Telehealth Reimbursement Guide for California

California

Telehealth Resource Center

2022 Edition

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INTRODUCTIONABOUT CTRC

The California Telehealth Resource Center (CTRC) 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. The CTRC was created to support health care organizations by providing resources, training and technical support to unlock the full potential of telemedicine for both patients and providers. The CTRC's primary focus is on the state of California, we have an in-depth understanding of the unique needs of this region and its populations. CTRC understands the larger health care delivery system and works closely with community organizations, corporate and industry leaders, and policymakers to develop an environment that will support the continued expansion and optimization of virtual care. We give California providers access to evidence-based practices and leading-edge solutions.

WHAT IS TELEHEALTH?

Telehealth is a collection of means or methods for enhancing delivery of health care, public health, and health education services and support using telecommunications technologies to facilitate the diagnosis, consultation, and treatment of a patient's health care while a patient is at one location and a health care provider is at another.

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 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, and home health, among 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 HIT nor HIE are considered telehealth.

ABOUT THIS GUIDE

This guide is intended to help organizations obtain accurate information about telehealth billing and reimbursement programs for most major payors in the state of California. For information about national telehealth billing and reimbursement policies, please refer to the Center for Connected Health Policy (CCHP).

Telehealth service and reimbursement information can become outdated quickly and is often subject to change without notice. CTRC publishes updates to this guide as often as possible and makes the most current version available on our website. CTRC also distributes this guide to our email list. To sign up for CTRC email updates, please visit www.caltrc.org/contact/.

Despite these comprehensive efforts, CTRC may not always be aware of all California payor policies or changes to these policies. It is advisable to directly check periodically with your public, private, and commercial payors to remain current on all telehealth services eligible for reimbursement as well as rates of reimbursement for those services.

Please note: The content provided in this guide does not constitute legal advice. Many factors can impact the successful submission of claims for reimbursement. ***The ability to bill for a service does not necessarily guarantee reimbursement***. CTRC does not guarantee payment for any service. Use the information in this guide in consultation with your billing specialist and other telehealth billing advisers.

GLOSSARY OF COMMON TELEHEALTH TECHNOLOGY TERMS

Virtual Care: This broad term encompasses the full range of digital modes by which health providers remotely interact with patients in the course of delivering care. Similar terms include connected health care. Providers and patients may use a blend of synchronous and asynchronous digital technologies to complement care delivered in person.

Synchronous (Live Audio and/or Video): Two-way digitally transmitted communications in real time between a provider and patient or provider to provider when each is in person in a physically different location. Synchronous technologies may use audiovisual telecommunications solutions such as secure videoconferencing or audio-only telephone communication. Some payors may require certain billable activities to be conducted using both audio and video capabilities, while audio-only technologies may be permitted in other cases.

Asynchronous (Store-and-Forward): Store-and-forward technologies electronic transmit medical information such as secure messages, digital images, lab results, and documents from one practitioner to another to evaluate and provide diagnoses or recommendations later. Store-and-forward methods are standard features of patient portals integrated into electronic health record systems to facilitate secure communication between patients and members of their care team.

eConsult: eConsult services are a type of store-and-forward service by which primary care provider consults with a specialist via electronic messages including lab and imaging results and other information documented in the patient chart. eConsults can expedite a specialist referral when a higher level of care is needed.

Virtual Check-In: Brief services administered in real time between a practitioner and a patient via digital communications technologies such as secure live video, telephone, or online patient portal.

Remote Patient Monitoring/Remote Physiological Monitoring (RPM): RPM describes self-collected patient health and medical data gathered in one location and transmitted via electronic communication technologies to a provider in a different location for use in care and related support. RPMs include digital devices self-administered by patients to monitor a health condition from home. Examples include wireless blood pressure cuffs, glucometers, and continuous glucose meters (CGMs). CMS uses the terminology Remote Physiological Monitoring to describe these activities.

Remote Therapeutic Monitoring/Remote Treatment Management (RTM): RTM describes the self-collection and electronic transmission of patient health information captured with medical devices that track non-physiological data such as medication adherence, responses to medications, or levels of pain.

Direct-to-Consumer or Direct-to-Patient (DTC or DTP): These describe telehealth modes by which a provider engages with patients directly via a live video visit. Generally, the patient participates from the home or another location. These types of visits encompass both clinicians seeing their own patients, or

as well as patients engaging with a telehealth company directly. Direct-to-Patient is often an integrated model that combines the patient exam, diagnosis, treatment, and electronically prescribing medications as needed.

Communication Technology-Based Services (CTBS):

Medicare's Definition of Telehealth

Medicare only includes **virtual care services that have an in-person equivalent** under the umbrella definition of telehealth.

All other reimbursable Medicare services delivered via telehealth technologies are considered to be communication technology-based services (CTBSs). Examples include:

- **Virtual Check-In**: Established patient-initiated secure messaging or transmission of images and/or pre-recorded video via asynchronous store-and-forward methods followed up with a brief phone call or video chat between patient and provider
- **E-Visit**: Asynchronous or synchronous medical evaluation conducted via a patient portal
- **E-Consult**: Interprofessional online consultation

REIMBURSEMENT INFORMATION BY PROGRAM

TRADITIONAL MEDICARE

The Centers for Medicare and Medicaid Services (CMS) published current payment policies, payment rates, and other service provisions in the CY 2022 Medicare Physician Fee Schedule (PFS).

Summary of key provisions effective on or after January 1, 2022:

- Revises telehealth services under the Consolidated Appropriations Act, 2021; allows audio-only communications technology to furnish mental health services in certain circumstances.
- Finalizes recent changes to Evaluation and Management (E/M) visit codes, such as policies for split or shared E/M visits, critical care services, and services furnished by teaching physicians.
- Modifies payment for therapy services furnished in whole or in part by a physical therapist assistant or occupational therapy assistant.
- Updates payment regulation for medical nutrition therapy services.
- Finalizes considerations for vaccine administration services.

Reimbursement for traditional Medicare telehealth has specific criteria for payment that have been updated as of 2022. *Reference the glossary of terms for Medicare's definition of telehealth as well as the designation of communication technology-based services (CTBSs) as it pertains to billable Medicare telehealth services.*

What Types of Credentialed Practitioners are Eligible to Bill for Telehealth Services?

Medicare eligible practitioners:

- Physicians
- Nurse Practitioners (NPs)
- Physician Assistants (PAs)
- Nurse-midwives
- Clinical Nurse Specialists (CNSs)
- Certified Registered Nurse Anesthetists (CRNAs)
- Clinical Psychologists (CPs)*
- Clinical Social Workers (CSWs)*
- Registered Dieticians or Nutritional Professionals
- X-waivered providers supporting SUD/MAT/Opioid Treatment Programs (OTP)

***Note**: 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

What is an Originating Site?

As defined by CMS, an originating site is the location of the Medicaid patient at the time the service being furnished via a telecommunications system occurs

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- **Rural Health Professional Shortage Areas (HPSAs)** are geographic areas within a rural census tract
- Counties located **outside Metropolitan Statistical Areas (MSA)**

For details, reference the CMS Telehealth Services Guide listed under Additional Resources at the end of this section.

How to Identify Eligible Originating Site Locations

Tip: HRSA developed the Medicare Telehealth Payment Eligibility Analyzer, a tool to help providers determine geographic eligibility for Medicare originating site telehealth services.

NOTE: Medicare does not apply originating site geographic conditions to hospital-based and critical access hospital-based renal dialysis centers, renal dialysis facilities, and beneficiary homes when practitioners furnish monthly home dialysis **end-stage renal disease** (ESRD)-related medical evaluations. Independent renal dialysis facilities are not eligible originating sites.

NOTE: As of 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 originating site list to include **rural emergency hospitals**. The Act also requires an in-clinic visit

six months prior in order for a patient to receive **telehealth mental health services in the home**.

Authorized Originating Sites Include:

- Hospitals (inpatient or outpatient)
- Critical Access Hospitals
- Rural Health Clinics
- Federally Qualified Health Centers
- Skilled Nursing Facilities
- Community Mental Health Centers
- Mobile Stroke Units
- Rural Emergency Hospitals
- Hospital-based or critical access hospital-based renal dialysis centers (including satellites)
- Home of a patient for mental health services
  Geographical requirements do not apply if certain conditions are met, including an initial in-person visit with the telehealth provider six months prior to provision of telehealth mental health services
- Home of a patient for:
  - ◊ Monthly end stage renal disease (ESRD)-related clinical assessments
  - ◊ Treatment of a substance use disorder or a co-occurring mental health disorder
  - ◊ The home of a patient who is a

What is a Distant Site?

CMS defines a distant site as where the health care provider is located when providing live, real-time telehealth services via audio and/or visual telecommunications. Providers cannot be located outside of the United States when providing telehealth services. The distant site for the purpose of telehealth can be different from the provider's administrative location. This allows the practitioner to be in a location suitable to conduct telehealth encounters, such as a home office, that is not necessarily in a clinic facility.

BILLING AND REIMBURSEMENT

Originating Site Fee

The originating site is eligible to receive a facility fee for providing services via telehealth. As of January 2022, the payment amount is 80% of the lesser of the actual charge, or $27.59. The site receives a flat reimbursement rate, outside of any other reimbursement arrangements such as inpatient prospective payment systems (IPPS)/diagnosis-related groups (MS-DRGs) under or Rural Health Center (RHC) per-visit payments.

Billing Instructions for Various Originating Site Facilities

Community Mental Health Centers (CMHCs)

- The originating site facility fee does not count toward the number of services used to determine payment for partial hospitalization services.

Critical Access Hospitals (CAHs)

- Traditional Medicare payment amount is 80 percent of the originating site facility fee

FQHCs 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 (AIR).

Medicare Telehealth Billing Reference

- In addition to FQHCs, RHCs, and CAHs, Chapter 12 of the ***Medicare Claims Processing Manual, Section 190*** describes Medicare payment for telehealth services delivered in a variety of originating and distant sites

Distant Site Clinical Services Fees

⚠ **NOTE: A distant site designates 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.**

- Distant Site Clinical Services Fees provide reimbursement to the health professional delivering the clinical service at the same rate 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 site practitioners billing telehealth services under the CAH Optional Payment Method (Method II) will submit institutional claims using the GT modifier.

- Distant sites use Place of Service (POS) 02 (Telehealth) for all encounters.

- Although FQHCs and RHCs are included on the eligible list of facility types that may serve as distant site providers, FQHCs and RHCs are not paid the typical prospective payment system (PPS) or all-inclusive rate (AIR). While these entities may provide services via telehealth under Medicare, they will not be paid a set rate calculated by CMS for each eligible service delivered via telehealth, all of which are billed using HCPCS code G2023. The amount is based on a formula created by CMS.

Telehealth Place of Service (POS) Codes

CMS publishes a list of Place of Service (POS) codes to use on the CMS-1500 Health Insurance Claim Form to indicate where the provider and patient are located during a health encounter. The treatment location affects reimbursement, CPT code categories, and modifiers to use with CPT codes.

Synchronous Services POS Codes

- The **POS 02** code is required to bill for Medicare synchronous telehealth services on billing form CMS 100.
- In 2022, CMS introduced the code **POS 10** for telehealth patients receive when located in their homes.

POS 02: Telehealth Provided Other than in a Patient's Home. This code designates that the place of service where the patient receives health services and health-related services provided via telecommunication

technology is not the patient's home. Policy went into effect 1/1/17. An updated description went into effect 1/1/2022, and is applicable for Medicare as of 4/1/22.

POS 10: Telehealth Provided in a Patient's Home. This code designates the patient's home as the place of service where health services and health-related services are provided or received through telecommunication technology as opposed to locations other than the patient's home such as a hospital, clinic, or other care facility. Effective 1/1/2022, and applicable for Medicare 4/1/2022.

- HCPCS Originating Site Facility Fee Code: **Q3014**
- Type of Service: **9-Other Items and Services**
- Place of Service: **02-Telehealth**
- Bill the Medicare Administrative Contractor (MAC) for the separately billable originating site facility under Medicare Part B

LIST OF MEDICARE TELEHEALTH SERVICES

Effective January 1, 2022
Updated January 5, 2022

Code	Short Descriptor	Status	Audio-only Allowable	Medicare Payment Limitations
0362T	Bhv id suprt assmt ea 15 min	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
0373T	Adapt bhv tx ea 15 min	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
77427	Radiation tx management x5	Temporary Addition for the PHE for the COVID-19 Pandemic		
90785	Psytx complex interactive		Yes	
90791	Psych diagnostic evaluation		Yes	
90792	Psych diag eval w/med srvcs		Yes	
90832	Psytx w pt 30 minutes		Yes	
90833	Psytx w pt w e/m 30 min		Yes	
90834	Psytx w pt 45 minutes		Yes	
90836	Psytx w pt w e/m 45 min		Yes	
90837	Psytx w pt 60 minutes		Yes	
90838	Psytx w pt w e/m 60 min		Yes	
90839	Psytx crisis initial 60 min		Yes	
90840	Psytx crisis ea addl 30 min		Yes	
90845	Psychoanalysis		Yes	
90846	Family psytx w/o pt 50 min		Yes	
90847	Family psytx w/pt 50 min		Yes	
90853	Group psychotherapy		Yes	
90875	Psychophysiological therapy	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		Non-covered service
90951	Esrd serv 4 visits p mo <2yr			
90952	Esrd serv 2-3 vsts p mo <2yr			
90953	Esrd serv 1 visit p mo <2yrs	Available through December 31, 2023		

90954	Esrd serv 4 vsts p mo 2-11			
90955	Esrd srv 2-3 vsts p mo 2-11			
90956	Esrd srv 1 visit p mo 2-11	Available through December 31, 2023		
90957	Esrd srv 4 vsts p mo 12-19			
90958	Esrd srv 2-3 vsts p mo 12-19			
90959	Esrd serv 1 vst p mo 12-19	Available through December 31, 2023		
90960	Esrd srv 4 visits p mo 20+			
90961	Esrd srv 2-3 vsts p mo 20+			
90962	Esrd serv 1 visit p mo 20+	Available through December 31, 2023		
90963	Esrd home pt serv p mo <2yrs			
90964	Esrd home pt serv p mo 2-11			
90965	Esrd home pt serv p mo 12-19			
90966	Esrd home pt serv p mo 20+			
90967	Esrd svc pr day pt <2			
90968	Esrd svc pr day pt 2-11			
90969	Esrd svc pr day pt 12-19			
90970	Esrd svc pr day pt 20+			
92002	Eye exam new patient	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
92004	Eye exam new patient	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
92012	Eye exam establish patient	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
92014	Eye exam&tx estab pt 1/>vst	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
92507	Speech/hearing therapy	Available through December 31, 2023	Yes	
92508	Speech/hearing therapy	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20	Yes	
92521	Evaluation of speech fluency	Available through December 31, 2023	Yes	
92522	Evaluate speech production	Available through December 31, 2023	Yes	
92523	Speech sound lang comprehend	Available through December 31, 2023	Yes	
92524	Behavral qualit analys voice	Available through December 31, 2023	Yes	

92526	Oral function therapy	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 3/30/21		
92550	Tympanometry & reflex thresh	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 3/30/21		
92552	Pure tone audiometry air	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 3/30/21		
92553	Audiometry air & bone	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 3/30/21		
92555	Speech threshold audiometry	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 3/30/21		
92556	Speech audiometry complete	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 3/30/21		
92557	Comprehensive hearing test	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 3/30/21		
92563	Tone decay hearing test	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 3/30/21		
92565	Stenger test pure tone	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 3/30/21		
92567	Tympanometry	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 3/30/21		
92568	Acoustic refl threshold tst	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 3/30/21		
92570	Acoustic immitance testing	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 3/30/21		
92587	Evoked auditory test limited	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 3/30/21		
92588	Evoked auditory tst complete	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 5/10/21		
92601	Cochlear implt f/up exam <7	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
92602	Reprogram cochlear implt <7	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
92603	Cochlear implt f/up exam 7/>	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
92604	Reprogram cochlear implt 7/>	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
92607	Ex for speech device rx 1hr	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 3/30/21		
92608	Ex for speech device rx addl	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 3/30/21		
92609	Use of speech device service	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 3/30/21		
92610	Evaluate swallowing function	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 3/30/21		
92625	Tinnitus assessment	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 3/30/21		
92626	Eval aud funcj 1st hour	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 3/30/21		
92627	Eval aud funcj ea addl 15	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 3/30/21		
93750	Interrogation vad in person	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 10/14/20		
93797	Cardiac rehab	Available through December 31, 2023		

93798	Cardiac rehab/monitor	Available through December 31, 2023		
94002	Vent mgmt inpat init day	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
94003	Vent mgmt inpat subq day	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
94004	Vent mgmt nf per day	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
94005	Home vent mgmt supervision	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		Bundled code
94625	Phy/qhp op pulm rhb w/o mntr	Available through December 31, 2023		
94626	Phy/qhp op pulm rhb w/ mntr	Available through December 31, 2023		
94664	Evaluate pt use of inhaler	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
95970	Alys npgt w/o prgrmg	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 10/14/20		
95971	Alys smpl sp/pn npgt w/prgrm	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 10/14/20		
95972	Alys cplx sp/pn npgt w/prgrm	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 10/14/20		
95983	Alys brn npgt prgrmg 15 min	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 10/14/20		
95984	Alys brn npgt prgrmg addl 15	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 10/14/20		
96105	Assessment of aphasia	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 3/30/21		
96110	Developmental screen w/score	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		Non-covered service
96112	Devel tst phys/qhp 1st hr	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
96113	Devel tst phys/qhp ea addl	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
96116	Nubhvl xm phys/qhp 1st hr		Yes	
96121	Nubhvl xm phy/qhp ea addl hr		Yes	
96125	Cognitive test by hc pro	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 3/30/21		
96127	Brief emotional/behav assmt	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20	Yes	
96130	Psycl tst eval phys/qhp 1st	Available through December 31, 2023	Yes	
96131	Psycl tst eval phys/qhp ea	Available through December 31, 2023	Yes	
96132	Nrpsyc tst eval phys/qhp 1st	Available through December 31, 2023	Yes	
96133	Nrpsyc tst eval phys/qhp ea	Available through December 31, 2023	Yes	
96136	Psycl/nrpsyc tst phy/qhp 1st	Available through December 31, 2023	Yes	

96137	Psycl/nrpsyc tst phy/qhp ea	Available through December 31, 2023	Yes	
96138	Psycl/nrpsyc tech 1st	Available through December 31, 2023	Yes	
96139	Psycl/nrpsyc tst tech ea	Available through December 31, 2023	Yes	
96156	Hlth bhv assmt/reassessment		Yes	
96158	Hlth bhv ivntj indiv 1st 30		Yes	
96159	Hlth bhv ivntj indiv ea addl		Yes	
96160	Pt-focused hlth risk assmt		Yes	
96161	Caregiver health risk assmt		Yes	
96164	Hlth bhv ivntj grp 1st 30		Yes	
96165	Hlth bhv ivntj grp ea addl		Yes	
96167	Hlth bhv ivntj fam 1st 30		Yes	
96168	Hlth bhv ivntj fam ea addl		Yes	
96170	Hlth bhv ivntj fam wo pt 1st	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		Non-covered service
96171	Hlth bhv ivntj fam w/o pt ea	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		Non-covered service
97110	Therapeutic exercises	Available through December 31, 2023		
97112	Neuromuscular reeducation	Available through December 31, 2023		
97116	Gait training therapy	Available through December 31, 2023		
97129	Ther ivntj 1st 15 min	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 3/30/21		
97130	Ther ivntj ea addl 15 min	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 3/30/21		
97150	Group therapeutic procedures	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
97151	Bhv id assmt by phys/qhp	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
97152	Bhv id suprt assmt by 1 tech	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
97153	Adaptive behavior tx by tech	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
97154	Grp adapt bhv tx by tech	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
97155	Adapt behavior tx phys/qhp	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
97156	Fam adapt bhv tx gdn phy/qhp	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
97157	Mult fam adapt bhv tx gdn	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		

97158	Grp adapt bhv tx by phy/qhp	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
97161	Pt eval low complex 20 min	Available through December 31, 2023		
97162	Pt eval mod complex 30 min	Available through December 31, 2023		
97163	Pt eval high complex 45 min	Available through December 31, 2023		
97164	Pt re-eval est plan care	Available through December 31, 2023		
97165	Ot eval low complex 30 min	Available through December 31, 2023		
97166	Ot eval mod complex 45 min	Available through December 31, 2023		
97167	Ot eval high complex 60 min	Available through December 31, 2023		
97168	Ot re-eval est plan care	Available through December 31, 2023		
97530	Therapeutic activities	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
97535	Self care mngment training	Available through December 31, 2023	Yes	
97542	Wheelchair mngment training	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
97750	Physical performance test	Available through December 31, 2023		
97755	Assistive technology assess	Available through December 31, 2023		
97760	Orthotic mgmt&traing 1st enc	Available through December 31, 2023		
97761	Prosthetic traing 1st enc	Available through December 31, 2023		
97802	Medical nutrition indiv in		Yes	
97803	Med nutrition indiv subseq		Yes	
97804	Medical nutrition group		Yes	
99202	Office/outpatient visit new			
99203	Office/outpatient visit new			
99204	Office/outpatient visit new			
99205	Office/outpatient visit new			
99211	Office/outpatient visit est			
99212	Office/outpatient visit est			
99213	Office/outpatient visit est			

99214	Office/outpatient visit est			
99215	Office/outpatient visit est			
99217	Observation care discharge	Available through December 31, 2023		
99218	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic		
99219	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic		
99220	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic		
99221	Initial hospital care	Temporary Addition for the PHE for the COVID-19 Pandemic		
99222	Initial hospital care	Temporary Addition for the PHE for the COVID-19 Pandemic		
99223	Initial hospital care	Temporary Addition for the PHE for the COVID-19 Pandemic		
99224	Subsequent observation care	Available through December 31, 2023		
99225	Subsequent observation care	Available through December 31, 2023		
99226	Subsequent observation care	Available through December 31, 2023		
99231	Subsequent hospital care			
99232	Subsequent hospital care			
99233	Subsequent hospital care			
99234	Observ/hosp same date	Temporary Addition for the PHE for the COVID-19 Pandemic		
99235	Observ/hosp same date	Temporary Addition for the PHE for the COVID-19 Pandemic		
99236	Observ/hosp same date	Temporary Addition for the PHE for the COVID-19 Pandemic		
99238	Hospital discharge day	Available through December 31, 2023		
99239	Hospital discharge day	Available through December 31, 2023		
99281	Emergency dept visit	Available through December 31, 2023		
99282	Emergency dept visit	Available through December 31, 2023		
99283	Emergency dept visit	Available through December 31, 2023		
99284	Emergency dept visit	Available through December 31, 2023		
99285	Emergency dept visit	Available through December 31, 2023		
99291	Critical care first hour	Available through December 31, 2023		
99292	Critical care addl 30 min	Available through December 31, 2023		
99304	Nursing facility care init	Temporary Addition for the PHE for the COVID-19 Pandemic		

99305	Nursing facility care init	Temporary Addition for the PHE for the COVID-19 Pandemic		
99306	Nursing facility care init	Temporary Addition for the PHE for the COVID-19 Pandemic		
99307	Nursing fac care subseq			
99308	Nursing fac care subseq			
99309	Nursing fac care subseq			
99310	Nursing fac care subseq			
99315	Nursing fac discharge day	Available through December 31, 2023		
99316	Nursing fac discharge day	Available through December 31, 2023		
99324	Domicil/r-home visit new pat	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
99325	Domicil/r-home visit new pat	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
99326	Domicil/r-home visit new pat	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
99327	Domicil/r-home visit new pat	Temporary Addition for the PHE for the COVID-19 Pandemic		
99328	Domicil/r-home visit new pat	Temporary Addition for the PHE for the COVID-19 Pandemic		
99334	Domicil/r-home visit est pat			
99335	Domicil/r-home visit est pat			
99336	Domicil/r-home visit est pat	Available through December 31, 2023		
99337	Domicil/r-home visit est pat	Available through December 31, 2023		
99341	Home visit new patient	Temporary Addition for the PHE for the COVID-19 Pandemic		
99342	Home visit new patient	Temporary Addition for the PHE for the COVID-19 Pandemic		
99343	Home visit new patient	Temporary Addition for the PHE for the COVID-19 Pandemic		
99344	Home visit new patient	Temporary Addition for the PHE for the COVID-19 Pandemic		
99345	Home visit new patient	Temporary Addition for the PHE for the COVID-19 Pandemic		
99347	Home visit est patient			
99348	Home visit est patient			
99349	Home visit est patient	Available through December 31, 2023		
99350	Home visit est patient	Available through December 31, 2023		

99354	Prolong e&m/psyctx serv o/p		Yes	
99355	Prolong e&m/psyctx serv o/p		Yes	
99356	Prolonged service inpatient		Yes	
99357	Prolonged service inpatient		Yes	
99406	Behav chng smoking 3-10 min		Yes	
99407	Behav chng smoking > 10 min		Yes	
99441	Phone e/m phys/qhp 5-10 min	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20	Yes	
99442	Phone e/m phys/qhp 11-20 min	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20	Yes	
99443	Phone e/m phys/qhp 21-30 min	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20	Yes	
99468	Neonate crit care initial	Temporary Addition for the PHE for the COVID-19 Pandemic		
99469	Neonate crit care subsq	Available through December 31, 2023		
99471	Ped critical care initial	Temporary Addition for the PHE for the COVID-19 Pandemic		
99472	Ped critical care subsq	Available through December 31, 2023		
99473	Self-meas bp pt educaj/train	Temporary Addition for the PHE for the COVID-19 Pandemic		
99475	Ped crit care age 2-5 init	Temporary Addition for the PHE for the COVID-19 Pandemic		
99476	Ped crit care age 2-5 subsq	Available through December 31, 2023		
99477	Init day hosp neonate care	Temporary Addition for the PHE for the COVID-19 Pandemic		
99478	Ic lbw inf < 1500 gm subsq	Available through December 31, 2023		
99479	Ic lbw inf 1500-2500 g subsq	Available through December 31, 2023		
99480	Ic inf pbw 2501-5000 g subsq	Available through December 31, 2023		
99483	Assmt & care pln pt cog imp			
99495	Trans care mgmt 14 day disch			
99496	Trans care mgmt 7 day disch			
99497	Advncd care plan 30 min		Yes	
99498	Advncd care plan addl 30 min		Yes	
G0108	Diab manage trn per indiv		Yes	

G0109	Diab manage trn ind/group		Yes	
G0270	Mnt subs tx for change dx		Yes	
G0296	Visit to determ ldct elig		Yes	
G0396	Alcohol/subs interv 15-30mn		Yes	
G0397	Alcohol/subs interv >30 min		Yes	
G0406	Inpt/tele follow up 15		Yes	
G0407	Inpt/tele follow up 25		Yes	
G0408	Inpt/tele follow up 35		Yes	
G0410	Grp psych partial hosp 45-50	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		Statutory exclusion
G0420	Ed svc ckd ind per session		Yes	
G0421	Ed svc ckd grp per session		Yes	
G0422	Intens cardiac rehab w/exerc	Available through December 31, 2023		
G0423	Intens cardiac rehab no exer	Available through December 31, 2023		
G0425	Inpt/ed teleconsult30		Yes	
G0426	Inpt/ed teleconsult50		Yes	
G0427	Inpt/ed teleconsult70		Yes	
G0438	Ppps, initial visit		Yes	
G0439	Ppps, subseq visit		Yes	
G0442	Annual alcohol screen 15 min		Yes	
G0443	Brief alcohol misuse counsel		Yes	
G0444	Depression screen annual		Yes	
G0445	High inten beh couns std 30m		Yes	
G0446	Intens behave ther cardio dx		Yes	
G0447	Behavior counsel obesity 15m		Yes	
G0459	Telehealth inpt pharm mgmt		Yes	
G0506	Comp asses care plan ccm svc		Yes	
G0508	Crit care telehea consult 60			

G0509	Crit care telehea consult 50			
G0513	Prolong prev svcs, first 30m		Yes	
G0514	Prolong prev svcs, addl 30m		Yes	
G2086	Off base opioid tx 70min		Yes	
G2087	Off base opioid tx, 60 m		Yes	
G2088	Off base opioid tx, add30		Yes	
G2211	Complex E/M visit add on		Yes	Bundled code
G2212	Prolong outpt/office vis		Yes	
G9685	Acute nursing facility care	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
S9152	Speech therapy, re-eval	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		Not valid for Medicare purposes

CMS EXPANSION OF TELEHEALTH: ADVANCING VIRTUAL CARE

In 2019, CMS put forth new regulations intended to advance greater patient access to care via virtual options using communication technologies.

 NOTE: Some of these services are not considered “traditional telehealth” for Medicare. Therefore, they are not subject to the same restrictions as traditional telehealth services.

Under Virtual Care Programs, CMS will reimburse for the following telehealth services:

- Substance use disorder (SUD) treatment and co-occurring mental health disorders
- Virtual check-ins (remote evaluation of patient-submitted images or pre-recorded video via store-and-forward technologies followed by a 5-10-minute real-time telephone call or video chat between patient and provider)
- E-visits (communications with a provider via a patient portal initiated by established patients)
- eConsults (aka interprofessional online consultations)

Virtual Care Program Reimbursement for FQHCs and RHCs

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. FQHCs and RHCs are not eligible for reimbursement of interprofessional online consultations (eConsult), as the PPS includes all costs associated with a billable visit, including consultations with other practitioners.

SUD Treatment

Effective July 1, 2019, the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT) removed the originating site geographic conditions and added 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 CY 2020 Physician Fee Schedule, Medicare added three bundled payment HCPSCS codes for medication-assisted treatment (MAT) for opioid use disorder (OUD):

- **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).

Virtual Check-In

CMS defines virtual check-ins as the remote evaluation of images or pre-recorded video electronically submitted by an established patient via store-and-forward technologies followed by a brief 5- to 10-minute telephone call or video chat

between the patient and provider to determine if an office visit is necessary.

- Unlike Medicare telehealth visits, which require both audio and visual capabilities for real-time communication, virtual check-ins can be conducted using a broader range of communication methods
- Virtual check-in services can only be billed when the billing practice has an established relationship with the patient.
- This service is not limited to rural settings or certain geographic locations.
- Individual services need to be agreed to by the patient by verbal consent; however, practitioners may educate beneficiaries on the availability of the service prior to patient agreement.

Remote Evaluation of Patient-Submitted Images or Pre-Recorded Video (Store-and-Forward)

- **HCPCS code G2010**: Remote evaluation of recorded video and/or images electronically submitted by an established patient via store-and-forward technologies, including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.

- **FQHCs and RHCs use HCPCS Code G0071**: FQHCs and RHCs may bill for remote evaluation services and brief follow-up (aka Virtual Check-In) when an established patient electronically sends recorded video or images to the FQHC/RHC. Remote evaluation services 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) rate.

Brief (5-10 Minute) Follow-Up Phone Call or Video Chat

- **HCPCS code G2012**: Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

E-Visits

In all types of locations, including the patient's home, and in all geographic areas (not just rural locations), established Medicare patients may use patient portals to initiate E-visits –defined by CMS as non-face-to-face telecommunications with their providers.

E-Visits can only be billed when established patients initiate the communication with a provider. The patient must verbally consent to receive virtual check-in services. Communications pertaining to a single patient query can occur via the portal over a 7-day period.

E-Visits may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable. Medicare coinsurance and deductibles apply to these services.

Medicare Part B reimburses for E-Visits (aka patient-initiated online evaluation and management conducted via a patient portal). Practitioners who may independently bill Medicare for evaluation and management visits (for instance, physicians and nurse practitioners) can bill using the following CPT codes:

- **99421:** Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes
- **99422**: Online digital evaluation and management service, for an established patient, for up to 7 days

cumulative time during the 7 days; 11– 20 minutes
- **99423:** Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes.

Clinicians who may not independently bill for evaluation and management visits (for example – physical therapists, occupational therapists, speech language pathologists, clinical psychologists) can provide care via E-Visits and bill using the following codes:

- **G2061:** Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes
- **G2062:** Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11–20 minutes
- **G2063:** Qualified non-physician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes.

E-Consults (aka Interprofessional Internet Consultation)

E-consults (aka interprofessional internet consultations) are defined by CMS as instances when an established patient's treating physician or provider uses the telephone, internet, electronic health record, or other means of telecommunications to consult with a specialty provider on diagnosis, treatment or care management advice without requiring face-to-face contact between the patient and consulting provider.

Please note that FQHCs and RHCs are not permitted to bill for E-consults (aka interprofessional internet consultations) because the AIR and PPS includes all costs associated with a billable visit, including consultations with other practitioners.

E-consult requirements and billing codes are as follows:

- Patient verbal consent and acknowledgement of cost sharing is required
- E-consults are limited to practitioners who can independently bill Medicare for E/M visits
- E-consults are billed using the following CPT 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 healthcare 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 healthcare 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 healthcare professional, 30 minutes

Chronic Care Management (CCM) / Primary Care Management (PCM)

Chronic Care Management

Chronic care management refers to services furnished between office visits for patients with two or more chronic conditions that are expected to continue for at least a year into the future or until the patient's death. These conditions place the patient at significant risk of death, acute exacerbation/decompensation or functional decline. Examples of eligible chronic conditions include asthma, diabetes, depression, hypertension, and HIV/AIDS. CCM services are typically not delivered face-to-face.

An initiating visit is required prior to CCM services for new patients or a patient the provider has not seen within the last year.
Billing providers who furnish extensive assessment and care planning beyond the typical CCM initiating visit may use the one-time add-on billing code **HCPCS G0506.** Providers must obtain written or verbal patient consent for CCM services before billing for these services.

Consult the CMS Chronic Care Management Services Fact Sheet under Additional Resources at the end of this section for details about concurrent billing rules.

Practitioners eligible to bill for CCM services include physicians and the following non-physician practitioners:

- Certified Nurse Midwives (CNMs)
- Clinical Nurse Specialists (CNSs)
- Nurse practitioners (NPs)
- Physician Assistants (PAs)

Use the following CPT codes for care that meets CCM criteria:

Only use these CPT codes for time **spent by the billing practitioner**.

- **99491**: At least 30 minutes of Chronic Care Management (CCM) services per calendar month **furnished personally by a physician or other qualified health care provider** that meet the following qualifying elements:
    - Two or more chronic conditions expected to last at least 12 months or until the death of the patient
    - Chronic conditions place patient at significant risk of death, exacerbation/decompensation, or functional decline
    - Comprehensive plan is established, implemented, revised, or monitored
- **99437:** Each additional 30 minutes of Chronic Care Management (CCM) **furnished personally by a physician or other qualified health care provider** for conditions that meet the same qualifying elements as CPT **99491.** (List this code separately in addition to primary procedure.)
- **99487**: At least 60 minutes of **complex** Chronic Care Management (CCM) services per calendar month **furnished personally by a physician or other qualified health care provider** that meet the following qualifying elements:
    - Two or more chronic conditions expected to last at least 12 months or until the death of the patient
    - Chronic conditions place patient at significant risk of death, exacerbation/decompensation, or functional decline
    - Establishment or substantial revision of comprehensive care plan
    - Moderate to high-complexity decision making

Use these CPT codes for time spent **by clinical staff under supervision of the billing provider** on an incident to basis.

- **99489**: Each additional 30 minutes of complex Chronic Care Management (CCM) services per calendar month **furnished by clinical staff under the supervision of a physician or other qualified health care provider** on top of the 60 minutes of complex CCM services furnished in a given month directly by the provider under CPT **99487.** (List this code separately in addition to primary procedure code.)
- **99490**: Chronic Care Management (CCM) services for at least 20 minutes of care per calendar month **furnished by clinical staff under the supervision of a physician or other qualified health care provider** for conditions that meet the same qualifying elements as CPT **99491.** (99490 assumes 15 minutes of work per month by the billing practitioner)
- **99439** (as of 2022, this add-on code replaces G2058): Each additional 20 minutes of Chronic Care Management (CCM) services **furnished by clinical staff under the supervision of a physician or other qualified health care provider** after the initial 20 minutes per calendar month of CCM billed under CPT **99490.** (List this code separately in addition to primary procedure code.)

Reference the FQHC and RHC section of this guide for details about billable CCM and Transitional Care Management (TCM) services.

Remote Physiological Monitoring / Remote Therapeutic Monitoring

Under the Chronic Care Management program, CMS defines remote physiological monitoring as physiological data such as blood pressure readings or blood glucose levels that are collected, digitally stored, and/or transmitted by the patient and/or caregiver to the Home Health agency furnishing skilled services in the patient's home.

Note: Remote physiological monitoring is only reimbursable when reported as a service in the provision of another skilled service such as Home Health services.

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

Remote Physiological Monitoring CPT codes are as follows:

- **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.
- **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.
- **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.
- **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.

CPT codes for Remote Therapeutic Monitoring/Treatment Management are available to reimburse for patients using medical devices that track non-physiological data such as medication adherence, responses to medications, or levels of pain.

Remote Therapeutic Monitoring CPT codes are as follows:

- **98975:** Remote therapeutic monitoring (e.g. respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment
- **98976**: Remote therapeutic monitoring (e.g. respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g. daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 day
- **98977**: Remote therapeutic monitoring (e.g. respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g. daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days
- **98980**: Remote therapeutic monitoring treatment, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes
- **98981**: Remote therapeutic monitoring treatment, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; each additional 20 minutes

Principal Care Management

The CMS Principal Care Management (PCM) program payment and coding structure recognizes that considerable time is often required to manage one chronic condition (aka a principal condition).

Under the PCM program, CMS requires the practitioner billing for PCM in the patient's medical record to document all ongoing communication and care coordination between all practitioners furnishing care to the beneficiary.

Use the following CPT codes for care that meets the PCM criteria. As of 2022, these codes replace CPT codes **G2064** and **G2065**:

- **99424**: Principal Care Management (PCM) services for the first 30 minutes per calendar month of care **furnished personally by a physician or other qualified health care provider** for a single high-risk disease with the following qualifying elements:
    - One complex chronic condition expected to last at least 3 months, which is the focus of the care plan
    - Condition is of sufficient severity to place patient at risk of hospitalization, exacerbation/decompensation, functional decline, or death
    - Condition requires development, monitoring or revision of disease- specific care plan
    - Condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities
    - Condition requires frequent and ongoing communication and care coordination between practitioners furnishing care
- **99425**: Each additional 30 minutes after the initial 30 minutes per calendar month of Principal Care Management (PCM) services **furnished personally by a physician or other qualified health care provider** for a single high-risk disease with the same qualifying elements as CPT **94924**. (List this code separately in addition to primary procedure code.)

- **99426:** Principal Care Management (PCM) services for the first 30 minutes per calendar

month of care **furnished by clinical staff under the supervision of a physician or other qualified health care provider** for a single high-risk disease with the following qualifying elements:

- One complex chronic condition expected to last at least 3 months, which is the focus of the care plan
- Condition is of sufficient severity to place patient at risk of hospitalization, exacerbation/decompensation, functional decline, or death
- Condition requires development, monitoring or revision of disease- specific care plan
- Condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities
  Condition requires frequent and ongoing communication and care coordination between practitioners furnishing care

Additional Resources

CMS Telehealth Services Fact Sheet
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf

CMS Chronic Care Management Services Fact Sheet
https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

CMS Rural Health Center Fact Sheet
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralHlthClinfctsht.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

- UnitedHealthcare uses the same billing codes as Medicare for services. See the Medicare section of this manual for detailed information on program restrictions.
- UnitedHealthcare 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.
- UnitedHealthcare recognizes the home as an originating site for telehealth services.
- UnitedHealthcare designates therapy providers as eligible distant site providers.

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 **UnitedHealthcare Designated Virtual Network 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 furnished by AmWell and Doctor on Demand.

Virtual Visits are not appropriate for treating all medical conditions. 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
Telehealth | UHCprovider.com

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, licensure for providers who are certified by the Behavior Analyst Certification Board 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 programs requirements

Covered Services

Synchronous: Live Video

- Health care providers must use interactive audio, video, or data telecommunications systems that permit real-time communication between the health care provider at the distant site and the patient at the originating site.
- The audio-video telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through telehealth.
- The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.
- 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.
- The E&M service must be in real-time or near-real-time (i.e., a 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.
- 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.

Asynchronous: Store-and-Forward

- Asynchronous store-and-forward describes the electronic transmission of a patient's medical information from an originating site to a secure repository where it is stored until which time that it is accessed by a 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 services include but are not limited to teleophthalmology, teledermatology, teledentistry, teleradiology and must meet the following requirements:

    - 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

    - 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.

eConsults

- eConsults 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 eConsult 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:

    - The distant site provider (consultant) saw the patient within the last 14 days.
    - The eConsult 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 eConsult request, the entirety of the service and cumulative discussion and information review time should be reported only once.

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 comparable in-person services.
- 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.

Notes to Providers

- 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.
- Health care providers are no longer required to document a barrier to an in-person visit (W&I Code, Section 14132.72[d]).
- Health care providers at the distant site are no longer required to document cost-effectiveness of telehealth to be reimbursed.

Medi-Cal Provider Documentation Requirements for eConsult
The **health care provider at the originating site** must create and maintain the following:

- A record that the eConsult is the result of patient care that has occurred or will occur and relates to ongoing patient management
- A record of a request for an eConsult by the health care provider at the originating site

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
- 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 healthcare 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 Sites)

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 Sites)

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

- Licensed in the state of California
- Enrolled as a Medi-Cal provider
- Located in California or reside in a border community *
- A health care provider who is part of a group with an office physically located in California; but may reside outside California.

* Border communities
  - Oregon: Ashland, Brookings, Cave Junction, Grants Pass, Jacksonville, Klamath Falls, Lakeview,

Medford, Merrill

- Nevada: Carson City, Henderson, Incline Village, Minden, Reno, Sparks, Zephyr Cove
- Arizona: Bullhead City, Kingman, Lake Havasu City, Parker, Yuma

Billing and Reimbursement

Place of Service Codes

- **Health care providers are required to document Place of Service (POS) 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**.

Additional Place of Service Codes

- **Independent Clinic (POS49)** designates a clinic that is not a part of a hospital and is for outpatient treatment. The employees in this type of practice will be able to act under general or direct supervision of the treating practitioner who is managing patients' care. This means "incident to" billing can occur, which can impact on remote physiological monitoring (RPM) codes and billing for some chronic care management (CCM) services. This can be an originating site for Medicare service if eligible under HRSA guidelines as well as a distant site. Remote Physiological Monitoring and CCM do not fall under geographical restrictions as they are not telehealth.
- **Off-campus Outpatient Hospital Clinic (POS19):** designates a type of clinic that employs staff who do not have a direct relationship with the ordering physicians.

Modifiers

- Only bill services rendered from the distant site 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 synchronous store-and-forward services, including eConsult

Originating Site Fee

- Bill for originating site fees with code: **Q3014**
- Originating 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 2022, the payment amount is $27.59.

Transmission Fee: Live Interactive

- To bill for the live interactive transmission fee, 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-and-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
- The benefits or services provided via telehealth meet all laws regarding confidentiality of healthcare information and a patient's right to his or her medical information.

Medi-Cal removed all telehealth-specific CPT and HCPCS codes from their policy, instead allowing providers to utilize telehealth as an appropriate modality for care for any clinical condition deemed appropriate by the provider and coding in the same manner as they would for a face-to-face visit.

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: 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

- Medicaid: COVID-19 Screening and Testing
- Medicaid: Telehealth and Virtual Communication
- Medicaid: Narcotic Treatment Program
- Medicaid: Behavioral Health Information Notice 20-009
- Medicaid: Behavioral Health Information Notice 20-031
- Medicaid: Behavioral Health Information Notice 20-055
- Medicaid: State Plan Amendment
- Medicaid 1135 Waiver: Medi-Cal 2020
- Medicaid 1915(c) Waiver: Multiple Section Flexibilities
- Medicaid 1915(c) Waiver: Appendix K HCBS Waiver
- Medicaid 1915(c) Waiver: Appendix K Assisted Living Waiver

- Medicaid 1915(c) Waiver: Appendix K HIV/AIDS

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. Enrolled Denti-Cal billing providers may submit documents for services rendered utilizing teledentistry.

The goal of teledentistry is to:

- Allow Medi-Cal providers to practice teledentistry as defined to mean the digital transmission of medical information to be reviewed at a later time, or in real time, by a licensed dental provider at a distant site
- 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 by **CDT code D9996**.
- However, CDT code D9996 is not reimbursable. The billing dental provider is 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 lists eligible teledentistry 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 the health care provider believes the service is clinically appropriate, live transmissions can be conducted and are reimbursable. Live transmission teledentistry claims for synchronous care encounters delivered via telephone or live video chat are identified using CDT code D9995.

- Live transmissions are limited to 90 minutes per member per provider, per day, at a rate of $.24/minute
- 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.
- CDT code D9995 is for Medi-Cal patient-initiated contact with a Medi-Cal dental provider

This code is not used to bill for:

- Dental assistant time
- Dental hygienist time
- Provider-initiated calls to the patient
- Time spent contacting pharmacies on a patient's behalf.

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 enrolled in FFS Medicaid (if there is a path of enrollment)
- Providers will be reimbursed at the same rate as a standard office visit if the service is the same, regardless of care delivery modality.

Coverage of Telehealth

Live interactive

Eligible Member Populations

All Aetna Better Health of California Members

Policy

To offer telehealth services, Aetna providers must comply with the following:

- Maintain documentation of either verbal or written patient consent for the use of telehealth
- Comply with all state and federal laws regarding the confidentiality of health care information
- Patient rights to their own medical information applies to telehealth interactions
- 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 supports 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 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

Available to Anthem Medi-Cal members at no cost, the Bright Heart Health Medication Assisted Treatment (MAT) program for opioid use disorder and alcohol use disorder is a website and mobile application that gives members 24/7 access to opioid addiction treatment via virtual Substance Use Disorder (SUD) treatment programs. Bright Heart Health provides discrete outpatient treatment programs via smartphone, 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) that administrates the behavioral health benefits for some Medi-Cal Managed Care Plans.

Coverage of Telehealth

Live interactive

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 to enable members to be seen in their homes by a licensed clinician using a smartphone, laptop, or tablet. Members must be screened by a member services representative before a referral 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-faqs/

CALIFORNIA HEALTH & WELLNESS / HEALTH NET

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 ophthalmology, dermatology, and optometry.

Policy

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

- Member requires services that are usually provided in a traditional clinical setting
- Services are authorized by the member's contracting/participating medical group or California Health &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 (CCAH)

Coverage of Telehealth

- Live interactive
- Store-and-forward (including eConsult)

Policy

The Alliance provides coverage for telehealth services as defined above. These services are intended specifically to provide access to specialty care that would otherwise be limited. Services may be delivered via asynchronous store-and-forward or synchronous interaction. Services provided by telehealth may require a referral from the primary care provider.

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.

Ophthalmologists, dermatologists, and optometrists may provide store-and-forward services.

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

Additional Resources

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

CCAH 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, 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 that the services delivered via telehealth meet the procedural definitions and components of the CPT or HCPCS code(s) associated with the covered services.

The services provided via telehealth meet all laws regarding confidentiality of healthcare 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 (EAP) 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 via 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 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 (e.g., 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 the 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 (PHC)

Coverage of Telehealth

- Live interactive
- Store and forward including eConsult

Eligible Member Populations

All Partnership Health Plan of California 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 perMCUP3124 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 can be provided by the following Medi-Cal certified health care providers: ophthalmologists, dermatologists, optometrists, and specialists participating in PHC's eConsult program.

A health care provider at a distant site may bill for an eConsult with the appropriate code 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 (SFHP)

SFHP members can access telehealth services through Teladoc®.

Coverage of Telehealth

Live interactive

Eligible Member Populations

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

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.

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.

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.

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

Coverage of Telehealth

- Live interactive
- Store-and-forward
-

Eligible Member Populations

All TriCare West members

Policy

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

Telehealth services may be synchronous (live, real-time two-way audio and video) or asynchronous (store-and-forward).

Services provided via telemedicine follow the same approval criteria and limitations that apply to in-person medical and psychological services. A new or separate approval to render each instance of already-authorized services via telemedicine is not required.

Additional Services

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 and RURAL HEALTH CLINICS

ADD INFO RE: CCM https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

Federally Qualified Health Centers (FQHC) And Rural Health Clinics (RHC) play a critical role in the provision of primary care to 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 section includes illustrated examples of common reimbursement scenarios that have been developed with input from many different stakeholders including health plans and clinics.

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.

Many factors 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 of the distant site virtually using telehealth

Other factors to consider include:

- Where the patient is physically located at the time of the visit (aka the originating site)
- 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 four walls of the FQHC or RHC.

As of 2022, FQHCs and RHCs are permitted to bill for Chronic Care Management (CCM) and Transitional Care Management (TCM) services for the same patient during the same time period.

Fee-for-Service Medi-Cal

Fee-for-Service Medi-Cal has developed specific policies for FQHCs and RHCs that differ from policies for other types of providers.

Glossary of Terms

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:

- An illness or injury where
  - There is a need for the aid of supportive devices such as crutches, canes, wheelchair, or walker; or
  - The use of special transportation; or
  - The assistance of another person in order to leave their place of residence.
- 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:

- 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
- 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.
- 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 FQCHs or RHCs service area.
- All consent for telehealth services for these patients must be documented.

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.

CMS issued the CY 2022 Medicare Physician Fee Schedule (PFS) final rule that updates payment policies, payment rates, and other provisions for services. See a summary of key provisions, effective on or after January 1, 2022:

- Revises telehealth services under the Consolidated Appropriations Act, 2021; allows use of audio-only communications technology when furnishing mental health services in certain circumstances.
- Finalizes recent changes to Evaluation and Management (E/M) visit codes, such as policies for split (or shared) E/M visits, critical care services, and services furnished by teaching physicians.
- Modifies payment for therapy services furnished in whole or in part by a Physical Therapist Assistant or Occupational Therapy Assistant.
- Updates a payment regulation for Medical Nutrition Therapy services.
- Finalizes considerations for vaccine administration services.

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.

- 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.
- An FQHC or RHC billable provider furnishes services as a distant site.
- 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, given the following conditions are in place:

- The patient must be an established patient and either homeless, homebound, or a migratory or seasonal worker.
- 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:

- 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.
- The person rendering the service must be employed or under contract with the FQHC or RHC at the time the services are rendered.
- Services must be rendered within the FQHC's Health Resources and Services Administration's (HRSA) approved service area.

Note: These restrictions do not apply to telehealth services for mental health, substance abuse, and chronic conditions as defined by CMS

Asynchronous Store-and-Forward Services: Reimbursement is permitted for an established patient for ophthalmology, dermatology, and dentistry, and is 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:

- 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.
- 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.

- 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.
- 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:

- Only one visit can be reimbursed at the PPS rate regardless of the services rendered at the Originating Site.
- 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.
- The Originating Site FQHC or RHC must compensate the Distant Site for the Store and Forward Services furnished to its patients.
- 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 Billing and Reimbursement Guide. The CTRC strives to include entries for as many managed care plan policies as possible. In the absence of a policy, please reach out to your specific plan's 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. Some managed care plans permit FQHCs to be both the 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.

For additional information related to managed care plans in California, please contact them directly. If you are not sure what managed care plan services are available in your county, please see the list of plans at the end of this guide.

FQHC AND RHC REIMBURSEMENT MODELS

The following fourteen scenarios illustrate examples issues encountered in FQHC and RHC billing and reimbursement. While this section primarily addresses Medi-Cal, it also finds information to assist FQHC and RHC providers to understand Medicare billing options.

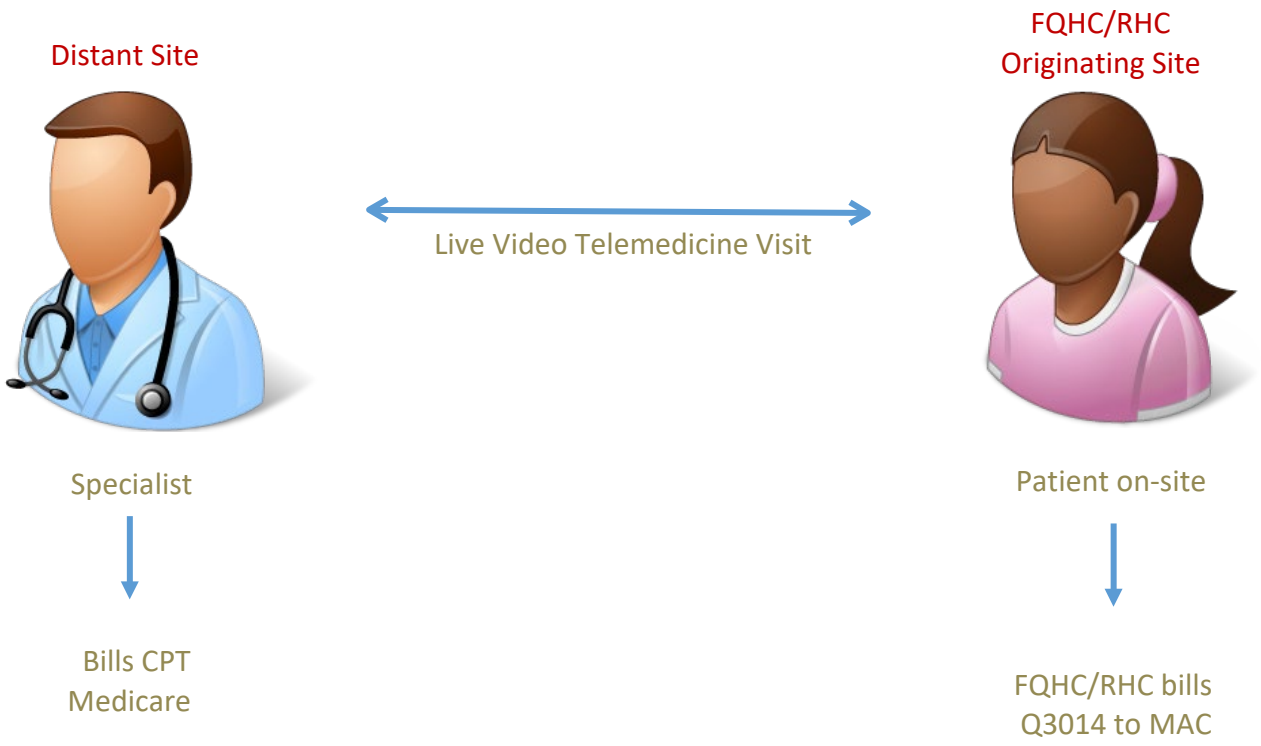
MEDICARE – TRADITIONAL TELEHEALTH LIVE VIDEO VISIT
FQHC/RHC Originating Site to a Distant Site

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).



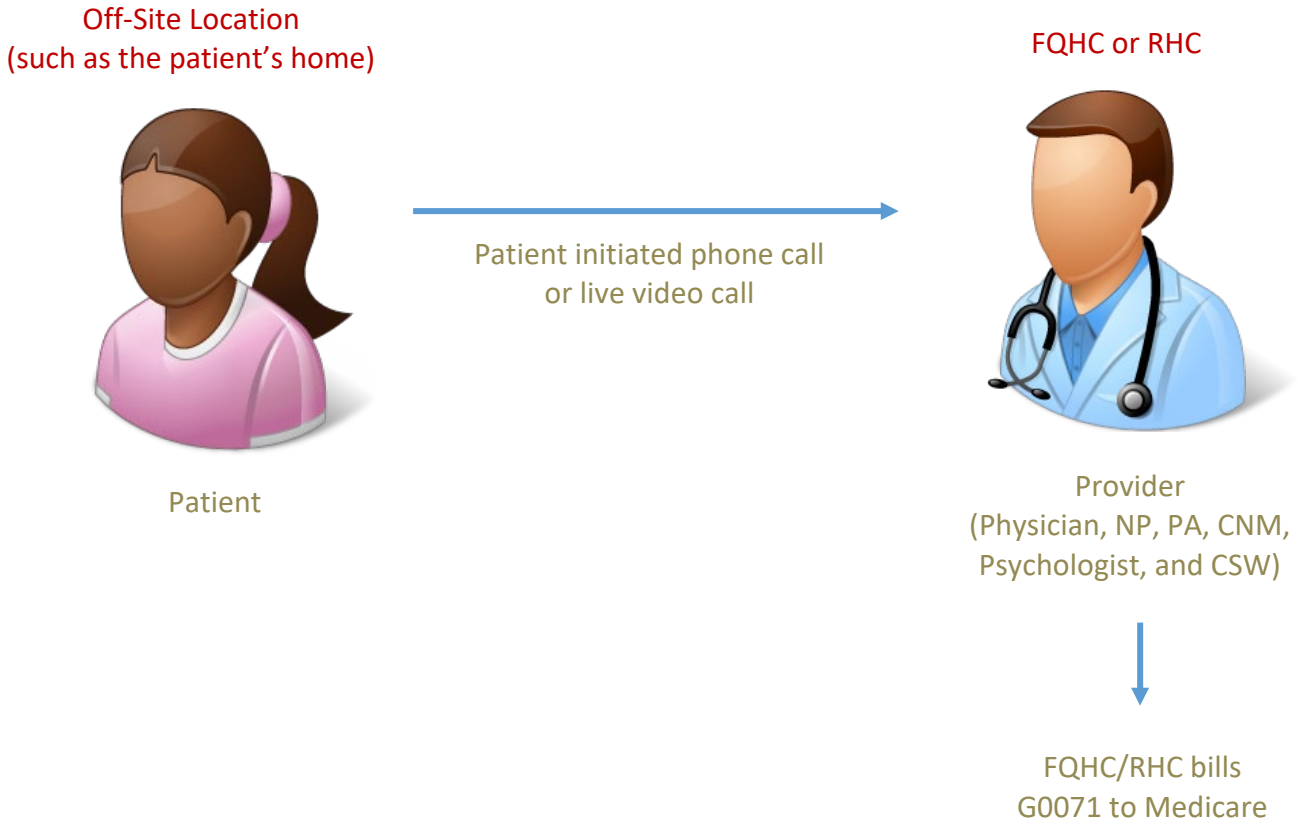
MEDICARE VIRTUAL VISIT
Patient (off-site) to an FQHC/RHC

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.



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

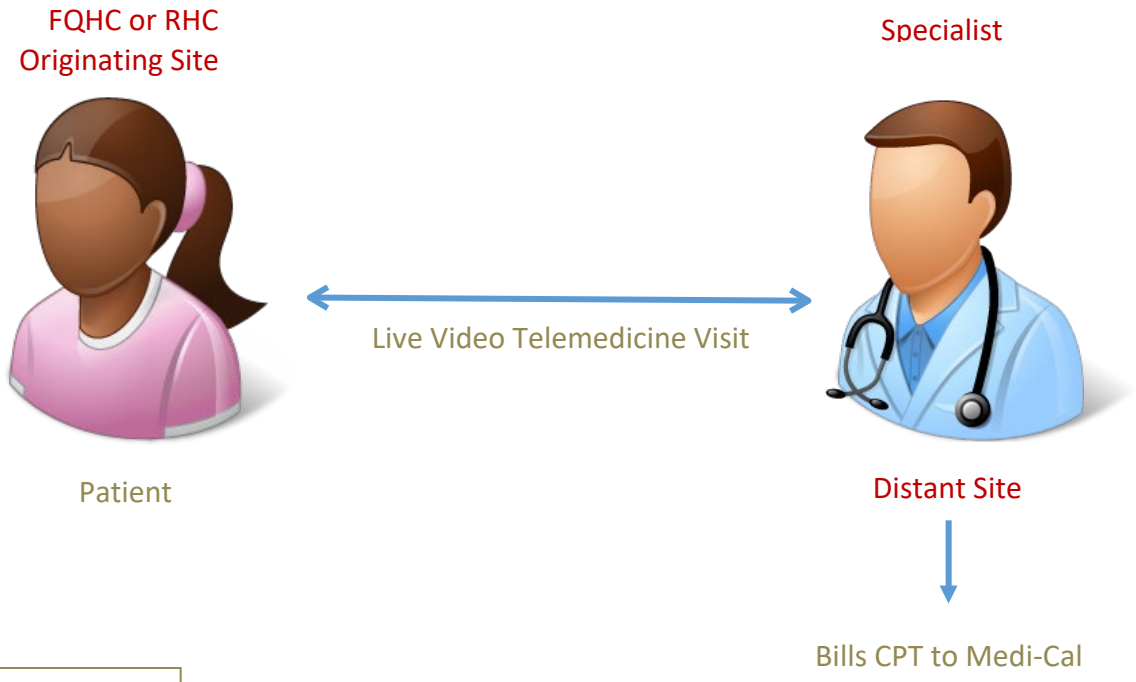
MEDI-CAL FEE-FOR-SERVICE
FQHC/RHC Originating Site to a Fee-For-Service Distant Site

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.

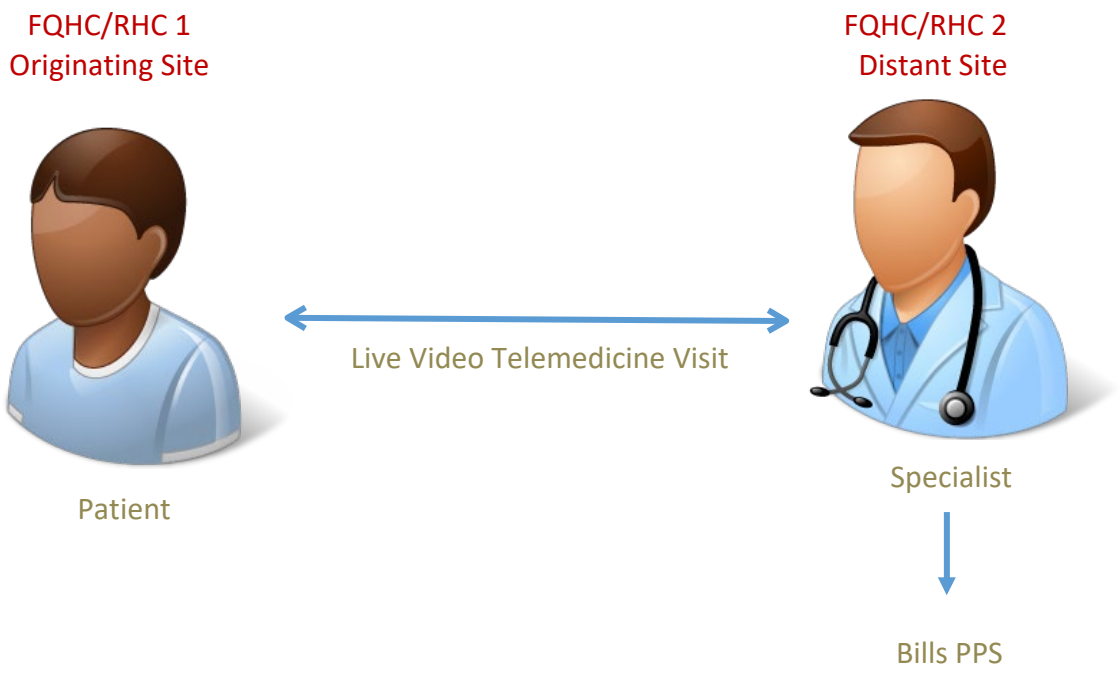
Medi-Cal Fee-For-Service
FQHC/RHC to FQHC/RHC (Two Different Organizations)

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.



*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.*

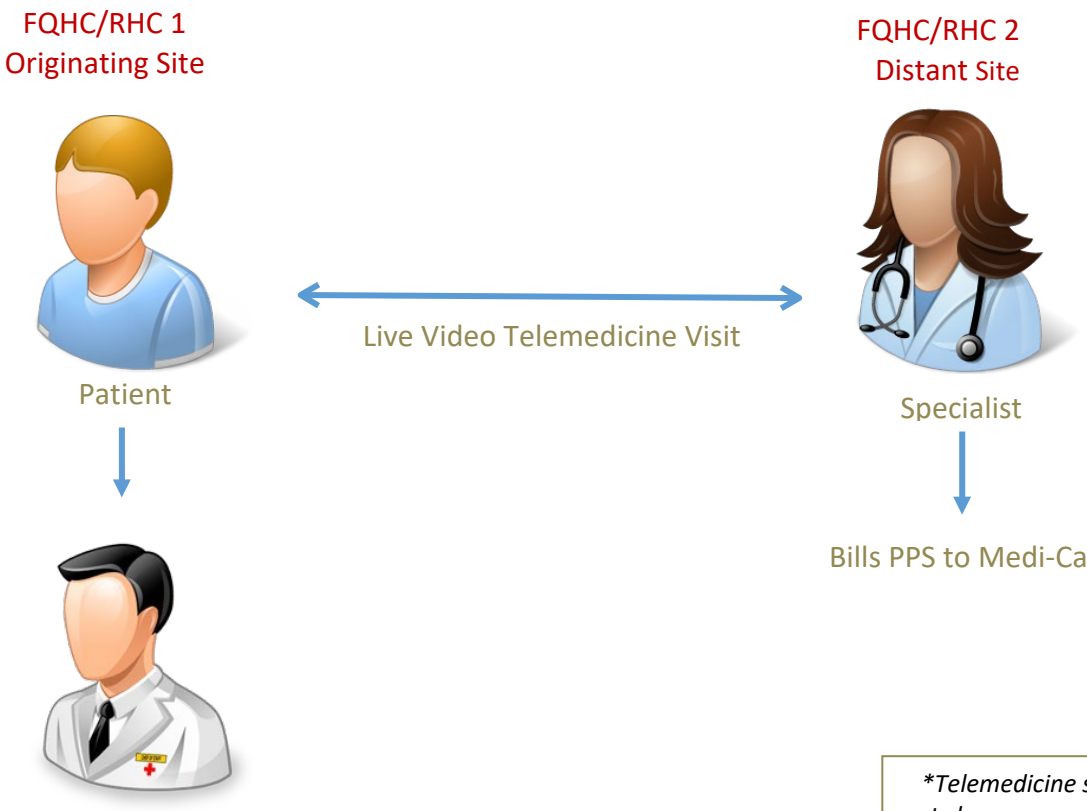
MEDI-CAL FEE-FOR-SERVICE
FQHC/RHC (Provider Present) to FQHC/RHC (Two Different Organizations)

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.



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

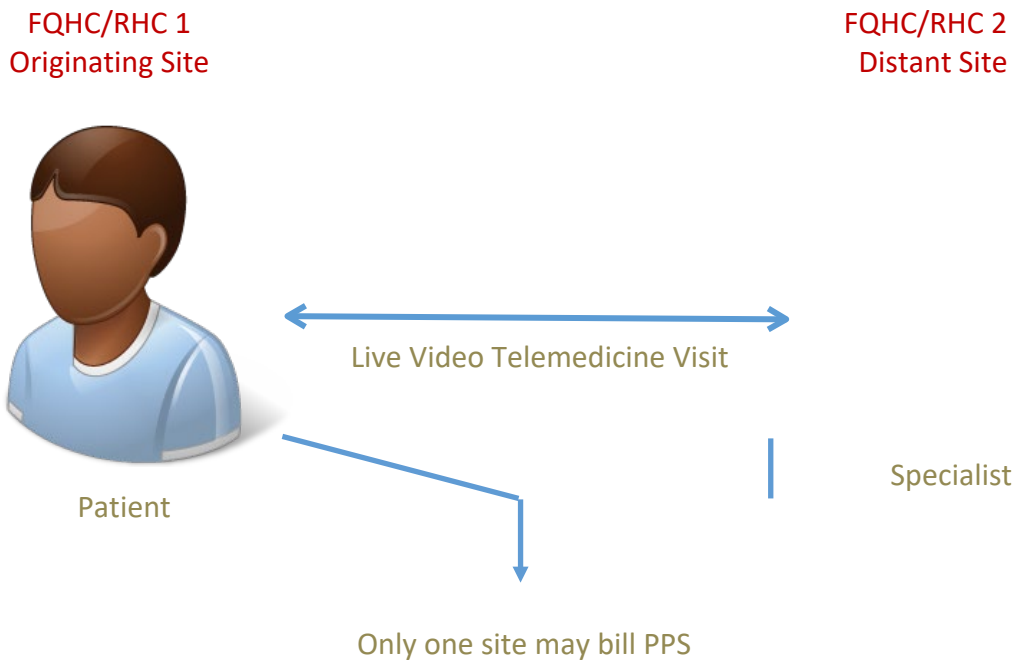
MEDI-CAL FEE-FOR-SERVICE
FQHC/RHC to FQHC/RHC (Within Same Organization)

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.



*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

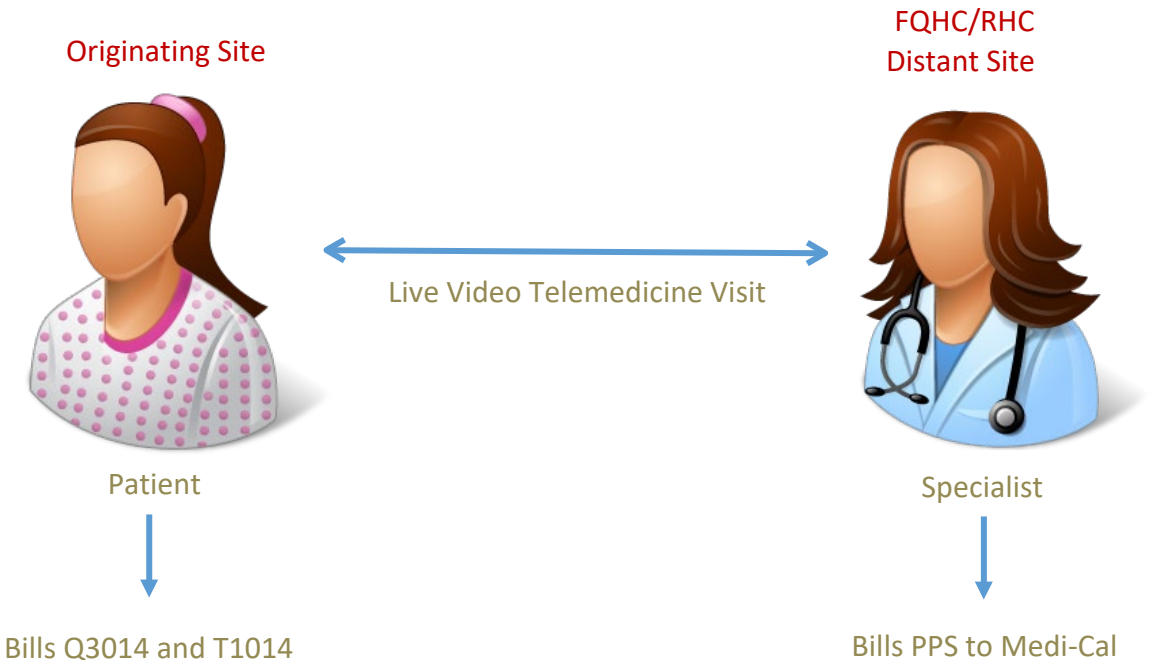
Scenario 8

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.



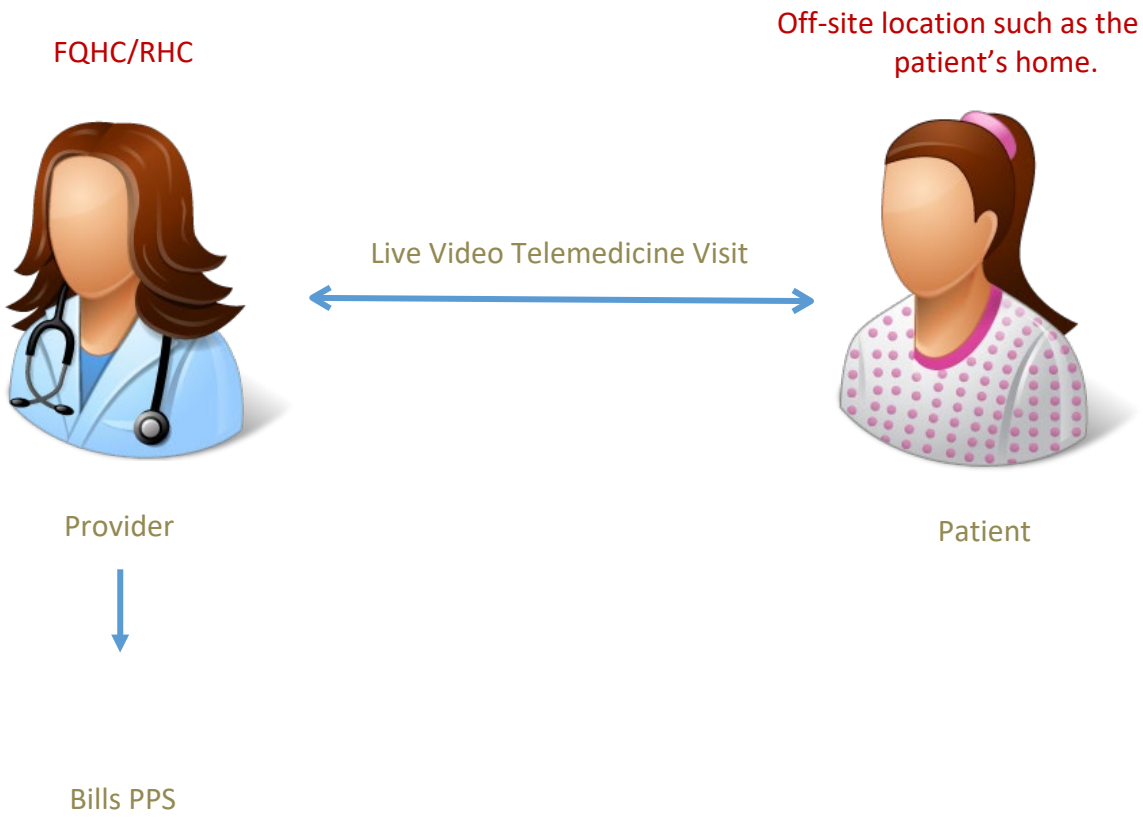
MEDI-CAL FEE-FOR-SERVICE
FQHC/RHC to HHMS Patient Home

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

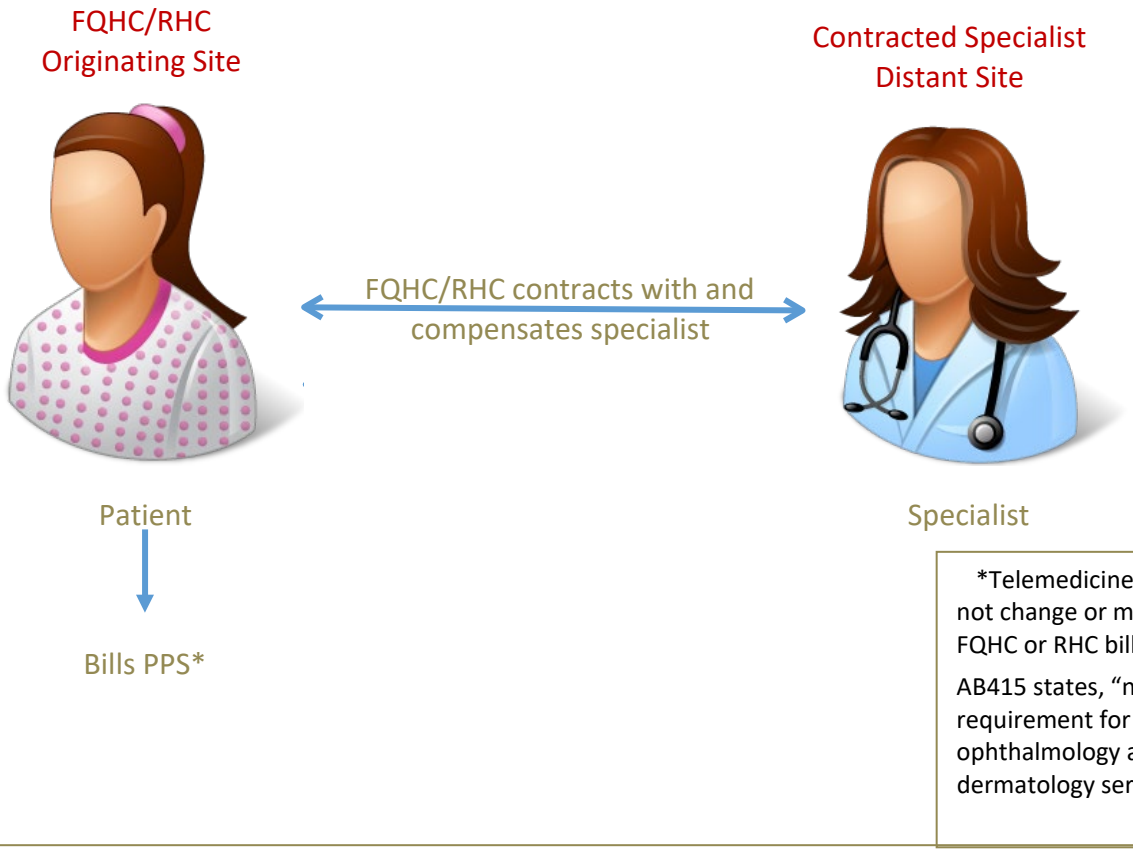
Patient is physically present at FQHC/RHC Site.
Specialist is not physically at the FQHC/RHC.
FQHC/RHC and specialist have a written agreement to provide services. FQHC/RHC compensates specialist outside of an insurance plan.

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



*Telemedicine services do not change or modify other FQHC or RHC billing provisions.

AB415 states, “no face-to-face requirement for ophthalmology and dermatology services.”

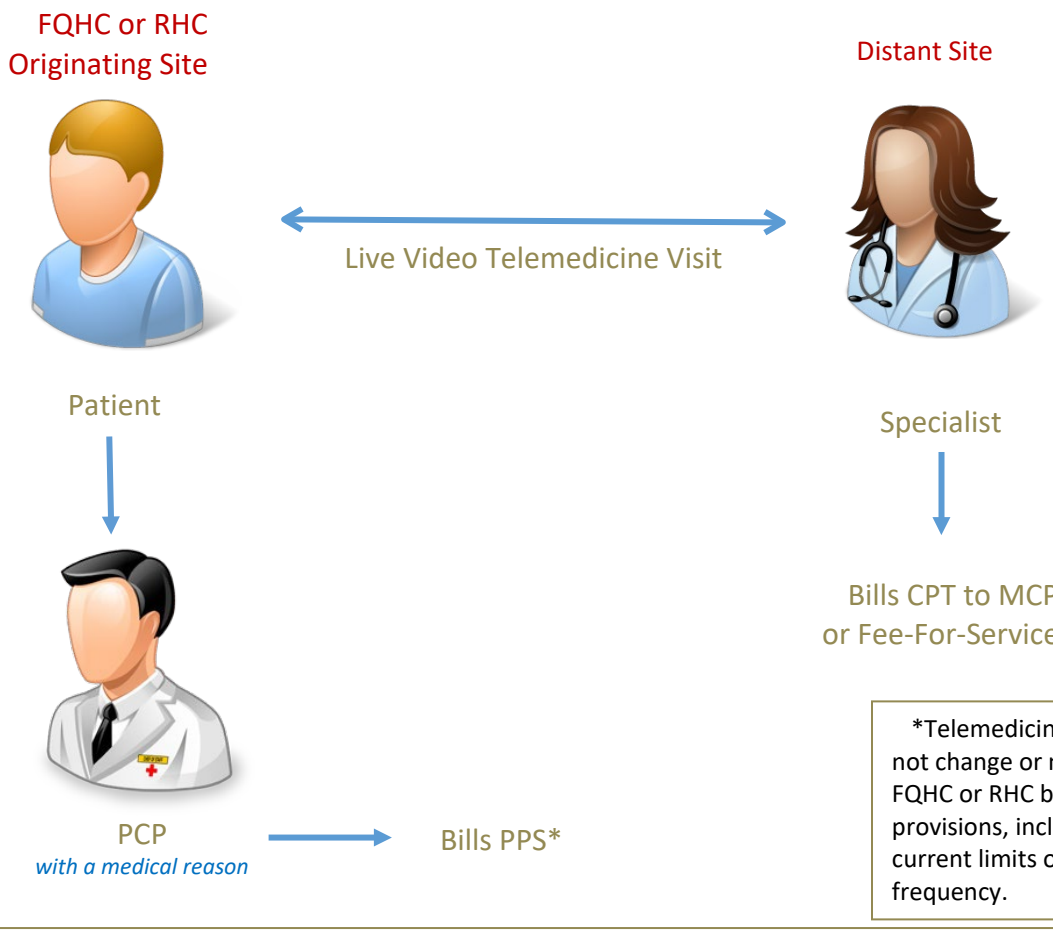
MEDI-CAL FEE-FOR-SERVICE AND MULTIPLE MANAGED CARE PLANS
FQHC/RHC Originating Site (Provider Present) to a Distant Site

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



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

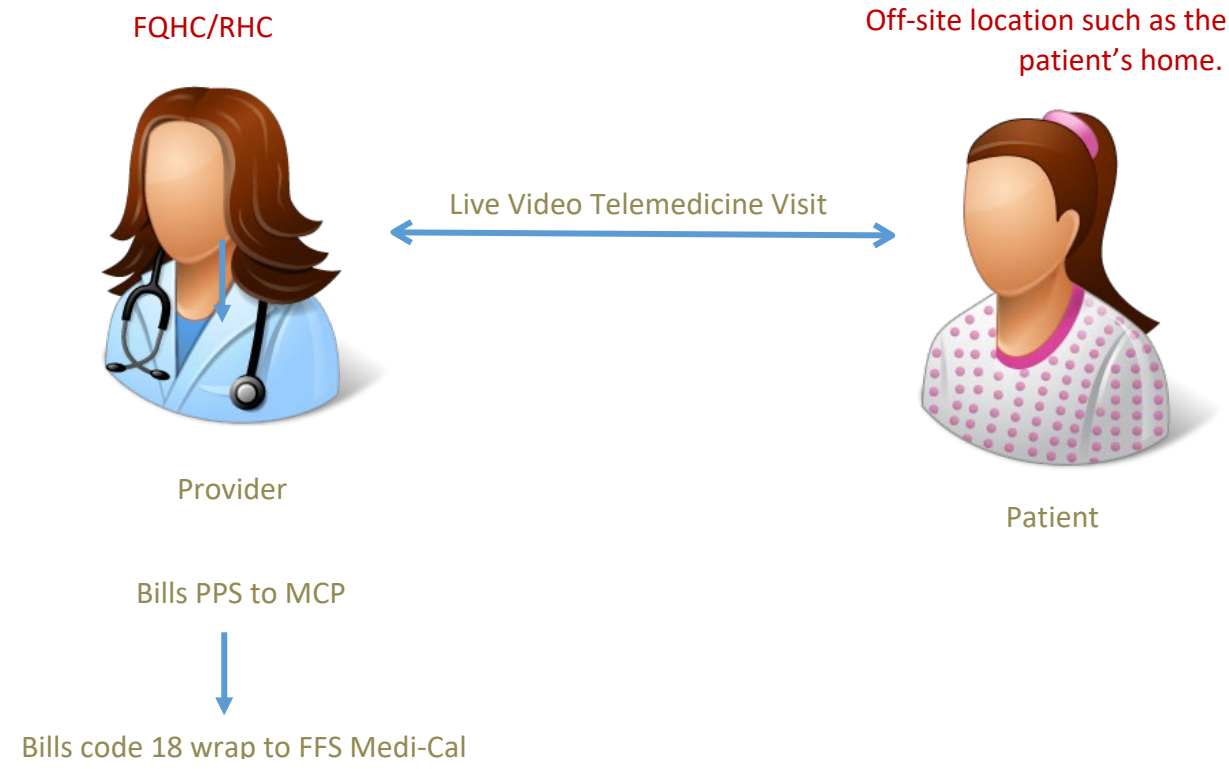
MEDI-CAL MANAGED CARE PLAN (MCP)
FQHC/RHC to HHMS Patient Home

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.



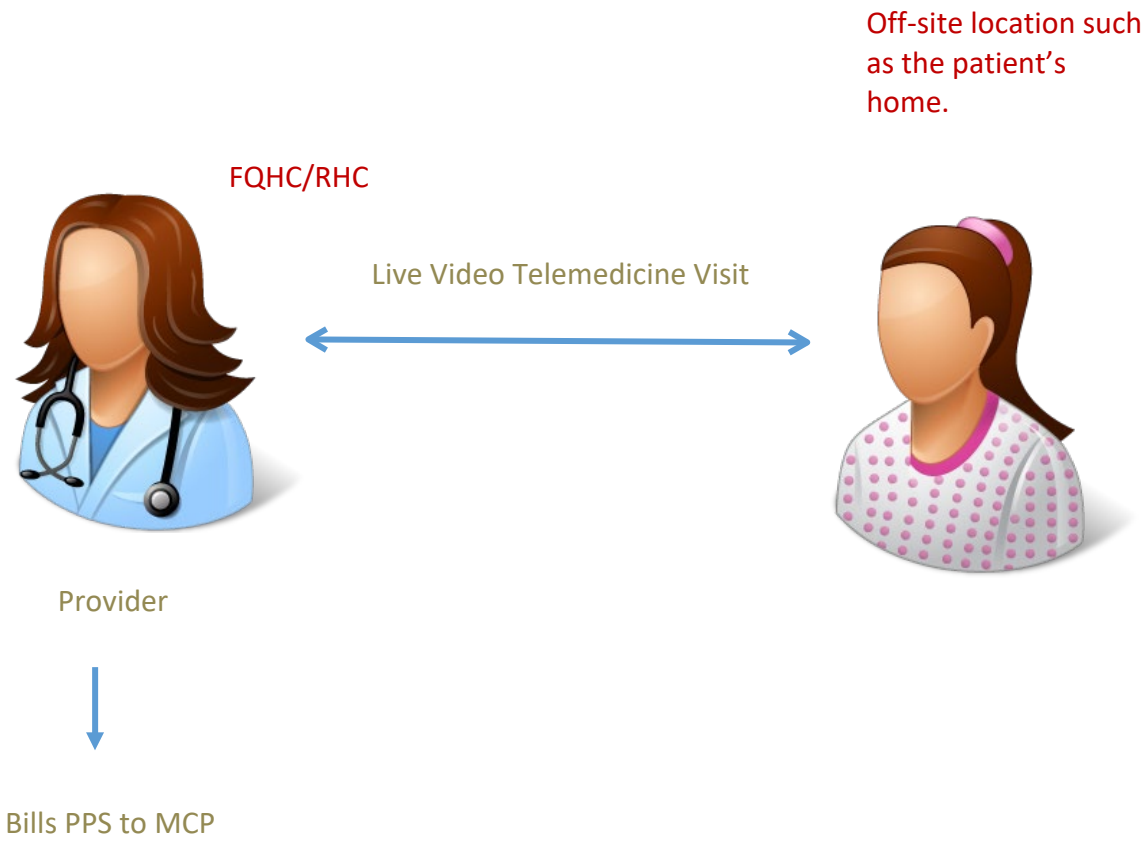
MEDI-CAL MANAGED CARE PLAN (MCP)
FQHC/RHC to Non-HHMS Patient Home

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, therefor 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

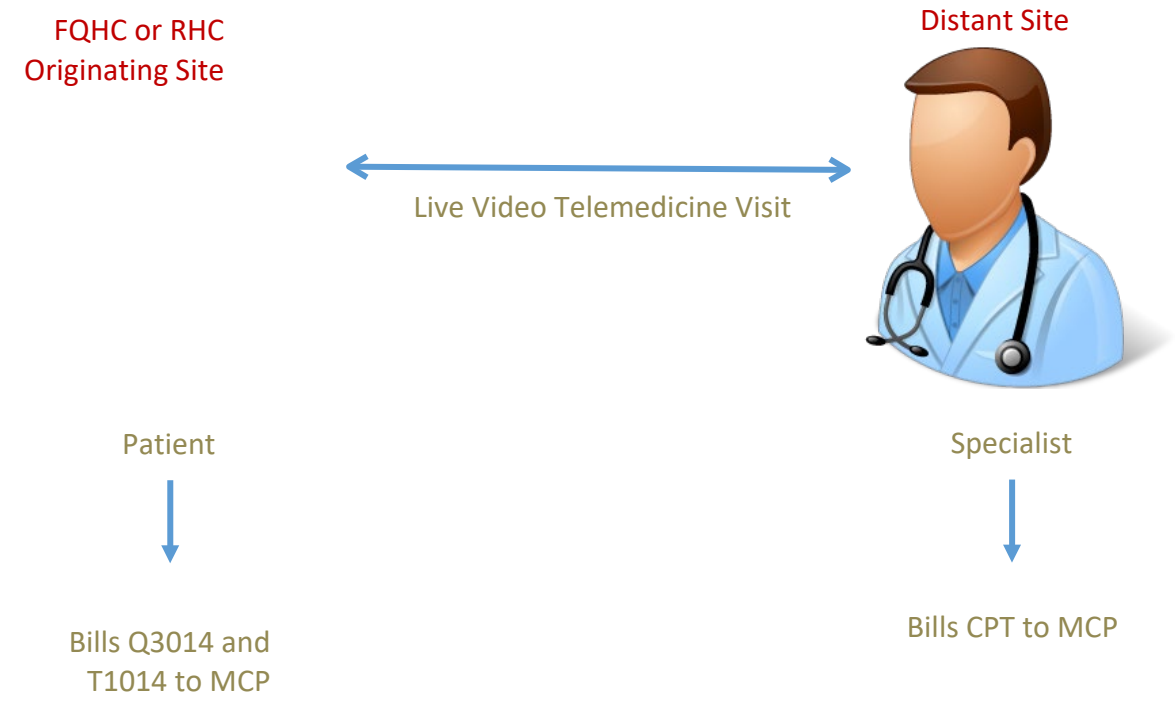
Scenario 14

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

3. California Department of Health Services, Medi-Cal Program, Telehealth Resource Page https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthResources.aspx

4. California Department of Health Services, Medi-Cal Program, Telehealth FAQ https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthFAQ.aspx

5. California Department of Health Services, APL 19-009 https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-009.pdf

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

7. Medicare Telehealth Services Fact Sheet https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcsfctsht.pdf

8. HHS Telehealth Webpage https://telehealth.hhs.gov/

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10. *Medicare Benefit Policy* (CMS Publication 100-02), Internet publication only, Baltimore, Maryland, Centers for Medicare and Medicaid Services. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

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

- Medicaid: Telehealth and Virtual Communication
  Department of Managed Health Care: Reimbursement for Telehealth Services (APL 20-009)
- Department of Managed Health Care: Telehealth Services (APL 20-13)Department of Managed Health Care:
- All Plan Letter (20-032) Continuation of APL 20-013 & 20-009; FAQs
- AB 32: Telehealth Access B 133: Extends COVID-19 Medicaid Waivers and Flexibilities Related to Delivery and Reimbursement of Services via Telehealth until December 31, 2022