POLICY AND PROCEDURE

DEPARTMENT: Telehealth	**DOCUMENT NAME:** Health Net of California Telehealth Programs
PAGE: 1 of 30	**REPLACES DOCUMENT:**
APPROVED:	**RETIRED:**
EFFECTIVE DATE:	**REVIEWED/REVISED:**
PRODUCT TYPE: Medi-Cal	**REFERENCE NUMBER:**

SCOPE:
Health Net (Plan), Quality Improvement, Contracting, Provider Relations, Member Services Departments, the Credentialing Committee and the Plan's affiliates and delegates.

PURPOSE:
To provide a description of the Telehealth programs and services available to Plan members. This policy provides general guidance regarding Federal and State regulations as they relate to telehealth activities. Additionally, included are a review of covered services for telehealth technologies, the delivery system of the services, reimbursement structure, and service requirements.

POLICY:
This policy is for guidance purposes. Reimbursement of covered procedures is subject to the Member's eligibility status and covered benefits, adherence to authorization and utilization management requirements as outlined in the provider's network contract, Health Net's policy and procedures requirements, and the provider's contractual agreement for billing and reimbursement. Health Net reserves the right to conduct research on all billing submissions and utilizes technology to assist in claim editing and clinical review. This research may include, but is not limited to, reviewing reimbursement for procedures for a single date and/or multiple dates of service as well as researching billing submissions across dates of service to analyze unbundling of pre- and post-service procedures. This research may result in recovery of payment should there be any billing discrepancies.

A. State Statutes

1. **California Health and Safety Code 1374.13**
    a. For the purposes of this section, the definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code shall apply.
    b. It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the health care provider.
    c. No health care service plan shall require that in-person contact occur between a health care provider and a patient before payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee

or subscriber and the health care service plan, and between the health care service plan and its participating providers or provider groups.

d. No health care service plan shall limit the type of setting where services are provided for the patient or by the health care provider before payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee or subscriber and the health care service plan, and between the health care service plan and its participating providers or provider groups.
e. The requirements of this section shall also apply to health care service plan and Medi-Cal managed care plan contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code
f. Notwithstanding any other provision, this section shall not be interpreted to authorize a health care service plan to require the use of telehealth when the health care provider has determined that it is not appropriate.

2. **California Health and Safety Code 1375.1**
    a. A procedure for prompt payment or denial of provider and subscriber or enrollee claims, including those telehealth services, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, covered by the plan. Except as provided in Section 1371, a procedure meeting the requirements of Subchapter G of the regulations (29 C.F.R. Part 2560) under Public Law 93-406 (88 Stats. 829-1035, 29 U.S.C. Secs. 1001 et seq.) shall satisfy this requirement.

3. **California Business and Professions Code, 2290.5**
    a. For purposes of this division, the following definitions shall apply:
        i. “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 without the presence of the patient.
        ii. “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.
        iii. “Health care provider” means either of the following:
            1. A person who is licensed under this division.

2. An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3.

iv. "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.

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

vi. "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 while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

b. 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.

c. Nothing in this section 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.

d. The failure of a health care provider to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

e. This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

f. All laws regarding the confidentiality of health care information and a patient's rights to his or her medical information shall apply to telehealth interactions.

h. i. Notwithstanding any other provision of law and for purposes of this section, the governing body of the hospital whose patients are receiving the telehealth services may grant privileges to, and verify and approve credentials for, providers of telehealth services based on its medical staff recommendations that rely on information provided by the distant-site hospital or telehealth entity, as described in Sections 482.12, 482.22, and

485.616 of Title 42 of the Code of Federal Regulations.
ii. By enacting this subdivision, it is the intent of the Legislature to authorize a hospital to grant privileges to, and verify and approve credentials for, providers of telehealth services as described in paragraph iii. For the purposes of this subdivision, "telehealth" shall include "telemedicine" as the term is referenced in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

B. Telehealth Models of Care

1. Traditional Synchronous Telehealth Services

a. Live Video is two-way interaction between a person (patient, caregiver, or provider) and a provider using audiovisual telecommunications technology. This type of service is also referred to as "real-time" and may serve as a substitute for an in-person encounter when it is not available. For reimbursement guidelines, refer to Appendix A.

2. Asynchronous Telehealth Services or "Store and Forward" Services

a. Store-and-forward technologies allow for the electronic transmission of medical information, such as digital images, documents, and pre-recorded videos through secure email communication. For reimbursement guidelines, refer to Appendix B.

C. Coverage

1. Telehealth services are covered only when all of the following criteria are met:

a. Member requires services that are usually provided by in a traditional clinical setting
b. Services are authorized by the member's contracting/participating medical group or Health Net
c. The healthcare provider has determined Telehealth Services are appropriate
    i. Provider obtains verbal or written consent from member to provide telehealth services

2. Synchronous Telehealth Services and Settings

a. Synchronous telehealth services can be provided to Plan members by any Plan-credentialed licensed provider.

b. 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]).
c. For services or benefits provided via synchronous, interactive audio and telecommunications systems, the health care provider bills with modifier 95 (August 2019 Medi-Cal Manual: Telehealth).

3. Asynchronous Telehealth Services & Settings

a. 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:
    i. Ophthalmologists
    ii. Dermatologists
    iii. Optometrists (licensed pursuant to Chapter 7 (commencing with Section 3000 of Division 2 of the Business and Professions Code)
b. 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.
c. 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]). The type of setting may include, but is not limited to, a hospital, medical office, community clinic or the member's home.
d. For services or benefits provided via asynchronous store and forward telecommunications systems, the health care provider bills with modifier GQ.

4. Documentation

a. Documentation for benefits or services delivered via telehealth should be the same as for a comparable in-person service.
b. Providers should note the following:
    i. 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 the Medi-Cal provider manual.

ii. 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]).

iii. 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.

c. 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.

5. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

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

D. Health Plan Regulations

1. Consent

a. 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:

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

b. 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 member consent and should be kept in the member's medical file.

c. Providers will manage the beneficiary-level opt-in and data sharing consents. Including data sharing revocations, including without limitation, providing access to Health Net to access such opt-in and data sharing consents of Health Net beneficiaries/members.

2. Confidentiality

a. All applicable federal and state laws regarding the confidentiality of health care information and a member's rights to his or her medical information apply to telehealth services.

b. Providers will comply with all applicable laws and Health Plan policies pertaining to the confidentiality, use, and disclosure of PHI including but not limited to:

- HIPAA / 45 C.F.R. Parts 160 and 164 (Privacy & Security Rules)
- Lanterman-Petris-Short Act (LPS) / W & I Code Sections 5328-5328.15
- 45 C.F.R. Part 2 (Substance Use Disorders – SUD)
- HITECH Act (42. U.S.C. Section 17921 et. seq.)
- Confidentiality of Medical Information Act (CMIA) (Ca Civil Code 56 through 56.37)
- Title 9, CCR, Section 1810.370(a)(3)

c. If the disclosure of Member information would include information and records obtained in the course of providing mental health services from a facility subject to the additional privacy protections under the Lanterman-Petris-Short Act ("Lanterman Act") or if it would be information originating from a federally assisted drug abuse program subject to the additional privacy protections provided by 42 C.F.R. Part 2 that identifies a patient as having or having had a Substance Use Disorder (SUD), the party making the disclosure will obtain the appropriate authorization(s) or consent(s) required by the Lanterman Act and/or 42 C.F.R. Part 2 from the Member prior to making the disclosure.

3. HIPAA

a. Use or disclosure of Member information qualifying as "protected health information" ("PHI"), as that term is defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH"), shall be made in accordance with the requirements and any regulations promulgated thereunder (collectively, the "HIPAA Rules").

b. If a covered entity utilizes telehealth that involves PHI, the entity must meet the same HIPAA Rules that it would for a service provided in person. The entity will need to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to PHI confidentiality, integrity and availability (Centers for Medicare and Medicaid Services). Providers will comply with all applicable laws and Health Plan policies pertaining to HIPAA.

c. PHI shared under this Telehealth Program shall be the minimally necessary PHI needed to carry out the purposes of telehealth and is shared for the purpose of treatment, coordination of care and/or other health care operations.

4. Credentialing of Providers of Telehealth Services to Members in an Outpatient Setting

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

5. Credentialing of Providers of Telehealth Services to Members in a Hospital Setting

a. Licensed providers providing telehealth services to Plan members, outside a hospital setting, need to be credentialed through the Plan, or an organization with delegated authority for credentialing, as approved by the Credentialing Committee.

b. The governing body of the hospital whose patients are receiving telehealth services may grant privileges to, and verify and approve credentials for, providers of telehealth services based on its medical staff recommendations that rely on information provided by the distant site hospital or telehealth

entity, as described in Sections 482.12, 482.22 and 485.616 of Title 42 of the Code of Federal Regulations.

6. Required Equipment

a. The audio-video equipment must, at a minimum, have the capability of meeting the procedural definition of the code provided through telehealth. The telecommunication equipment must be of a quality to adequately complete all necessary components to document the level of service for the CPT-code or HCPCS code billed.

7. Required Documentation

a. Health care providers at the "distant site" are not required to document medical necessity or cost effectiveness to be reimbursed for telehealth services or store and forward services.

8. Referrals and Prior-Authorizations

a. All Health Net referral and authorization requirements apply. Refer to Health Net Provider Manual and applicable Health Net policies and procedures.

9. Interpretation Services

a. When interpretation services are necessary during telehealth encounters all requirements of the Health Net Interpreter Services Policy CA.CLAS.06.

10. Store and Forward Guidelines

a. Store and forward teleophthalmology and teledermatology is a medical service separate from an interactive telemedicine consultation and must meet the following requirements:
    i. The images must be specific to the patient's condition and adequate for meeting the procedural definition of the national code that is billed.
    ii. A member 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 may occur at the time of the consultation or within 30 days of the member's notification of the results of the consultation.
    iii. 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.

b. A health care provider at the distant site may bill for an e-consult with the CPT code 99451 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 the Medi-Cal provider manual.

11. Exclusions

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

12. Distant Site Services

a. Distant site providers are entitled to bill for certain services. These services and reimbursement guidelines are outlined in Appendix D.

13. Benefits Application

a. Providers are reminded to verify member eligibility, the Evidence of Coverage and the Provider Manual via the web or phone, *prior to the provision of any service or procedure* for which reimbursement will be requested.

www.healthnet.com

Health Net Member and Provider Services:

Health Net Provider Services Center (Except Medi-Cal and Medicare)	1-800-641-7761
Provider Services Medi-Cal	1-800-675-6110 1-800-281-2999 (fax)
Provider Services Cal MediConnect - Los Angeles County - San Diego County	1-855-464-3571 1-855-464-3572
Provider Services Medicare Advantage Plans: - Green, Ruby, Healthy Heart I, Violet - Amber, Amber I, Amber II, Healthy Heart II	1-800-929-9224 1-800-646-5614
EDI (Electronic claims submission)	1-800-977-3568
First Health Provider Relations	1-800-937-6824
Hospital Inpatient Notification	1-800-995-7890 1-800-676-7969 (fax)
Pharmacy - Group, Individual and Family plans - Medicare/Medi-Cal	1-800-548-5524, option 3 1-800-314-6223 (fax) 1-800-867-6564 1-800-977-8226 (fax)

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REFERENCES:

1. Medi-Cal Provider Manual: Telehealth
2. Health Net Policy 2018 HN "California UM CM Program Description"
3. Health Net Provider Manual
4. Health Net Policy CA.CLAS.06 "Interpreter Services"
5. California Business and Professions Code Section 2290.5
6. Welfare and Institutions Code, Section 14132.72
7. Business and Professions Code, Division 2, Section 3000, Chapter 7
8. California Department of Health Care Services FAQ Telehealth Payments Webpage http://www.dhcs.ca.gov/provgovpart/Pages/FAQ-Telehealth-Payments.aspx (Accessed September 12, 2016)

ATTACHMENTS:

a. Appendix A: Medi-Cal Reimbursement for Synchronous Traditional Telehealth Services
b. Appendix B: Medi-Cal Reimbursement for Asynchronous Telehealth Services
c. Appendix C: Medi-Cal Reimbursement for E-Consults
d. Appendix D: Medi-Cal Reimbursement for Synchronous Provider to Patient Telehealth Services
e. Appendix E: Medi-Cal Reimbursement for Distant Site Providers
f. Appendix F: Medi-Cal Guidelines for FQHC/RHC

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DEFINITIONS:

Telehealth: 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 while the patient is at the originating site and the health care provider is at a distant site. telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers. (California Business and Professions Code Sec. 2290.5)

Licensed provider: A person who is licensed by the State of California Department of Health Care Services. To provide services to Medi-Cal members, the health care provider must be Medi-Cal.

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

Asynchronous store and forward: The transmission of a member's medical information from an originating site to the health care provider at a distant site without the presence of the member.

Originating site: The member is located at the time health care services are provided via a telecommunications system, or where the asynchronous store and forward service originates.

Distant site: The licensed provider is located while providing services via a telecommunication system.

Medical Necessity: Reasonably necessary services required to preserve and protect life, to prevent significant illness or disability, or to alleviate severe pain and suffering through the diagnoses and treatment of disease, illness or injury.

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E-Consults: E-Consults are asynchronous health record consultation services that provide an assessment and management service in which the member'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 member face-to-face contact with the consultant.

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REVISION LOG

REVISION	DATE
Description of revision	MM/YY
Description of revision	MM/YY

POLICY AND PROCEDURE APPROVAL

The electronic approval is retained in Compliance 360

Director of Telehealth Programs Department: _____

Chief Medical Officer: _____

Appendix A

Medi-Cal Reimbursement for Traditional Synchronous Telehealth Services

Billing Guidelines for Originating Site Providers:

Originating Site	
Service	**CPT/HCPCS Code**
Originating Site Facility	Q3014 (once per day, same patient, same provider)
Transmission Cost Fee:	T1014 (per minute for maximum of 90 minutes per day, same recipient, same provider)
Licensed Provider Fee (*if present*)	E&M codes 99201 - 99215 and other CPT codes for services distinct and in addition to those rendered by the Distant Site Provider

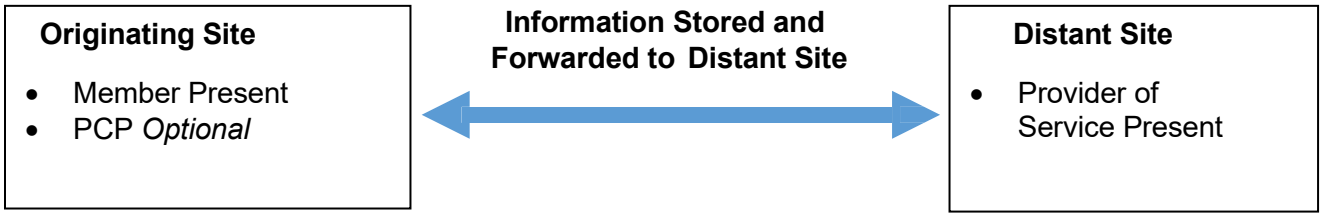
If a licensed provider is present at the telehealth originating site with the member present, medical necessity is established and documented in a progress note generated by the originating provider, the visit is reimbursable. The scope of the interaction with the originating site provider should be documented in the progress note that are distinct from those provided by the Distant Site and will be the basis of the E&M and other CPT code(s) billed. If an E&M code is included, the transmission cost fees may be billed by eligible sites. No modifier is needed at the originating site.

Medi-Cal Billing Guidelines for Distant Site Providers

Distant Site	
Service	**CPT/HCPCS Code**
Transmission Cost Fee:	T1014 (per minute for maximum of 90 minutes per day, same recipient, same provider)
Initial Hospital Care or Subsequent Hospital Care: (new or established patient)	99221 – 99233
Consultations: Office or other outpatient (initial or follow-up) Inpatient, and confirmatory	99241 – 99275
Required Modifier:	GT modifier required for all CPT-Codes except Transmission Cost codes

Appendix B

Medi-Cal Reimbursement for Asynchronous Telehealth Services (Store and Forward) for Teleophthalmology, Teleoptometry and Teledermatology Services



Billing Guidelines for Originating Site Providers

Originating Site	
Service	**CPT/HCPCS Code**
Site Facility Fee: (billable by eligible sites only when no provider at visit)	Q3014 (once per day, same patient, same provider)
Transmission Cost Fee: (billable by eligible sites)	T1014 (per minute for maximum of 90 minutes per day, same provider)
Licensed Provider Fees: (*if present*)	E&M codes 99201 - 99215 and other CPT codes for services distinct and in addition to those rendered by the Distant Site Provider

If a licensed provider is present at the telehealth originating site with the member present, medical necessity is established and documented in a progress note generated by the originating provider, the visit is reimbursable. The scope of the interaction with the originating provider should be documented in the progress note that are distinct from those provided by the Distant Site and will be the basis of the E&M and other CPT code(s) billed. If an E&M code is included, the transmission cost fees may be billed by eligible sites. No modifier is needed at the originating site.

Medi-Cal Special Billing Guidelines for Asynchronous Retinal Photography - Originating Site Providers

If an originating site licensed provider uses asynchronous telehealth for diabetic eye exam screenings, through the use of a retinal camera located at the originating site special billing guidelines apply - when the originating site is paying the specialist directly for reading the results of the retinal photographs. In non-FQHC and non-RHC facilities, an originating site licensed provider does not need to be present for retinal photography service to be reimbursable. If no originating site licensed provider is present at the visit, bill using the following CPT codes:

Distant Site	
Service	**CPT Codes**
Office Consultation: new or established patient	99241 - 99243
Retinal Photography: with interpretation for services provided by optometrists or ophthalmologists (should not be used if originating site is submitting claims with this code)	92250

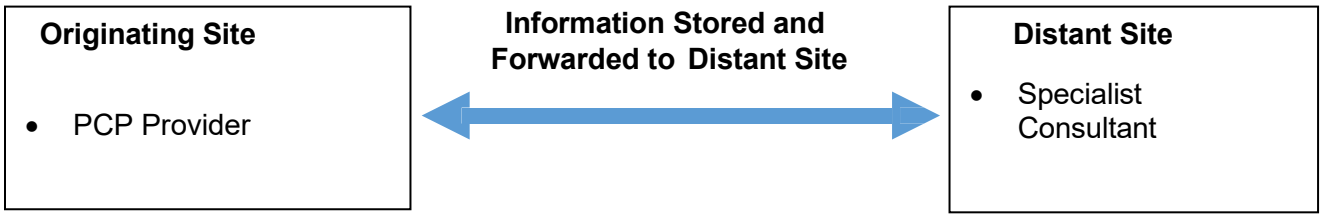
If an originating site licensed provider is present at visit, E&M codes can also be billed as usual. The scope of the interaction with the originating provider should be documented in the progress note. The originating site fee and the transmission cost fees may still be billed by eligible sites. No modifier is needed.

Medi-Cal Billing Guidelines for Distant Store and Forward Site Providers

Originating Site	
Service	**CPT Codes**
Retinal Photography: with interpretation for services provided by optometrists or ophthalmologists	92250 (Do not use modifier)
Site Facility Fee: (billable with or without provider) present)	Q3014 (once per day, same patient, same provider)
Transmission Cost Fee:	T1014 (per minute for a maximum of 90 minutes per day, same recipient, same provider)
Distant Site	
Service	**CPT Codes**
Office Consultation: new or established patient	99241 - 99243
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)	92250

Appendix C

Medi-Cal Reimbursement for Asynchronous Telehealth Services (Store and Forward) for E-Consults



Billing Guidelines for Distant Site Providers

Originating Site	
Service	**CPT/HCPCS Code**
E-Consult: Interprofessional telephone/internet/electronic health record assessment	99451

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.

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).

Appendix D
Medi-Cal Reimbursement for Synchronous Telehealth Services: Provider to Patient Telehealth Services

Telehealth Advancement Act of 2011 allows for telehealth services to be provided between a qualified provider and patient at a distant location. The location may be a health facility, residential home, patient's home or other location.

Medi-Cal Billing Guidelines for the Distant Site

Distant Site	
Service	**CPT/HCPCS Code**
Transmission Cost Fee:	T1014 (per minute for maximum of 90 minutes per day, same recipient, same provider)
Licensed Provider Fees:	**See Tables A and B below**

A licensed provider who provides E&M services for a patient utilizing telehealth technology to access the provider's office may submit claims for this service using the E&M code, without the modifier. The contracted arrangements for primary care providers and specialty providers continue to apply. HCPCS Code T1014 Transmission Cost fee may also be billed by eligible sites

Appendix E

Medi-Cal Reimbursement for Distant Site Professional Services

Services that are eligible for reimbursement when provided at a Distant Site in accordance with this policy, are identified in **Tables A and B**. Providers must submit the CPT code which most accurately identifies the service provided. Providers at the Distant Site **must** append the GT or GQ modifier to the CPT code to identify and bill any service furnished via telemedicine. These modifiers are outlined in **Table C.** Distant sites are also eligible for the reimbursement of Transmission Costs outlined in **Table D.**

Table A: Synchronous Professional Services Provided at a Distant Site	
CPT® 4 Codes	**Description**
CPT Codes 99201-99215	Office or other outpatient visit (new or established patient)
CPT Codes 99221-99233	Initial hospital care or subsequent hospital care (new or established patient)
CPT Codes 99241-99275	Consultations: Office or other outpatient, initial or follow-up inpatient, and
CPT Code 90785	Interactive complexity (List separately in addition to the code for primary
CPT Code 90791	Psychiatric diagnostic evaluation
CPT Code 90792	Psychiatric diagnostic evaluation with medical services
CPT Code 90832	Psychotherapy, 30 minutes with patient/or family member
CPT Code 90834	Psychotherapy, 45 minutes with patient/or family member
CPT Code 90837	Psychotherapy, 60 minutes with patient/or family member
CPT Code 90839	Psychotherapy for crisis; first 60 minutes
CPT Code 90840	Additional 30 minutes
CPT Code 90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy

Table B: Asynchronous Professional Services Provided at a Distant Site	
CPT® 4 Codes	**Description**
99241-99243	Office consultation, new or established patient
99251-99253	Initial inpatient consultation
99211-99214	Office or other outpatient visit
99231-99233	Subsequent hospital care
99451	eConsult

Table C: Telehealth Modifiers for Use by Distant Sites	
Modifier	**Description**
GT	Via interactive audio and video telecommunication
GQ	Via asynchronous telecommunications systems

Table D: Facility Fees Reimbursable to Distant Sites	
HCPCS Code	**Description**
T1014	Transmission Cost Fee (per minute for maximum of 90 minutes per day, same recipient, same provider)

Table E: Place of Service Code	
Code	**Description**
02	Services provided or received through a telecommunication system. The Place of Service Code 02 requirement is not applicable for FQHCs, RHCs, or HIS-MOA clinics.

Appendix F

Telehealth Billing Guidelines for FQHC/RHC

SYNCHRONOUS TELEHEALTH		
Originating Site Location of Patient	**Distant Site Location of Telehealth Provider**	**Billing and Reimbursement Policy**
FQHC/RHC Corporation (Corp) A – Site 1 ***Established patient with non-billable provider***	**FQHC/RHC Corp A – Site 2** ***Billable provider***	**FQHC/RHC Corp A – Site 2 can bill one visit at the PPS rate.**
FQHC/RHC Corp A – Site 1 ***Established patient with billable provider***	**FQHC/RHC Corp A – Site 2** ***Billable provider***	**Only one site can bill one visit at the PPS rate.**
FQHC/RHC Corp A ***Established patient with non-billable provider***	**FQHC/RHC Corp B** ***Billable provider***	**FQHC/RHC Corp B can bill one visit at the PPS rate.** **No PPS rate reimbursement is permitted for FQHC/RHC Corp A.**
FQHC/RHC Corp A ***Established patient with billable provider***	**FQHC/RHC Corp B** ***Billable provider***	**FQHC/RHC Corp A can bill one visit at the PPS rate if it is medically necessary for a billable provider to be present.** **FQHC/RHC Corp B can bill one visit at the PPS rate.**
FQHC/RHC Corp A ***Established patient with non-billable provider***	**Non-FQHC/RHC Medi-Cal Provider** ***Billable provider*** ***(no service payment contract)***	**The provider at the non-FQHC/RHC can bill the MCP or fee-for-service directly if no service payment contract exists between FQHC/RHC Corp A and the non-FQHC/RHC billable provider.** **No PPS rate reimbursement is permitted for FQHC/RHC Corp A.**

Originating Site Location of Patient	**Distant Site Location of Telehealth Provider**	**Billing and Reimbursement Policy**
FQHC/RHC Corp A ***Established patient with billable provider***	**Non-FQHC/RHC Medi-Cal Provider** ***Billable provider*** ***(no service payment contract)***	**FQHC/RHC Corp A can bill one visit at the PPS rate if it is medically necessary for a billable provider to be present.** **The provider at the non-FQHC/RHC can bill the MCP or fee-for-service directly if no service payment contract exists between FQHC/RHC Corp A and the non-FQHC/RHC billable provider.**
Non-FQHC/RHC Medi-Cal Provider ***Established patient with non-billable provider***	**FQHC/RHC Corp A** ***Billable provider***	**FQHC/RHC Corp A can bill one visit at the PPS rate.** **No PPS rate reimbursement is permitted for the non-FQHC/RHC.**
Non-FQHC/RHC Medi-Cal Provider ***Established patient with billable provider (no service payment contract)***	**FQHC/RHC Corp A** ***Billable provider***	**The non-FQHC/RHC can bill the MCP or fee-for-service directly if no service payment contract exists between FQHC/RHC Corp A and the non-FQHC/RHC billable provider.** **FQHC/RHC Corp A can bill one visit at the PPS rate.**
FQHC/RHC Corp A ***HHMS established patient***	**FQHC/RHC Corp A** ***Billable provider***	**FQHC/RHC Corp A can bill one visit at the PPS rate.**
FQHC/RHC Corp A ***HHMS established patient with billable provider***	**FQHC/RHC Corp A** ***Billable provider***	**Only one site can bill one visit at the PPS rate.**
FQHC/RHC Corp A ***HHMS established patient with billable provider***	**FQHC/RHC Corp B** ***Billable provider***	**FQHC/RHC Corp A can bill one visit at the PPS rate if it is medically necessary for a billable provider to be present.** **FQHC/RHC Corp B can bill one visit at the PPS rate.**

ASYNCHRONOUS STORE AND FORWARD TELEHEALTH		
Originating Site Location of Patient	**Distant Site Location of Telehealth Provider**	**Billing and Reimbursement Policy**
FQHC/RHC Corp A – Site 1 ***Established patient with non-billable provider***	**FQHC/RHC Corp A – Site 2** ***Billable provider***	**FQHC/RHC Corp A – Site 2 can bill one visit at PPS rate.**
FQHC/RHC Corp A – Site 1 ***Established patient with billable provider***	**FQHC/RHC Corp A – Site 2** ***Billable provider***	**Only one site can bill one visit at the PPS rate.**
FQHC/RHC Corp A – Site 1 ***Established patient with non-billable provider***	**FQHC/RHC Corp B** ***Billable provider***	**FQHC/RHC Corp B can bill one visit at the PPS rate.** **No PPS rate reimbursement is permitted for FQHC/RHC Corp A.**
FQHC/RHC Corp A ***Established patient with billable provider***	**FQHC/RHC Corp B** ***Billable provider***	**Only one site can bill one visit at the PPS rate.**
FQHC/RHC Corp A ***Established patient with non-billable provider***	**Non-FQHC/RHC Medi-Cal Provider** ***Billable provider*** ***(no service payment contract)***	**The provider at the non-FQHC/RHC can bill the MCP or fee-for-service directly if no service payment contract exists between FQHC/RHC Corp A and the non-FQHC/RHC billable provider.** **No PPS rate reimbursement is permitted for FQHC/RHC Corp A.**
FQHC/RHC Corp A ***Established patient with billable provider***	**Non-FQHC/RHC Medi-Cal Provider** ***Billable provider*** ***(no service payment contract)***	**FQHC/RHC Corp A can bill one visit at the PPS rate if it is medically necessary for a billable provider to be present.** **The provider at the non-FQHC/RHC can bill the MCP or fee-for-service directly if no service payment contract exists between FQHC/RHC Corp A and the non-FQHC/RHC billable provider.**

ASYNCHRONOUS STORE AND FORWARD TELEHEALTH (continued)		
Originating Site Location of Patient	**Distant Site Location of Telehealth Provider**	**Billing and Reimbursement Policy**
Non-FQHC/RHC Medi-Cal Provider ***Established patient with non-billable provider***	**FQHC/RHC Corp A** ***Billable provider***	**FQHC/RHC Corp A can bill one visit at the PPS rate.** **No PPS rate reimbursement is permitted for the non-FQHC/RHC.**
Non-FQHC/RHC Medi-Cal Provider ***Established patient with billable provider*** ***(no service payment contract)***	**FQHC/RHC Corp A** ***Billable provider***	**The non-FQHC/RHC can bill the MCP or fee-for-service directly if no service payment contract exists between FQHC/RHC Corp A and the non-FQHC/RHC billable provider.** **FQHC/RHC Corp A can bill one visit at the PPS rate.**
FQHC/RHC Corp A ***HHMS established patient***	**FQHC/RHC Corp A** ***Billable provider***	**FQHC/RHC Corp A can bill one visit at the PPS rate.**
FQHC/RHC Corp A ***HHMS established patient with billable provider***	**FQHC/RHC Corp A** ***Billable provider***	**Only one site can bill one visit at the PPS rate.**
FQHC/RHC Corp A ***HHMS established patient with billable provider***	**FQHC/RHC Corp B** ***Billable provider***	**Only one site can bill one visit at the PPS rate.**