n) of Section 56.06 of the Civil Code.
- This includes all covered SMHS, DMC, and DMC-ODS services.

- When the patient requests that the provider utilizes synchronous audio-only interactions or attests they do not have access to video.
- When the visit is designated by DHCS to meet another exception developed in consultation with stakeholders.

SMHS, DMC, and DMC-ODS providers shall comply with all applicable federal and state laws, regulations, bulletins/information notices, and guidance when establishing a new patient relationship via telehealth.

The use of telehealth modifiers on SMHS, DMC, and DMC-ODS claims is mandatory and necessary for accurate tracking of telehealth usage in behavioral health. Billing codes must be consistent with the level of care provided. The following code shall be used in SMHS, DMC, and DMC-ODS for audio-only:

- Synchronous audio-only interaction service: SC

See notice for additional program specific information.

SOURCE: CA Department of Health Care Service (DHCS). Behavioral Health Information Notice No.: 23-018. Apr. 25, 2023. Pg. 3-5, 8 (Accessed Apr. 2024).

Family PACT

Family PACT providers may also establish a relationship with new patients via audio-only synchronous interaction only if one or more of the following applies:

- The visit is related to the provision of family planning services in accordance with California Family Code Section 6925, subd. (a), Welfare and Institutions Code (W&I Code), Section 24003, subd. (b), or medical care related to the diagnosis, treatment and/or prevention of sexually transmitted infections (STIs) according to California Family Code Section 6926, et seq. obtained by a patient at or above the minimum age specified for consenting to these services.
- The patient requests an audio-only modality.
- The patient attests they do not have access to video

SOURCE: CA Department of Health Care Services. Family PACT Clinical Services manual. Aug. 2023. Pg. 7. (Accessed Apr. 2024).

A Family PACT provider may enroll and recertify clients through synchronous video or audio-only synchronous telehealth modalities. See manual for more information.

SOURCE: CA Department of Health Care Services. Family PACT Client Eligibility Manual. Apr. 2023. Pg. 1. (Accessed Apr. 2024).

CCS Service Code Groupings

Effective for dates of service on or after July 1, 2023, CPT® codes 99358 (Prolonged evaluation and management service before and/or after direct patient care; first hour) and 99359 (Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes) have been added to the California Children's Services (CCS) Service Code Grouping (SCG).

SOURCE: CA Dept. of Health Care Services. CCS Service Code Groupings Policy Update. June 2023. (Accessed Apr. 2024).

Children's Services Program

CCS providers must request prior authorization services from CCS paneled physicians (22, CCR Section 41412) who are available to provide telehealth services. Prior authorization requests are also authorized to CCS-approved hospitals and outpatient special care centers. GHPP providers must be Medi-Cal enrolled providers.

Physical and Occupational Therapy may be offered through appropriate telehealth modalities. Medical Therapy Unit therapists may offer remote/virtual teletherapy services as an alternative to in-person visits, as appropriate and directed by the Medical Therapy Conference and directing physicians. CCS clients receiving services through a Special Care Center and/or Medical Therapy Program Medical Therapy Conference must have an annual in-person evaluation by a CCS-paneled physician. GHPP clients require an annual evaluation to ensure continued program coverage.

Billing for telehealth services is contingent upon the CCS Program or GHPP clients meeting all eligibility criteria, with an approved CCS Program/GHPP SAR, and in conformance with required Medi-Cal claims submission procedures as outlined in the DHCS Medi-Cal Telehealth Policy.

- When submitting a SAR for synchronous telemedicine services, the provider must use codes provided in the American Medical Association (AMA's) CPT Manual, Appendix P.
- Telehealth modifiers (93, 95 or GQ) are required on SARs to differentiate the telehealth service from the equivalent in-person service.
- For services or benefits provided via synchronous, telephone or other interactive audio-only telecommunications systems, the health care provider bills with modifier 93.
- For services or benefits provided via asynchronous store-and-forward telecommunications systems, the health care provider bills with modifier GQ.

For Whole Child Model (WCM) counties, the client's managed care plan (MCP) shall be responsible for authorizing, coordinating, and covering CCS telehealth services.

SOURCE: Department of Health Care Services. Numbered letter 03-0723 to the Children's Services Program and Genetically Handicapped Persons Program (GHPP). Jul. 7, 2023 – supersedes Department of Health Care Services. Numbered letter 16-1217 to the CA Children's Services Program and Genetically Handicapped Persons Program (GHPP). Dec. 22, 2017. (Accessed Apr. 2024).

CONSENT REQUIREMENTS

Last updated 04/02/2024

Health care providers must inform the patient prior to the initial delivery of telehealth services about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services.

If a health care provider, whether at the originating site or distant site, maintains a general consent agreement that specifically mentions use of telehealth as an acceptable modality for delivery of services and includes the required information, as explained below, then this is sufficient for documentation of patient consent and should be kept in the patient's medical file. Providers also need to document when a patient consents to receive services via audio-only prior to initial delivery of services.

The consent shall be documented in the patient's medical file and be available to DHCS upon request. Providers are required to share additional information with beneficiaries regarding:

- Right to in-person services
- Voluntary nature of consent
- Availability of transportation to access in-person services when other available resources have been reasonably exhausted
- Limitations/risks of receiving services via telehealth, if applicable
- Availability of translation services

Consent requirements may be found in Business and Professions Code, Section 2290.5 [b] and Welfare and Institutions Code, Section 14132.725 [d]. Model patient consent language may be found on the DHCS website.

FQHCs and RHCs are directed to refer to the above on consent requirements.

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth. (Jan. 2023), Pg. 5., CA Department of Health Care Services (DHCS). Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHC) Outpatient Services Manual. Mar. 2024. Pg. 14. (Accessed Apr. 2024).

Applies to Healthcare Providers including FQHCs/RHCs

In addition to any existing law requiring beneficiary consent to telehealth, including, but not limited to, subdivision (b) of Section 2290.5 of the Business and Professions Code, all of the following shall be communicated by a health care provider, FQHC, and RHC to a Medi-Cal beneficiary, in writing or verbally, on at least one occasion prior to, or concurrent with, initiating the delivery of one or more health care services via telehealth to a Medi-Cal beneficiary:

- An explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit;
- An explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi-Cal services in the future;
- An explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted; and
- The potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the provider, FQHC, or RHC.

The provider, FQHC, or RHC shall document in the patient record the provision of this information and the patient's verbal or written acknowledgment that the information was received.

The department shall develop, in consultation with affected stakeholders, model language for purposes of the communication described in this subdivision.

This subdivision does not apply to Medi-Cal covered services delivered by providers via any telehealth modality to eligible inmates in state prisons, county jails, or youth correctional facilities.

SOURCE: Welfare and Institutions Code 14132.725 & Welfare and Institutions Code 14132.100, as amended by SB 184 (2022 Session). (Accessed Apr. 2024).

State law requires the health care provider initiating the use of telehealth to obtain written or verbal consent once before the initial delivery of telehealth services. Medi-Cal has developed Telehealth Patient Consent Language, which includes language outlining a beneficiary's right to in-person services, the voluntary nature of consent, the availability of transport to access in-person services if needed, and potential limitations/risks of receiving services via telehealth. Providers are not required to use DHCS model language but rather can be utilized as a resource. Patient consent can be

completed verbally or in writing. Patients who consent to synchronous video must separately consent to synchronous audio-only services.

Health care providers may document consent either by having the beneficiary sign a paper or electronic form that can be included in the patient's medical record or by having the provider note consent in the patient's medical record. Group practices need to obtain and document a patient's initial consent for purposes of telehealth services prior to the initiation of health care services via telehealth. If consent is documented by the group practice, it is not necessary for each provider rendering health care services via telehealth to document consent.

Minors who receive confidential care, including sexual health, reproductive health, mental health under the Minor Consent Program, may consent to receive the same services via telehealth that are appropriate for telehealth. More information is available on the Minor Consent Program.

SOURCE: CA Department of Health Care Services. Telehealth FAQs. (Accessed Apr. 2024).

Indian Health Services, Memorandum of Understanding Agreement (IHS-MOA)

Refer to fee-for-service policy. All consent for homeless patients must be documented.

SOURCE: CA Department of Health Care Services (DHCS). Indian Health Services, Memorandum of Agreement (MOA) 638, Clinics Manual. Jan. 2023. Pg. 8. (Accessed Apr. 2024).

Vision Care

Providers must include a record of the written or verbal request for the consultation by the referring provider or other source in the medical record. Verbal and written informed consent from the patient or the patient's legal representative is required if the consulting provider has ultimate authority over the care or primary diagnosis of the patient.

SOURCE: CA Department of Health Care Services, Vision Care: Professional Services Manual. (Oct. 2022), Pg. 5. (Accessed Apr. 2024).

Local Education Agency Services

All of the following shall be communicated by a health care provider to a Medi-Cal beneficiary, in writing or verbally, on at least one occasion prior to, or concurrent with, initiating the delivery of one or more health care services via telehealth to a Medi-Cal beneficiary:

- An explanation that beneficiaries have the right to access covered services that may be delivered via telehealth through an in-person, face-to-face visit;
- An explanation that the use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the Medi-Cal beneficiary without affecting their ability to access covered Medi-Cal services in the future;
- An explanation of the availability of Medi-Cal coverage for transportation services to inperson visits when other available resources have been reasonably exhausted; and
- The potential limitations or risks related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the provider.

Documentation of written or verbal consent to receive services via telehealth must be maintained in the student's file. Consent requirements outlined in the Local Educational Agency provider manual section related to accessing public benefits or insurance or releasing medical information in personally identifiable form from the student's education record must also be followed.

SOURCE: CA Department of Health Care Services (DHCS). Local Education Agency (LEA) Telehealth. Jun. 2023. Pg. 7. (Accessed Apr. 2024).

Audio-Only

Providers must document in the patient's medical chart that the patient has given a written or verbal consent to the audio-only telehealth encounter.

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth. (Mar. 2024), Pg. 9. (Accessed Apr. 2024).

Remote Physiological Monitoring

Prior to or at the time RPM services are furnished, the patient must give consent to receive the services. Consent may be verbal (written consent is not required) but must be documented in the medical record, along with justification for the use of RPM services.

SOURCE: CA DHCS Evaluation and Management Manual (Dec. 2022), p. 42. (Accessed Apr. 2024).

Family PACT

Family PACT providers must inform the client prior to the initial delivery of telehealth services about the use of telehealth and obtain verbal or written consent from the client for the use of telehealth as an acceptable mode of delivering health care services.

If a provider, whether at the originating site or distant site, maintains a general consent agreement that specifically mentions use of telehealth as an acceptable modality for

delivery of services and includes the required information, as explained below, then this is sufficient for documentation of client consent, and should be kept in the client's medical record.

Providers must also document when a client consents to receive services via audio-only prior to initial delivery of services. The consent shall be documented in the client's medical record and be available to DHCS upon request.

Providers are required to share additional information with clients regarding:

- Right to in-person services
- Voluntary nature of consent
- Limitations/risks of receiving services via telehealth, if applicable
- Availability of translation services

Consent requirements may be found in Business and Professions Code, Section 2290.5 [b]. Model patient consent language may be found on the DHCS website.

SOURCE: CA Department of Health Care Services. Medi-Cal Clinical Services Manual. (Jun. 2023). Pg. 8. (Accessed Apr. 2024).

Managed Care & Behavioral Health

Providers must inform Members/Beneficiaries prior to the initial delivery of Covered Services via Telehealth about the use of Telehealth and obtain verbal or written consent from Members/Beneficiaries for the use of Telehealth as an acceptable mode of delivering services.

If a Provider, whether at the originating site or distant site, retains a general consent agreement that specifically mentions the use of Telehealth as an acceptable modality for the delivery of Covered Services and includes the required information below, this is sufficient for documentation of consent. Providers also need to document when a Member/Beneficiary consents to receive Covered Services via Telehealth prior to the initial delivery of the services. Consent must be documented in the Member's/Beneficiary's Medical Record and made available to DHCS upon request.

In addition to documenting consent prior to initial delivery of Covered Services via Telehealth, Providers are also required to explain the following to Members/Beneficiaries:

- The Member's/Beneficiaries right to access Covered Services delivered via Telehealth inperson.
- That use of Telehealth is voluntary and that consent for the use of Telehealth can be withdrawn at any time by the Member/Beneficiary without affecting their ability to access

Medi-Cal Covered Services in the future.

- The availability of Non-Medical Transportation to in-person visits.
- The potential limitations or risks related to receiving Covered Services through Telehealth as compared to an in-person visit, if applicable.

DHCS has created model Member/Beneficiary consent language for MCPs and Providers to use, which can be found on the DHCS website.

SOURCE: CA Department of Health Care Services (DHCS). All Plan Letter 23-007: Telehealth Services Policy. Apr. 10, 2023, p. 3-4; CA Department of Health Care Service (DHCS). Behavioral Health Information Notice No.: 23-018. Apr. 25, 2023. Pg. 3-4. (Accessed Apr. 2024).

OUT OF STATE PROVIDERS

Last updated 04/02/2024

Provider must be licensed in CA, enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community.

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth. (Mar. 2024), Pg. 3.; Welfare and Institutions Code 14132.725, as amended by SB 184 (2022 Session). (Accessed Apr. 2024).

A person who is licensed as a health care practitioner in another state and is employed by a tribal health program does not need to be licensed in California to perform services for the tribal health program in California or a border community (Business and Professions Code section 719).

SOURCE: CA Department of Health Care Services. Telehealth FAQ. (Accessed Apr. 2024).

MISCELLANEOUS

Last updated 04/02/2024

Establishing New Patients via Telehealth

Providers may establish a relationship with new patients via synchronous video telehealth visits. Providers may establish a relationship with new patients via audio-only synchronous interaction only if one or more of the following applies:

- The visit is related to sensitive services as defined in subsection (n) or Section 56.06 of the Civil Code. Section 56.06 of the Civil Code defines “sensitive services” as all health care

services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender-affirming care, and intimate partner violence, and includes services described in Sections 6924 through 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.

- The patient requests an audio-only modality.
- The patient attests they do not have access to video.

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth. (Mar. 2024), Pg. 3. (Accessed Apr. 2024).

Documentation

All health care practitioners providing covered benefits or services to Medi-Cal patients must maintain appropriate documentation to substantiate the corresponding technical and professional components of billed CPT® or HCPCS codes. Documentation for benefits or services delivered via telehealth should be the same as for a comparable in-person service. The distant site provider can bill for Medi-Cal covered benefits or services delivered via telehealth using the appropriate CPT or HCPCS codes with the corresponding modifier and is responsible for maintaining appropriate supporting documentation. This documentation should be maintained in the patient's medical record.

Providers should note the following:

- Health care providers at the distant site must determine that the covered Medi-Cal service or benefit being delivered via telehealth meets the procedural definition and components of the CPT or HCPCS code(s) associated with the Medi-Cal covered service or benefit as well as any other requirements described in this section of the Medi-Cal provider manual.
- Health care providers are not required to document a barrier to an in-person visit for Medi-Cal coverage of services provided via telehealth (W&I Code, Section 14132.72[d]).
- Health care providers at the distant site are not required to document cost effectiveness of telehealth to be reimbursed for telehealth services or store and forward services.

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth. (Jan. 2023), Pg. 4. (Accessed Apr. 2024).

Family PACT

Documentation for benefits or services delivered via telehealth should be the same as for a comparable in-person service. The distant site provider can bill for Family PACT covered benefits or services delivered via telehealth using the appropriate CPT® or

HCPCS codes with the corresponding modifier and is responsible for maintaining appropriate supporting documentation. This documentation must be maintained in the client's medical record.

SOURCE: CA DHCS Medi-Cal Provider Enrollment and Responsibilities Manual. (June 2023). Pg. 18. (Accessed Apr. 2024).

Disabled Individuals

Telehealth services and supports are among the services and supports authorized to be included by individual program plans developed for disabled individuals by regional centers that contract with the State Department of Developmental Disabilities.

SOURCE: Welfare and Institutions Code Sec. 4512. (Accessed Apr. 2024).

Network Adequacy

Medicaid must ensure that all managed care covered services are available and accessible to enrollees of Medicaid managed care plans in a timely manner. Telehealth can be used as a means to meet time and distance standards in some circumstances. See APL for details.

SOURCE: CA Welfare and Institutions Code Sec. 14197. & CA Department of Health Care Services (DHCS). All Plan Letter 23-001: Network Certification Requirements. Jan. 6, 2023. (Accessed Apr. 2024).

Emergency Clinic Telephonic Services

Telehealth services, telephonic services and other specified services must be reimbursed when provided by specific entities during or immediately following an emergency, subject to the Department obtaining federal approval and matching funds. The Department is required to issue guidance for entities to facilitate reimbursement for telehealth or telephonic services in emergency situations by July 1, 2020.

SOURCE: Welfare and Institutions Code Sec. 14132.723 & 724 (AB 1494 – 2019 Legislative Session). (Accessed Apr. 2024).

Privileges/Credentialing

Issues of privileges and credentialing for distant physicians to care for patients via telehealth are determined by the policies of the originating hospital. Hospitals can accept the privileges and credentials for providers at distant hospitals.

SOURCE: Telehealth FAQs, Providers. (Accessed Apr. 2024).

COVID Telehealth Flexibilities

The department shall seek any federal approvals it deems necessary to extend the approved waiver or flexibility implemented pursuant to subdivision (a), as of July 1, 2021, that are related to the delivery and reimbursement of services via telehealth modalities in the Medi-Cal program. Subject to subdivision (e), the department shall implement those extended waivers or flexibilities for which federal approval is obtained, to commence on the first calendar day immediately following the last calendar day of the federal COVID-19 public health emergency period, and through December 31, 2022.

The department may authorize the use of remote patient monitoring as an allowable telehealth modality for covered health care services and provider types it deems appropriate for dates of service on or after July 1, 2021. The department may establish a fee schedule for applicable health care services delivered via remote patient monitoring.

For purposes of informing the 2022–23 proposed Governor's Budget, released in January 2022, the department shall convene an advisory group consisting of consultants, subject matter experts, and other affected stakeholders to provide recommendations to inform the department in establishing and adopting billing and utilization management protocols for telehealth modalities to increase access and equity and reduce disparities in the Medi-Cal program. The advisory group shall analyze the impact of telehealth in increased access for patients, changes in health quality outcomes and utilization, best practices for the appropriate mix of in-person visits and telehealth, and the benefits or liabilities of any practice or care model changes that have resulted from telephonic visits.

SOURCE: AB 133, Sec. 380 (2021 Session). (Accessed Apr. 2024).

Consent

The department shall develop, in consultation with affected stakeholders, an informational notice to be distributed to fee-for-service Medi-Cal beneficiaries and for use by Medi-Cal managed care plans in communicating to their enrollees. Information in the notice shall include, but not be limited to, all of the following:

- The availability of Medi-Cal covered telehealth services.
- The beneficiary's right to access all medically necessary covered services through in-person, face-to-face visits, and a provider's and Medi-Cal managed care plan's responsibility to offer or arrange for that in-person care, as applicable.
- An explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn by the Medi-Cal beneficiary at any time without affecting their ability to access covered Medi-Cal services in the future.

- An explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted.
- Notification of the beneficiary's right to make complaints about the offer of telehealth services in lieu of in-person care or about the quality of care delivered through telehealth.

The informational notice shall be translated into threshold languages determined by the department pursuant to subdivision (b) of Section 14029.91 and provided in a format that is culturally and linguistically appropriate.

This subdivision does not apply to Medi-Cal covered services delivered by providers via any telehealth modality to eligible inmates in state prisons, county jails, or youth correctional facilities.

SOURCE: Welfare and Institutions Code 14132.725 (e), as amended by SB 184 (2022 Session). (Accessed Apr. 2024).

DHCS Telehealth Research and Evaluation Plan

On or before January 1, 2023, the department shall develop a research and evaluation plan that does all of the following:

- Proposes strategies to analyze the relationship between telehealth and the following: access to care, access to in-person care, quality of care, and Medi-Cal program costs, utilization, and program integrity.
- Examines issues using an equity framework that includes stratification by available geographic and demographic factors, including, but not limited to, race, ethnicity, primary language, age, and gender, to understand inequities and disparities in care.
- Prioritizes research and evaluation questions that directly inform Medi-Cal policy.

SOURCE: Welfare and Institutions Code 14132.725 (g), as amended by SB 184 (2022 Session). (Accessed Apr. 2024).

HIPAA/Privacy Compliance

Applicable health care services provided through asynchronous store and forward, video synchronous interaction, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities as described in this section shall comply with the privacy and security requirements contained in the federal Health Insurance Portability and Accountability Act of 1996 found in Parts 160 and 164 of Title 45 of the Code of Federal Regulations, the Medicaid State Plan, and any other applicable state and federal statutes and regulations.

SOURCE: Welfare and Institutions Code 14132.725 (h), as amended by SB 184 (2022 Session). (Accessed Apr. 2024).

Telehealth Requirements

Pursuant to an effective date designated by the department that is no sooner than January 1, 2024, a Medi-Cal provider – including FQHCs/RHCs – furnishing applicable health care services via audio-only synchronous interaction shall also offer those same health care services via video synchronous interaction to preserve beneficiary choice. The department may provide specific exceptions to the requirement based on a Medi-Cal provider's access to requisite technologies, which shall be developed in consultation with affected stakeholders and published in departmental guidance. In making such exceptions, the department may also take into consideration the availability of broadband access based on speed standards set by the Federal Communications Commission or other applicable federal law or regulation.

Pursuant to an effective date designated by the department that is no sooner than January 1, 2024, a Medi-Cal provider – including FQHCs/RHCs – furnishing applicable health care services via synchronous video interaction or audio-only synchronous interaction shall also offer those same health care services in-person or facilitate access to in-person services for the patient. The department shall consider additional recommendations from affected stakeholders regarding the need to maintain access to in-person services without unduly restricting access to telehealth services.

SOURCE: Welfare and Institutions Code 14132.725 & Welfare and Institutions Code 14132.100, as amended by SB 184 (2022 Session), AB 32 (2022 Session), and AB 1241 (2023 Session). (Accessed Apr. 2024).

Patient Choice of Telehealth Modality

Medi-Cal providers can offer a variety of telehealth modalities for covered Medi-Cal services to the extent that the service can be appropriately rendered via the allowable telehealth modalities. For Medi-Cal providers who do offer telehealth modalities, they are required to offer Medi-Cal recipients the ability to choose whether they want to receive covered Medi-Cal services via:

- Synchronous, interactive audio/visual telecommunication systems (for example, video) or
- Synchronous, telephone or other interactive audio-only telecommunications systems.

While Medi-Cal providers are required to offer both video and telephone telehealth modalities, Medi-Cal recipients may freely choose, and change at any time, their desired telehealth modalities, which includes the ability to decline video modalities and select audio-only (telephone) modalities if preferred and/or necessary given the recipient's needs. For example, if the visit is related to sensitive services as defined in subsection (s)

of Section 56.05 of the Civil Code, then the Medi-Cal recipient may prefer to utilize an audio-only (telephone) modality. Medi-Cal recipients shall be given the choice of how they receive their covered Medi-Cal services.

Exception to Telehealth Modalities Provider Requirement

Since broadband is necessary to ensure quality and effective communication between Medi-Cal providers and recipients, Medi-Cal providers are exempt from the requirement to offer both telehealth modalities if the Medi-Cal provider does not have access to broadband. Note: Broadband refers to high-speed internet access that is always on and faster than traditional dial-up access. Broadband includes several high-speed transmission technologies, such as fiber, wireless, satellite, digital subscriber line, and cable. For the purposes of delivering telehealth services to patients, DHCS uses the Federal Communications Commission's (FCC) definition of broadband and the FCC minimum mbps upload/download speeds. Medi-Cal providers claiming this exception must maintain appropriate supporting documentation, which should be made available to DHCS upon request. For example, supporting documentation might include confirmation from an internet services provider regarding the lack of broadband service in a particular coverage area.

Right to In-person Services

Medi-Cal providers furnishing services to Medi-Cal recipients through telehealth modalities must also either offer services in-person or have a documented process in place to link Medi-Cal recipients to in-person care within a reasonable time if in-person services are unavailable from the provider.

If the Medi-Cal provider chooses to link the Medi-Cal recipient to in-person care to satisfy this requirement, then they must provide a referral to and facilitation of in-person care that does not require a recipient to independently contact a different Medi-Cal provider to arrange for such care. The Medi-Cal provider may initiate a process by which a different Medi-Cal provider in their office or an affiliated in-person care site contacts the Medi-Cal recipient directly to schedule an in-person visit.

The referring Medi-Cal provider or a member of their staff must confirm the referred Medi-Cal provider has at least attempted to contact the recipient to schedule an in-person appointment. However, the Medi-Cal referring provider is not required to schedule an appointment with a different provider on behalf of the Medi-Cal recipient. The Medi-Cal provider must offer referral and facilitation support that is minimally burdensome to the Medi-Cal recipient. Medi-Cal providers must maintain

documentation of their process to link Medi-Cal recipients to in-person care, which should be made available to DHCS upon request.

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth (Mar. 2024). Pg. 6-7. (Accessed Apr. 2024).

Medi-Cal Enrollment Procedure and Exemptions for Remote Mental Health Services

Effective March 29, 2023, the Department of Health Care Services (DHCS) is establishing Medi-Cal provider enrollment requirements and procedures that will be exempt from certain established place of business requirements for the following modes of service:

- Remote service providers who offer mental health services exclusively through telehealth modalities, and
- Transportation providers located in California.

In accordance with Welfare & Institutions (W&I) Code Section 14043.75(b), enrollment requirements and procedures are established for providers offering Medi-Cal covered mental health services exclusively through telehealth modalities, including non-specialty mental health services (NSMHS) covered under Medi-Cal Fee-For-Service and Medi-Cal Managed Care Plans and Specialty Mental Health Services (SMHS) covered by county mental health plans, and for Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) providers.

The following provider types are able to apply for enrollment as remote service-only providers:

- Licensed Clinical Social Workers;
- Licensed Marriage and Family Therapists;
- Licensed Professional Clinical Counselors;
- Nurse Practitioners specializing in Psychiatry;
- Physicians specializing in Psychiatry; and
- Psychologists

Remote service providers requesting consideration for enrollment in the Medi-Cal program must complete and submit an application for their appropriate provider type through the Provider Application and Validation for Enrollment (PAVE) portal with the required supporting documents and a completed and signed Remote Services-Only Provider Attestation. For more detailed information, providers may refer to the Requirements and Procedures for the Medi-Cal Enrollment of Providers Offering

Services Remotely or Indirectly from their Business Address located on the Provider Enrollment page of the Medi-Cal Provider website.

SOURCE: CA Dept. of Health Care Services. Medi-Cal Update – Psychological Services. March 2023. (Accessed Apr. 2024).

Community-Based Adult Services (CBAS)

CBAS Emergency Remote Services (ERS) are authorized under the California Advancing and Innovating Medi-Cal (CalAIM) 1115 Demonstration Waiver (Waiver) that was implemented October 1, 2022. CBAS supports and services delivered in the community, at the doorstep or in the home, and via telehealth allow for immediate response during participant emergencies. DHCS and MCPs are required to cover ERS as part of the CBAS benefit when participants meet the criteria established in ERS policy, including that ERS is determined to be the appropriate service for the participant and their emergency situation, and the CBAS provider meets the criteria specified in this ACL. See ACL for additional information.

SOURCE: CA Dept. of Health Care Services. All Center Letter 22-04. Launch of New CBAS ERS. Aug. 2022. (Accessed Apr. 2024).

Signature Requirement for Medication Delivery

In accordance with W&I Code, Section 14043.341, providers must obtain either a handwritten or electronic signature for prescription medications sent to a client. Providers may obtain the signature of a client or the recipient either before the medication is sent, or upon receipt when delivered to the client.

Signature Prior to Delivery – Providers have two options to obtain a client's signature when the client is not in person, such as during a telehealth visit:

- Recorded oral signature: Providers must ensure that they are able to collect an audio or video recording that can be stored in the provider's case record and retrieved upon request. Providers may use either of the following two options for audio or videorecorded signatures
    - Recording only the signature portion of the telehealth visit. When recording only the signature portion of the visit, providers must record the portion of the visit where the client acknowledges and confirms the medications they will be receiving and provides their understanding that the oral signature holds the same weight as a written signature; or –
    - Recording the entire visit with the oral signature included
- Electronic signature: Providers may obtain an electronic signature. Consistent with the Uniform Electronic Transactions Act, California Civil Code Section 1633.2, an "electronic signature" is an electronic sound, symbol, or process attached to or logically associated with

an electronic record and executed or adopted by a person with the intent to sign the electronic record. An electronic signature includes a "digital signature" defined in subdivision (d) of Section 16.5 of the Government Code to mean an electronic identifier, created by a computer, intended by the party using it to have the same force and effect as a manual signature. Regardless of the type of electronic signature collected, providers must ensure that they are able to store and/or easily access documentation of the electronic signature in the client's medical record

Signature upon Receipt of Delivery – Providers may obtain a client's handwritten or electric signature upon receipt of delivery if the delivery service offers physical or electronic return receipts, such as those offered through the United States Postal Service. Providers must retain documentation of the signature in the client's medical record.

SOURCE: CA DHCS Medi-Cal Provider Enrollment and Responsibilities Manual. (Aug. 2022). Pg. 20-21. (Accessed Apr. 2024).

Workers' Compensation

Telehealth is included in the Official Medical Fee Schedule (OMFS) for California's Workers' Compensation system and consistent with Medicare's List of Telehealth Services for Calendar Year 2023 (ZIP).

Recently passed regulations authorize a remote health evaluation or medical-legal evaluations through the use of electronic means of creating a virtual meeting between the physician and injured worker when both parties can visually see and hear each other and may not be in the same physical space or site. Evaluations can be completed through remote health when a hands on physical examination is not necessary and certain conditions are met.

Remote health is defined as remote visits via video-conferencing, video-calling, or such similar technology that allows each party to see and converse with the other via a video and audio connection. The evaluation must be conducted with the same standard of care as in person visit and must comply with all relevant state and federal privacy laws.

SOURCE: CA Division of Workers' Compensation Order of the Administrative Director – Effective July 1, 2023; CA Code of Regulations, Title 8, Section 9789.1.2 & CA Code of Regulations, Title 8, Section 46.3, as proposed to be added by permanent rule. (Accessed Apr. 2024).

Professional Requirements

DEFINITIONS

Last updated 04/02/2024

"Telehealth means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers."

SOURCE: CA Business & Professions Code Sec. 2290.5. (Accessed Apr. 2024)

Veterinarians

"Telehealth" means the mode of delivering veterinary medicine via electronic communication technologies to facilitate the diagnosis, consultation, care management, or treatment of an animal patient, and includes, but is not limited to, synchronous video and audio communication; synchronous, two-way audio communication; and electronic transmission of images, diagnostics, data, and medical information.

SOURCE: CA Business and Professions Code Section 4825.1 as amended by AB 1399 (2023 Session). (Accessed Apr. 2024).

CONSENT REQUIREMENTS

Last updated 04/02/2024

Before the delivery of health care via telehealth, the health care provider initiating the use of telehealth shall inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health. The consent shall be documented.

SOURCE: CA Business & Professions Code Sec. 2290.5. (Accessed Apr. 2024).

Occupational Therapy

An occupational therapist must obtain patient's consent prior to providing services via telehealth.

SOURCE: CA Code of Regulations, Title 16, Div. 39, Art. 8, Sec. 4172(b). (Accessed Apr. 2024).

Behavioral Sciences

A licensee must obtain informed consent from a client upon initiation of telehealth services.

SOURCE: CA Code of Regulations, Title 16, Div. 18, Art. 1, Sec. 1815.5(c). (Accessed Apr. 2024).

Psychologists

A licensee must obtain and document informed consent for the provision of psychological health care services via telehealth from the client. Such consent shall cover concerns unique to the receipt of psychological health care services via telehealth, including risks to confidentiality and security, data storage policies and procedures specific to telehealth, the possibility of disruption and/or interruption of service due to technological failure, insurance coverage considerations, and other issues that the licensee can reasonably anticipate regarding the non-comparability between psychological health care services delivered in person and those delivered via telehealth.

SOURCE: CA Code of Regulations, Title 16, Div. 13.1, Art. 8, Sec. 1396.8(a). (Accessed Apr. 2024).

Veterinarians

Before delivering veterinary medicine via telehealth, the veterinarian shall inform the client about the use and potential limitations of telehealth and obtain consent from the client to use telehealth, including acknowledgment of all of the following:

- The same standards of care apply to veterinary medicine services via telehealth and in-person veterinary medical services.
- The client has the option to choose an in-person visit from a veterinarian at any time.
- The client has been advised how to receive follow-up care or assistance in the event of an adverse reaction to the treatment or in the event of an inability to communicate resulting from technological or equipment failure.

SOURCE: CA Business and Professions Code Section 4826.6 as added by AB 1399 (2023 Session). (Accessed Apr. 2024).

ONLINE PRESCRIBING

Last updated 04/02/2024

Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care.

SOURCE: CA Business & Professions Code Sec. 2242 (a). (Accessed Apr. 2024).

Remote Dispensing Site Pharmacies

Remote dispensing site pharmacies are permitted to dispense or provide pharmaceutical care services in medically underserved areas. A supervising pharmacy must provide telepharmacy services to the remote dispensing site pharmacy and shall not be located greater than 150 road miles from the remote dispensing site pharmacy.

SOURCE: CA Business & Professions Code Sec. 4130-4135 (Accessed Apr. 2024).

Occupational Therapy

An occupational therapist shall determine whether an in-person evaluation or in-person interventions are necessary considering: the complexity of the patient's/client's condition; his or her own knowledge, skills, and abilities; the nature and complexity of the intervention; the requirements of the practice setting; and the patient's/client's context and environment.

SOURCE: CA Code of Regulations, Title 16, Div. 39, Art. 8, Sec. 4172(c). (Accessed Apr. 2024).

Veterinarians

A veterinarian shall not prescribe, dispense, or administer a drug, medicine, application, or treatment of whatever nature for the prevention, cure, or relief of a wound, fracture, bodily injury, or disease of animals unless a veterinarian-client-patient relationship exists or as otherwise permitted by law, except when the animal patient is a wild animal or the owner of the animal patient is unknown. A veterinarian-client-patient relationship exists if all of the following conditions are met:

- The client has authorized the veterinarian to assume responsibility for medical judgments regarding the health of the animal patient.
- The veterinarian possesses sufficient knowledge of the animal patient to initiate at least a general or preliminary diagnosis of the animal patient's medical condition.
- The veterinarian has assumed responsibility for making medical judgments regarding the health of the animal patient and has communicated with the client a medical, treatment, diagnostic, or therapeutic plan appropriate to the circumstances.

A veterinarian possesses sufficient knowledge of the animal patient if the veterinarian has recently seen, or is personally acquainted with, the care of the animal patient by doing any of the following:

- Examining the animal patient in person.

- Examining the animal patient by use of synchronous audio-video communication.
- Making medically appropriate and timely visits to the premises on which the animal patient is kept.

Synchronous audio-video communication is not required for the delivery of veterinary medicine via telehealth after a veterinarian-client-patient relationship has been established unless the veterinarian determines that it is necessary in order to provide care consistent with prevailing veterinary medical practice.

A veterinarian-client-patient relationship shall not be established solely by audio-only communication or by means of a questionnaire.

Only a person who holds a current license to practice veterinary medicine in this state is authorized to practice veterinary medicine via telehealth on an animal patient located in this state.

Before delivering veterinary medicine via telehealth, the veterinarian shall inform the client about the use and potential limitations of telehealth and obtain consent from the client to use telehealth, including acknowledgment of all of the following:

- The same standards of care apply to veterinary medicine services via telehealth and in-person veterinary medical services.
- The client has the option to choose an in-person visit from a veterinarian at any time.
- The client has been advised how to receive follow-up care or assistance in the event of an adverse reaction to the treatment or in the event of an inability to communicate resulting from technological or equipment failure.

A veterinarian who practices veterinary medicine via telehealth shall do all of the following:

- Ensure that the technology, method, and equipment used to provide veterinary medicine services via telehealth comply with all current privacy protection laws.
- Have historical knowledge of the animal patient by obtaining and reviewing the animal patient's relevant medical history, and, if available, medical records. If medical records exist from a previous in-person visit and are available to the client, the client may transmit those records, including any diagnostic data contained therein, to the veterinarian electronically.
- Employ sound professional judgment to determine whether using telehealth is an appropriate method for delivering medical advice or treatment to the animal patient and providing quality of care consistent with prevailing veterinary medical practice.
- Be familiar with available medical resources, including emergency resources near the animal patient's location, be able to provide the client with a list of nearby veterinarians who may be

able to see the animal patient in person upon the request of the client, and keep, maintain, and make available a summary of the animal patient record, as specified in Section 4855.

- Provide the client with the veterinarian's name, contact information, and license number.
- Secure an alternative means of contacting the client if the electronic means is interrupted.

A veterinarian shall not prescribe a drug for a duration of time that is inconsistent with the medical condition of the animal patient or the type of drug prescribed.

A veterinarian who established the required veterinarian-client-patient relationship by examining the animal patient in person or by making medically appropriate and timely visits to the premises on which the animal patient is kept shall not prescribe a drug for a duration of time that is longer than one year from the date that the veterinarian examined the animal patient in person or visited the premises and prescribed the drug.

Except as provided in paragraphs (4) to (8), inclusive, a veterinarian who practices veterinary medicine via telehealth may order, prescribe, or make available drugs, as defined in Section 11014 of the Health and Safety Code, in accordance with all relevant state and federal regulations.

A veterinarian who established the required veterinarian-client-patient relationship using synchronous audio-video communication shall not prescribe a drug to the animal patient for use for a period longer than six months from the date upon which the veterinarian examined the animal patient or prescribed the drug. The veterinarian shall not issue another prescription to the animal patient for the same drug unless they have conducted another examination of the animal patient, either in person or using telehealth.

A veterinarian who established the required veterinarian-client-patient relationship using synchronous audio-video communication shall not prescribe an antimicrobial drug to the animal patient for a period longer than 14 days of treatment. The veterinarian shall not issue any further antimicrobial drug prescription, including a refill, to treat the condition of the animal patient unless the veterinarian has conducted an in-person examination of the animal patient.

The veterinarian shall not order, prescribe, or make available a controlled substance, as defined in Section 4021, or xylazine, unless the veterinarian has performed an in-person physical examination of the animal patient or made medically appropriate and timely visits to the premises where the animal patient is kept.

The veterinarian shall notify the client that some prescription drugs or medications may be available at a pharmacy and, if requested, the veterinarian shall submit a prescription to a pharmacy that the client chooses.

A veterinarian shall not prescribe via telehealth any drug or medication for use on a horse engaged in racing or training at a facility under the jurisdiction of the California Horse Racing Board pursuant to Chapter 4 (commencing with Section 19400) of Division 8.

As used in this section, “drug” means any controlled substance, as defined in Section 4021, or any dangerous drug, as defined in Section 4022.

A veterinarian is permitted to use telehealth without establishing a veterinarian-client-patient relationship in order to provide advice in an emergency, as defined in Section 4840.5.

SOURCE: CA Business and Professions Code Section 4826.6 as added by AB 1399 (2023 Session). (Accessed Apr. 2024).

CROSS-STATE LICENSING

Last updated 04/02/2024

Physicians need not reside in California, as long as they have a valid, current California license.

Physicians using telehealth technologies to provide care to patients located in California must be licensed in California. Physicians are held to the same standard of care, and retain the same responsibilities of providing informed consent, ensuring the privacy of medical information, and any other duties associated with practicing medicine regardless of whether they are practicing via telehealth or face-to-face, in-person visits.

SOURCE: Medical Board of California. Telehealth Resources. (Accessed Apr. 2024).

Licensure exceptions may apply to a practitioner located outside this state, when in actual consultation, whether within this state or across state lines, with a licensed practitioner of this state, or when an invited guest of the California Medical Association or the California Podiatric Medical Association, or one of their component county societies, or of an approved medical or podiatric medical school or college for the sole purpose of engaging in professional education through lectures, clinics, or demonstrations, if he or she is, at the time of the consultation, lecture, or demonstration a licensed physician and surgeon or a licensed doctor of podiatric medicine in the state

or country in which he or she resides. This practitioner shall not open an office, appoint a place to meet patients, receive calls from patients within the limits of this state, give orders, or have ultimate authority over the care or primary diagnosis of a patient who is located within this state.

SOURCE: CA Business and Professions Code Section 2060. (Accessed Apr. 2024).

Notwithstanding any other law, an eligible out-of-state physician and surgeon may practice medicine in the state if the practice is limited to delivering health care via telehealth to an eligible patient, which is a person that has an immediately life-threatening disease or condition as defined in Section 111548.1 of the Health and Safety Code, and has given written informed consent for, or, if the person lacks the capacity to consent, their legally authorized representative has given written informed consent on their behalf for, both of the following:

- The use of an eligible out-of-state physician and surgeon's telehealth health care services.
- The release of certified medical records to their primary physician and surgeon by the out-of-state physician.

The eligible patient also must not have been accepted to participate in the clinical trial nearest to their home for the immediately life-threatening disease or condition within one week of completion of the clinical trial application process, or, in the medical judgment of a physician and surgeon it is unreasonable for the patient to participate in that clinical trial due to the patient's current condition and stage of disease. The eligible patient must also have documentation from their primary physician and surgeon attesting that they meet all requirements.

An eligible out-of-state physician and surgeon means a person who is licensed as a physician and surgeon in another state in good standing with no history of prior discipline, and whose medical expertise is that of the eligible patient's illness.

SOURCE: CA Business and Professions Code Section 2052.5 as added by AB 1369 (2023 Session). (Accessed Apr. 2024).

All persons engaging in the practice of marriage and family therapy, educational psychology, clinical social work, or professional clinical counseling via telehealth, as defined in Section 2290.5 of the Code, with a client who is physically located in this State must have a valid and current license or registration issued by the Board.

SOURCE: CA Code of Regulations, Title 16, Div. 18, Art. 1, Sec. 1815.5(a). (Accessed Apr. 2024).

In order to provide occupational therapy services via telehealth as defined in Section 2290.5 of the Code, an occupational therapist or occupational therapy assistant providing services to a patient or client in this State must have a valid and current license issued by the Board.

SOURCE: CA Code of Regulations, Title 16, Div. 39, Art. 8, Sec. 4172(a). (Accessed Apr. 2024).

A licensee is permitted to provide psychological health care services via telehealth subject to the laws and regulations of the other jurisdiction where either the licensee and/or the client is located, including, but not limited to, the following circumstances:

- To a client at an originating site in this State, as defined in section 2290.5 of the Code, when a licensee is located at a distant site within this State.
- To a client who has received services in this State, and who is temporarily located outside of this State.
- To a client who is located in this State when a licensee is temporarily located outside of this State.

SOURCE: CA Code of Regulations, Title 16, Div. 13.1, Art. 8, Sec. 1396.8(a). (Accessed Apr. 2024).

Marriage and Family Therapists, Clinical Social Workers, and Professional Clinical Counselors

A person who holds a license in another jurisdiction of the United States as a marriage and family therapist/clinical social worker/professional clinical counselor may provide marriage and family therapy/clinical social work/professional clinical counseling services in this state for a period not to exceed 30 consecutive days in any calendar year, if all of the following conditions are met:

- The license from another jurisdiction is at the highest level for independent clinical practice in the jurisdiction in which the license was granted.
- The license from another jurisdiction is current, active, and unrestricted.
- The client is located in California during the time the person seeks to provide care in California.
- The client is a current client of the person and has an established, ongoing client-provider relationship with the person at the time the client became located in California.
- The person informs the client of the limited timeframe of the services and that the person is not licensed in California.
- The person provides the client with the Board of Behavioral Sciences' internet website address.

- The person informs the client of the jurisdiction in which the person is licensed and the type of license held and provides the client with the person's license number.

A person who intends to provide marriage and family therapy/clinical social work/professional clinical counseling services pursuant to this section shall provide the board with all of the following information before providing services:

- The name under which the person is licensed in another jurisdiction, the person's mailing address, the person's phone number, the person's social security number or individual taxpayer identification number, and the person's electronic mailing address, if the person has an electronic mailing address.
- The jurisdiction in which the person is licensed, the type of license held, and the license number.
- The date on which the person will begin providing marriage and family therapy/clinical social work/professional clinical counseling services to the person's client in California.

A person who provides services pursuant to this section is deemed to have agreed to practicing under the jurisdiction of the board and to be bound by the laws of this state.

This section does not apply to any person licensed by the board whose license has been suspended or revoked.

This section shall remain in effect only until January 1, 2026, and as of that date is repealed.

SOURCE: Business and Professions Code Section 4980.11, 4996.16.1, and 4999.23, as added by AB 232 (2023 Session). (Accessed Apr. 2024).

LICENSURE COMPACTS

Last updated 04/02/2024

No Reference Found

PROFESSIONAL BOARDS STANDARDS

Last updated 04/02/2024

CA Board of Occupational Therapy

SOURCE: Title 16, Div. 39, Sec. 4172 (Accessed Apr. 2024).

CA Board of Behavioral Sciences

SOURCE: Title 16, Div. 18, Art. 1, Sec. 1815.5 (Accessed Apr. 2024).

CA Medical Board

Physicians are held to the same standard of care, and retain the same responsibilities of providing informed consent, ensuring the privacy of medical information, and any other duties associated with practicing medicine regardless of whether they are practicing via telehealth or face-to-face, in-person visits.

SOURCE: Medical Board of California. Telehealth Resources. (Accessed Apr. 2024).

CA Board of Psychology

SOURCE: Title 16, Div. 13.1, Art. 8, Sec. 1396.8 (Accessed Apr. 2024)

Veterinarians

SOURCE: CA Business and Professions Code Section 4826.6 as added by AB 1399 (2023 Session). (Accessed Apr. 2024).

MISCELLANEOUS

Last updated 04/02/2024

Any individual, partnership, corporation or other entity that provides dental services through telehealth shall make available the name, telephone number, practice address and California state license number of any dentist who will be involved in the provision of services to a patient prior to the rendering of services and when requested by a patient.

SOURCE: CA Business and Professions Code, Sec. 1683.1 (Accessed Apr. 2024).

All laws and regulations governing professional responsibility, unprofessional conduct, and standards of practice that apply to a health care provider under the health care provider's license shall apply to that health care provider while providing telehealth services.

SOURCE: CA Business and Professions Code, Sec. 2290.5. (Accessed Apr. 2024).

An examination, assessment, or evaluation specified, required, or authorized for purposes of involuntary commitments may be conducted using telehealth.

SOURCE: CA Health and Safety Code 1799.111; Welfare and Institutions Code 5150.5 & 5151. (Accessed Apr. 2024).

An associate clinical social worker and a clinical counselor trainee or associate may provide services via telehealth that are in their scope of practice.

SOURCE: CA Business and Professions Code, Secs. 4996.23.2 & 4999.46.3, as amended by AB 1759 (2022 Session). (Accessed Apr. 2024).

On or after July 1, 2023, an applicant for licensure as a marriage and family therapist, educational psychologist, clinical social worker, and professional clinical counselor shall show, as part of the application, that they have completed a minimum of three hours of training or coursework in the provision of mental health services via telehealth, which shall include law and ethics related to telehealth. See statutes for additional details.

SOURCE: CA Business and Professions Code, Secs. 4980.395, 4989.23.1, 4996.27.1, and 4999.67, as added by AB 1759 (2022 Session). (Accessed Apr. 2024).

California law governs in any action in this state, whether civil, administrative, or criminal, against any person who provides, receives, aids or abets in providing or receiving, or attempts to provide or receive, by any means, including telehealth, reproductive health care services and gender-affirming health care services if the provider was located in this state or any other state where the care was legal at the time of the challenged conduct.

SOURCE: CA Health and Safety Code Section 123468.5 as added by SB 345 (2023 Session). (Accessed Apr. 2024).

Nursing Facilities

Prior to prescribing a psychotherapeutic drug for a resident, the prescriber shall personally examine and obtain the informed written consent of the resident or the resident's representative. For purposes of obtaining informed written consent pursuant to this subdivision, the use of remote technology, including, but not limited to, telehealth, to allow a prescriber to examine and obtain informed written consent, and for the prescriber, the resident or the resident's representative to use electronic signatures, shall be permitted.

SOURCE: CA Health and Safety Code Section 1599.15 as added by AB 48 (2023 Session). (Accessed Apr. 2024).

Veterinarians

All veterinary premises shall be registered with the board. The location where a veterinarian practices telehealth shall be exempt from the requirement that it be registered pursuant to this section if certain requirements are satisfied.

SOURCE: CA Business and Professions Code Section 4853 as amended by AB 1399 (2023 Session). (Accessed Apr. 2024).

Federally Qualified Health Center (FQHC)

DEFINITION OF VISIT

Last updated 04/02/2024

A visit is a face-to-face encounter or an interaction using a telehealth modality (synchronous video, synchronous audio-only or asynchronous store and forward) between an RHC or FQHC recipient and a physician (refer to “Physician Defined” on a previous page in this section), physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, marriage and family therapist, licensed acupuncturist, registered dental hygienist or visiting nurse (as defined in Code of Federal Regulations, Title 42, Section 405.2416), hereafter referred to as a “health professional,” to the extent the services are reimbursable under the State Plan and the interactions meet the applicable standards of care.

A face-to-face encounter or an interaction using a telehealth modality with a Comprehensive Perinatal Services Program (CPSP) practitioner also qualifies as a visit. Refer to “CPSP Practitioner Defined” on a previous page in this section.

SOURCE: CA Dept. Health Care Services, Medi-Cal Provider Manual, Part 2: RHCs and FQHCs (Mar. 2024), p. 6. (Accessed Apr. 2024).

An FQHC “visit” means a face-to-face encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, or a visiting nurse. A visit shall also include a face-to-face encounter between an FQHC patient and a comprehensive perinatal practitioner, as defined in Section 51179.7 of Title 22 of the California Code of Regulations, providing comprehensive perinatal services, a four-hour day of attendance at an adult day health care center, and any other provider identified in the state plan’s definition of an FQHC visit. A visit shall also include a face-to-face encounter between an FQHC patient and a dental hygienist, a dental hygienist in alternative practice, or a marriage and family therapist.

A visit shall also include an encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and

family therapist using video synchronous interaction, when services delivered through that interaction meet the applicable standard of care.

A visit shall also include an encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and family therapist using audio-only synchronous interaction, when services delivered through that modality meet the applicable standard of care.

A visit shall also include an encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and family therapist using an asynchronous store and forward modality, when services delivered through that modality meet the applicable standard of care.

SOURCE: WIC 14132.100, as amended by SB 184 (2022 Session). (Accessed Apr. 2024).

MODALITIES ALLOWED

Last updated 04/02/2024

Live Video

Synchronous interaction means a real-time audio-visual, two-way interaction between a new or established patient and an FQHC or RHC billable provider at a distant site.

Medi-Cal benefits or services being provided are clinically appropriate and meet the procedural and billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter.

An FQHC patient who receives telehealth services shall otherwise be eligible to receive in-person services from the FQHC pursuant to the federal Health Resources Services Administration requirements.

A patient may be “established” via synchronous interaction if all of the conditions of the “New Patient” requirements in this manual section are met.

SOURCE: CA Department of Health Care Services (DHCS). Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHC) Outpatient Services Manual. Mar. 2024. Pg. 16. (Accessed Apr. 2024).

A visit shall also include an encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and family therapist using video synchronous interaction, when services delivered through that interaction meet the applicable standard of care.

SOURCE: WIC 14132.100, as amended by SB 184 (2022 Session). (Accessed Apr. 2024).

In regard to patient choice of telehealth modality and right to in-person services requirements, FQHC/RHC providers are directed to refer to the policies found in more detail in the Telehealth Manual.

SOURCE: CA Dept. of Health Care Services, Part 2 Manual, Medi-Cal Rural Health Clinics and Federally Qualified Health Centers (Mar. 2024), p. 15. (Accessed Apr. 2024).

See: CA Medicaid Live Video

Store and Forward

Asynchronous store and forward means the transmission of a patient's medical information from an originating site to the billable provider at a distant site.

Medi-Cal benefits or services being provided are clinically appropriate and meet the procedural and billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter.

A patient may be "established" on an asynchronous store and forward service, if all of the conditions of the "New Patient" requirements in this manual section are met.

Only one visit or store and forward service may be billed at the PPS rate when there is a service payment contract with a non-FQHC/RHC, contractor, or another FQHC or RHC. Conversely, the non-FQHC/RHC or contractor may request fee-for-service reimbursement for a visit or store and forward service directly from the appropriate managed care plan or the Medi-Cal Fiscal Intermediary if no service payment contract exists with the FQHC or RHC.

An e-consult, e-visit, or remote patient monitoring is not a reimbursable telehealth service for FQHCs or RHCs.

SOURCE: CA Department of Health Care Services (DHCS). Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHC) Outpatient Services Manual. Jan. 2023. Pg. 15-17. (Accessed Apr. 2024).

A visit shall also include an encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and family therapist using an asynchronous store and forward modality, when services delivered through that modality meet the applicable standard of care.

SOURCE: WIC 14132.100, as amended by SB 184 (2022 Session). (Accessed Apr. 2024).

See: CA Medicaid Store and Forward

Remote Patient Monitoring

An e-consult, e-visit, or remote patient monitoring is not a reimbursable telehealth service for FQHCs or RHCs.

SOURCE: CA Department of Health Care Services (DHCS). Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHC) Outpatient Services Manual. Mar. 2024. Pg. 15. (Accessed Apr. 2024).

See: CA Medicaid RPM

Audio-Only

An audio-only synchronous interaction is eligible for reimbursement if provided by a billable provider and FQHC or RHC patient.

Medi-Cal benefits or services being provided are clinically appropriate and meet the procedural and billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter.

A patient may not be “established” using an audio-only synchronous interaction unless the visit is related to a “sensitive service”, as defined in the California Civil Code, section 56.05, subdivision (n), or if the patient requests “audio only” or does not have access to video.

SOURCE: CA Department of Health Care Services (DHCS). Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHC) Outpatient Services Manual. Mar. 2024. Pg. 16. (Accessed Apr. 2024).

A visit shall also include an encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, visiting nurse, comprehensive perinatal services program practitioner, dental hygienist, dental hygienist in alternative practice, or marriage and family therapist using audio-only synchronous interaction, when services delivered through that modality meet the applicable standard of care.

SOURCE: WIC 14132.100, as amended by SB 184 (2022 Session). (Accessed Apr. 2024).

In regard to patient choice of telehealth modality and right to in-person services requirements, FQHC/RHC providers are directed to refer to the policies found in more detail in the Telehealth Manual.

SOURCE: CA Dept. of Health Care Services, Part 2 Manual, Medi-Cal Rural Health Clinics and Federally Qualified Health Centers (Mar. 2024), p. 15. (Accessed Apr. 2024).

See: CA Medicaid Email, Phone, & Fax

SAME DAY ENCOUNTERS

Last updated 04/02/2024

Encounters with more than one health care professional and multiple encounters with the same health care professional that take place on the same day and at a single location constitute a single visit. More than one visit may be counted on the same day (which may be at a different location) in either of the following situations:

- When a patient, after the first visit, suffers illness or injury that requires another health diagnosis or treatment
- When a patient is seen by a health care professional or CPSP practitioner and also receives dental services on the same day

Clinic visits at which the patient receives services “incident to” physician services (for example, a laboratory or X-ray appointment) do not qualify as reimbursable visits.

Federally Qualified Health Centers/Rural Health Clinics (Provider Type 035) in the counties of San Mateo, Sacramento, and Los Angeles will be able to bill for differential payments for one medical and one dental visit for the same recipient on the same day of service.

SOURCE: CA Department of Health Care Services (DHCS). Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHC) Outpatient Services Manual. Mar. 2024. Pg. 6. (Accessed Apr. 2024).

ELIGIBLE ORIGINATING SITE

Last updated 04/02/2024

Yes, see manual for originating site scenarios and billing/reimbursement policies applicable.

The billable provider, employed or under direct contract with an FQHC or RHC can respond from any location, including their home, during a time that they are scheduled to work for the FQHC or RHC.

For the purposes of payment for covered treatment or services provided through telehealth, the department shall not limit the type of setting where services are provided for the patient or by the health care provider.

SOURCE: CA Department of Health Care Services (DHCS). Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHC) Outpatient Services Manual. (Mar. 2024), p. 17-21. (Accessed Apr. 2024).

ELIGIBLE DISTANT SITE

Last updated 04/02/2024

Yes, see manual for distant site scenarios and billing/reimbursement policies applicable.

The billable provider, employed or under direct contract with an FQHC or RHC can respond from any location, including their home, during a time that they are scheduled to work for the FQHC or RHC.

For the purposes of payment for covered treatment or services provided through telehealth, the department shall not limit the type of setting where services are provided for the patient or by the health care provider.

SOURCE: CA Department of Health Care Services (DHCS). Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHC) Outpatient Services Manual (Mar. 2024), p. 17-21. (Accessed Apr. 2024).

FACILITY FEE

Last updated 04/02/2024

FQHCs are not eligible to bill an originating site fee or transmission charges. The costs of these services should be included in the PPS rate, as applicable.

SOURCE: CA Department of Health Care Services (DHCS). Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHC) Outpatient Services Manual. Mar. 2024. Pg. 13. (Accessed Apr. 2024).

PPS RATE

Last updated 04/02/2024

Telehealth services are billed utilizing existing claiming processes that include billing the appropriate managed care plan first. If applicable, once the managed care plan payment is received, submit the claim to the Med-Cal Fiscal Intermediary for the Prospective Payment System (PPS) rate wrap.

Only one visit or store and forward service may be billed at the PPS rate when there is a service payment contract with a non-FQHC/RHC, contractor, or another FQHC or RHC. Conversely, the non-FQHC/RHC or contractor may request fee-for-service reimbursement for a visit or store and forward service directly from the appropriate managed care plan or the Medi-Cal Fiscal Intermediary if no service payment contract exists with the FQHC or RHC.

SOURCE: CA Dept. Health Care Services, Medi-Cal Provider Manual, Part 2: RHC and FQHC (Mar. 2024), p. 17. (Accessed Apr. 2024).

Video synchronous and audio-only synchronous visits and visits using an asynchronous store and forward modality shall be reimbursed at the applicable FQHC's per-visit PPS rate to the extent the department determines that the FQHC has met all billing requirements that would have applied if the applicable services were delivered via a face-to-face encounter and when services delivered through that modality meet the applicable standard of care.

SOURCE: WIC 14132.100, as amended by SB 184 (2022 Session) (Accessed Apr. 2024).

HOME ELIGIBLE

Last updated 04/02/2024

New Patient – FQHCs and RHCs are not precluded from establishing a new patient relationship through a synchronous video interaction or asynchronous store and forward if all the following conditions are met:

- The patient is physically present at an originating site that is a licensed or intermittent site of the FQHC or RHC at the time the service is performed.

- The individual who creates the patient records at the originating site is an employee or contractor of the FQHC or RHC, or other person lawfully authorized by the FQHC or RHC to create a patient record.
- The FQHC or RHC determines that the billing provider is able to meet the applicable standard of care.
- An FQHC or RHC patient who receives telehealth services shall otherwise be eligible to receive in-person services.

Established Patient – A Medi-Cal eligible recipient who meets one or more of the following conditions:

- The patient has a health record with the FQHC that was created or updated during a visit that occurred in the clinic or during a synchronous telehealth visit in a patient's residence or home with a clinic provider and a billable provider at the clinic. The patient's health record must have been created or updated within the previous three years.
- The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit occurring within the last three years that was provided outside the originating site clinic, but within the FQHC's service area. All consent for telehealth services for these patients must be documented.
- The patient is assigned to the FQHC by their Managed Care Plan (MCP) pursuant to a written agreement between the plan and the FQHC.

The billable provider, employed or under direct contract with an FQHC or RHC can respond from any location, including their home, during a time that they are scheduled to work for the FQHC or RHC.

For the purposes of payment for covered treatment or services provided through telehealth, the department shall not limit the type of setting where services are provided for the patient or by the health care provider.

SOURCE: CA Department of Health Care Services (DHCS). Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHC) Outpatient Services Manual. Mar. 2024. Pg. 13, 17. (Accessed Apr. 2024).

FQHC manual refers to fee-for-service policy for the definition of an 'originating site':

"Originating site" means a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates. For purposes of reimbursement for covered treatment or services provided through telehealth, the type of setting where services are provided for the patient or by the health care provider is not limited (*Welfare and Institutions Code*

[W&I Code], Section 14132.72[e]). The type of setting may include, but is not limited to, a hospital, medical office, community clinic or the patient's home.

SOURCE: CA Department of Health Care Services. Medi-Cal Part 2 General Medicine Manual. Telehealth (Aug. 2020). Pg. 2. (Accessed Apr. 2024).

PATIENT-PROVIDER RELATIONSHIP

Last updated 04/02/2024

An FQHC is not precluded from establishing a new patient relationship through video synchronous interaction.

An FQHC may not establish a new patient relationship using an audio-only synchronous interaction. Notwithstanding this prohibition, the department may provide for specific exceptions to this prohibition, which shall be developed in consultation with affected stakeholders and published in departmental guidance. Exceptions shall include but not be limited to:

- An FQHC or RHC may establish a new patient relationship using an audio-only synchronous interaction when the visit is related to sensitive services, as defined in subdivision (n) of Section 56.05 of the Civil Code, or when the patient requests an audio-only modality or attests they do not have access to video – in accordance with department-specific requirements and consistent with federal and state laws, regulations, and guidance.

An FQHC is not precluded from establishing a new patient relationship through an asynchronous store and forward modality, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, if the visit meets all of the following conditions:

- The patient is physically present at the FQHC or RHC, or at an intermittent site of the FQHC or RHC, at the time the service is performed.
- The individual who creates the patient records at the originating site is an employee or contractor of the FQHC, or other person lawfully authorized by the FQHC to create a patient record.
- The FQHC determines that the billing provider is able to meet the applicable standard of care.
- An FQHC patient who receives telehealth services shall otherwise be eligible to receive in-person services from that FQHC pursuant to HRSA requirements.

SOURCE: WIC 14132.100, as amended by SB 184 (2022 Session) and AB 32 (2022 Session). (Accessed Apr. 2024).

New Patient – FQHCs and RHCs are not precluded from establishing a new patient relationship through a synchronous video interaction or asynchronous store and forward if all the following conditions are met:

- The patient is physically present at an originating site that is a licensed or intermittent site of the FQHC or RHC at the time the service is performed.
- The individual who creates the patient records at the originating site is an employee or contractor of the FQHC or RHC, or other person lawfully authorized by the FQHC or RHC to create a patient record.
- The FQHC or RHC determines that the billing provider is able to meet the applicable standard of care.
- An FQHC or RHC patient who receives telehealth services shall otherwise be eligible to receive in-person services.

Established Patient – A Medi-Cal eligible recipient who meets one or more of the following conditions:

- The patient has a health record with the FQHC that was created or updated during a visit that occurred in the clinic or during a synchronous telehealth visit in a patient's residence or home with a clinic provider and a billable provider at the clinic. The patient's health record must have been created or updated within the previous three years.
- The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit occurring within the last three years that was provided outside the originating site clinic, but within the FQHC's service area. All consent for telehealth services for these patients must be documented.
- The patient is assigned to the FQHC by their Managed Care Plan (MCP) pursuant to a written agreement between the plan and the FQHC.

SOURCE: CA Department of Health Care Services (DHCS). Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHC) Outpatient Services Manual. Mar. 2024. Pg. 13. (Accessed Apr. 2024).