

UPDATE “MEDICINE: TELEHEALTH” SECTION OF THE PROVIDER MANUAL

Revised 09/28/18

The “Medicine: Telehealth” policy was established pursuant to Assembly Bill 415 (Logue, Chapter 547, Statutes of 2011), known as the Telehealth Advancement Act of 2011 (Act).

I. Definitions

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

Telehealth

“Telehealth” means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

Asynchronous Store and Forward

“Asynchronous store and forward” means the transmission of a patient’s medical information from an originating site to the health care provider at a distant site without the presence of the patient.

E-Consult

Falling under the auspice of store and forward, an “e-consult” is an asynchronous electronic consultation service for health care providers designed to offer a coordinated multidisciplinary case review, advisory opinion, and recommendation of care for complicated symptoms or illnesses. E-consults are permissible only between health care providers. Consultations via asynchronous electronic transmission initiated directly by patients do not constitute e-consults under this policy.

Synchronous Interaction

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

Distant Site

“Distant site” means a site where a health care provider who provides health care services is located while providing these services via a telecommunications system.

Originating Site

“Originating site” means a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates. For purposes of reimbursement for covered treatment or services provided through telehealth, the type of setting where services are provided for the patient or by the health care provider is not limited (Welfare and Institutions Code [WIC] Section 14132.72(e)). This may include, but is not limited to, a hospital, medical office, community clinic, or the patient’s home. For additional originating site policy and billing information specific to Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) or Indian Health Services Memorandum of Agreement 638 clinic (IH) services, please see those sections of the Medi-Cal Provider Manual (*rural and ind health*).

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II. Provider Requirements

The health care provider billing for Medi-Cal covered benefits or services provided via a telehealth modality and who has the ultimate responsibility for the care of the patient must be licensed in the State of California and enrolled as a Medi-Cal provider. A billing health care provider delivering services via telehealth must be located in and licensed in California, or reside in a border community, and be enrolled as a Medi-Cal provider. A health care provider rendering to a group may be located outside California. For policy and billing information specific to FQHCs and RHCs, or IH services, please see those sections of the Medi-Cal Provider Manual (*rural and ind health*).

III. Documentation Requirements

Health care providers at the distant site must determine and document that the covered Medi-Cal service or benefit being delivered via a telehealth modality meets the procedural definition and components of the national CPT-4 or HCPCS code(s) associated with the Medi-Cal covered service or benefit, and the extended guidelines that pertain to CPT 99358 and 99359 with GQ modifier, as described in Section V below.

In-person contact between health care providers and patients are not required for services to be delivered via telehealth, subject to reimbursement policies adopted by the Department to compensate a health care provider who provides health care services via telehealth that are otherwise reimbursable pursuant to the Medi-Cal program (WIC Section 14132.72[c]). As a result, health care providers are not required to document a barrier to an in-person visit for Medi-Cal coverage of services provided via telehealth (WIC, Section 14132.72[d]).

Health care providers at the “distant site” are not required to document cost effectiveness of telehealth to be reimbursed for telehealth services or store and forward services.

Informed Consent

In addition, health care providers must also inform the patient about the use of telehealth and obtain verbal consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health. The consent shall be documented in the patient’s medical file (Business and Professions Code Section 2290.5(b)) and be available to the Department upon request.

For teleophthalmology, teledermatology, or teledentistry services or benefits delivered via asynchronous store and forward, health care providers must also meet the following requirements in state statute (Welfare and Institutions Code [WIC] Section 14132.725[b]):

- A patient receiving teleophthalmology, teledermatology, or teledentistry by store and forward shall be notified of the right to receive interactive communication with the distant specialist

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physician, optometrist, or dentist and shall receive an interactive communication with the distant specialist physician, optometrist, or dentist, upon request. If requested, communication with the distant specialist physician, optometrist, or dentist may occur either at the time of the consultation, or within 30 days of the patient’s notification of the results of the consultation. *For additional information about informed consent and other policy requirements relating to teledentistry, please refer to the teledentistry portion of the Denti-Cal Provider Handbook.*

Medical Record: Technical & Professional Components

All medical information transmitted during the delivery of Medi-Cal covered benefits or services via a telehealth modality must become part of the patient’s medical record maintained by the health care provider at the distant site. Health care providers should ensure that the technical component of Medi-Cal covered benefits or services are performed at the originating site during a telehealth transmission and billed according to standard Medi-Cal policy. When the professional component of these procedures is furnished to a patient from the distant site via telehealth, the service must include an interpretation and written report – such as for X-rays and electrocardiograms performed via asynchronous store and forward – for inclusion in the patient’s medical record.

Place of Service Code 02

Health care providers are required to document place of service code 02 on the claim, which indicates that services were provided or received through a telecommunications system. The Place of Service Code 02 requirement is not applicable for FQHCs, RHCs or IH services. For policy and billing information specific to FQHCs and RHCs, or IH services, please see those sections of the Medi-Cal Provider Manual (*rural and ind health*).

IV. Telehealth Reimbursable Services, Generally

Medi-Cal covered benefits or services, identified by CPT-4 or HCPCS codes and subject to all existing Medi-Cal coverage and reimbursement policies, including any treatment authorization requirements, may be provided via a telehealth modality, as outlined in this section, if all of the following are satisfied:

- The treating health care provider at the distant site believes that the benefits or services being provided are clinically appropriate based upon evidence-based medicine and best practices to be delivered via telehealth;
- The benefits or services delivered via telehealth meet the procedural definition and components of the national CPT-4 or HCPCS code(s), as defined by the American Medical Association (AMA), associated with the Medi-Cal covered service or benefit, as well as any extended guidelines as described in this section of the Medi-Cal Provider Manual; and
- The benefits or services provided via telehealth meet all laws regarding confidentiality of health care information and a patient’s right to his or her medical information.

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Covered benefits or services provided via a telehealth modality are reimbursable when billed in one of two ways:

- For services or benefits provided via synchronous, interactive audio and telecommunications systems, the health care provider bills with Modifier 95.
- For services or benefits provided via asynchronous store and forward telecommunications systems, the health care provider bills with modifier GQ.

Additional billing details are described in the Section V, Billing Requirements below. The Modifier 95 and GQ requirements are not applicable for FQHCs, RHCs or IH services. For policy and billing information specific to FQHCs and RHCs, or IH services, please see those sections of the Medi-Cal Provider Manual (*rural and ind health*).

For policy and billing information specific to Specialty Mental Health Services, please see the Mental Health Services Division (MHSD) Medi-Cal Billing Manual (*MHSD M/C Billing Manual*) and for Substance Use Disorder (SUD) services, Drug Medi-Cal Organized Delivery System (DMC-ODS), see the 1115 Bridge to Reform demonstration waiver.

Examples of Services Not Appropriate for Telehealth

Certain types of benefits or services that would not be expected to be appropriately delivered via telehealth include, but are not limited to benefits or services that: are performed in an operating room or while the patient is under anesthesia, require direct visualization or instrumentation of bodily structures, involve sampling of tissue or insertion/removal of medical devices, and/or would otherwise require the in-person presence of the patient for any reason.

V. Billing Requirements:

Synchronous, Interactive Audio and Telecommunications Systems: Modifier 95

Modifier 95 must be used for Medi-Cal covered benefits or services delivered via synchronous, interactive audio/visual, telecommunications systems. Only the portion(s) of the telehealth service rendered at the distant site are billed with modifier 95. The use of modifier 95 does not alter reimbursement for the CPT-4 or HCPCS code.

Health care providers must use interactive audio, video or data telecommunications system that permits real-time communication between the health care provider at the distant site and the beneficiary at the originating site. The audio-video telemedicine system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through telemedicine. The telecommunication equipment must be of a quality or resolution to

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adequately complete all necessary components to document the level of service for the CPT-4 code or HCPCS code billed.

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

Evaluation and Management (E/M) and all other covered Medi-Cal services provided at the originating site (in-person with the patient) during a telehealth transmission are billed according to standard Medi-Cal policies (without a 95 modifier). The E/M service must be in real-time or near real-time (delay in seconds or minutes) to qualify as an interactive two-way transfer of medical data and information between the patient and health care provider.

*Asynchronous Store
and Forward
Telecommunications
Systems: Modifier
GQ*

Modifier GQ must be used for Medi-Cal covered benefits or services, including, but not limited to, teleophthalmology, teledermatology, x-rays, and electrocardiograms, delivered via asynchronous store and forward telecommunications systems, including through e-consult. Only the services(s) rendered from the distant site are billed with modifier GQ. The use of modifier GQ does not alter reimbursement for the CPT-4 or HCPCS code billed. For additional information about policy and billing requirements relating to teledentistry, please refer to the teledentistry portion of the *Medi-Cal Dental Services Provider Handbook*.

For billing purposes, health care providers must ensure that the documentation, typically images, sent via store and forward be specific to the patient's condition and adequate for meeting the procedural definition and components of the national CPT or HCPCS code that is billed. In addition, all services billed via store and forward, including e-consult, are subject to all existing Medi-Cal coverage and reimbursement policies, including any treatment authorization requirements. Asynchronous store and forward, including e-consult, does not include single mode consultations by telephone calls or images transmitted via facsimile machines or electronic mail.

E-Consults

E-consults via asynchronous electronic consultation services are reimbursable between two health care providers for the purpose of offering a coordinated multidisciplinary case review, advisory opinion, and recommendation of care for complicated symptoms or illnesses. A health care provider at the distant site may bill for an e-consult with one or both of the CPT-4 codes listed below when the benefits or services delivered meet the procedural definition and components of the national CPT-4 code as defined by the AMA, as well as any extended guidelines as described in this section of the Medi-Cal Provider Manual. When billing for e-consults, both health care

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providers at the originating and distant sites must clearly document all information relating to previous but related primary health care services and maintain this information in the patient’s medical record. The records shall be available to DHCS upon request, as described in detail below.

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

<u>CPT Code</u>	<u>Description</u>
99358	Prolonged evaluation and management service before and/or after direct patient care; first hour
99359	Each additional 30 minutes

Do not report 99358 or 99359 during the same month with 99487 through 99489, or when performed during the service time of codes 99495 or 99496.

The following are requirements and extended guidelines for e-consults:

- The health care provider at the originating site must create and maintain the following:
 - Record that the e-consult is the result of patient care that has occurred or will occur and relates to ongoing patient management;
 - Record of a request for an e-consult by the health care provider at the originating site; and
 - Record of patient consent for transmission of medical information.
- The health care provider at the distant site must create and maintain the following:
 - Record of the review and analysis of the transmitted medical information with written documentation of date of service and time spent (greater than 30 minutes);
 - Record of preparing a written report of case findings and recommendations with conveyance to the originating site; and
 - Record of maintenance of transmitted medical records in patient’s medical record.

Medi-Cal covered benefits or services provided at the originating site (in-person) with the patient during the service that will be provided by

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asynchronous store and forward transaction, including e-consult, are billed according to standard Medi-Cal policies (without a GQ modifier).

VI. Originating Site and Transmission Fees

The originating site facility fee is reimbursable only to the originating site when billed with HCPCS code Q3014 (telehealth originating site facility fee). Transmission costs incurred from providing telehealth services via audio/video communication is reimbursable when billed with HCPCS code T1014 (telehealth transmission, per minute, professional services bill separately).

Originating Site and Transmission Fee Restrictions

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

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

If billing store and forward, including e-consult, providers at the originating site may bill the originating site fee with HCPCS Code Q3014, but may not bill for the transmission fee.

The originating site and transmission fee restrictions and billing rules are not applicable for FQHCs, RHCs or IH services. For policy and billing information specific to FQHCs and RHCs, or IH services, please see those sections of the Medi-Cal Provider Manual (*rural and ind health*).