Medi-Cal Telehealth Updated Policy (Aug. 2019)

The California Department of Health Care Services (DHCS) released its finalized telehealth policy update to its Medi-Cal fee-for-service program. However, at this time, an updated version of the teledentistry manual has not been posted. In addition to the fee-for-service updated telehealth policy, the manuals or Departmental letter that are available include:

- Managed Care
- Indian Health Services, Memorandum of Agreement, Clinics (IHS-MOAs)
- Family Plan, Access, Care and Treatment (Family PACT)
- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- Local Education Agency
- Vision Care

The majority of the changes occurred in fee-for-service and the other manuals make references back to that policy. The intent of the Department for the updates was to increase flexibility for the use of telehealth in Medi-Cal and clarify certain policies.

Some highlights include:

- Providers decide what modality, live video or store-and-forward, 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 FQHCs/RHCs and IHS-MOAs.
- What constitutes as an originating site includes the home and there is no requirement that a provider be with the patient at the time of the telehealth interaction.
- Addition of e-consult as a subset of store-and-forward and reimbursement for one specific code.
- 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.

Each Section is summarized in more detail below:

FEE-FOR-SERVICE

Definitions

The proposed manual update offered specific definitions for the following terms:

- Telehealth
- Asynchronous Store-and-forward
- E-Consult
- Synchronous interaction
- Distant Site
- Originating Site

Noteworthy changes to definitions include the explicit exclusion of patient initiated electronic transmissions for **"asynchronous store-and-forward"**:

> *The transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient.* **Consultations via asynchronous electronic transmission initiated directly by patients, including through mobile phone applications, are not covered under this policy.**

The term **"e-consult"**, a significant addition to the fee-for-service Medi-Cal policy is defined as:

> *"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.*

The definition for **"Originating Site"** now explicitly includes the patient home, however it should be noted that the short list provided in the manual should not be taken as the only eligible locations.

> *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.*

The definition also does not cite the necessity of a health care provider's presence with the patient for the telehealth interaction to be reimbursable.

Finally, a clarification was made in the definition of a **"distant site"** that *"for purposes of telehealth [the distant site] can be different from the administrative location".*

Reimbursable Services

The Department has finalized a policy that leaves it up to the distant site provider as to whether the interaction should take place via live video, store-and-forward or in-person. All benefits or services are covered under Medi-Cal, including any Treatment Authorization Request (TAR) requirements. The decision that services can be appropriately provided by the selected telehealth modality is based on the provider's belief it is clinically appropriate due to evidence-based medicine and best practices. Additionally, for the telehealth delivered service to be eligible for Medi-Cal reimbursement, it must:

- Be a service Medi-Cal reimburses for in general
- The service meets the general definition and components of the CPT or HCPCS code used
- All laws regarding confidentiality of health care information and patient's rights to medical information are met

Only live video and store-and-forward are available modalities for reimbursement. These changes are a significant departure from current Medi-Cal telehealth policies. The provider's ability to decide when it is appropriate to use telehealth based upon his or her knowledge and professional experience makes Medi-Cal's revised policy one of the most advanced telehealth Medicaid policies in the nation. One thing to note however is that this is only for live video and store-and-forward. Remote patient monitoring is not included.

E-Consult

E-consult code 99451 in conjunction with the GQ modifier (indicating store-and-forward) is reimbursed, when the following requirements are met for distant and originating site providers:

ORIGINATING SITE PROVERS 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
DISTANT SITE PROVERS MUST CREATE AND MAINTAIN THE FOLLOWING:	• A record of the review and analysis of the transmitted medical information with written documentation of the date of service and time spent; and • A written report of case findings and recommendations with conveyance to the originating site.

The definition of **CPT Code 99451** is: *Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time.*

It is not 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.

It is not reimbursable more than once in a seven day period. If more than one contact or encounter is required to complete the e-consult request, the entirety of the service and cumulative discussion and review time should be reported only once using CPT code 99451. E-consults are not applicable for FQHCs, RHCs, or IHS-MOA clinics.

Provider Requirements

The manual now includes specific requirements for providers to be eligible to receive reimbursement for telehealth provided services. Providers must meet all of the following criteria:

- *The provider rendering covered benefits or services must meet the requirements of B&P 2290.5(a)(3) or equivalent requirements under California law in which the provider is considered licensed (ex: Behavior Analyst Certification Board).*
- *Provider 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.*

Documentation Requirements

Unlike previous manuals, the new Medi-Cal telehealth manual imposes specific documentation requirements to substantiate the corresponding technical and professional components of billed CPT or HCPCS codes. Providers are not required to document a barrier to in-person visit for Med-Cal coverage or to document the cost effectiveness of telehealth or store-and-forward. The distant site provider is,

however, responsible for billing Medi-Cal for the covered services and supplying the appropriate supporting documentation.

Consent

Providers must obtain either verbal or written consent from patients before utilizing telehealth. If a healthcare provider at the originating or distant site maintains a general consent agreement that addresses the use of telehealth that is sufficient for documentation of patient consent and must be kept in the patient's medical file.

For teleophthalmology, teledermatology or teledentistry services or benefits delivered via asynchronous store-and-forward, the patient must be notified of their right to request and receive interactive communication with the distant specialist physician, optometrist or dentist and the communication may occur during the time of the consultation or within 30 days of the patient being notified of the consultation results.

Other Items

Use of the Place of Service (POS) code of 02 (not applicable for FQHCs/RHCs) and modifiers 95 (for live video) and GQ (for store-and-forward) is also required. The originating site and transmission fees are also still available. However, only the originating site fee is available for store-and-forward, including, e-consult.

FAMILY PACT

Changes to Family PACT mirror the changes in Medi-Cal Fee-for-Service, including reimbursement of the new e-consult CPT code 99451.

MANAGED CARE

The managed care All Plan Letter (APL) refers to the requirements in Assembly bill 415 and the fee-for-service telehealth policy manual as well as DHCS' telehealth web page for information and announcements on telehealth. The APL specifies that existing Medi-Cal covered services may be provided via a telehealth modality, if certain conditions are met (see the Medi-Cal fee-for-service section for the associated requirements). For managed care, telehealth may be used for purposes of meeting network adequacy requirements.

INDIAN HEALTH SERVICES (IHS), MEMORANDUM OF AGREEMENT (MOA) 638, CLINICS

The Indian Health Services, Memorandum of Agreement (MOA) 638, Clinics manual (referred to as IHS-MOA manual) refers providers to the Medi-Cal fee-for-service telehealth policy, but then provides additional requirements for the IHS-MOA program specifically.

The manual defines a medical visit, mental health visit and an ambulatory visit as a face-to-face encounter between an IHS-MOA recipient and the eligible provider, with specific exceptions noted below. It specifies that all IHS-MOA covered services are eligible to be rendered via telehealth. 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. E-consult is not a reimbursable telehealth service of IHS-MOA clinics.

Telehealth can be used to "establish" a patient when the following conditions are met:

REQUIREMENTS TO "ESTABLISH" A PATIENT THROUGH TELEHEALTH:	• Has a health record with the IHS-MOA clinic created or updated during a visit that occurred in the clinic. Per the aforementioned definition of "visit," a synchronous interaction qualifies as a "visit" for an IHS-MOA clinic. • Must be a synchronous telehealth visit in a patient's residence or home **with a clinic provider and a billable provider at the clinic.** (Emphasis added). Synchronous telehealth can be used to establish a patient when that interaction is done in the patient home, but a clinic provider must be physically present with the patient as well as another provider at the distant site, which is the IHS-MOA clinic.

Very similar language on "established patient" appears in the FQHC/RHC manual.

Asynchronous store-and-forward reimbursement may not be used to "establish" a patient, with the exception of a homeless patient. Reimbursement is permitted for established patients for teleophthalmology, teledermatology and teledentistry, when it is furnished by a billable provider at the distant site.

THE DEFINITION OF AN ESTABLISHED PATIENT IS AN ELIGIBLE MEDI-CAL RECIPIENT WHO MEETS ONE OR MORE OF THE FOLLOWING CONDITIONS:	• The patient has a health record with the IHS-MOA clinic that was created or updated during a visit that occurred in the clinic, within the previous three years. • The patient is homeless and has an established health record that was created from a visit occurring within the last three years that was provided within or outside of the IHS-MOA clinic. • The patient is assigned to the IHS-MOA clinic by their Managed Care Plan (MCP) pursuant to a written agreement between the plan and the IHS-MOA clinic.

See the HIS-MOA Manual pages 11-13 for a chart of different originating site and distant site scenarios, and the associate telehealth billing and reimbursement policy.

FQHC/RHC

The FQHC/RHC manual refers providers to the Medi-Cal fee-for-service telehealth policy, but then provides additional requirements which closely mirrors what was in IHS.

The manual defines a visit as a face-to-face encounter between an RHC or FQHC recipient and a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, licensed acupuncturist or visiting nurse.

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. E-consult is not a reimbursable telehealth service of FQHCs/RHCs. FQHCs and RHCs are also not eligible to bill an originating site fee or transmission fee, as that is included within the PPS rate.

Asynchronous store-and-forward reimbursement may not be used to "establish" a patient, with the exception of a homeless, homebound or a migratory or seasonal worker (HHMS). Reimbursement is permitted for established patients for teleophthalmology, teledermatology and teledentistry, when it is furnished by a billable provider at the distant site.

THE DEFINITION OF AN ESTABLISHED PATIENT IS AN ELIGIBLE MEDI-CAL RECIPIENT WHO MEETS ONE OR MORE OF THE FOLLOWING CONDITIONS:	• The patient has a health record with the FQHC/RHC that was created or updated during a visit that occurred in the clinic, 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 FQCH's or RHC's service area. • The patient is assigned to the FQHC or RHC by their Managed Care Plan (MCP) pursuant to a written agreement between the plan and the FQHC or RHC.

See the FQHC/RHC Manual pages 13-16 for a chart of different originating site and distant site scenarios, and the associate telehealth billing and reimbursement policy.

VISION CARE: PROFESSIONAL OPHTHALMOLOGICAL SERVICES AND PROGRAM COVERAGE

This manual defines **teleophthalmology by Optometrists (by store and forward)** as:

> *An asynchronous transmission of medical information to be reviewed at a later time by a physician or optometrist at a distant site, where the physician or optometrist at the distant site reviews the medical information without the patient being present in real-time. 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.*
>
> *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). Audio clips, video clips, still images and photographs must be specific to the patient's condition and adequate for rendering or confirming a diagnosis and/or treatment plan.*

The telehealth equipment and transmission speed must be sufficient to support the services billed to Medi-Cal. Staff involved in the telehealth encounter must be trained in the use of the telehealth equipment and understand its use. The images must be specific to the patient's condition and adequate for meeting the procedural definition of the national code that is billed.

Optometrist providers may submit claims to Medi-Cal for teleophthalmology services provided via store and forward using the following office consultation CPT codes:

- **99241 – 99243 - Office consultation, new or established patient**

Specific documentation, record keeping and consent requirements apply (see manual).

LOCAL EDUCATION AGENCY: SPEECH THERAPY

Only a licensed speech-language pathologist can be reimbursed for speech therapy services delivered via telehealth. The following are not reimbursable:

- Speech therapy services delivered via telehealth by an unlicensed speech-language pathologist with a valid preliminary or professional clear services credential
- Speech therapy services delivered via telehealth by an unlicensed speech-language pathologist with a valid clinical or rehabilitative services credential with an authorization in language, speech and hearing

A telemedicine service must use interactive audio, video or data communication to qualify for

reimbursement. The qualified 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 student and health care provider. Medi-Cal does not reimburse for telephone calls, electronic mail messages or facsimile transmissions.

Speech therapy services authorized in a student's IEP or IFSP are reimbursable when performed according to telemedicine guidelines and must be billed with modifier 95 (synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system) and the appropriate CPT code. See manual chart with CPT codes and modifiers that can be billed for speech therapy.

Prior to a student receiving services via telehealth, the health care provider at the originating site shall inform the student's parent or legal guardian, where appropriate, of the option to utilize a telehealth modality and then obtain oral consent from the student's parent or legal guardian. The student's written consent to telehealth services is not required. See the manual for specific consent requirements.

The facility fee and transmission costs incurred while providing telehealth services via audio/video communication are not reimbursable.

ADDITIONAL MANUALS

Other manuals were updated to align with the new telehealth polices, making minor changes such as indicating appropriate use of the 95 and GQ modifiers and adding the e-consult code. Manuals with these minor updates include: Obstetrics; Rehabilitation Clinics; Inpatient Services; and Chronic Dialysis Clinics.

RESOURCES

- Center for Connected Health Policy: www.cchpca.org
- DHCS, Medi-Cal & Telehealth: https://www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx
- DHCS, Telehealth Resources: https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthResources.aspx

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