Telehealth Reimbursement Guide
For California

May 2019

Compiled by the California Telehealth Resource Center and Includes:

Medicare
Medi-Cal
Denti-Cal
CCS/GHPP
Managed Care Health Plans
FQHC/RHC Billing Scenarios

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This document is intended as a guide to assist telehealth providers in obtaining information on reimbursement. This document does not constitute legal advice. Many factors affect the appropriateness of submitting a particular claim for reimbursement. The information should be used in consultation with your billing specialist and other advisers in initiating telehealth services billing. Reimbursement information can become outdated quickly and is subject to change without notice. We recommend review of this material on a regular basis to assure the information is up to date. Please visit www.caltrc.org to download the latest version. CTRC does not guarantee payment for any service.

The California Telehealth Resource Center is a leading source of expertise and comprehensive knowledge on the development and operation of telemedicine and telehealth programs. CTRC has received national recognition as one of fourteen federally designated Telehealth Resource Centers in the country since 2006.

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INTRODUCTION

What Is Telemedicine?

Telemedicine generally refers to the provision of clinical services from a distance. The Institute of Medicine of the National Academy of Science defines telemedicine as “the use of electronic information and communication technologies to provide and support health care when distance separates the participants”. Telemedicine is a component of telehealth.

What Is Telehealth?

Telehealth is a collection of means or methods for enhancing health care, public health, and health education delivery and support using telecommunications technologies.

As state and federal policymakers, private payors, practitioners, and consumers realize telehealth’s potential benefits, there is a growing need to create a consistent framework for understanding what is meant by “telehealth,” and how the term is accurately applied.

First and foremost, telehealth is a collection of means or methods, not a specific clinical service, to enhance care delivery and education. Ideally, there should not be any regulatory distinction between a service delivered via telehealth and a service delivered in person. Both should be held to the same quality and practice standards. The “tele-“descriptor should ultimately fade from use as these technologies seamlessly integrate into health care delivery systems.

While “telemedicine” has been more commonly used in the past, “telehealth” is a more universal term for the current broad array of applications in the field. Its use crosses most health service disciplines, including dentistry, counseling, physical therapy, and home health, and many other domains. Further, telehealth practice has expanded beyond traditional diagnostic and monitoring activities to include consumer and professional education.

While the State of California now uses the term “telehealth”, some providers and payor organizations still use the term “telemedicine” when referring to the provision of clinical care over a distance.

Note that while a connection exists between health information technology (HIT), health information exchange (HIE), and telehealth, neither HIE nor HIT are considered to be telehealth.
How Does Telehealth Work?

Today, telehealth encompasses four distinct domains of applications. Note, however, that each state Medicaid program and private insurer varies in its use and reimbursement of these applications. These are commonly known as:

- **Live Videoconferencing** (Synchronous): Live, two-way interaction between a person and a provider using audiovisual telecommunications technology.

- **Store-and-Forward** (Asynchronous): Transmission of images and recorded health history through an electronic communications system to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time or live interaction.

- **Remote Patient Monitoring** (RPM): Personal health and medical data collection from an individual in one location via electronic communication technologies, which is transmitted to a provider in a different location for use in care and related support.

- **Mobile Health** (mHealth): Health care and public health practice and education supported by mobile communication devices such as cell phones, tablet computers, and PDAs. Applications can range from targeted text messages that promote healthy behavior to wide-scale alerts about disease outbreaks, to name a few examples.

Is Telemedicine A Billable Service?

In many cases telemedicine services are covered benefits and are billable by government programs and private payors. This guide provides information on major telemedicine reimbursement programs in California. As the field is rapidly expanding, it should be noted that more and more public, private and commercial payors may begin to cover telemedicine. It is important that you check with your major payors on a regular basis to see if additional services have been added for reimbursement. CTRC can provide updates on many of the major payors but may not be aware of all payor policies.

Reimbursement Information By Program

The following pages provide details on reimbursement for many of the major payors within the state of California.

It should be noted that telehealth is a rapidly expanding field and changes in telehealth covered services and reimbursement are expected to occur during the next few years. It will be necessary for programs to review new reimbursement provisions on a regular basis. CTRC publishes changes to reimbursement on our website and distributes them to those on the CTRC email list.

To sign up for the CTRC email list, please visit [http://caltrc.org/about-us/contact-us/](http://caltrc.org/about-us/contact-us/)
Medicare

Reimbursement for Medicare telehealth has five criteria for payment of telehealth services:

1. **The patient was seen from an “originating site” as defined by CMS.** An originating site is the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. Originating sites authorized by law are:
   a. The offices of physicians or practitioners
   b. Hospitals
   c. Critical Access Hospitals (CAHs)
   d. Rural Health Clinics (RHC)
   e. Federally Qualified Health Centers (FQHC)
   f. Hospital-based or CAH-based Renal Dialysis Centers (including satellites)
   g. Skilled Nursing Facilities (SNFs) and
   h. Community Mental Health Centers (CMHCs)
   i. Renal Dialysis Facilities
   j. Homes of beneficiaries with End-Stage Renal Disease (ESRD) getting home dialysis
   k. Mobile Stroke Units

   **NOTE:** Medicare does not apply originating site geographic conditions to hospital-based and CAH-based renal dialysis centers, renal dialysis facilities, and beneficiary homes when practitioners furnish monthly home dialysis ESRD-related medical evaluations. Independent Renal Dialysis Facilities are not eligible originating sites. Independent Renal Dialysis Facilities are not eligible originating sites.

2. **The Originating Site is located in the following geographic areas:**
   a. Rural Health Professional Shortage Areas (HPSAs) located in a rural census tract; and
   b. Counties located outside Metropolitan Statistical Areas (MSA),

   **Determining an eligible Originating Site location:**

   HRSA has developed a tool that will help providers determine geographic eligibility for Medicare telehealth services. This tool, the Medicare Telehealth Payment Eligibility Analyzer, is available at [https://data.hrsa.gov/tools/medicare/telehealth](https://data.hrsa.gov/tools/medicare/telehealth)

3. **The encounter was performed at the “distant site” as defined by CMS as the site where the health care provider is located.** Eligible distant site practitioners are as follows:
   a. Physicians
   b. Nurse practitioners (NPs)
   c. Physician assistants (PAs)
   d. Nurse-midwives
   e. Clinical nurse specialists (CNSs)
   f. Certified registered nurse anesthetists
   g. Clinical psychologists (CPs) and clinical social workers (CSWs)*
   h. Registered dieticians or nutritional professionals

   *CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838
4. **The patient was present and the encounter involved interactive audio and video telecommunications** that provides real-time communication between the practitioner and the Medicare beneficiary.

5. **Type of Service provided** as specified in the Medicare Eligible Services located in Table 1.

**Billing and Reimbursement**

**Originating Site Fee**

The originating site is eligible to receive a facility fee for providing services via telehealth. As of January 2019, the payment amount is “80% of the lesser of the actual charge or $26.15”. The site receives a flat reimbursement rate, outside of any other reimbursement arrangements such as inpatient DRGs or RHC per-visit payments.

- Originating sites are to use HCPCS code Q3014 when submitting facility fee claims.
- The type of service is 9 - other items and services.
- The place of service code is 02 - Telehealth
- Bill the MAC for the originating site facility fee, which is a separately billable Part B payment.

**Medicare provides specific instructions for different originating facility types:**

- For FQHC and RHCs: the originating site facility fee for Medicare telehealth services is not an FQHC or RHC service. When an FQHC or RHC serves as the originating site, the originating site facility fee must be paid separately from the center or clinic all-inclusive rate.
- For Critical Access Hospitals, the payment amount is 80 percent of the originating site facility fee.
- For CMHC, the originating site facility fee does not count toward the number of services used to determine payment for partial hospitalization services.
- In addition to FQHCs, RHCs and CAHs, Chapter 12 of the Medicare Claims processing Manual, Section 190.6 describes payment methodologies for hospital outpatient departments, hospital inpatient, Physicians’ and practitioners’ offices, renal dialysis centers, skilled nursing facilities and community mental health centers.

**Distant Site Clinical Services Fees**

Reimbursement to the health professional delivering the clinical service is the same as the current fee schedule amount for the service provided without telemedicine.

Distant site claims for reimbursement should be submitted with the appropriate CPT code or HCPCS code for the professional services provided. **As of January 2018, a telehealth modifier is no longer required. Instead, you will submit the appropriate CPT code and use place of service 02 – Telehealth.**

Distant site practitioners billing telehealth services under the CAH Optional Payment Method will continue to submit institutional claims using the GT modifier.

**NOTE:** FQHCs and RHCs are **not** authorized to serve as a distant site for telehealth consultations. A distant site is the location of the practitioner at the time the telehealth service is furnished. The cost of a visit may not be billed or included on the cost report.
The following table provides a listing of all eligible services with CPT and HCPCS codes effective January 2019. Eligible services are usually updated once a year effective in January.

### Table 1
**Medicare Eligible Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT or HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telehealth consultations, emergency department or initial inpatient</td>
<td>HCPCS codes G0425–G0427</td>
</tr>
<tr>
<td>Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs</td>
<td>HCPCS codes G0406–G0408</td>
</tr>
<tr>
<td>Office or other outpatient visits</td>
<td>CPT codes 99201–99215</td>
</tr>
<tr>
<td>Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days</td>
<td>CPT codes 99231–99233</td>
</tr>
<tr>
<td>Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days</td>
<td>CPT codes 99307–99310</td>
</tr>
<tr>
<td>Individual and group kidney disease education services</td>
<td>HCPCS codes G0420 and G0421</td>
</tr>
<tr>
<td>Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training</td>
<td>HCPCS codes G0108 and G0109</td>
</tr>
<tr>
<td>Individual and group health and behavior assessment and intervention</td>
<td>CPT codes 96150–96154</td>
</tr>
<tr>
<td>Individual psychotherapy</td>
<td>CPT codes 90832–90838</td>
</tr>
<tr>
<td>Telehealth Pharmacologic Management</td>
<td>HCPCS code G0459</td>
</tr>
<tr>
<td>Psychiatric diagnostic interview examination</td>
<td>CPT codes 90791 and 90792</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment</td>
<td>CPT codes 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents (effective for services furnished on and after January 1, 2016)</td>
<td>CPT code 90963</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents (effective for services furnished on and after January 1, 2016)</td>
<td>CPT code 90964</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents (effective for services furnished on and after January 1, 2016)</td>
<td>CPT code 90965</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 20 years of age and older (effective for services furnished on and after January 1, 2016)</td>
<td>CPT code 90966</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age (effective for services furnished on and after January 1, 2017)</td>
<td>CPT code 90967</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 2-11 years of age (effective for services furnished on and after January 1, 2017)</td>
<td>CPT code 90968</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 12-19 years of age (effective for services furnished on and after January 1, 2017)</td>
<td>CPT code 90969</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 20 years of age and older (effective for services furnished on and after January 1, 2017)</td>
<td>CPT code 90970</td>
</tr>
<tr>
<td>Individual and group medical nutrition therapy</td>
<td>HCPCS code G0270</td>
</tr>
<tr>
<td>Neurobehavioral status examination</td>
<td>CPT code 96116</td>
</tr>
<tr>
<td>Smoking cessation services</td>
<td>HCPCS codes G0436–G0437</td>
</tr>
<tr>
<td>Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services</td>
<td>HCPCS codes G0396 and G0397</td>
</tr>
<tr>
<td>Annual alcohol misuse screening, 15 minutes</td>
<td>HCPCS code G0442</td>
</tr>
<tr>
<td>Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes</td>
<td>HCPCS code G0443</td>
</tr>
<tr>
<td>Annual depression screening, 15 minutes</td>
<td>HCPCS code G0444</td>
</tr>
<tr>
<td>High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes</td>
<td>HCPCS code G0445</td>
</tr>
<tr>
<td>Service Description</td>
<td>Code</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Annual, face-to-face intensive behavioral therapy for cardiovascular disease,</td>
<td></td>
</tr>
<tr>
<td>individual, 15 minutes</td>
<td>G0446</td>
</tr>
<tr>
<td>Face-to-face behavioral counseling for obesity, 15 minutes</td>
<td>G0447</td>
</tr>
<tr>
<td>Transitional care management services with moderate medical decision complexity</td>
<td></td>
</tr>
<tr>
<td>(face-to-face visit within 14 days of discharge)</td>
<td>99495</td>
</tr>
<tr>
<td>Transitional care management services with high medical decision complexity</td>
<td></td>
</tr>
<tr>
<td>(face-to-face visit within 7 days of discharge)</td>
<td>99496</td>
</tr>
<tr>
<td>Advance Care Planning, 30 minutes (effective for services furnished on and after</td>
<td></td>
</tr>
<tr>
<td>January 1, 2017)</td>
<td>99497</td>
</tr>
<tr>
<td>Advance Care Planning, additional 30 minutes (effective for services furnished on</td>
<td></td>
</tr>
<tr>
<td>and after January 1, 2017)</td>
<td>99498</td>
</tr>
<tr>
<td>Psychoanalysis</td>
<td>90845</td>
</tr>
<tr>
<td>Family psychotherapy (without the patient present)</td>
<td>90846</td>
</tr>
<tr>
<td>Family psychotherapy (conjoint psychotherapy) (with patient present)</td>
<td>90847</td>
</tr>
<tr>
<td>Prolonged service in the office or other outpatient setting requiring direct</td>
<td></td>
</tr>
<tr>
<td>patient contact beyond the usual service; first hour</td>
<td>99354</td>
</tr>
<tr>
<td>Prolonged service in the office or other outpatient setting requiring direct</td>
<td></td>
</tr>
<tr>
<td>patient contact beyond the usual service; each additional 30 minutes</td>
<td>99355</td>
</tr>
<tr>
<td>Prolonged service in the inpatient or observation setting requiring unit/floor</td>
<td></td>
</tr>
<tr>
<td>time beyond the usual service; first hour</td>
<td>99356</td>
</tr>
<tr>
<td>Prolonged service in the inpatient or observation setting requiring unit/floor</td>
<td></td>
</tr>
<tr>
<td>time beyond the usual service; each additional 30 minutes (list separately</td>
<td>99357</td>
</tr>
<tr>
<td>in addition to code for prolonged service)</td>
<td></td>
</tr>
<tr>
<td>Annual Wellness Visit, includes a personalized prevention plan of service (PPPS)</td>
<td></td>
</tr>
<tr>
<td>first visit (effective for services furnished on and after January 1, 2015)</td>
<td>G0438</td>
</tr>
<tr>
<td>Annual Wellness Visit, includes a personalized prevention plan of service (PPPS)</td>
<td></td>
</tr>
<tr>
<td>subsequent visit (effective for services furnished on and after January 1, 2015)</td>
<td>G0439</td>
</tr>
<tr>
<td>Telehealth Consultation, Critical Care, initial, physicians typically spend 60</td>
<td></td>
</tr>
<tr>
<td>minutes communicating with the patient and providers via telehealth (effective</td>
<td>G0508</td>
</tr>
<tr>
<td>for services furnished on and after January 1, 2017)</td>
<td></td>
</tr>
<tr>
<td>Telehealth Consultation, Critical Care, subsequent, physicians typically spend 50</td>
<td></td>
</tr>
<tr>
<td>minutes communicating with the patient and providers via telehealth (effective</td>
<td>G0509</td>
</tr>
<tr>
<td>for services furnished on and after January 1, 2017)</td>
<td></td>
</tr>
<tr>
<td>Counseling visit to discuss need for lung cancer screening using low dose CT scan</td>
<td></td>
</tr>
<tr>
<td>(LDCT) (service is for eligibility determination and shared decision making</td>
<td>G0296</td>
</tr>
<tr>
<td>Interactive Complexity Psychiatry Services and Procedures (effective for services</td>
<td>90785</td>
</tr>
<tr>
<td>furnished on and after January 1, 2018)</td>
<td></td>
</tr>
<tr>
<td>Health Risk Assessment (effective for services furnished on and after January 1,</td>
<td></td>
</tr>
<tr>
<td>2018)</td>
<td>96160</td>
</tr>
<tr>
<td>Comprehensive assessment of and care planning for patients requiring chronic care</td>
<td></td>
</tr>
<tr>
<td>management (effective for services furnished on and after January 1, 2018)</td>
<td>G0506</td>
</tr>
<tr>
<td>Psychotherapy for crisis (effective for services furnished on and after January 1,</td>
<td></td>
</tr>
<tr>
<td>2018)</td>
<td>90839</td>
</tr>
<tr>
<td>Prolonged preventative services</td>
<td>G0513</td>
</tr>
</tbody>
</table>

- Clinical psychologists (CPs) and clinical social workers (CSWs). CPs and CSWs cannot bill for codes 90792, 90833, 90836, and 90838.
- For ESRD-related services, a physician, NP, PA, or CNS must furnish at least one “hands on” visit (not telehealth) each month to examine the beneficiary’s vascular access site.
CMS Expansion of Telehealth in 2019 – Advancing Virtual Care

In 2019 CMS put forth new regulations to help advance virtual care. The intent of these regulations is to support access to care using communication technologies.

CMS will reimburse for the following:

- Opioid Use Disorder and MAT treatment
- Virtual Check-Ins
- Remote Evaluation of patient submitted photos or recorded video
- Interprofessional Internet Consultation

FQHCs and RHCs will be reimbursed for communication technology-based services and remote evaluation services that are furnished by an FQHC or RHC practitioner when there is no associated billable visit. They are not eligible for reimbursement of Interprofessional Internet Consultations, as because the PPS includes all costs associated with a billable visit, including consultations with other practitioners.

Please note that none of these services are considered “telehealth” for CMS, therefore, they do not have the same restrictions as traditional telehealth services.

Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT)

Beginning July 1, 2019, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act removes the originating site geographic conditions and adds an individual’s home as a permissible originating telehealth services site for treatment of a substance use disorder or a co-occurring mental health disorder.

Brief communication technology-based service, e.g. Virtual check-in

Virtual check-in interactions take place over telephone or live video and involve a physician or non-physician practitioner having a brief, at least five minute, check in with a patient to assess whether the patient needs to come in for an office visit.

Virtual check-ins must be for a condition that is not related to an Evaluation and Management service provided within the previous 7 days and does not lead to an Evaluation and Management Service, or procedure, in the following 24 hours or the soonest available appointment.

A practitioner may respond to the patient’s concern by telephone, audio or video, secure text messaging, email, or the use of a patient portal.

Billable providers are Physicians, Nurse Practitioners, Physician Assistants, Certified Nurse Midwives, Clinical Psychologists, and Clinical Social Workers. If the discussion can be conducted by Nurse, Health Educator, or other clinical personnel it will not be billable as a Virtual Communication Service. Outside of an FQHC or RHC, the code billed will be G2012.

FQHCs and RHCs are allowed to bill for virtual check-ins. Virtual check-ins will be billed with code G0071.

There are no frequency limitations at this time.

Remote Evaluation Of Pre-Recorded Patient Information

Remote evaluation services consist of a practitioner evaluating an established patient’s transmitted information via pre-recorded video or image.
The service can only be billed if a condition is not related to an Evaluation and Management service provided within the previous 7 days and does not lead to an Evaluation and Management service within the following 24 hours, or the soonest available appointment.

A practitioner may respond to the patient’s concern by a telephone, audio or video, secure text messaging, email, or the use of a patient portal.

Billable providers are Physicians, Nurse Practitioners, Physician Assistants, Certified Nurse Midwives, Clinical Psychologists, and Clinical Social Workers. If the discussion can be conducted by Nurse, Health Educator, or other clinical personnel, it would not be billable as a Remote Evaluation Service. Outside of an FQHC or RHC the code billed will be G2010.

FQHCs and RHCs are allowed to bill for remote evaluation services. The code billed will be G0071.

There are no frequency limitations at this time.

**Interprofessional Internet Consultation**

Interprofessional internet consultations covers consultations between professionals performed by a communications technology such as telephone or internet.

Verbal consent and acknowledgement of cost-sharing is required from the patient.

This service is limited to practitioners that can independently bill Medicare for Evaluation and Management visits. This is not a covered FQHC or RHC service.

The codes billed will be 99446 through 99449, 99451, and 99452.

**Remote Physiological Monitoring**

The new definition for remote patient monitoring is “a collection of physiological data (for example; ECG blood pressure glucose monitoring) digitally stored and/ or transmitted by the patient or caregiver or both to the Home Health agency”.

Under this new definition remote patient monitoring will only be reimbursable when reported as a service in the provision of another skilled service.

Home visits for the purpose of supplying, or maintaining, remote patient monitoring equipment without the provision of another skilled service will not be separately billable but will constitute an allowable administrative cost under the amendments to 42 CFR 409.46.

The Remote Patient Monitoring CPT codes are as follows:

- **CPT Code 99453**: Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment.

- **CPT Code 99454**: Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days.
• CPT Code 99457: Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month

Additional Resources

CMS Telehealth Services Fact Sheet

CMS Federally Qualified Health Center Fact Sheet

CMS MLN Matters number: MM10583, Revised September 6, 2018

Chapter 12 of the Medicare Claims processing Manual, Section 190.6

UnitedHealthcare

Medicare Plans

UnitedHealthcare offers telemedicine and telehealth services to UnitedHealthcare Medicare patients. Telemedicine and telehealth services are covered for patients under this plan when Medicare coverage criteria are met.

Originating site requirements and allowable practitioners listed in the Medicare section of this manual apply to all telemedicine visits. UnitedHealthcare uses the same billing codes as Medicare for services.

See Medicare section of this manual for detail information on program restrictions.

Virtual Visits – HMP, EPO, POS Plans

The Virtual Visit benefit is designed to reimburse for telemedicine services rendered to a patient who is located at a location that is not a clinical Originating Site, (i.e. their home or workplace). Such services would not normally be covered under the existing telemedicine benefit. However, the addition of the Virtual Visit benefit provides coverage for those services when the member is not at a clinical Originating Site and uses a Designated Virtual Visit provider.

Conditions Required for Telehealth Use

Virtual visits are provided for the diagnosis and treatment of low acuity medical conditions. Examples include, but are not limited to:

• Bronchitis
• Seasonal Flu
• Pink Eye
• Sore Throat
• Sinus Problems

The diagnosis and treatment is provided through the use of interactive audio and visual telecommunication and transmissions and audio visual communication technology. The virtual visit must provide communication of medical information in real-time between the patient and a distant
physician or health specialist through the use of interactive audio and video communications equipment outside of a medical facility.

The virtual visit must be provided by a UnitedHealthcare Designated Virtual Network Provider. Services are currently provided by AmWell and Doctor on Demand.

Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.

**Patient Consent**

Prior to 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.

Nothing shall preclude a patient from receiving in-person health care delivery services during a specified course of health care and treatment after agreeing to receive services via telehealth.

Telemedicine/Telehealth services are covered only when all of the following criteria are met:

- Member requires services that are usually provided by direct contact with the provider
- Services are authorized by the member’s contracting/participating medical group or UnitedHealthcare
- The healthcare provider has determined telehealth services are appropriate
- Provider obtains verbal consent from member to provide telehealth services

**Exclusions**

This section shall not apply to a patient under the jurisdiction of the Department of Corrections and Rehabilitation or any other correctional facility.

**Additional Resources**

United HealthCare Policy Number: BIP181.E: TELEMEDICINE/TELEHEALTH SERVICES/VIRTUAL VISITS


United HealthCare Virtual Visits FAQ

http://uhcvirtualvisits.com/FAQs
Medi-Cal Fee For Service

In-person contact between a health care provider and a patient is not required for services provided through telehealth, subject to reimbursement policies adopted by the Department of Health Care Services to compensate a licensed health care provider who provides health care services through telehealth that are otherwise reimbursable pursuant to the Medi-Cal program (Welfare and Institutions Code [W&I Code], Section 14132.72[c]).

The health care provider is 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]).

Medi-Cal Coverage of Telehealth

Live Interactive: Covered Service

- A telemedicine service must use interactive audio, video or data communication to qualify for reimbursement. 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.
- The audio-video telemedicine system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through telemedicine. The telecommunication equipment must be of a quality to adequately complete all necessary components to document the level of service for the CPT-4 code billed. If a peripheral diagnostic scope is required to assess the patient, it must provide adequate resolution or audio quality for decision-making.
- The health care provider who has the ultimate responsibility for the care of the patient must be licensed in the State of California and enrolled as a Medi-Cal provider.
- All medical information transmitted during the delivery of health care via telemedicine must become part of the patient’s medical record maintained by the licensed health care provider.

Store and Forward: Limited to Ophthalmology and Dermatology

Store and forward is defined as an asynchronous transmission of medical information to be reviewed at a later time by a physician at a distant site, where the physician at the distant site reviews the medical information without the patient being present in real-time. Store and forward teleophthalmology and teledermatology is a medical service separate from an interactive telemedicine consultation and must meet the following requirements:

- The images must be specific to the patient’s condition and adequate for meeting the procedural definition of the national code that is billed.
- Teleophthalmology and teledermatology by store and forward must be rendered by a physician who has completed training in an Accreditation Council for Graduate Medical Education (ACGME)-approved residency in ophthalmology or dermatology respectively.
- A patient receiving teleophthalmology or teledermatology by store and forward shall be notified of the right to receive interactive communication with the distant specialist physician consulted through store and forward, upon request. If requested, communication with the distant specialist physician may occur either at the time of consultation or within 30 days of the patient’s notification of the results of the consultation.
Exclusions

A telephone conversation, email, fax are not considered live interactive or Store and forward telehealth visits and are specifically excluded from the definition of telemedicine.

Conditions Required for Telehealth Use

Patient Consent – Live Video

The health care provider at the originating site must first obtain oral consent from the patient prior to providing service via telehealth and shall document the oral consent in the patient’s medical record, including the following:

- A description of the risks, benefits and consequences of telemedicine
- The patient retains the right to withdraw at any time
- All existing confidentiality protections apply
- The patient has access to all transmitted medical information
- No dissemination of any patient images or information to other entities without further written consent

Patient Consent – Store and Forward

The health care provider shall comply with the informed consent provision of Section 2290.5 of the Business and Professions Code when a patient receives teleophthalmology and teledermatology by store and forward.

Eligible Originating Sites (Patient Site)

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 (W&I Code Section 14132.72(e)).

Eligible Distant Site Practitioners (Provider Site)

No restrictions on types or locations; however, requires licensure in State of California, enrollment as a Medi-Cal Provider, and adherence to licensure scope of practice. In addition, the distant (provider) site is only a billable visit if it meets all the requirements of the Medi-Cal program.

Billing and Reimbursement

Modifiers

Only services rendered from the distant site are billed with modifiers. Claims for reimbursement should be submitted with the appropriate CPT code or HCPCS code for the professional services provided and one of the following Telemedicine modifiers:

- GT or 95 for interactive audio and video telecommunications system (live interactive) or
- GQ for Store and forward applications.

Originating Site Fee

The originating site is eligible to receive a facility fee for providing services via telehealth. As of January 2018, the site facility fee is $22.94. Sites are instructed to use HCPCS code Q3014 when submitting facility fee claims. Sites fee are limited to once per day, same recipient, same provider.
**Transmission Fee: Live Interactive**

Medi-Cal allows payment of transmission costs associated with live interactive services. This fee can be paid to originating and distant sites. It is limited to a maximum of 90 minutes per day, same recipient, and same provider. One unit of service is equal to one minute of transmission cost.

Sites are instructed to use code T1014: telehealth transmission, per minute. As of January 2018 the transmission fee is $0.24 per minute.

**Clinical Fees: Live Interactive**

Table 2 provides a listing of all eligible live interactive services with CPT and HCPCS codes

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT and HCPCS Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office or Other Outpatient Visit – new or established patient</td>
<td>99201 – 99215</td>
</tr>
<tr>
<td>Initial Hospital Care or Subsequent Hospital Care – new or established patient</td>
<td>99231 – 99233</td>
</tr>
<tr>
<td>Consultations – office or other outpatient, initial or follow-up inpatient, and confirmatory</td>
<td>99241 – 99255</td>
</tr>
<tr>
<td>Psychiatric Diagnostic Evaluation with and without medical services</td>
<td>90791 and 90792</td>
</tr>
<tr>
<td>Psychotherapy, 30 and 60 minute, with patient</td>
<td>90832 and 90837</td>
</tr>
<tr>
<td>Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services</td>
<td>90863</td>
</tr>
<tr>
<td>Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth</td>
<td>G0508</td>
</tr>
<tr>
<td>Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth</td>
<td>G0509</td>
</tr>
</tbody>
</table>

**Clinical Fees: Store and Forward**

Table 3 provides a listing of all eligible store and forward services with CPT and HCPCS codes

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office or other outpatient visit</td>
<td>99211 – 99214</td>
</tr>
<tr>
<td>Subsequent hospital care</td>
<td>99231 – 99233</td>
</tr>
<tr>
<td>Office consultation, new or established patient</td>
<td>99241 – 99243</td>
</tr>
<tr>
<td>Initial inpatient consultation</td>
<td>99251 – 99253</td>
</tr>
</tbody>
</table>

A beneficiary receiving telehealth services by store and forward may also request to have real-time communication with the distant site provider at the time of the consultation or within 30 days of the original consultation.

**Additional Resources**

Medi-Cal Telemedicine Guidelines  

Medi-Cal & Telehealth: Resources  
http://www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx
Denti-Cal Services

Effective July 2015, The Department of Health Care Services has opted to permit the use of teledentistry as a modality for the provision of select dental services. Therefore, enrolled Denti-Cal billing providers may submit documents for services rendered utilizing teledentistry.

Please note that allied dental professionals, such as Registered Dental Hygienists in Alternative Practice, shall not be permitted to bill for services rendered via teledentistry.

Billing and Reimbursement

Providers may use CDT Code D9999 for reimbursement of live transmission costs associated with teledentistry (D0999). When submitting a claim for reimbursement of live transmission costs, CDT Code D9999 will only be payable when CDT Code D0999 has been rendered. The reimbursed rate is 24 cents per minute, up to a maximum of 90 minutes. Procedure D9999 may only be used once per date of service per beneficiary, per provider. Written documentation is required and must include the number of minutes the transmission occurred.

Teledentistry claims are identified using Current Dental Terminology (CDT) code D0999 (“Unspecified diagnostic procedure, by report”) with a date of service on or after July 1, 2015. As of October 2018, the Schedule of Maximum Allowance (SMA) for D0999 used for teledentistry is $46.00.

Live transmissions are only billable at the beneficiary’s request. If the live transmission cannot occur at the precise time of the beneficiary request, then a subsequent agreed upon time may be scheduled between the beneficiary and provider within a 30 day time period.

Table 4 provides a listing of all eligible live interactive services with CPT codes.

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unspecified diagnostic procedure, by report</td>
<td>D0999</td>
</tr>
<tr>
<td>Transmission Fee</td>
<td>D9999</td>
</tr>
</tbody>
</table>

Clinical Fees: Store and Forward

Teledentistry claims are identified using Current Dental Terminology (CDT) code D0999 (“Unspecified diagnostic procedure, by report”) with a date of service on or after July 1, 2015. As of October 2018, the Schedule of Maximum Allowance (SMA) for D0999 used for teledentistry is $46.00.

Providers may bill for teledentistry on the same claim form as other types of procedure codes unless they are in conflict with the Denti-Cal Manual of Criteria (MOC).

A beneficiary receiving teledentistry services by store and forward may also request to have real-time communication with the distant dentist at the time of the consultation or within 30 days of the original consultation.
Table 5 provides a listing of all eligible store and forward services with CPT codes effective 2018

Table 5
**Denti-Cal Eligible Telemedicine Services**
Store and Forward

<table>
<thead>
<tr>
<th>Service</th>
<th>CDT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unspecified diagnostic procedure, by report</td>
<td>D0999</td>
</tr>
<tr>
<td>Periodic oral evaluation — established patient</td>
<td>D0120</td>
</tr>
<tr>
<td>Comprehensive oral evaluation — new or established patient</td>
<td>D0150</td>
</tr>
<tr>
<td>Intraoral — complete series of radiographic images</td>
<td>D0210</td>
</tr>
<tr>
<td>Intraoral — periapical first radiographic image</td>
<td>D0220</td>
</tr>
<tr>
<td>Intraoral — periapical each additional radiographic image</td>
<td>D0230</td>
</tr>
<tr>
<td>Intraoral — occlusal radiographic image</td>
<td>D0240</td>
</tr>
<tr>
<td>Bitewing — single radiographic image</td>
<td>D0270</td>
</tr>
<tr>
<td>Bitewings — two radiographic images</td>
<td>D0272</td>
</tr>
<tr>
<td>Bitewings — four radiographic images</td>
<td>D0274</td>
</tr>
<tr>
<td>Panoramic radiographic image</td>
<td>D0330</td>
</tr>
<tr>
<td>Oral/Facial photographic images</td>
<td>D0350</td>
</tr>
</tbody>
</table>

**Additional Resources**

Denti-Cal Quick Reference Guide

Denti-Cal Teledentistry Tutorial
https://www.denti-cal.ca.gov/DC_media/providers/teledentistry_tutorial.mp4
California Children’s Services (CCS) and Genetically Handicapped Persons Program (GHPP)

CCS and GHPP programs follow Medi-Cal policies and procedures concerning coverage and reimbursement of telemedicine services.

Table 6 provides a listing of all eligible live interactive services with CPT codes.

<table>
<thead>
<tr>
<th>Service</th>
<th>CDT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tympanometry and reflex threshold measurements</td>
<td>92550</td>
</tr>
<tr>
<td>Acoustic reflex testing, threshold/unlisted audiologic services</td>
<td>92568</td>
</tr>
<tr>
<td>Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system/limited/unlisted audiologic services</td>
<td>92586</td>
</tr>
<tr>
<td>Evoked optoacoustic emissions, limited/unlisted audiologic services</td>
<td>92587</td>
</tr>
<tr>
<td>Evoked optoacoustic emissions, comprehensive or diagnostic evaluation/unlisted audiologic services</td>
<td>95288</td>
</tr>
<tr>
<td>Office or Other Outpatient Visit – new or established patient</td>
<td>99201-99215</td>
</tr>
<tr>
<td>Genetics counseling</td>
<td>50255</td>
</tr>
<tr>
<td>Physical therapy evaluation, approval from PT, first 30 minutes and add 15 min</td>
<td>X3920-X3922</td>
</tr>
<tr>
<td>Occupation therapy evaluation, first 30 minutes and add 30 min</td>
<td>X4100-X4102</td>
</tr>
<tr>
<td>Speech therapy language and speech evaluation plus report</td>
<td>X4300-X4302</td>
</tr>
<tr>
<td>Speech-language therapy, individual, 1/2 hour</td>
<td>X4304</td>
</tr>
<tr>
<td>Center coordinator, non-physician, case, registered diettitian</td>
<td>Z4300</td>
</tr>
<tr>
<td>Assessment, intervention, with instruction, ed., nurse specialist</td>
<td>Z4301</td>
</tr>
<tr>
<td>Team case conference, other allied health care professional</td>
<td>Z4302</td>
</tr>
<tr>
<td>Physician SCC chart review, intermediate</td>
<td>Z4303</td>
</tr>
<tr>
<td>Physician, extensive/comprehensive visit</td>
<td>Z4304</td>
</tr>
<tr>
<td>Physician visit, per patient/per date of service</td>
<td>Z4305</td>
</tr>
<tr>
<td>Physician/Dentist coordinating activity</td>
<td>Z4306</td>
</tr>
<tr>
<td>Social Worker, comprehensive assessment/intervention, 30 minutes.</td>
<td>Z4307</td>
</tr>
<tr>
<td>Registered Dietitian, comprehensive assessment/intervention, 30 minutes</td>
<td>Z4308</td>
</tr>
<tr>
<td>Other Allied Health Professional, comprehensive assessment/intervention, 30 min</td>
<td>Z4309</td>
</tr>
<tr>
<td>Nurse Specialist, participation SCC team case conference, 15 minutes</td>
<td>Z4310</td>
</tr>
<tr>
<td>Social Worker, SCC comprehensive team case conference, 15 minutes</td>
<td>Z4311</td>
</tr>
<tr>
<td>Registered Dietitian, SCC comp. team case conference, 15 minutes</td>
<td>Z4312</td>
</tr>
<tr>
<td>Physician, Group Teaching, counseling, &amp; support</td>
<td>Z4313</td>
</tr>
<tr>
<td>Other Allied Health Professional, Group Teaching, counselling &amp; support</td>
<td>Z4314</td>
</tr>
<tr>
<td>Physician/parent conference</td>
<td>Z4315</td>
</tr>
<tr>
<td>Allied Prof. NEC-Program/Clinical Consult.-Hr</td>
<td>Z5408</td>
</tr>
<tr>
<td>Program consultation/Clinic (Med) – Hr.</td>
<td>Z5422</td>
</tr>
<tr>
<td>EPSDT Services – Initial audiology evaluation, &lt; 2 years of age and 2-5 years of age</td>
<td>Z5900-Z5902</td>
</tr>
<tr>
<td>PSDT Services – Auditory brainstem response, tone burst</td>
<td>Z5914</td>
</tr>
<tr>
<td>EPSDT Services – Acoustic immittance testing, monaural and binaural, including tympanometry and acoustic reflex testing</td>
<td>Z5922-Z5924</td>
</tr>
<tr>
<td>EPSDT Services – Evoked otoacoustic emissions, comprehensive or diagnostic evaluation (comparison of transient and/or distortion</td>
<td>Z5934-Z5936</td>
</tr>
<tr>
<td>EPSDT Services – Aural rehabilitation related to use of a conventional hearing aid, 30 minutes</td>
<td>Z5940</td>
</tr>
<tr>
<td>EPSDT Services – Aural rehabilitation following cochlear implantation, 30 minutes</td>
<td>Z5942</td>
</tr>
</tbody>
</table>

Additional Resources

CCS Numbered Letter No. 14-123 Telehealth Services for CCS and GHPP Programs

CCS Numbered Letter No. 16-1217 Telehealth Services Code Update for CCS and GHPP Programs.
https://www.dhcs.ca.gov/services/ccs/Documents/ccsnl161217.pdf
Anthem Blue Cross Telehealth Programs

Anthem Blue Cross has telehealth services available through a variety of programs administered and operated by Anthem Blue Cross. This section outlines the Anthem Blue Cross Telehealth Program provisions and benefits.

Anthem Blue Cross Coverage of Telehealth

- Live interactive
- Store and forward

In order for telehealth services to be eligible for reimbursement, the provider’s services must be rendered from one of the following locations:

a. Provider’s office
b. Hospital
c. Rural Health Clinic
d. Federally Qualified Health Center
e. Other location with prior plan approval

Service benefits are consistent across all programs with the exceptions below.

Conditions Required for Telehealth Use

Verbal and Written Patient Consent
All telehealth encounters require that verbal informed consent be obtained and documented by the Originating Site. This documentation is part of the medical record to be kept with other documentation.

Exclusions

A telephone conversation, email, fax are not considered live interactive or store and forward telehealth visits and are specifically excluded from the definition of telemedicine.

Eligible Member Populations

a. Anthem Blue Cross Medi-Cal Managed Care Plans
b. CalPERS Basic Plan
c. Butte Schools Self-funded Program
d. California’s Valued Trust (CVT)
e. Self-Insured Schools of California (SISC)
f. University of California (UC)

Eligible Originating and Distant Sites

Anthem Blue Cross limits participation in its telemedicine program to members of the Blue Cross Open Access Network. All originating (patient) and distant (provider) sites must be a member of this network.

Billing and Reimbursement

Anthem Blue Cross of California uses standardized billing procedures when submitting claims.
**Modifiers**
To be used by the distant site

- GT for live interactive telemedicine encounters
- GQ for store and forward telemedicine encounters

**Originating Site Fee – Live Video**

Specialty Sites may not bill for an originating site fee.

**Originating Site Fee – Store and Forward**

Presenting sites serving eligible Medi-Cal members may bill site fees for store and forward consults.

<table>
<thead>
<tr>
<th>Table 7</th>
<th><strong>Anthem Blue Cross Eligible Telemedicine Services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Site Fee Billing Codes</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Live Interactive</strong></td>
<td><strong>Presentation Site</strong></td>
</tr>
<tr>
<td>CMS-1500 Q3014</td>
<td>G9002</td>
</tr>
<tr>
<td>CMS-1450 Q3014</td>
<td>G9002</td>
</tr>
<tr>
<td><strong>Store and Forward</strong></td>
<td><strong>CMS-1500 Q3014</strong></td>
</tr>
<tr>
<td><strong>CMS-1450 Q3014</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Transmission Fees**

- Anthem Blue Cross will pay claims for Blue Cross members’ telecommunication charges for live interactive consultations only.
- Only the site that initiates the live interactive telemedicine encounter may bill. Table 7 below shows the appropriate codes.
- Each minute (or part thereof) is equal to one (1) unit of occurrence with a maximum of 90 minutes of occurrence (1.5 hours billable maximum).

<table>
<thead>
<tr>
<th>Table 8</th>
<th><strong>Anthem Blue Cross Eligible Telecommunications Codes</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program</strong></td>
<td><strong>Code</strong></td>
</tr>
<tr>
<td>County Medical Services Program, Healthy Families, Path2Health Medi-Cal</td>
<td>T1014-GT</td>
</tr>
</tbody>
</table>

**Clinical Fees: Live Interactive**

Reimbursement to the health professional delivering the clinical service is the same as the current fee schedule amount for the service provided without telemedicine.

Table 9 provides a listing of all eligible live interactive services with CPT codes, effective 2018.
Table 9
Anthem Blue Cross Eligible Telemedicine Services
Live Interactive

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Providers</strong></td>
<td></td>
</tr>
<tr>
<td>New patient office visit</td>
<td>99201-99205</td>
</tr>
<tr>
<td>Established patient office visit</td>
<td>99211-99215</td>
</tr>
<tr>
<td><strong>Specialist</strong></td>
<td></td>
</tr>
<tr>
<td>Consultations</td>
<td>99241-99245</td>
</tr>
<tr>
<td>Follow-up visits</td>
<td>99211-99215</td>
</tr>
<tr>
<td><strong>Psychiatry</strong></td>
<td></td>
</tr>
<tr>
<td>Psychiatric diagnosis</td>
<td>90801-90809</td>
</tr>
<tr>
<td>Individual psychotherapy</td>
<td>90810-90815</td>
</tr>
<tr>
<td>Individual psychotherapy (inpt)</td>
<td>90816-90819</td>
</tr>
<tr>
<td>Individual psychotherapy (inpt)</td>
<td>90821-90829</td>
</tr>
<tr>
<td>Medical psychoanalysis</td>
<td>90833</td>
</tr>
<tr>
<td>Pharmacological psychiatric mgmt</td>
<td>90862</td>
</tr>
<tr>
<td>Consultations</td>
<td>99241-99245</td>
</tr>
<tr>
<td>Established member office visits</td>
<td>99211-99215</td>
</tr>
</tbody>
</table>

**Clinical Fees: Store and Forward**

Anthem Blue Cross pays for claims for the review of patient files for store and forward under codes:

- 99241-99245 Consultants

The preparation of the store and forward consult should be billed as part of the primary care provider’s office visit.

Store and forward is accomplished via secured email communication. As such, there are no telecommunication charges applicable. Therefore, there is no telecommunication reimbursement offered by Anthem Blue Cross.

**Live Health Online (LHO)**

LiveHealth Online (LHO) is a website and mobile application that gives patients 24/7 access to on-demand video visits (medical). It has an urgent care focus and provides convenient access anytime, anywhere in California, even at home, via smartphone, tablet or computer.

LHO connects patients with board-certified physicians supporting physical and behavioral health. Physicians can electronically prescribe to the member’s pharmacy.

*Note: Only noncontrolled substances can be prescribed.*

It is available at no cost for Anthem Blue Cross (Anthem) members enrolled in Medi-Cal Managed Care (Medi-Cal) beginning September 1, 2018.

**Additional Resources**

Anthem Blue Cross: Telemedicine Program Provider Operations Manual

Anthem Blue Cross Telemedicine Website
California Health & Wellness

This section outlines the California Health & Wellness Telehealth Program provisions and benefits.

California Health & Wellness Coverage of Telehealth

- Live interactive
- Store and forward

Conditions Required for Telehealth Use

**Verbal and Written Patient Consent**
Prior to each encounter of the delivery of health care services via telehealth, the licensed provider at the originating site must verbally inform the member that telehealth may be used and obtain verbal or written consent from the member. The verbal or written consent must be documented in the member’s medical record, including the following elements:
  a. A description of the risks, benefits, and consequences of telemedicine
  b. The member retains the right to withdraw at any time
  c. All existing confidentiality protections apply
  d. The member has access to all transmitted medical information
  e. No dissemination of any member images or information to other entities without further written consent

**Store and Forward Patient Consent**
The health care provider shall comply with the informed consent provision of Section 2290.5 of the Business and Professions Code when a member receives teleophthalmology and teledermatology by store and forward.

Members receiving teledermatology or teleophthalmology services by store and forward must be notified of the right to interactive communication with the distant specialist if requested. If requested, the communication may occur at the time of the consultation or within 30 days of the member’s notification of the results of the consultation.

Exclusions

Telehealth does not include email, telephone (voice only), text, inadequate resolution video, written communication between the providers, or between patients and providers.

Eligible Member Populations

Live interactive (synchronous) telehealth services can be provided to Plan members by any Plan-credentialed licensed provider.

Store and forward (asynchronous) telehealth services can be provided to Plan members by any Plan-credentialed licensed provider. The following licensed providers may provide store and forward services:
  a. Ophthalmologists
  b. Dermatologists
  c. Optometrists (licensed pursuant to Chapter 7 (commencing with Section 3000 of Division 2 of the Business and Professions Code)
Eligible Originating and Distant Sites

For purposes of reimbursement for covered treatment or services provided through telehealth, the type of setting where services are provided for the member or by the licensed provider is not limited (Welfare and Institutions Code [W&I Code], Section 14132.72[e]).

Billing and Reimbursement

California Health and Wellness uses standardized billing procedures when submitting claims.

Modifiers

To be used by the distant site

- GT for live interactive telemedicine encounters
- GQ for store and forward telemedicine encounters

Originating Site Fee – Live Video and Store and Forward

Q3014 - May be billed with or without a provider present

Transmission Fees

T1014 - (per minute for a maximum of 90 minutes per day, same recipient, same provider). Each minute (or part thereof) is equal to one (1) unit of occurrence.

Telehealth Models

There are two synchronous models of telehealth services available to Plan members.

a. Live interactive (synchronous) telehealth services, connects the patient with a distant licensed provider through audio-video equipment on a real-time basis.

b. Live interactive (synchronous) patient to provider telehealth services, connects a single licensed provider (primary care or specialty provider) to a member using audio-visual equipment on a real-time basis. The member can be in a health facility, residential group home or private residence or other setting, provided the appropriate equipment is used.

Table 10 provides a listing of all eligible live interactive services with CPT codes.

### Table 10

**California Health and Wellness Telemedicine Services**

**Live Interactive**

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office or other outpatient visit (new or established patient)</td>
<td>99201-99215</td>
</tr>
<tr>
<td>Initial hospital care or subsequent hospital care (new or established patient)</td>
<td>99221-99233</td>
</tr>
<tr>
<td>Consultations: Office or other outpatient, initial or follow-up inpatient, and</td>
<td>99241-99275</td>
</tr>
<tr>
<td>Interactive complexity (List separately in addition to the code for primary)</td>
<td>90785</td>
</tr>
<tr>
<td>Psychiatric diagnostic evaluation</td>
<td>90791</td>
</tr>
<tr>
<td>Psychiatric diagnostic evaluation with medical services</td>
<td>90792</td>
</tr>
<tr>
<td>Psychotherapy, 30 minutes with patient/or family member</td>
<td>90832</td>
</tr>
<tr>
<td>Psychotherapy, 45 minutes with patient/or family member</td>
<td>90834</td>
</tr>
<tr>
<td>Psychotherapy, 60 minutes with patient/or family member</td>
<td>90837</td>
</tr>
<tr>
<td>Psychotherapy for crisis; first 60 minutes</td>
<td>90839</td>
</tr>
<tr>
<td>Additional 30 minutes</td>
<td>90840</td>
</tr>
<tr>
<td>Pharmacologic management, including prescription and review of medication, when performed with psychotherapy</td>
<td>90863</td>
</tr>
</tbody>
</table>
**Clinical Fees: Store and Forward**

Asynchronous telehealth services or store and forward services, connects a member with a distant licensed provider of ophthalmology, dermatology or certain optometry services using audio-video equipment, but not on a real-time basis. Generally an image or picture is taken and forwarded to the distant licensed provider to review at a later time.

Table 11 provides a listing of all eligible store and forward services with CPT codes.

### Table 11
**California Health and Wellness Telemedicine Services**
**Store and Forward**

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office consultation, new or established patient</td>
<td>99241-99243</td>
</tr>
<tr>
<td>Initial inpatient consultation</td>
<td>99251-99253</td>
</tr>
<tr>
<td>Office or other outpatient visit</td>
<td>99211-99214</td>
</tr>
<tr>
<td>Subsequent hospital care</td>
<td>99231-99233</td>
</tr>
<tr>
<td>Retinal Photography: with interpretation for services provided by optometrists or ophthalmologists (should not be used if the originating site is submitting claims with this code)</td>
<td>92259</td>
</tr>
</tbody>
</table>

**Additional Resources**

California Health & Wellness Telehealth Policy
Central California Alliance for Health

This section outlines the Central California Alliance for Health (CCAH) Telehealth Program provisions and benefits. The goal of telehealth with the Alliance is to improve both access and quality health services provided in rural and other medically underserved areas through the use information and telecommunications technologies.

In order to ensure members have sufficient access to care, especially in specialties and regions in which access is limited, the Alliance supports the use of telehealth when appropriate for the provision of these services.

Central California Alliance for Health Coverage of Telehealth

- Live interactive
- Store and forward

Conditions Required for Telehealth Use

**Verbal and Written Patient Consent**

The health care provider at the originating site must inform the member that telehealth services will be used and obtain the member’s verbal or written consent, which will be documented in the member’s medical record. The health care provider will disclose to enrollees the use telehealth in the delivery of specialty or other care and, if applicable, directions for how enrollees can elect to use telehealth services for their care.

**Store and Forward Patient Consent**

In situations when the asynchronous store and forward system is used, members must be notified of their right to have interactive communication with the distant specialist at the time of the consultation or within 30 days of the patient’s notification of the results of the consultation. In all circumstances, providers will abide by HIPAA laws, including not disclosing a member’s personal health information to any third party without written consent.

Exclusions

The Alliance will not reimburse under this policy for routine e-mail, telephone (voice only), text, written communication between providers or between members and providers, or images with inadequate resolution.

Eligible Member Populations

Live interactive (synchronous) telehealth services can be provided to Alliance members by any Alliance credentialed health care provider with the member’s verbal consent, as documented in the patient’s medical record.

Store and forward (asynchronous) telehealth services provides for the review of medical information at a later time by a physician or optometrist at a distant site without the patient being present in real time.

Eligible Originating and Distant Sites

- a. a physician office
- b. clinic setting
c. hospital  
d. skilled nursing facility  
e. residential care setting  
f. patient home

Billing and Reimbursement

The Alliance uses standardized billing procedures when submitting claims.

Modifiers
To be used by the distant site

- GT for Live Interactive telemedicine encounters
- GQ for Store and forward telemedicine encounters

Originating Site Fee – Live Video and Store and Forward

For the originating site, a licensed provider must be present if the provider fee and site facility fee are to be reimbursable. If a licensed provider is not present at the originating site, only a site facility fee may be billed for the visit. The scope of the interaction of the originating provider must be documented in the member’s medical record. The scope of the visit should determine the codes used for billing. For lines of business that require a copay for direct patient care services, the payment will be collected at the time of the member’s visit to the originating site.

Transmission Fees

Transmission cost fees may be billed whether or not a licensed provider is present.

Managed Behavioral Health Organization (MBHO)

The Alliance contracts with a Managed Behavioral Health Organization (MBHO) to provide mild to moderate mental health services and BHT for eligible members with ASD from licensed/certified behavioral health providers as defined by Health & Safety Code Section 1374(c)(3).

Table 12 provides a listing of all eligible live interactive services with CPT codes.

Table 12  
Central California Alliance for Health Telemedicine Services  
Live Interactive

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office or other outpatient visit (new or established patient)</td>
<td>99201-99215</td>
</tr>
<tr>
<td>Initial hospital care or subsequent hospital care, critical care (new or established patient)</td>
<td>99221-99233, 99291, 99292</td>
</tr>
<tr>
<td>Extended Inpatient Care</td>
<td>99356 – 99357</td>
</tr>
<tr>
<td>Consultations: Office or other outpatient, initial or follow-up inpatient, Inpatient, and confirmatory</td>
<td>99241-99275</td>
</tr>
<tr>
<td>Genetic Counseling</td>
<td>96040, 50265</td>
</tr>
<tr>
<td>Nutrition Counseling per PHC Guidelines (See Policy MCUP3052)</td>
<td>97802, 97803, 97804, 99539</td>
</tr>
<tr>
<td>Interactive complexity (List separately in addition to the code for primary)</td>
<td>90785</td>
</tr>
<tr>
<td>Psychiatric diagnostic evaluation</td>
<td>90791</td>
</tr>
<tr>
<td>Psychiatric diagnostic evaluation with medical services</td>
<td>90792</td>
</tr>
<tr>
<td>Psychotherapy, 30 minutes with patient/or family member</td>
<td>90832</td>
</tr>
<tr>
<td>Psychotherapy, 45 minutes with patient/or family member</td>
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</tr>
<tr>
<td>Psychotherapy, 60 minutes with patient/or family member</td>
<td>90837</td>
</tr>
<tr>
<td>Psychotherapy for crisis; first 60 minutes</td>
<td>90839</td>
</tr>
<tr>
<td>Additional 30 minutes</td>
<td>90840</td>
</tr>
</tbody>
</table>
Pharmacologic management, including prescription and review of medication, when performed with psychotherapy

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Originating Site Fee</td>
<td>Q3014</td>
</tr>
<tr>
<td>Transmission Fee</td>
<td>T1014</td>
</tr>
</tbody>
</table>

Clinical Fees: Store and Forward

Store and forward (asynchronous) services, connects a member with a distant licensed provider of ophthalmology, dermatology or certain optometry services using audio-video equipment, but not on a real-time basis. Generally an image or picture is taken and forwarded to the distant licensed provider to review at a later time. The following Medi-Cal certified health care providers may provide store and forward services:

a. Ophthalmologists
b. Dermatologists
c. Optometrists (licensed pursuant to Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code)
d. Specialists participating in PHC’s eConsult Program

Table 13 provides a listing of all eligible store and forward services with CPT codes.

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office or other outpatient visit (new or established patient)</td>
<td>99201-99215</td>
</tr>
<tr>
<td>Consultations: Office or other outpatient, initial or follow-up inpatient, Inpatient, and confirmatory</td>
<td>99241-99243, 99231-99233</td>
</tr>
<tr>
<td>eConsult, electronic consultation</td>
<td>99444</td>
</tr>
<tr>
<td>Retinal Photography: with interpretation for services provided by optometrists or ophthalmologists</td>
<td>92250</td>
</tr>
<tr>
<td>Originating Site Fee</td>
<td>Q3014</td>
</tr>
<tr>
<td>Transmission Fee</td>
<td>T1014</td>
</tr>
</tbody>
</table>

Additional Resources

CCAH Provider Manual

CCAH Provision of Telehealth Services to Alliance Members Policy 404-1727
Partnership HealthPlan of California

This section outlines the Partnership HealthPlan of California (Partnership) Telehealth Program provisions and benefits. The goal of telehealth with Partnership is to improve both access and quality health services provided in rural and other medically underserved areas through the use of information and telecommunications technologies.

Partnership fully supports the advancement of telehealth services in their regions as a means of improving access and quality of care to members as well as providing expert advice and specialty consultation to primary care providers (PCPs) in the Partnership network. The effective date of this policy is for dates of service on or after March 1st, 2012. Current Partnership referral and authorization requirements apply to telehealth services per policy MCUP3124 Referral to Specialists (RAF) Policy.

Telemedicine services may also be used to provide mild-moderate severity Mental Health Services to Partnership members. Such services are provided through Partnership’s contracted Behavioral Health Managed Services organization.

**Partnership Coverage of Telehealth**

- Live interactive
- Store and forward

**Conditions Required for Telehealth Use**

*Verbal and Written Patient Consent*
Prior to the delivery of health care services via telehealth, the health care provider at the originating site must verbally inform the patient that telehealth may be used and obtain verbal consent from the patient for this use. The verbal consent must be documented in the patient’s medical record.

*Store and Forward Patient Consent*
Members receiving teledermatology or teleophthalmology services by store and forward must be notified of the right to interactive communication with the distant specialist if requested. If requested, the communication may occur at the time of the consultation or within 30 days of the member’s notification of the results of the consultation.

**Exclusions**

Telehealth does not include email, telephone (voice only), text, inadequate resolution video, written communication between the providers, or between patients and providers.

**Eligible Member Populations**

Live interactive (synchronous) telehealth services can be provided to Partnership members by any PHC credentialed health care provider with the member’s verbal consent, as documented in the patient’s medical record.

Store and forward (asynchronous) telehealth services provides for the review of medical information at a later time by a physician or optometrist at a distant site without the patient being present in real time.
The following Medi-Cal certified health care providers may provide store and forward services:

a. Ophthalmologists
b. Dermatologists
c. Optometrists [licensed pursuant to Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code]
d. Specialists participating in PHC’s eConsult Program

Eligible Originating and Distant Sites

For purposes of reimbursement for covered treatment or services provided through telehealth, the type of setting where services are provided for the member or by the licensed provider is not limited (Welfare and Institutions Code [W&I Code], Section 14132.72[e]).

Billing and Reimbursement

Partnership uses standardized billing procedures when submitting claims.

Modifiers
To be used by the distant site
- GT for live interactive telemedicine encounters
- GQ for store and forward telemedicine encounters

Originating Site Fee – Live Video and Store and Forward

Q3014 – May be billed without a provider present

Transmission Fees

T1014 - (per minute for a maximum of 90 minutes per day, same recipient, same provider). Each minute (or part thereof) is equal to one (1) unit of occurrence.

Telehealth Models

There are two synchronous models of telehealth services available to Plan members.

a. Live interactive (synchronous) Telehealth Services connects the patient with a distant provider of health services through audio-video equipment on a real-time basis. This model is commonly used between specialty centers such as UCSF or UCD with outlying physician offices or community health centers.

b. Live interactive (synchronous) Patient to Provider Telehealth Services connects a single provider (primary care or specialty provider) to a patient using audio-visual equipment on a real-time basis. The patient can be in a health facility, residential group home or private residence or other setting, provided the appropriate equipment is used.

Table 14 provides a listing of all eligible live interactive services with CPT codes.
Table 14
Partnership HealthPlan Telemedicine Services
Live Interactive

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office or other outpatient visit (new or established patient)</td>
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<td>99241-99275</td>
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<tr>
<td>Interactive complexity (List separately in addition to the code for primary)</td>
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</tr>
<tr>
<td>Psychiatric diagnostic evaluation</td>
<td>90791</td>
</tr>
<tr>
<td>Psychiatric diagnostic evaluation with medical services</td>
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</tr>
<tr>
<td>Psychotherapy, 30 minutes with patient/or family member</td>
<td>90832</td>
</tr>
<tr>
<td>Psychotherapy, 45 minutes with patient/or family member</td>
<td>90834</td>
</tr>
<tr>
<td>Psychotherapy, 60 minutes with patient/or family member</td>
<td>90837</td>
</tr>
<tr>
<td>Psychotherapy for crisis; first 60 minutes</td>
<td>90839</td>
</tr>
<tr>
<td>Additional 30 minutes</td>
<td>90840</td>
</tr>
<tr>
<td>Pharmacologic management, including prescription and review of medication, when performed with psychotherapy</td>
<td>90863</td>
</tr>
<tr>
<td>Originating Site Fee</td>
<td>Q3014</td>
</tr>
<tr>
<td>Transmission Fee</td>
<td>T1014</td>
</tr>
</tbody>
</table>

Clinical Fees: Store and Forward

Store and forward (asynchronous) services, connects a member with a distant licensed provider of ophthalmology, dermatology or certain optometry services using audio-video equipment, but not on a real-time basis. Generally an image or picture is taken and forwarded to the distant licensed provider to review at a later time.

Table 15 provides a listing of all eligible store and forward services with CPT codes.

Table 15
Partnership HealthPlan Telemedicine Services
Store and Forward

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office or other outpatient visit (new or established patient)</td>
<td>99201-99215</td>
</tr>
<tr>
<td>Consultations: Office or other outpatient, initial or follow-up inpatient, Inpatient, and confirmatory</td>
<td>99241-99243, 99231-99233</td>
</tr>
<tr>
<td>eConsult, electronic consultation</td>
<td>99444</td>
</tr>
<tr>
<td>Retinal Photography: with interpretation for services provided by optometrists or ophthalmologists</td>
<td>92250</td>
</tr>
<tr>
<td>Originating Site Fee</td>
<td>Q3014</td>
</tr>
<tr>
<td>Transmission Fee</td>
<td>T1014</td>
</tr>
</tbody>
</table>

Additional Resources

Partnership Health Plan Telehealth Policy
http://www.partnershiphp.org/Providers/Policies/Documents/Utilization%20Management/MCUP3113.docx

Partnership Health Plan Telehealth Service Website
http://www.partnershiphp.org/Providers/Quality/Pages/Telehealth-Services.aspx
Federally Qualified Health Centers and Rural Health Clinics

Federally Qualified Health Centers (FQHC) And Rural Health Clinics (RHC) play a critical role in the provision of primary care to our rural and underserved populations. Many FQHC/RHSs are patient and / or provider sites for the delivery of telemedicine services. Telemedicine can improve patient access to specialty care and reduce travel hardships when needed services are far away. These valuable rural healthcare resources have played an important role in the development of telemedicine in California.

One of the questions most commonly asked of the California Telehealth Resource Center (CTRC) and the California Department of Health Care Services (DHCS) is about allowable billing for telemedicine by an FQHC/RHC. Many of the clinics have questions about “four walls” policies and how they are applied when telemedicine services are provided.

CTRC has worked with many rural clinic administrators and with DHCS to clearly identify the different reimbursement scenarios and the payment rules that surround each scenario. This document has been developed with input from DHCS staff. For MEDICARE patients, RHCs and FQHCs can be originating sites. They cannot provide services as a distant site.

This portion of the guide is designed to assist in maximizing allowable billing for telemedicine and to assist in determining the type of provider relationship that will best meet programmatic needs. It is written for FQHCs operating in California under the Prospective Payment System (PPS). Please note that rules for other states may differ.

There are several factors that determine how to bill for telemedicine services.

Two principles form the foundation:

- The place determined to be the provider site is the billing site and
- A provider can, under certain circumstances, enter the four walls virtually using telemedicine

The factors that determine the billing scenario are:

- Where the patient is physically located
- Characteristics of the specialty provider site
- Payment arrangement with the specialty provider
- If there is medical reason for a provider to be present with the patient

The application of these factors is described in the following eight scenarios.
Medi-Cal Managed Care Plan (MCP)

### Scenario 1: FQHC/RHC Originating Site to a Distant Site

- Patient is physically present at the FQHC or RHC
- Specialist is a MCP contracted provider not physically present at the FQHC or RHC
- FQHC or RHC and specialist have an agreement to provide services, but the FQHC or RHC does not compensate the specialist
- No medical reason for a provider to be present with the patient at the FQHC or RHC Site

### Outcome

- MCP contracted specialist is the Distant Site and can bill MCP
- FQHC or RHC is the Originating Site, did not provide a medical service, and cannot bill PPS for a face-to-face. However, the FQHC or RHC, in most instances, can bill an Originating Site fee and transmission fee to the MCP

FQHC or RHC Originating Site

**Patient**

Bills Q3014 and T1014 to MCP

**Telemedicine**

Distant Site

**Specialist**

Bills CPT to MCP
Medi-Cal Fee-For-Service

**Scenario 1a  FQHC/RHC Originating Site to a Distant Site**
- Patient is physically present at the FQHC or RHC
- Specialist is a Medi-Cal fee-for-service provider not physically present at the FQHC or RHC
- FQHC or RHC and specialist have an agreement to provide services, however the FQHC or RHC does not compensate the specialist
- No medical reason for a provider to be present with the patient at the FQHC or RHC Site

**Outcome**
- Medi-Cal specialist is the Distant Site and can bill fee-for-service rate
- FQHC or RHC is the Originating Site, did not provide a medical service, and cannot bill PPS for a face-to-face

*Per the Medi-Cal handbook: FQHCs, RHCs, and IHS clinic PPS sites may not bill for originating site or transmission fees.*
Multiple Managed Care Plans and Fee-For-Service Medi-Cal

**Scenario 1b**  
FQHC/RHC Originating Site (Provider Present) to a Distant Site

- Patient is physically present at the FQHC or RHC
- Specialist is a Medi-Cal fee-for-service provider not physically present at the FQHC or RHC
- FQHC or RHC and specialist have an agreement to provide services, however the FQHC or RHC does not compensate the specialist
- Medical reason for a provider to be present with the patient at the FQHC or RHC Site

**Outcome**

- Medi-Cal specialist is the Distant Site and can bill fee-for-service
- FQHC/RHC is the Originating Site, provided a medically necessary service, and can bill PPS for a face-to-face visit

*Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.*
Multiple Managed Care Plans and Fee-For-Service Medi-Cal

**Scenario 2**  
**FQHC/RHC Originating Site to Contracted Distant Site**

- Patient is physically present at FQHC/RHC Site
- Specialist is not physically at the FQHC/RHC
- FQHC/RHC and specialist have a written agreement to provide services. FQHC/RHC compensates specialist outside of an insurance plan.
  - The agreement should be in writing and clearly state: The time period during which the agreement is in effect; the specific services it covers; any special conditions under which the services are to be provided; and the terms and mechanisms for billing and payment.  
    (See BPHC Policy Information notice 98-23)
- FQHC or RHC has credentialed the contracted provider in house and with the health plan (if applicable)
- Specialist virtually enters FQHC site via telemedicine

**Outcome**

- FQHC/RHC becomes the Distant Site and can bill PPS for a face-to-face visit

---

*Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.*
Medi-Cal Fee-For-Service

Scenario 3 FQHC/RHC Originating Site to FQHC/RHC Distant Site

- Patient is physically present at the FQHC/RHC 1
- Specialist is physically at and receives compensation from FQHC/RHC 2
- FQHC/RHC 1 and FQHC/RHC 2 have an agreement to provide services, however FQHC/RHC 1 cannot compensate FQHC/RHC 2
- No medical reason for a provider to be present with the patient at the FQHC/RHC 1 Site

Outcome

- FQHC/RHC 2 is the Distant Site and can bill PPS for a face-to-face visit
- FQHC/RHC 1 is the Originating Site, did not provide a medical service, and cannot bill PPS for a face-to-face visit

*Per the Medi-Cal handbook: FQHCs, RHCs, and IHS clinic PPS sites may not bill for originating site or transmission fees.
*Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.
**Medi-Cal Fee-For-Service**

**Scenario 3a**  
FQHC/RHC Originating Site (Provider Present) to FQHC/RHC Distant Site

- Patient is physically present at the FQHC/RHC 1,
- Specialist is physically present at and receives compensation from FQHC/RHC 2
- FQHC/RHC 1 and FQHC/RHC 2 have an agreement to provide services, but FQHC/RHC 1 cannot compensate FQHC/RHC 2
- Medical reason for a provider to be present with the patient at the FQHC/RHC 1 site

**Outcome**

- FQHC/RHC 2 specialist is the Distant Site and can bill PPS for a face-to-face visit
- FQHC/RHC 1 is the Originating Site, provided a medically necessary service, and can bill PPS for a face-to-face visit

*Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.*
Medi-Cal Fee-For-Service

Scenario 4  Non FQHC/RHC Originating Site to FQHC/RHC Distant Site

- Patient is physically present at Originating Site (non FQHC/RHC)
- Specialist is physically located at and receives compensation from FQHC/RHC
- Originating Site and FQHC/RHC have an agreement to provide services, however Originating Site does not compensate FQHC/RHC
- No medical reason for a provider to be present with the patient at the Originating Site

Outcome

- FQHC/RHC is the Distant Site and can bill PPS for a face-to-face visit
- Non FQHC/RHC Clinic site is the Originating Site, did not provide a medical service, and cannot bill for a face-to-face visit. However, the clinic site can bill an Originating Site fee and transmission fee

```
<table>
<thead>
<tr>
<th>Originating Site</th>
<th>Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>Bills Q3014 and T1014</td>
</tr>
<tr>
<td>FQHC/RHC Distant Site</td>
<td></td>
</tr>
<tr>
<td>Bills PPS to Medi-Cal</td>
<td></td>
</tr>
</tbody>
</table>
```

Telemedicine
Multiple Managed Care Plans and Fee-For-Service Medi-Cal

Scenario 5  FQHC/RHC to Patient Home *

- Provider is physically located at and receives compensation from FQHC/RHC
- Patient is an established patient and is not physically present at FQHC/RHC. In this example we will use the patient’s home.

*Please check with your plan for eligibility

Outcome

- FQHC/RHC is the Distant Site and can bill PPS for a face-to-face visit
FQHC Specialty Care Frequently Asked Questions

Can an FQHC contract with a specialist to provide services?

FQHCs are allowed to contract with specialty providers to provide services to their patients. The live-interactive component of telemedicine enables the FQHC to bill for a face-to-face encounter.

PIN 98-23 3–Contracting for Health Services Health centers may have contracts or other types of agreements to secure services for health center patients that it does not provide directly. The service delivery arrangement must contribute to the desired outcomes of availability, accessibility, quality, comprehensiveness, and coordination. Arrangements for the provision of services that the grantee organization provides through a subcontractor should be in writing and clearly state: the time period during which the agreement is in effect; the specific services it covers; any special conditions under which the services are to be provided; and the terms and mechanisms for billing and payment. Other areas that should be addressed in the written agreement include but are not limited to: credentialing of contracted service providers; the extent to which the contracted services and/or providers are subject to the health center’s quality improvement and risk management guidelines and requirements; and any data reporting requirements.

Can an FQHC add specialty care service to their practice?

If an FQHC wishes to provide a service via telemedicine that is not currently a part of their ‘scope of practice’ they must contact their project officer for permission, or wait until their annual grant renewal to do so. HRSA PIN 2009-02 specifically addresses the topic of adding primary care services. In general, a health center must demonstrate how the new service will support the provision of the required primary care services provided by the health center. Although prior approval is still necessary, in general the addition of services listed as examples of ‘additional health services’, such as behavioral and mental health, will be considered appropriate for inclusion within the health center’s federal scope of project. The request must not require any additional 330 funding.

Does FTCA coverage apply to contract employees?

FTCA coverage is an ongoing concern affecting the provision of telemedicine because there are various ways that telemedicine consults could potentially void this coverage. For this reason it is recommended that the health center has wrap-around coverage. PAL 2005-01 states that “for contract providers, the contract must be between the Health Center and the individual provider. All payments for services must be from the Health Center to individual contract provider. A contract between a deemed Health Center and a provider’s corporation does not confer FTCA coverage on the provider.”

Additionally, FTCA only applies to part-time licensed or certified healthcare practitioner contractors (who are not corporations) providing part-time services in the fields of family practice, general internal medicine, general pediatrics, or obstetrics and gynecology.
Useful References


2. California Department of Health Services, Medi-Cal Program, Internet version, Sacramento, California.
   http://www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx

3. Medicare Telehealth Program
   http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/

4. Medicare Telehealth Services Fact Sheet 2018


6. *Medicare Benefit Policy* (CMS Publication 100-02), Internet publication only, Baltimore, Maryland, Centers for Medicare and Medicaid Services.

7. *Medicare Claims Processing Manual* (CMS Publication 100-04), Internet publication only, Baltimore, Maryland, Centers for Medicare and Medicaid Services.

8. *Medicare Benefit Policy Manual - Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services*


10. Anthem Blue Cross of California, *Anthem Blue Cross of California Telemedicine Program for Healthy Families and Medi-Cal Program – Telemedicine Billing Guidelines*,

11. *Partnership Health Plan Telehealth*
    http://www.partnershipphp.org/Providers/Quality/Pages/Telehealth-Services.aspx