

Telehealth Reimbursement Guide for California



California Telehealth
Resource Center

2021 Edition

Disclaimer

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

This document is intended as a guide to assist organizations in obtaining information on telehealth reimbursement. This document does not constitute legal advice. Many factors affect the appropriateness of submitting a particular claim for reimbursement and CTRC does not guarantee payment for any service. The information in the guide should be used in consultation with your billing specialist and other advisers in initiating telehealth 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Reimbursement information can become outdated quickly and is subject to change without notice.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. CTRC publishes changes to this reimbursement guide as often as possible. This document can be found on our website and is distributed to those on the CTRC email list.

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INTRODUCTION

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.

The State of California uses the term *telehealth*, though some providers and payors may use the term *telemedicine* when referring to the provision of health care at a distance. While the term *telemedicine* has been more commonly used in the past, *telehealth* is a more universal term that covers the broad array of applications in the field. Its use crosses most health service disciplines, including dentistry, counseling, physical therapy, home health, and many other domains.

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. 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?

Telehealth encompasses many distinct domains of applications. These are commonly known as:

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

Asynchronous (Store-and-Forward): Store and Forward 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.

eConsult: E-consult services fall under the auspice of store and forward services. Electronic messages are exchanged (including clinical question and related diagnostic data) initiated by the primary care physician to a specialist. Specialist can convert an eConsult to a referral if necessary.

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.

Direct to Consumer or Direct to Patient (DTC or DTP): Typically, live video visits where providers engage with patients directly, often when the patient is at home or another location. These visits can include a clinician seeing their own patient, or they could include a patient engaging with a telehealth company directly. Direct to Patient is often an integrated model that combines everything from the patient initial exam, diagnosis, treatment, and prescription fulfillment, if needed.

IS TELEHEALTH A BILLABLE SERVICE?

In many cases telehealth services are covered benefits and are billable by government programs and private payors. This guide provides information on major telehealth reimbursement programs in California. As the field is rapidly expanding, it should be noted that more and more public, private, and commercial payors are covering telehealth services. It is important that you check with your 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 payers within the state of California. It should be noted that telehealth is still a rapidly expanding field and changes in telehealth covered services and reimbursement occur every year. It will be necessary for programs to review new reimbursement policies on a regular basis. CTRC publishes changes to this reimbursement guide as often as possible.

TRADITIONAL MEDICARE

Reimbursement for Traditional Medicare telehealth has five criteria for payment:

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:
 - The office of a physician or practitioner
 - Hospitals (inpatient or outpatient)
 - Critical Access Hospitals
 - Rural Health Clinic
 - Federally Qualified Health Center
 - A hospital-based or critical access hospital-based renal dialysis center (including satellites)
 - Skilled Nursing Facility
 - Community Mental Health Center
 - Mobile Stroke Unit
 - Patient home – for monthly end stage renal, ESRD-related clinical assessments, and for purposes of treatment of a substance use disorder or a co-occurring mental health disorder



NOTE: Independent renal dialysis facilities are not eligible originating sites

2. **The Originating Site is located in one of the following geographic areas:**
 - a. Rural Health Professional Shortage Areas (HPSAs) located in a rural census tract;
-OR-
 - 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>



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.



NOTE: Beginning January 1, 2019, the Bipartisan Budget Act of 2018 removed the originating site geographic conditions and added eligible originating sites to diagnose, evaluate, or treat symptoms of an acute stroke.



NOTE: The Consolidated Appropriations Act of 2021 included an update to the eligible site list to include Rural Emergency Hospitals. The Act also requires an in-clinic visit 6 months prior in order for a patient to be seen for mental health services in the home.

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:**

- Physicians
- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Nurse-midwives
- Clinical nurse specialists (CNSs)
- Certified registered nurse anesthetists
- Clinical psychologists (CPs)*
- Clinical social workers (CSWs)*
- Registered dietitians or nutritional professionals
- Opioid Treatment Programs (OTP)

*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 2021, the payment amount is “80% of the lesser of the actual charge or \$27.02”. 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 **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.

Traditional 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.

Distant sites will submit the appropriate CPT code and use Place of Service 02 (Telehealth) for all encounters.

*Distant site practitioners billing telehealth services under the CAH Optional Payment Method (Method II) 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 table below provides a listing of all eligible services with CPT and HCPCS codes (Effective January 2021)

Synchronous Live Video Service	CPT or HCPCS Code
Telehealth consultations, emergency department or initial inpatient	G0425–G0427
Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs	G0406–G0408
Office or other outpatient visits	99202–99215
Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days	99231–99233
Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days	99307–99310
Individual and group kidney disease education services	G0420, G0421
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	G0108, G0109
Individual psychotherapy	90832–90838
Telehealth Pharmacologic Management	G0459
Psychiatric diagnostic interview examination	90791, 90792
End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment	90951-90961
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	90963
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	90964
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	90965

End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 20 years of age and older	90966
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	90967
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	90968
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	90969
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	90970
Individual and group medical nutrition therapy	G0270 or 97802–97804
Neurobehavioral status examination	96116
Neurobehavioral status examination (each additional hour)	96121
Smoking cessation services	99406–99407
Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services	G0396 G0397
Annual alcohol misuse screening, 15 minutes	G0442
Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	G0443
Annual depression screening, 15 minutes	G0444
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	G0445
Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	G0446
Face-to-face behavioral counseling for obesity, 15 minutes	G0447
Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)	99495
Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)	99496
Advance Care Planning, 30 minutes	99497
Advance Care Planning, additional 30 minutes (effective for services furnished on and after January 1, 2017)	99498
Psychoanalysis	90845
Family psychotherapy (without the patient present)	90846
Family psychotherapy (conjoint psychotherapy) (with patient present)	90847
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour	99354
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes	99355
Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; first hour (list separately in addition to code for inpatient evaluation and management service)	99356
Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; each additional 30 minutes (list separately in addition to code for prolonged service)	99357
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) first visit	G0438
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) subsequent visit	G0439

Telehealth Consultation, Critical Care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth	G0508
Telehealth Consultation, Critical Care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth	G0509
Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (service is for eligibility determination and shared decision making)	G0296
Interactive Complexity Psychiatry Services and Procedures	90785
Health Risk Assessment	96160 and 96161
Comprehensive assessment of and care planning for patients requiring chronic care management	G0506
Psychotherapy for crisis	90839 and 90840
Prolonged preventative services	G0513-G0514
Group psychotherapy (other than of a multiple-family group)	90853
Health behavior assessment or reassessment – includes health-focused clinical interviews, behavioral observations, and clinical decision making	96156
Health behavior intervention; individual; each additional 15 minutes	96159
Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes	96164
Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes	96165
Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	96167
Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes	96168
Domiciliary, Rest Home, or Custodial Care Services, Established Patients	99334, 99335
Home Visits, Established Patient	99347, 99348
Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home	99483
Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month	G2086
Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month	G2087
Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes	G2088
Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)	G2211
Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to cpt codes 99205, 99215 for office or other outpatient evaluation and management services)	G2212

- 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 – 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.



NOTE: Some of these services are not considered “traditional telehealth” for Medicare, therefore, they do not have the same restrictions as traditional telehealth services.

CMS will reimburse for the following under the Virtual Care programs:

- 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 Virtual Visits 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 (eConsult), as the PPS includes all costs associated with a billable visit, including consultations with other practitioners.

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 removed 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 via live video.

In the finalized Physician Fee Schedule for 2020, Medicare added three bundled payments for MAT treatment. The codes are:

- G2086: Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month.
- G2087: Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month.
- G2088: Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure).

BRIEF COMMUNICATION TECHNOLOGY-BASED SERVICE, E.G. VIRTUAL CHECK-IN

Virtual Check-Ins are billed with code **G2012**. *

These interactions are patient initiated telephone or live video interactions. They involve a physician or non-physician practitioner having a brief, at least 5-minute, check-in with an established patient to

assess whether the patient needs to come in for an office visit. The practitioner may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.

The virtual check-in must be for a condition not related to an E/M service provided within the previous 7 days and does not lead to an E/M service or procedure within the next 24 hours or soonest available appointment. There are no frequency limitations at this time.

Billable providers are physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, and clinical social workers. If the discussion could be conducted by a nurse, health educator, or other clinical personnel, it would not be billable as a virtual communication service.

* FQHCs and RHCs are allowed to bill for a Virtual Check-In. Virtual Check-Ins at an FQHC or RHC are billed with code **G0071**. The rate charged will be the physician fee schedule rate, not the all-inclusive rate (AIR) or prospective payment system (PPS).

REMOTE EVALUATION OF PRE-RECORDED, PATIENT SUBMITTED PHOTOS OR RECORDED VIDEO

Remote Evaluation Services are billed with code **G2010**. *

Remote evaluation services are patient initiated and consist of a practitioner evaluating an established patient's transmitted information via pre-recorded video or image. The practitioner may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.

The services can only be billed if the condition is not related to a service provided within the previous 7 days and does not lead to a service provided within the next 24 hours or soonest available appointment. There are no frequency limitations at this time.

Billable by physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, and clinical social workers. If the discussion could be conducted by a nurse, health educator, or other clinical personnel, it would not be billable as a virtual communication service.

*FQHCs/RHCs will be allowed to bill for Remote Evaluation services when an established patient sends recorded video or images to the FQHC/RHC. Remote Evaluation Services are billed with code **G0071**.

INTERPROFESSIONAL INTERNET CONSULTATION (ECONSULT)

Interprofessional Internet Consultation is defined by CMS as "Assessment and management services conducted through telephone, internet, or electronic health record consultations furnished when an established patient's treating physician or other qualified healthcare professional requests the opinion and/or treatment advice of a consulting physician or qualified healthcare professional with specific specialty expertise to assist with the diagnosis and/or management of the patient's problem without the need for the patient's face-to-face contact with the consulting physician or qualified healthcare professional." Interprofessional internet consultations covers consultations between professionals performed by a communications technology such as telephone or internet.

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

Interprofessional Internet Consultations are limited to practitioners that can independently bill Medicare for E/M visits and are billed using the following codes:

99446: Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review

99447: Same as 99446, but 11-20 minutes of medical consultative discussion and review

99448: Same as 99446, but 21-30 minutes of medical consultative discussion and review

99449: Same as 99446, but 31 minutes or more of medical consultative discussion and review

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 or more minutes of medical consultative time

99452: Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes

FQHCs and RHCs are not allowed to bill for interprofessional internet consultations because the AIR and PPS includes all costs associated with a billable visit, including consultations with other practitioners.

CHRONIC CARE MANAGEMENT: REMOTE PHYSIOLOGICAL MONITORING

The definition for remote physiological monitoring under the Chronic Care Management Program 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 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 physiological 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 Physiological 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

- CPT Code 99458: Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; additional 20 minutes

PRINCIPAL CARE MANAGEMENT SERVICE

Beginning January 1, 2020, CMS finalized a new Principal Care Management Program payment and coding structure, recognizing that there is considerable time needed to manage one chronic condition.

- G2064: CCM for a single high-risk disease, e.g. PCM, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities.
- G2065: CCM for a single high-risk disease, e.g. PCM, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional time per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities.

CMS also added a requirement that ongoing communication and care coordination between all practitioners furnishing care to the beneficiary must be documented by the practitioner billing for PCM in the patient's medical record.

ADDITIONAL RESOURCES

CMS Telehealth Services Fact Sheet

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctstht.pdf>

CMS Rural Health Center Fact Sheet

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralHlthClinfctstht.pdf>

CMS Federally Qualified Health Center Fact Sheet

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fqhcfactsheet.pdf>

CMS Virtual Visits FAQ for Federally Qualified Health Centers

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf>

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

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10583.pdf>

UNITEDHEALTHCARE MEDICARE PLANS

Telemedicine and telehealth services are covered for patients 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. In addition, UnitedHealthcare recognizes the home as an originating site for telehealth services and Therapy providers as eligible distant site providers.

UnitedHealthcare uses the same billing codes as Medicare for services.

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

VIRTUAL VISITS – HMO, EPO, PPO 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.

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, and Sinus Problems.

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.

ADDITIONAL RESOURCES

UnitedHealthcare Telehealth Policy

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-reimbursement/COMM-Telehealth-and-Telemedicine-Policy.pdf>

UnitedHealthcare - Medicare Advantage Plans Telehealth Policy

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medadv-coverage-sum/telemedicine-telehealth-services.pdf>
[10/2020](#)

UnitedHealth Billing Guide for providers:

<https://www.uhcprovider.com/content/dam/provider/docs/public/resources/news/2020/Telehealth-Patient-Scenarios.pdf>

UnitedHealthcare Virtual Visits FAQ

<http://uhcvirtualvisits.com/FAQs>

MEDI-CAL FEE-FOR-SERVICE



NOTE: The information in this section does not apply to FQHC or RHC provider types. Please refer to the FQHC/RHC section for Medi-Cal information.

COVERAGE OF TELEHEALTH

In-person contact between a health care provider and a patient is not required for services provided through telehealth.

Provider Requirements

The health care provider rendering Medi-Cal covered benefits or services provided via a telehealth modality must meet the requirements of *Business and Professions Code* (B&P Code), Section 2290.5(a)(3), or equivalent requirements under California law in which the provider is considered to be licensed, for example, providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission for Certifying Agencies. Providers billing for services delivered via telehealth must be enrolled as Medi-Cal providers.

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

Covered Service: Synchronous - Live Video

1. Health care providers must use interactive audio, video, or data telecommunications system that permits real-time communication between the health care provider at the distant site and the patient at the originating site.
2. The audio-video telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through telehealth. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.
3. The presence of a health care provider is not required at the originating site as a condition of payment unless the health care provider at the originating site is medically necessary as determined by the health care provider at the distant site.
4. 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.
5. 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.

Covered Service: Asynchronous - Store and Forward

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

under this policy. Store and forward includes, but is not limited to teleophthalmology, teledermatology, teledentistry, teleradiology and must meet the following requirements:

1. The documentation, typically images, must be specific to the patient's condition and adequate for meeting the procedural definition of the code that is billed.
2. 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.

Covered Service: eConsult

E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions, and recommendations of care. A health care provider at the distant site may bill for an e-consult when the benefits or services delivered meet the procedural definition and components of the CPT code.

eConsult is not reimbursable more than once in a seven-day period for the same patient and provider.

Providers should note that eConsult is not separately reportable, or reimbursable, if any of the following are true:

1. The distant site provider (consultant) saw the patient within the last 14 days.
2. 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.
3. 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.

Covered Service: eVisits

eVisits are communications between a patient and their provider through an online patient portal.

DOCUMENTATION REQUIREMENTS

Documentation for benefits or services delivered via telehealth should be the same as for a comparable in-person service. All documentation should be maintained in the patient's medical record. All health care practitioners providing covered benefits or services to Medi-Cal patients must maintain appropriate documentation to substantiate the corresponding technical and professional components of billed CPT or HCPCS codes.

Providers should note the following:

1. Health care providers at the distant site must determine that the covered service or benefit meets the procedural definition and components of the CPT or HCPCS code.
2. Health care providers are no longer required to document a barrier to an in-person visit (W&I Code, Section 14132.72[d]).

3. Health care providers at the distant site are no longer required to document cost effectiveness of telehealth to be reimbursed.

For eConsult, Medi-Cal has specific documentation requirements:

The health care provider at the **originating site** must create and maintain the following:

1. 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
2. A record of a request for an e-consult by the health care provider at the originating site.

The health care provider at the **distant site** must create and maintain the following:

1. A record of the review and analysis of the transmitted medical information with written documentation of date of service and time spent; and
2. A written report of case findings and recommendations with conveyance to the originating site.

CONDITIONS REQUIRED FOR TELEHEALTH USE

Patient Consent

Health care providers must 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. The consent shall be documented in the patient's medical record and should include:

- 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

If a health care provider, whether at the Originating or Distant site, maintains a general consent that specifically mentions use of telehealth as an acceptable modality for delivery of services, then this is sufficient for documentation of patient consent and should be kept in the patient's medical file.

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. The type of setting may include, but is not limited to, a hospital, medical office, community clinic or the **patient's home**.

The presence of a health care provider is not required at the originating site as a condition of payment unless the health care provider at the originating site is medically necessary, as determined by the health care provider at the distant site.

ELIGIBLE DISTANT SITE PRACTITIONERS (PROVIDER SITE)

There are no restrictions on provider types; however, a distant site provider must:

1. Be licensed in the State of California
2. Enrolled as a Medi-Cal provider
3. Be located in California or reside in a border community *
 - a. A health care provider who is part of a group, with an office physically located in California, may reside outside California.

* Border communities (see source citation under additional information):

- Oregon: Ashland, Brookings, Cave Junction, Grants Pass, Jacksonville, Klamath Falls, Lakeview, Medford, Merrill
- Nevada: Carson City, Henderson, Incline Village, Las Vegas, Minden, Reno, Sparks, Zephyr Cove
- Arizona: Bullhead City, Kingman, Lake Havasu City, Parker, Yuma

BILLING AND REIMBURSEMENT

Place of Service

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 or RHCs.

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:

- 95 for Synchronous live video services.
- GQ for Asynchronous store and forward services, including eConsult.

Originating Site Fee

Sites are instructed to use **Q3014**. Site fees are limited to once per day, same recipient, same provider. The originating site fee is applicable to sites utilizing synchronous live video, asynchronous store and forward, and eConsult. As of January 2021, the payment amount is \$22.94.

Transmission Fee: Live Interactive

Sites are instructed to use code **T1014**: telehealth transmission, per minute. 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. Transmission fees are not applicable to asynchronous store and forward or eConsult services.

Synchronous Live video and Asynchronous Store & Forward:

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

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

Medi-Cal has removed all CPT and HCPC codes from their policy, instead allowing providers the ability to utilize telehealth as an appropriate modality for care for any clinical condition deemed appropriate by the provider.

eConsult:

To bill for e-consults, the health care provider at the distant site (consultant) may use the following CPT code in conjunction with the GQ modifier:

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

ADDITIONAL RESOURCES

Medi-Cal Telehealth Guidelines

<https://www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx>

Medi-Cal & Telehealth: Resources

<https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthResources.aspx>

CCHP Medi-Cal Telehealth Policy Fact Sheet

https://www.cchpca.org/sites/default/files/2019-08/Medi-Cal%20Fact%20Sheet%20FINAL_0.pdf

Border Communities: Medi-Cal SPA 09-004

<https://www.dhcs.ca.gov/formsandpubs/laws/Documents/09-004packageRAI.pdf>

Border Communities: Medi-Cal MHSUDS Informational Notice 18-041

https://www.dhcs.ca.gov/services/MH/Documents/MHSUDS_IN18-041enclosure_MEDI.pdf

DENTI-CAL

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

The goal of teledentistry is to:

1. Allow Medi-Cal providers to practice teledentistry, as defined to mean the transmission of medical information to be reviewed at a later time, or in real time, by a licensed dental provider at a distant site; and
2. Authorize modest scope of practice expansions.



NOTE: Allied dental professionals may render limited services via teledentistry so long as such services are within their scope of practice and are rendered under the general supervision of a licensed dentist.

DOCUMENTATION REQUIREMENTS

Providers may use CDT Code **D9999** for reimbursement of live transmission costs associated with teledentistry. Written documentation is required and must include the number of minutes the transmission occurred.

CONDITIONS REQUIRED FOR USE

Patient Consent

Providers must inform the patient about the use of teledentistry and obtain verbal or written consent from the patient for the use of teledentistry as an acceptable mode of delivering dental services. The consent shall be documented in the patient's dental record.

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.

BILLING AND REIMBURSEMENT

Asynchronous Store and Forward services

Teledentistry claims are identified CDT code **D9996**. CDT code D9996 is not reimbursable; instead, the billing dental provider would be reimbursed based upon the applicable CDT procedure code to be paid according to the Schedule of Maximum Allowance (SMA).

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).

The table below provides a listing of all eligible store and forward services with CDT codes effective 2021

Asynchronous Store and Forward Service	CDT Codes
Unspecified diagnostic procedure, by report	D9996
Periodic oral evaluation — established patient	D0120
Comprehensive oral evaluation – new or established patient	D0150
Intraoral — complete series of radiographic images	D0210
Intraoral — periapical first radiographic image	D0220
Intraoral — periapical each additional radiographic image	D0230
Intraoral — occlusal radiographic image	D0240
Bitewing — single radiographic image	D0270
Bitewings — two radiographic images	D0272
Bitewings — four radiographic images	D0274
Panoramic radiographic image	D0330
Oral/Facial photographic images	D0350

Synchronous Live Video Services

Traditionally, teledentistry is conducted by asynchronous store and forward. However, at the beneficiary’s request or if health care provider believes the service is clinically appropriate, live transmissions can be conducted and are reimbursable. Teledentistry claims are identified using Current Dental Terminology (CDT) code **D9995**. Live transmissions are limited to 90 minutes per member per provider, per day.

CDT code D9995 is a per-minute, \$.24/minute procedure payable up to 90 minutes.

- CDT code D9995 is for synchronous, meaning any telephone call or video call/chat, teledentistry encounter.
- CDT code D9995 is for Medi-Cal patient-initiated contact with a Medi-Cal dental provider. This code is not for:
 - Dental assistant time
 - Dental hygienist time
 - Provider-initiated calls to the patient
 - Time spent contacting pharmacies on a patient’s behalf.
- CDT code D9995 should be billed with the number of minutes noted in the “Quantity” field of the claim, or the documentation should clearly state the number of minutes being requested.

ADDITIONAL RESOURCES

Denti-Cal Provider Handbook

https://www.denti-cal.ca.gov/DC_documents/providers/provider_handbook/handbook.pdf

Denti-Cal Quick Reference Guide

https://www.denti-cal.ca.gov/DC_documents/providers/teledentistry_quick_reference_guide.pdf

Denti-Cal Teledentistry Tutorial

https://www.denti-cal.ca.gov/DC_media/providers/teledentistry_tutorial.mp4

AETNA BETTER HEALTH OF CALIFORNIA

Telehealth services are provided at no cost to members or providers. Providers must be licensed (or equivalent) and be enrolled in FFS Medicaid (if there is a path of enrollment) and will be reimbursed at the same rate as a standard office visit if the service is the same, regardless of modality of delivery.

COVERAGE OF TELEHEALTH

Live interactive

ELIGIBLE MEMBER POPULATIONS

All Aetna Better Health of California Members

POLICY

In order to offer Telehealth services, providers must comply with the following:

- Maintain documentation of either verbal or written consent for the use of telehealth from the patient. Comply with all state and federal laws regarding the confidentiality of health care information.
- Patient's rights to own medical information applies to telehealth interactions.
- The patient is not precluded from receiving in-person healthcare services after agreeing to receive telehealth services.

ADDITIONAL RESOURCES

Aetna Better Health of California Provider Manual

<https://www.caltrc.org/reimbursement/aetna-better-health-of-california/>

Aetna Website

<https://www.aetnabetterhealth.com/california/providers/index.html>

ANTHEM BLUE CROSS OF CALIFORNIA

Anthem Blue Cross has telehealth services available through a variety of programs administered and operated by Anthem Blue Cross.

COVERAGE OF TELEHEALTH

Live interactive
Store and forward

POLICY

Telehealth is a covered service when all of the following criteria have been met:

- Medical necessity
- An Anthem Blue Cross provider requests the service
- The member is not able to use a bus, taxi, car or van to get to their appointment
- It is approved in advance by Anthem Blue Cross (when required)

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.

BRIGHT HEART HEALTH

Now available to Anthem Medi-Cal members at no cost: Bright Heart Health Medication Assisted Treatment (MAT) program for opioid use disorder and alcohol use disorder.

Bright Heart Health is a website and mobile application that gives members 24/7 access to opioid addiction programs using virtual Substance Use Disorder (SUD) treatment programs. Bright Heart Health provides discrete outpatient treatment programs using your smart phone, tablet or computer.

Members will be referred to a BHH services coordinator who will work with them to explore MAT and other treatment options.

ADDITIONAL RESOURCES

Anthem Blue Cross: Telemedicine Program Provider Operations Manual
<https://www.caltrc.org/reimbursement/anthem-blue-cross-of-california/>

Anthem Blue Cross Website
<https://providers.anthem.com/california-provider/home>

BEACON HEALTH OPTIONS

Beacon is a Managed Behavioral Health Organization (MBHO). Beacon manages the behavioral health benefits for some of the Medi-Cal Managed Care Plans in California.

COVERAGE OF TELEHEALTH

Live interactive only

ELIGIBLE MEMBER POPULATIONS

Members with the following health plan affiliations: Alameda Alliance for Health, Anthem Blue Cross Cal MediConnect, Blue Shield Promise Health Plan – Medical and Cal MediConnect, Blue Shield of California Medicare, Central California Alliance for Health – IHSS, MCAP, Medi-Cal, Gold Coast Health Plan, Health Plan of San Joaquin, LA Care Medi-Cal and Cal MediConnect, Orange County Mental Health Plan, Partnership Health Plan, and San Francisco Health Plan.

POLICY

Telehealth services are live, interactive audio and visual transmissions of a physician/nurse- patient encounter from one site to another, using telecommunications technologies.

Telehealth may apply to all outpatient codes listed within the provider services agreement (PSA) including psychotherapy and all E & M codes. Coverage is determined by the executed PSA.

Reimbursement for these services is subject to the same restrictions as face-to-face contacts.

DIRECT TO CONSUMER OPTION

Beacon offers several platforms for members to be seen in their homes, by a licensed clinician, using their smart phone, laptop, or tablet. Members must be screened first by a member services representative before they can be referred for services.

ADDITIONAL RESOURCES

Beacon Telehealth Program Description

<https://www.beaconhealthoptions.com/material/telehealth-program-description/>

Beacon Telehealth Program Specifications

<https://www.beaconhealthoptions.com/material/telehealth-program-specs/>

Beacon Telehealth FAQ

<https://www.beaconhealthoptions.com/material/telehealth-fags/>

Beacon Telehealth Site Coordination

<https://www.beaconhealthoptions.com/material/telehealth-site-coordination/>

CALIFORNIA HEALTH & WELLNESS / HEALTH NET

This section outlines the California Health & Wellness and Health Net's Telehealth Program provisions.

COVERAGE OF TELEHEALTH

Live interactive
Store and forward including eConsult

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 for the following services: Ophthalmologists, Dermatologists, and Optometrists.

POLICY

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

- Member requires services that are usually provided by in a traditional clinical setting.
- Services are authorized by the member's contracting/participating medical group or California Health and Wellness
- The healthcare provider has determined Telehealth Services are appropriate.

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

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: Ophthalmologists, Dermatologists, and Optometrists.

ADDITIONAL RESOURCES

California Health & Wellness Telehealth Policy
<https://www.caltrc.org/reimbursement/california-health-and-wellness/>

California Health & Wellness Website
<https://www.cahealthwellness.com/providers.html>

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

This section outlines the Central California Alliance for Health (CAAH) Telehealth Program provisions and benefits.

COVERAGE OF TELEHEALTH

Live interactive
Store and forward (including eConsult)

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.

The Alliance will pay for asynchronous store and forward services in teledermatology, teleoptometry and teleophthalmology, as long as they meet federal and state guidelines for medical necessity and are covered benefits according to the Alliance member's Evidence of Coverage (EOC).

POLICY

The Alliance provides coverage for telehealth services, as defined above. This service is intended specifically to provide access to specialty services that would otherwise have limited availability. Services may be delivered as asynchronous store and forward or synchronous interaction.

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.

Asynchronous store and forward 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 health care providers may provide store and forward services: Ophthalmologists, Dermatologists, and Optometrists.

The Alliance will pay for services in teledermatology, teleoptometry and teleophthalmology, as long as they meet federal and state guidelines for medical necessity and are covered benefits according to the Alliance member's Evidence of Coverage (EOC). Services provided by telehealth may require a referral from the PCP. =

ADDITIONAL RESOURCES

CAAH Provider Manual
<https://www.caltrc.org/reimbursement/central-california-alliance-for-health/>

CAAH Website
<https://www.ccah-alliance.org/providers.html>

CONTRA COSTA HEALTH PLAN

COVERAGE OF TELEHEALTH

Live interactive
Store and forward

ELIGIBLE MEMBER POPULATIONS

All Contra Costa Health Plan members.

POLICY

Telehealth services may be provided at a physician office, clinic setting, hospital, skilled nursing facility, residential care setting or patient home or other setting.

The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment.

The member has provided verbal or written consent and it is documented in the medical record.

The medical record documentation substantiates the services delivered via telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the covered service.

The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to the patient's own medical information.

The patient is not precluded from receiving in-person health care services after agreeing to receive telehealth services.

ADDITIONAL RESOURCES

Contra Costa Health Plan Provider Manual
<https://www.caltrc.org/reimbursement/contra-costa-health-plan/>

Contra Costa Health Plan Website
<https://cchealth.org/healthplan/>

MAGELLAN

Members must have timely access to appropriate mental health, substance abuse and/or Employee Assistance Program services from an in-network provider 24 hours a day, seven days a week. Telehealth may be an acceptable channel to improve access under certain circumstances. During a natural disaster or national/regional crisis, Magellan follows CMS and state guidance.

COVERAGE OF TELEHEALTH

Live interactive

ELIGIBLE MEMBER POPULATIONS

The Magellan member must have a covered mental health benefit that permits telehealth in order for providers to receive payment for telehealth services.

POLICY

Telecommunications must be the combination of audio and live, interactive video. The provider is responsible for

- Completing and returning Magellan's telehealth services provider attestation.
- Meeting the specific requirements outlined in the telehealth services attestation surrounding the provision of telehealth services, including the ability to provide all telehealth sessions through secure and HIPAA compliant technology.

ADDITIONAL RESOURCES

Magellan Provider Manual

<https://www.caltrc.org/reimbursement/magellan-and-magellan-telehealth-faq/>

Magellan Website

<https://www.magellanprovider.com/>

Magellan Telehealth FAQs

<https://www.magellanprovider.com/education/telehealth.aspx>

MOLINA HEALTHCARE OF CALIFORNIA

COVERAGE OF TELEHEALTH

Live interactive

ELIGIBLE MEMBER POPULATIONS

Molina Members may obtain Covered Services by Participating Providers, through the use of Telehealth and Telemedicine services.

POLICY

Not all participating Providers offer Telehealth services. The following additional provisions apply to the use of Telehealth and Telemedicine services:

- Services must be obtained from a participating Provider
- Services are meant to be used when care is needed now for non-emergency medical issues
- Services are a method of accessing Covered Services, and not a separate benefit
- Services are not permitted when the Member and Participating Provider are in the same physical location
- Services do not include texting, facsimile or email only
- Services include preventive and/or other routine or consultative visits during a pandemic
- Member cost sharing associates to the Schedule of Benefits based upon the participating Provider's designation for Covered Services (i.e., Primary Care, Specialist or other Practitioner)
- Covered Services provided through store-and-forward technology, must include an in-person office visit to determine diagnosis or treatment

Upon at least ten days prior notice to Provider, Molina shall further have the right to a demonstration and testing of Provider telehealth service platform and operations. This demonstration may be conducted either virtually or face-to-face, as appropriate for telehealth capabilities and according to the preference of Molina. Provider shall make its personnel reasonably available to answer questions from Molina regarding telehealth operations.

ADDITIONAL RESOURCES

Molina Health Care of California Provider Manual
<https://www.caltrc.org/reimbursement/molina-healthcare-of-california/>

Molina Website
<https://www.molinahealthcare.com/providers/ca/medicaid/home>

PARTNERSHIP HEALTH PLAN OF CALIFORNIA

Synchronous telehealth services can be provided to PHC members by any PHC credentialed health care provider with the member's verbal consent, as documented in the patient's medical record.

Asynchronous store and forward telehealth services can be provided by the following Medi-Cal certified health care providers: Ophthalmologists, Dermatologists, Optometrists, and Specialists participating in PHC's E-Consult Program.

COVERAGE OF TELEHEALTH

Live interactive
Store and forward including eConsult

ELIGIBLE MEMBER POPULATIONS

All Partnership Health Plan Members

POLICY

PHC fully supports the advancement of telehealth services in our region 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 PHC network. Current PHC referral and authorization requirements apply to telehealth services per policy MCUP3124 Referral to Specialists (Referral Authorization Form [RAF]) Policy.

Synchronous telehealth services can be provided to PHC members by any PHC credentialed health care provider with the member's verbal consent, as documented in the patient's medical record.

Asynchronous store and forward 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: Ophthalmologists, Dermatologists, Optometrists, and Specialists participating in PHC's E-Consult Program

A health care provider at a distant site may bill for an E-consult with the appropriate when the benefits or services delivered meet the procedural definition and components of the national CPT/HCPCS code as defined by the American Medical Association (AMA) or any other extended guideline described in the Medi-Cal provider manual.

ADDITIONAL RESOURCES

Partnership Health Plan Telehealth Policy
<https://www.caltrc.org/reimbursement/partnership-health-plan-of-california/>

Partnership Health Plan Telehealth Service Website
<http://www.partnershiphp.org/Providers/Quality/Pages/Telehealth-Services.aspx>

SAN FRANCISCO HEALTH PLAN

San Francisco Health Plan members can access telehealth services through Teladoc. Teladoc is staffed by California-licensed physicians who can treat for simple medical problems, determine whether patients should seek urgent or emergent services, or instruct patients to seek follow-up care with their regular treating physician. Teladoc physicians can prescribe some medications, but not controlled substances.

COVERAGE OF TELEHEALTH

Live interactive

ELIGIBLE MEMBER POPULATIONS

All San Francisco Health Plan member, except those assigned to Kaiser.

POLICY

SFHP encourages providers to inform SFHP members about the availability of free telehealth (via video or telephone) consultations through Teladoc® when triage and screening within 30 minutes is not possible. Teladoc® physicians can prescribe some medications, but not controlled substances. Eligible SFHP members can receive care within 30 minutes, 24 hours a day, 7 days a week. A one-time registration and health history questionnaire via telephone or online is required.

ADDITIONAL RESOURCES

San Francisco Health Plan Provider Manual
<https://www.caltrc.org/reimbursement/san-francisco-health-plan/>

San Francisco Health Plan Website
<https://www.sfhp.org/providers/>

TRICARE WEST

TRICARE covers the use of secure video conferencing to provide medically and psychologically necessary services to beneficiaries at home. Specific technical requirements, outlined in TRICARE Policy Manual, Chapter 7, Section 22.1, must be met.

COVERAGE OF TELEHEALTH

Live interactive
Store and forward

ELIGIBLE MEMBER POPULATIONS

All TriCare West members

POLICY

Telehealth services may be synchronous (two-way audio and video, such as real-time video) or asynchronous (one direction at a time, such as submitting medical history from one party to another).

Services provided via telemedicine follow the same approval criteria and limitations that apply to in-person medical and psychological services. You do not need a new or separate approval to render already-authorized services via telemedicine.

ADDITIONAL RESOURCES

TriCare West Telehealth Policy
<https://www.caltrc.org/reimbursement/tricare-and-additional-information/>

Tricare West Telemedicine Billing Tips
https://www.tricare-west.com/content/hnfs/home/tw/prov/claims/billing_tips/telemedicine.html

FEDERALLY QUALIFIED HEALTH CENTERS 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/RHCs are patient and/or provider sites for the delivery of telehealth services. Telehealth can improve patient access to primary care, specialty care, and reduce travel hardships when needed services are far away. These valuable healthcare resources have played an important role in the development of telehealth in California.

One of the most commonly asked questions of the CTRC is about allowable billing for telehealth services by an FQHC/RHC. CTRC has worked with many rural clinic administrators and payors to clearly identify the different reimbursement scenarios and the payment rules that surround each scenario. This document has been developed with input from many different stakeholders, health plans, and clinics themselves.

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 and RHCs operating in California under the Prospective Payment System (PPS) or All Inclusive Rate (AIR). 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 distant or provider site is the billing site
- A contracted provider can, under certain circumstances, enter the four walls virtually using telehealth

The factors that determine the billing scenario are:

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

MEDICARE

Please refer to the Traditional Medicare section of this guide. In general, an FQHC/RHC is allowed to be an originating site for Medicare when the clinic is in an eligible geographic location and the patient is receiving services from a distant site provider while physically present within the 4 walls of the clinic.

FEE-FOR-SERVICE MEDI-CAL

Fee-For-Service Medi-Cal has developed specific policies for FQHCs and RHCs that differ from the other provider types. First, let us address a few definitions that will help to clarify the policies we will be diving in to in a bit.

HHMS: Homeless, Homebound, Migratory, or Seasonal Worker.

Homebound: means the patient must have a normal inability to leave home and leaving home must require considerable and taxing effort due to either:

1. An illness or injury where
 - a. There is a need for the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; or
 - b. The use of special transportation; or
 - c. The assistance of another person in order to leave their place of residence.
2. Having a documented condition such that leaving his or her home is medically contraindicated.

Homeless: Shall include all individuals who do not reside in a permanent residence, who do not have a fixed home, or mailing address.

Migratory or seasonal worker: An individual who meets the definition of migratory agricultural worker in Section 330(g)(3)(A) of the Public Health Service Act or seasonal agriculture worker in Section 330(g)(3)(B) of the Public Health Service Act.

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

1. The patient has a health record with the FQHC or RHC that was created, or updated, during a visit that occurred in the clinic within the previous 3 years; or
 - a. During a synchronous telehealth visit in a patient's residence or home with a clinic provider and a billable provider at the FQHC or RHC. The patient's health record must have been created or updated within the previous three years.
2. The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit, occurring within the last three years, that was provided outside the FQHC or RHC clinic, but within the FQHCs or RHCs service area. All consent for telehealth services for these patients must be documented.
3. The patient is assigned to the FQHC or RHC by their Managed Care Plan (MCP) pursuant to a written agreement between the plan and the FQHC or RHC.

Synchronous Live Video Telehealth Services:

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

1. FQHCs and RHCs may bill for an office visit if it is medically necessary for a billable provider to be present with a patient during the telehealth visit.
2. An FQHC or RHC billable provider furnishes services as a distant site.
3. FQHCs and RHCs must submit claims for telehealth services using the appropriate all-inclusive billing code sets and related claims submission requirements.

Telehealth to the patient's home:

FQHCs/RHCs are allowed to provide live video telehealth services to the patient home, however, the following conditions will be in place:

1. The patient must be an established patient and either homeless, homebound, or a migratory or seasonal worker.
2. The FQHC or RHC may bill its PPS rate for services provided outside the Four Walls. The FQHC or RHC must maintain documentation demonstrating that the person is homeless, homebound, or a migratory or seasonal worker. The FQHC or RHC shall meet all of the following requirements:
 - a. The visit must be at the patient's residence or current location for homeless patients. For RHCs, a patient's residence is the only location outside the Four Walls of an RHC that is eligible for visits to be reimbursed at the RHC's PPS rate.
 - b. The person rendering the service must be employed or under contract with the FQHC or RHC at the time the services are rendered.
 - c. Services must be rendered within the FQHC's Health Resources and Services Administration's (HRSA) approved service area.

Asynchronous Store and Forward Services:

Reimbursement is permitted for an established patient for teleophthalmology, teledermatology and teledentistry, and furnished by a billable provider at the distant site.

BILLING AND REIMBURSEMENT

Originating site and transmission fees:

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

Synchronous Live Video:

1. If the Originating Site and the Distant Site are FQHCs or RHCs that are part of the same organization, only one site may bill for the visit, even if a billable provider participates at each location.
2. If the Originating Site and the Distant Site are both FQHCs or RHCs but are not part of the same organization, both the Originating Site and Distant Site may each bill for the services at their respective PPS rates if both organizations use medically necessary billable providers. The Originating Site shall not compensate the Distant Site for the Telehealth Services rendered.
3. If the Originating Site is an FQHC or RHC and the Distant Site is not an FQHC or RHC, only the Originating Site can be reimbursed for the Telehealth Service at the PPS rate if a medically necessary billable provider is used. The Originating Site is responsible for reimbursing the Distant Site for the Telehealth Service rendered to its Established patient if a payment arrangement exists.
4. If the Originating Site is not an FQHC or RHC and the Distant Site is a FQHC or RHC, the Distant Site can be reimbursed for the Telehealth Service at the PPS rate. The Originating Site shall not compensate the Distant Site for the Telehealth Services.

Asynchronous Store and Forward:

An FQHC or RHC may bill at its PPS rate for store and forward ophthalmology, dermatology, and dentistry services provided to its established patient.

If the Distant Site is not an FQHC or RHC, the following requirements must be met for the Originating Site FQHC or RHC to be reimbursed at the PPS rate:

- a. Only one visit can be reimbursed at the PPS rate regardless of the services rendered at the Originating Site.
- b. The Originating Site FQHC or RHC must have an arrangement or current written agreement with the Distant Site to furnish the Store and Forward Services.
- c. The Originating Site FQHC or RHC must compensate the Distant Site for the Store and Forward Services furnished to its patients.
- d. The Distant Site must not directly bill Medi-Cal for the Store and Forward Services.

MEDI-CAL MANAGED CARE

Not all Medi-Cal Managed Care Plans in the state reimburse for telehealth services. You can find the policies for a few of these plans in other sections of the Reimbursement Guide. The CTRC strives to include as many Managed Care Plan policies as possible. In the absence of a policy, please reach out to your specific plans Provider Relations department to inquire about telehealth services.

For those Managed Care Plans that do reimburse for telehealth services, many of them do not have the same restrictions for FQHCs and RHCs as Fee-For-Service Medi-Cal. For example, an FQHC may be able to see a patient who is located in their home, via telehealth, and bill their PPS rate to the plan, regardless of the patient being HHMS.

Keep in mind that if a Managed Care Plan allows an FQHC to provide telehealth services to the patient's home without restrictions, Fee-For-Service Medi-Cal will NOT pay the wrap unless the patient is HHMS!

It is also important to keep contracting in mind when working with your Managed Care Plan around telehealth. As an FQHC, some Managed Care Plans will allow you to be both Distant Site and Originating Site. It is important to be sure that your FQHC is contracted correctly with the plan and that your rates are loaded into the claims system correctly.

FQHC AND RHC REIMBURSEMENT MODELS

The application of some of the factors we have discussed are described in the following fourteen scenarios. While this section has addressed Med-Cal specifically, Medicare scenarios have been added to help FQHC and RHC providers understand their billing options.

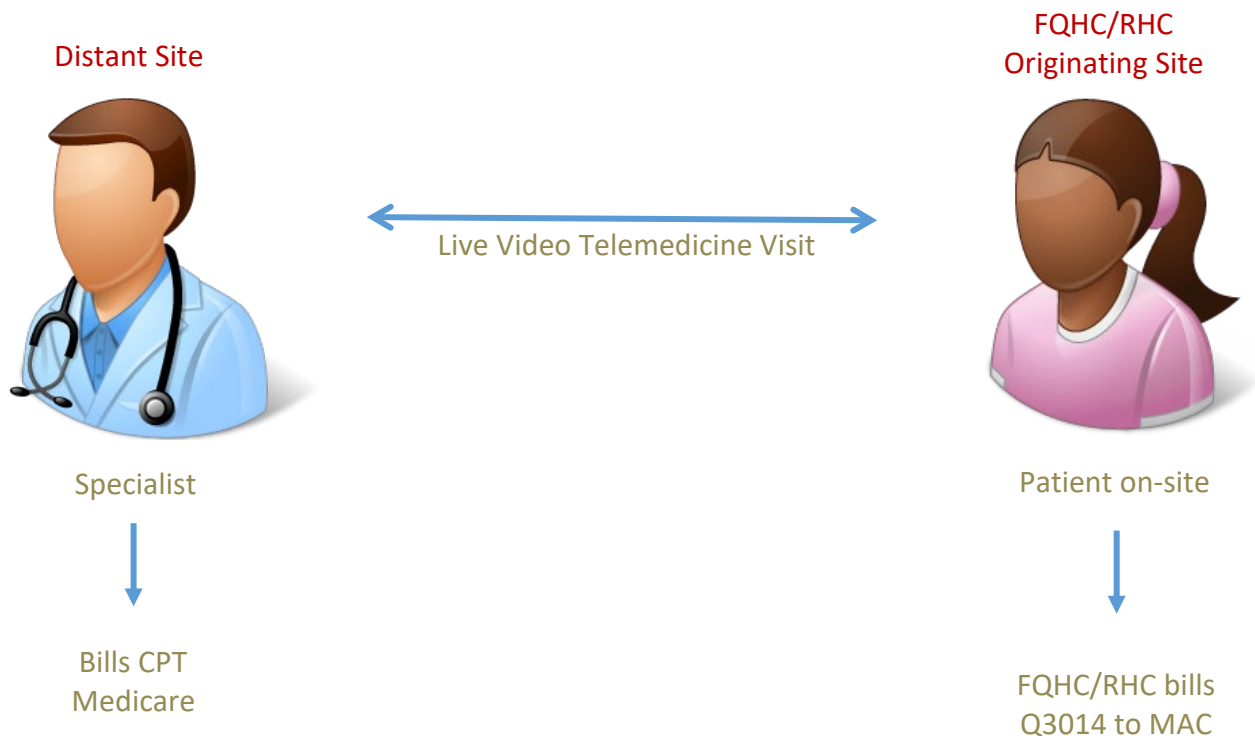
MEDICARE – TRADITIONAL TELEHEALTH LIVE VIDEO VISIT FQHC/RHC Originating Site to a Distant Site

Scenario 1

- Patient is physically present at the FQHC/RHC located **in an eligible location**.
- Specialist is a Medicare provider not physically present at the FQHC/ RHC.
- FQHC/RHC and specialist have an agreement to provide services, but the FQHC/RHC does not compensate the specialist.
- No medical reason for a provider to be present with the patient at the FQHC/RHC Site.

Outcome

- Medicare specialist is the Distant Site and can bill Medicare for a visit.
- FQHC/RHC is the Originating Site, did not provide an in person medical service, and cannot bill PPS for a face-to-face. However, the FQHC/RHC can bill an Originating Site fee to the Medicare Administrative Contractor (MAC).



MEDICARE VIRTUAL VISIT Patient (off-site) to an FQHC/RHC

Scenario 2

- Provider is physically located at and receives compensation from FQHC/RHC.
- Patient is not physically present at FQHC/RHC. In this example we will use the patient's home.
- Patient is an established patient and initiates a live video or phone call to see if they need to come in to the FQHC/RHC for an in person visit.
- FQHC billable provider spent at least 5 minutes talking to patient.
- Patient has NOT been seen for an E/M code in the previous 7 days, and the appointment does not lead to an in person visit within the next 24 hours or soonest available appointment.

Outcome

- FQHC or RHC can bill for the Virtual Visit Service.

Off-Site Location
(such as the patient's home)



Patient



Patient initiated phone call
or live video call

FQHC or RHC



Provider
(Physician, NP, PA, CNM,
Psychologist, and CSW)



FQHC/RHC bills
G0071 to Medicare

MEDICARE REMOTE EVALUATION Patient (off-site) to an FQHC/RHC

Scenario 3

- Provider is physically located at and receives compensation from FQHC/RHC.
- Patient is not physically present at FQHC/RHC. In this example we will use the patient's home.
- Patient is an established patient and initiates an asynchronous transmission of photos or video to the FQHC/RHC.
- FQHC billable provider evaluated the patient transmitted images or video.
- Patient has NOT been seen for an E/M code in the previous 7 days, and the appointment does not lead to an in person visit within the next 24 hours or soonest available appointment.

Outcome

- FQHC or RHC can bill for the Remote Evaluation service.

Off-Site Location
(such as the patient's home)



Patient



Patient initiated phone call
or live video call

FQHC or RHC



Provider
(Physician, NP, PA, CNM,
Psychologist, and CSW)



FQHC/RHC bills
G0071 to Medicare

MEDI-CAL FEE-FOR-SERVICE

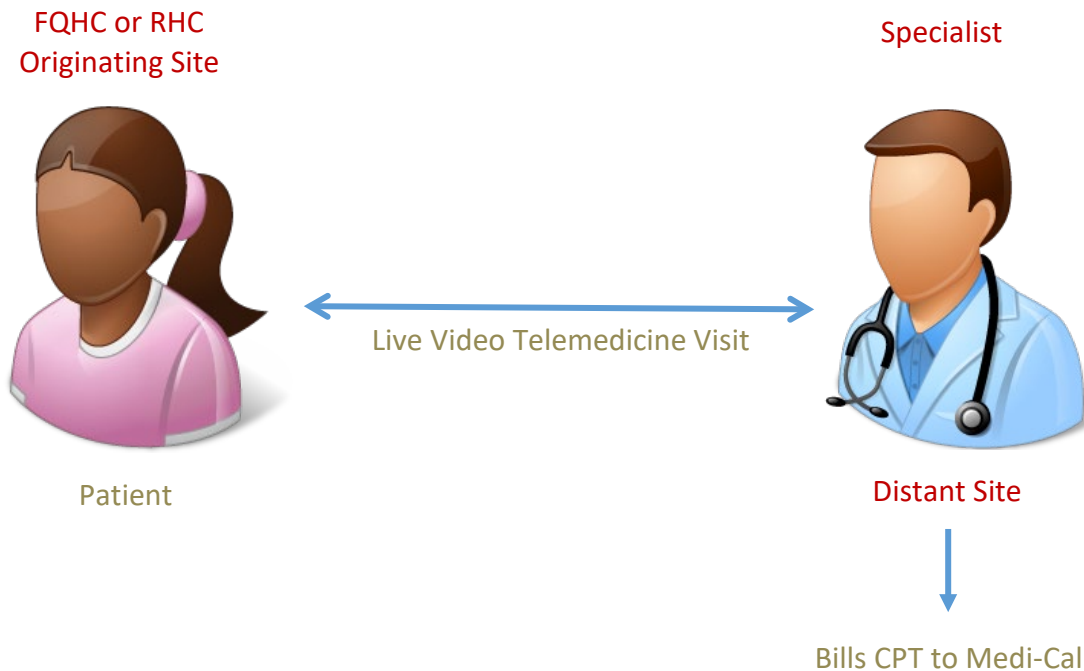
FQHC/RHC Originating Site to a Fee-For-Service Distant Site

Scenario 4

- 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.

Medi-Cal Fee-For-Service FQHC/RHC to FQHC/RHC (Two Different Organizations)

Scenario 5

- Patient is physically present at 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, however FQHC/RHC 1 cannot compensate FQHC/RHC 2.
- No medical reason for a provider to be present with the patient at FQHC/RHC 1.

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.

FQHC/RHC 1
Originating Site



Patient



FQHC/RHC 2
Distant Site



Specialist

Bills PPS

*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

FQHC/RHC (Provider Present) to FQHC/RHC (Two Different Organizations)

Scenario 6

- Patient is physically present at 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/RHC1 cannot compensate FQHC/RHC 2.
- Medical reason for a provider to be present with the patient at FQHC/RHC 1.

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.

FQHC/RHC 1
Originating Site



Patient



PCP

with a medical reason



Live Video Telemedicine Visit

FQHC/RHC 2
Distant Site



Specialist



Bills PPS to Medi-Cal



Bills PPS*

**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 FQHC/RHC to FQHC/RHC (Within Same Organization)

Scenario 7

- Patient is physically present at FQHC/RHC 1.
- Distant Site Provider is physically at, and receives compensation from, FQHC/RHC 2.
- FQHC/RHC 1 and FQHC/RHC 2 have an agreement to provide services and are part of the same organization.
- 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.
- FQHC/RHC 1 is the Originating Site.
- In this scenario, only one FQHC/RHC site may bill since they are part of the same organization.

FQHC/RHC 1
Originating Site



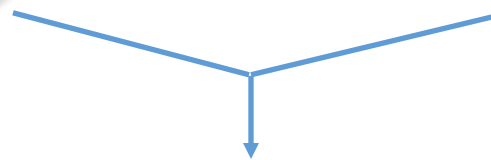
Patient

FQHC/RHC 2
Distant Site



Specialist

Live Video Telemedicine Visit



Only one site may bill PPS

*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

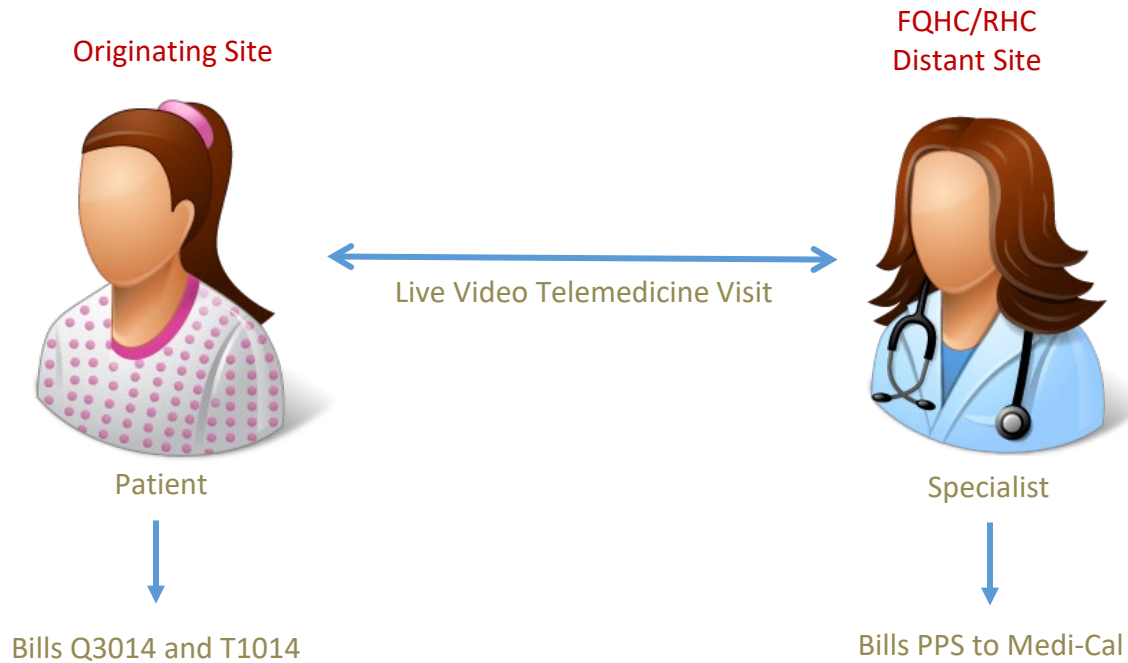
Non FQHC/RHC Originating Site to FQHC/RHC Distant Site

Scenario 8

- 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.



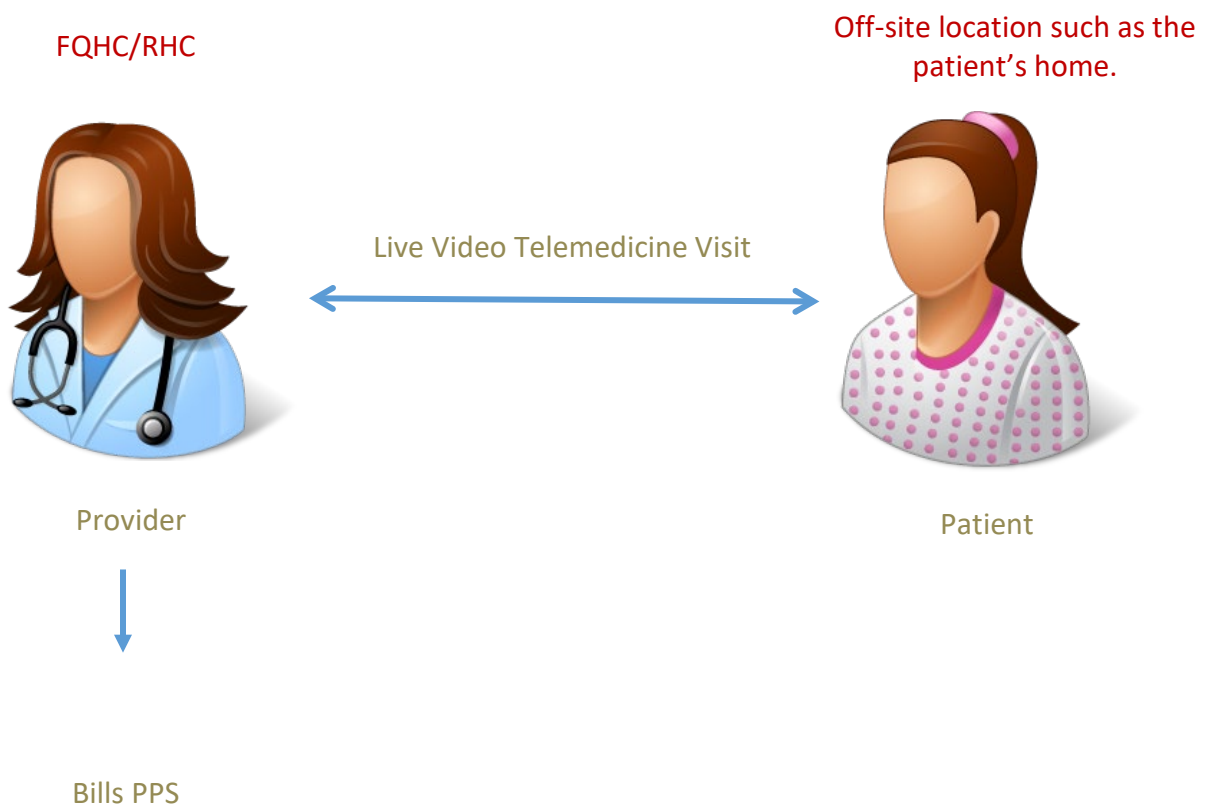
MEDI-CAL FEE-FOR-SERVICE FQHC/RHC to HHMS Patient Home

Scenario 9

- Provider is physically located at and receives compensation from FQHC/RHC.
- Patient is an established patient, and either **homebound, homeless, or a migratory or seasonal worker**.
- Patient is not physically present at FQHC/RHC. In this example we will use the patient's home.

Outcome

- FQHC/RHC is the Distant Site (or Provider Site) and can bill PPS for a face-to-face visit.



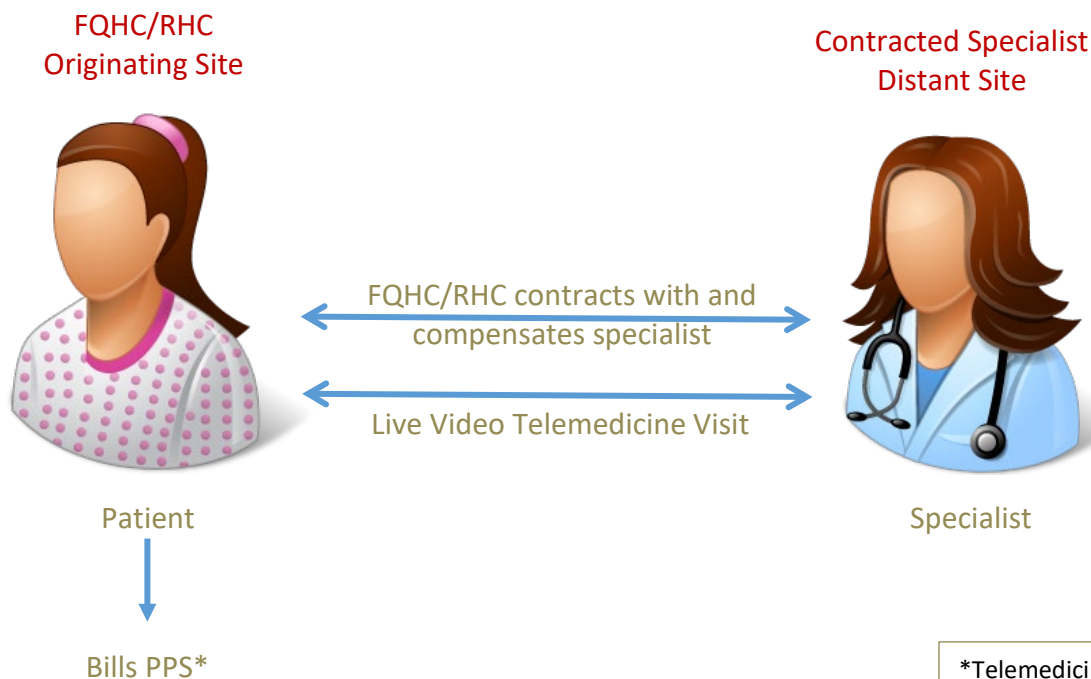
MEDI-CAL FEE-FOR-SERVICE AND MULTIPLE MANAGED CARE PLANS FQHC/RHC Originating Site to Contracted Distant Site

Scenario 10

- 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 AND MULTIPLE MANAGED CARE PLANS FQHC/RHC Originating Site (Provider Present) to a Distant Site

Scenario 11

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

FQHC or RHC
Originating Site



Patient



PCP

with a medical reason



Live Video Telemedicine Visit

Distant Site



Specialist



Bills CPT to MCP
or Fee-For-Service



Bills PPS*

*Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.

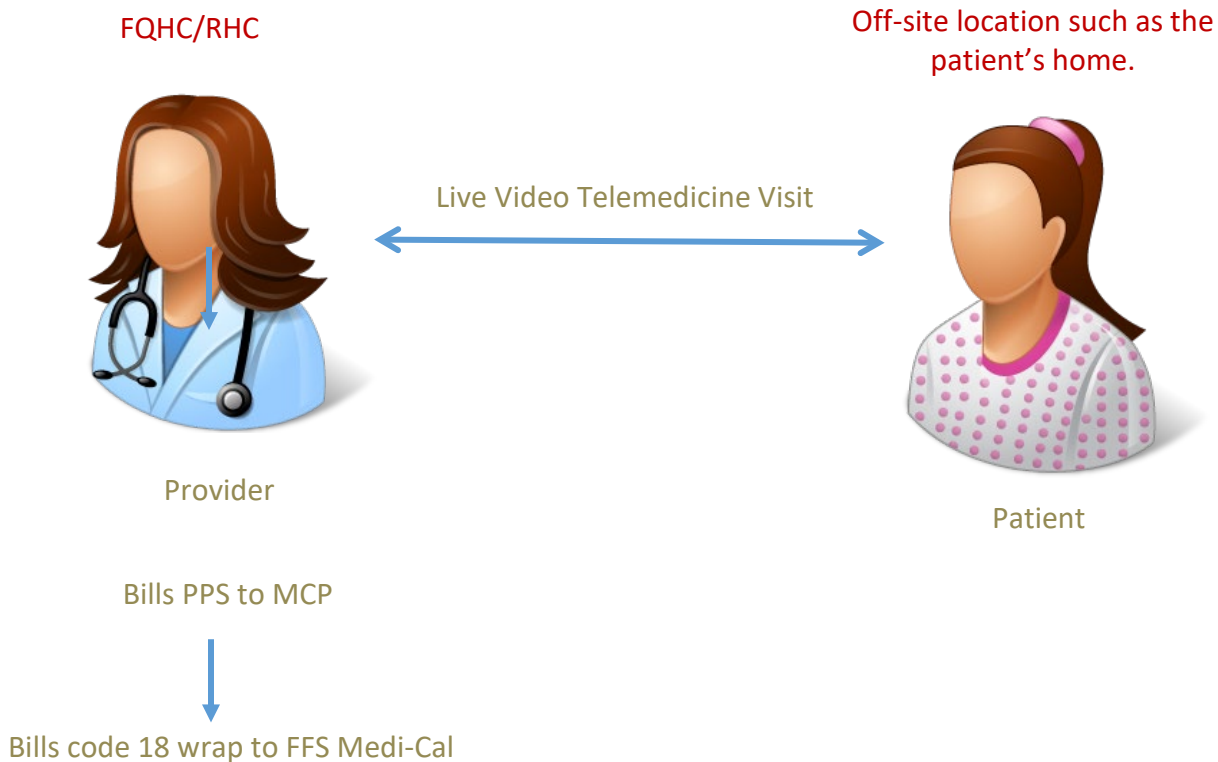
MEDI-CAL MANAGED CARE PLAN (MCP) FQHC/RHC to HHMS Patient Home

Scenario 12

- Provider is physically located at and receives compensation from FQHC/RHC.
- Patient is an established patient, and either **homebound, homeless, or a migratory or seasonal worker**.
- Patient is not physically present at FQHC/RHC. In this example we will use the patient's home.

Outcome

- FQHC/RHC is the Distant Site (or Provider Site) and can bill MCP.
- Patient is homebound, homeless, or a migratory or seasonal worker, therefore the code 18 wrap CAN be billed to the state.



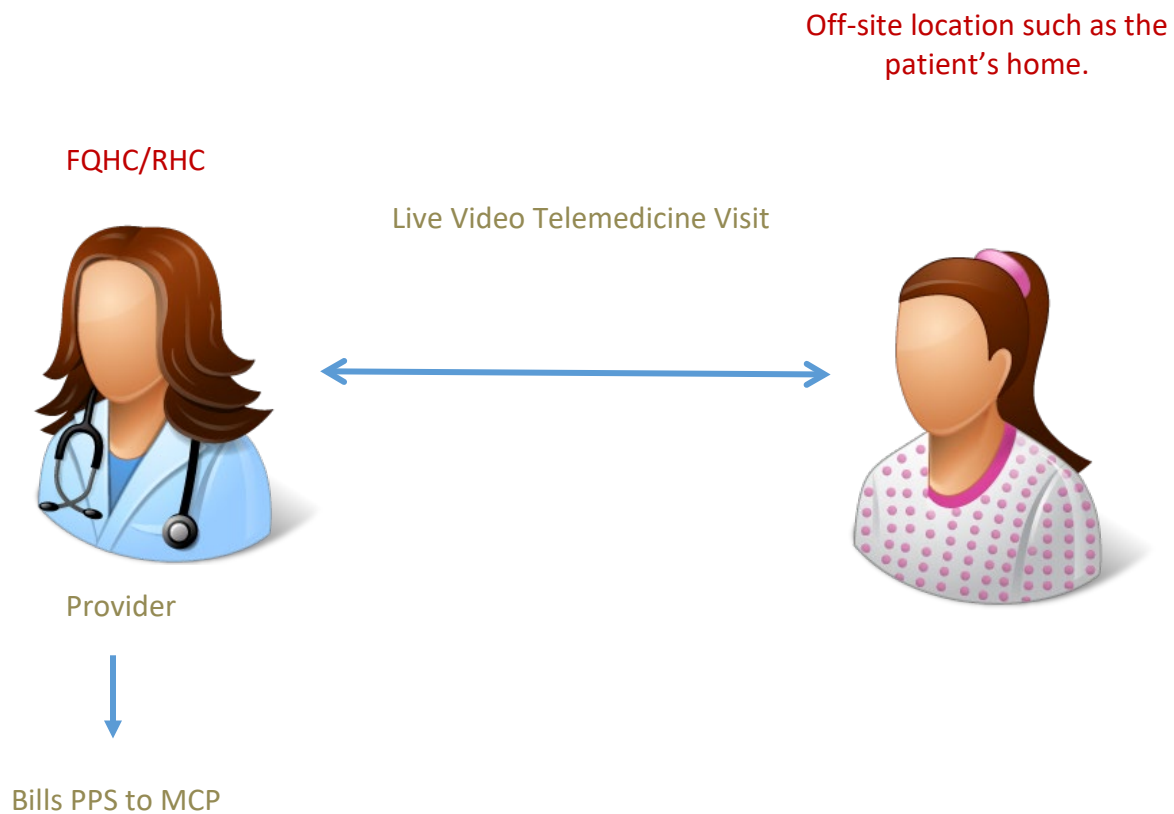
MEDI-CAL MANAGED CARE PLAN (MCP) FQHC/RHC to Non-HHMS Patient Home

Scenario 13

- Provider is physically located at and receives compensation from FQHC/RHC.
- Patient is an established patient but is NOT homebound, homeless, or a migratory or seasonal worker.
- Patient is not physically present at FQHC/RHC. In this example we will use the patient's home.

Outcome

- FQHC/RHC is the Distant Site (or Provider Site) and can bill MCP.
- Patient is not homebound, homeless, or a migratory or seasonal worker, therefore the code 18 wrap CANNOT be billed to the state.



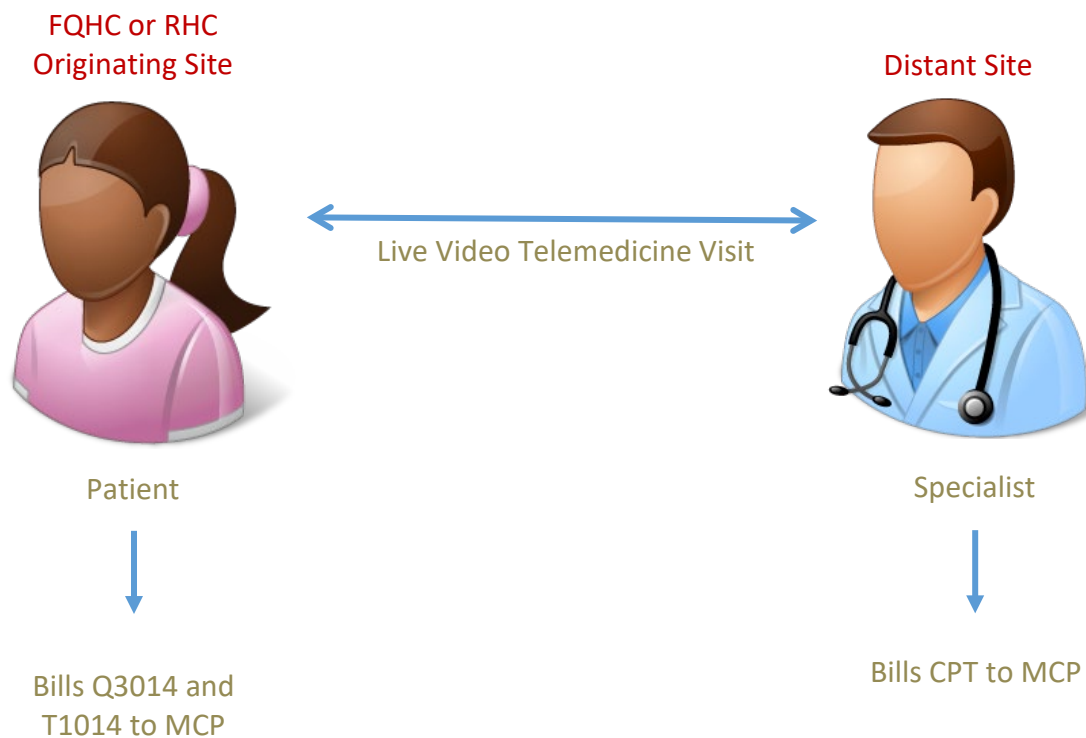
MEDI-CAL MANAGED CARE PLAN (MCP) FQHC/RHC Originating Site to an MCP Contracted Distant Site

Scenario 14

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

Outcome

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



USEFUL REFERENCES

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