
Medicine: Telehealth

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The policy in this section is established pursuant to Assembly Bill 415 (Logue, Chapter 547, Statutes of 2011), known as the Telehealth Advancement Act of 2011. All health care practitioners rendering Medi-Cal covered benefits or services under this policy must comply with all applicable state and federal laws.

Definitions

For purposes of this policy, the following definitions shall apply:

Telehealth

“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.

Asynchronous Store and Forward

“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

“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.

E-Visits

“E-visits” are communications between a patient and their provider through an online patient portal.

Synchronous Interaction

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

Distant Site

“Distant site” means a site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.

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.

For originating site policy and billing information specific to Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) or Indian Health Services – Memorandum of Agreement (IHS-MOA) 638, Clinics, refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* and *Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics* sections in the appropriate Part 2 manual.

Provider Requirements

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 equivalent requirements under California law in which the provider is considered to be licensed, for example, providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission for Certifying Agencies. Providers billing for services delivered via telehealth must be enrolled as Medi-Cal providers.

The 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 policy and billing information specific to FQHCs, RHCs or IHS-MOA clinics, providers may refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* and *Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics* sections in the appropriate Part 2 manual.

Documentation Requirements

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.

Consent

In addition, health care providers must also 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.

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, then this is sufficient for documentation of patient consent and should be kept in the patient's medical file.

The consent shall be documented in the patient's medical file (B&P Code, Section 2290.5(b)) and be available to the Department of Health Care Services (DHCS) upon request.

Place of Service Code "02"

Health care providers are required to document Place of Service code "02" on the claim, which indicates that services were provided or received through a telecommunications system. The Place of Service code "02" requirement is not applicable for FQHCs, RHCs or IHS-MOA clinics.

For policy and billing information specific to FQHCs, RHCs or IHS-MOA clinics, providers may refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* and *Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics* sections in the appropriate Part 2 manual.

Reimbursable Telehealth Services

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* (TAR) requirements, may be provided via a telehealth modality, as outlined in this section, 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; 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 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.

Examples of Services Not Appropriate for Telehealth

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.

Billing Requirements

The following provides information about billing requirements for specific telehealth services.

Synchronous, Interactive Audio and Telecommunications Systems: Modifier 95

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.

Health care providers must use an interactive audio, video or data telecommunications system that permits real-time communication between the health care provider at the distant site and the patient at the originating site. The audio-video 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.

Under federal regulations (*Code of Federal Regulations*, Title 42, Section 410.78), the presence of a health care provider is not required at the originating site as a condition of payment unless the health care provider at the originating site is medically necessary as determined by the health care provider at the distant site.

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.

Asynchronous Store and Forward Telecommunications Systems: Modifier GQ

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 through e-consult. 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 *Denti-Cal 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, including any TAR requirements.

E-Consults

For the definition of “e-consult,” providers may refer to the “Definitions” heading previously in this section.

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 the following CPT code in conjunction with the modifier GQ:

CPT Code	Description
99451	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

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).

The e-consult policy is not applicable for FQHCs, RHCs or IHS-MOA clinics. For policy and billing information specific to FQHCs, RHCs or IHS-MOA clinics, providers may refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) and Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics* sections in the appropriate Part 2 manual.

E-Visits

For the definition of “e-visit,” providers may refer to the “Definitions” heading previously in this section.

«HCPCS Codes for E-Visits»

HCPCS Code	Description
G2061*	Qualified non-physician health care professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the seven days; 5 thru 10 minutes
G2062*	Qualified non-physician health care professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the seven days; 11 thru 20 minutes
G2063*	Qualified non-physician health care professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the seven days; 21 or more minutes

Originating Site and Transmission Fees

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).

Originating Site and Transmission Fee Restrictions

Restrictions for billing originating site and transmission costs are as follows:

«HCPCS Codes with Restrictions for Billing»

HCPCS Code	Transmission Site	Frequency Limit
Q3014	Originating site	Once per day, same patient, same provider
T1014	Originating site and distant site	Maximum of 90 minutes per day (1 unit = 1 minute), same patient, same provider

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.

The originating site and transmission fee restrictions and billing rules are not applicable for FQHCs, RHCs or IHS-MOA clinics. For policy and billing information specific to FQHCs, RHCs or IHS-MOA clinics, providers may refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) and Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics* sections in the appropriate Part 2 manual.

«Legend»

«Symbols used in the document above are explained in the following table.»

Symbol	Description
«	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
»	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	A <i>Treatment Authorization Request</i> (TAR) form is required. Allowable modifiers are GN, GO and GP. Frequency limit is once in seven days, any provider, with no TAR override. Do not report this code with CPT code 98970, 98971 or 98972 for any provider.