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COVID-19 Guidance for Telehealth and Virtual/Telephonic Communications

March 19, 2020

In light of both the federal Health and Human Services Secretary's January 31, 2020, public health emergency declaration, as well as the President's March 13, 2020, national emergency declaration relative to COVID-19, the Department of Health Care Services (DHCS) is issuing additional guidance to enrolled Medi-Cal providers, including but not limited to physicians, nurses, mental health practitioners, substances use disorder practitioners, dentists – as well as Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Tribal 638 Clinics. This guidance is relative to all of the following:

- **Section I: Current Medi-Cal Policy for Enrolled Medi-Cal Providers:** As outlined in the Medi-Cal Provider Manual ([Medicine: Telehealth](#)) and/or posted to the [Medi-Cal Rates Information Page](#):
 - Traditional telehealth modalities, i.e., synchronous two-way interactive, audio-visual communication and asynchronous store and forward, inclusive of e-consults
 - Other virtual/telephonic communication modalities
- **Section II: Current Medi-Cal Policy for FQHCs, RHCs, Tribal 638 Clinics:** As outlined in various sections of the Medi-Cal Provider Manual ([Federally Qualified Health Centers/Rural Health Clinics](#), and [Indian Health Services Memorandum of Agreement 638 Clinics](#)), and/or posted to the [Medi-Cal Rates Information Page](#):
 - Traditional telehealth modalities, i.e., synchronous two-way interactive, audio-visual communication and asynchronous store and forward.
 - Other virtual/telephonic communication modalities
- **Section III: DHCS' Section 1135 Waiver Request Related to the Novel Coronavirus Disease (COVID-19), Submitted March 16, 2020**
 - Additional flexibilities and options relative to traditional telehealth modalities, i.e., synchronous two-way, audio-visual communication and asynchronous store and forward, inclusive of e-consults
 - Additional flexibilities and options relative to other virtual/telephonic communication modalities

SECTION I: CURRENT MEDI-CAL POLICY FOR ENROLLED MEDI-CAL PROVIDERS

Traditional Telehealth - Overview

For enrolled Medi-Cal providers, including but not limited to physicians, nurses, mental health practitioners, substances use disorder practitioners, dentists, etc., the below policy applies. Please note that this does not apply to FQHCs, RHCs, and Tribal 638 Clinics, for which the policy is described below.

- Medi-Cal providers may bill DHCS or their managed care plan as appropriate for any covered Medi-Cal benefits or services using the appropriate procedure codes, i.e., Current Procedural Terminology (CPT) or Health Care Procedures Coding System (HCPS) codes, as defined by the American Medical Association (AMA) in the most current version of the billing manual that are appropriate to be provided via a telehealth modality. The CPT or HCPCS code(s) must be billed using Place of Service Code "02" as well as the appropriate telehealth modifier, as follows:
 - Synchronous, interactive audio and telecommunications systems: Modifier 95
 - Asynchronous store and forward telecommunications systems: Modifier GQ

Please note that DHCS will use the telehealth modifiers to identify that the Medi-Cal covered benefit or service was provided via a telehealth modality for tracking and reporting purposes relative to COVID-19. As a result, DHCS requests that all providers ensure the appropriate modifier is included on all submitted claims.

Synchronous Telehealth

Medi-Cal benefits or services, inclusive of things such as medical, mental health, substance use disorder, and more, provided via a synchronous telehealth modality (two-way interactive, audio-visual communication) must meet all of the below criteria. Please note the teledentistry policy is included separately below.

- The treating health care practitioner at the distant site believes that the Medi-Cal benefits or services being provided are clinically appropriate based upon evidence-based medicine and/or best practices to be delivered via telehealth, subject to oral or written consent by the beneficiary. Below are some examples (not exhaustive) of benefits or services that would not be appropriate for a delivery via a telehealth modality:
 - Benefits or services that are performed in an operating room or while the patient is under anesthesia
 - Benefits or services that require direct visualization or instrumentation of bodily structures
 - Benefits or services that involve sampling of tissue or insertion/removal of medical devices
 - Benefits or services that otherwise require the in-person presence of the patient for any reason
- The benefits or services delivered via telehealth meet the procedural definition and components of the CPT or HCPCS code(s), as defined by the 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.
- The benefits or services provided via telehealth satisfies all laws regarding confidentiality of health care information and a patient's right to his or her medical information.

For Medi-Cal dental benefits or services, Medi-Cal enrolled dentists and allied dental professionals (under the supervision of a dentist) may render limited services via synchronous/live transmission teledentistry, so long as such services are within their scope of practice, when billed using Current Dental Terminology (CDT) code D9995. The following is Medi-Cal's teledentistry policy for synchronous/live transmissions.

- CDT code D9995 is reimbursed at 24 cents per minute, up to a maximum of 90 minutes, i.e., up to \$21.60 maximum reimbursement. Procedure D9999 may only be used once per date of service per beneficiary, per provider.

Asynchronous Store and Forward, inclusive of E-Consults

Medi-Cal benefits or services including, but not limited to, teleophthalmology, teledermatology, teledentistry, and teleradiology, may be provided via asynchronous store and forward, including E-Consults, when all of the following criteria are satisfied:

- Health care practitioners 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 CPT or HCPCS code that is billed.

E-Consults

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

- CPT Code 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

For Medi-Cal dental benefits or services, Medi-Cal enrolled dentists and allied dental professionals (under the supervision of a dentist) may render, so long as such services are within their scope of practice, limited services via asynchronous store and forward using CDT code D9996, which identifies the services as teledentistry. CDT code D9996 is not reimbursable; instead, the billing dental provider would be reimbursed based upon the applicable CDT procedure code to be paid according to the Schedule of Maximum Allowance (SMA). The following CDT codes may be billed under Medi-Cal's teledentistry policy for asynchronous store and forward:

- D0120: Periodic oral evaluation — established patient
- D0150: Comprehensive oral evaluation — new or established patient
- D0210: Intraoral — complete series of radiographic images
- D0220: Intraoral — periapical first radiographic image
- D0230: Intraoral — periapical each additional radiographic image

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- D0240: Intraoral — occlusal radiographic image
- D0270: Bitewing — single radiographic image
- D0272: Bitewings — two radiographic images
- D0274: Bitewings — four radiographic images
- D0330: Panoramic radiographic image
- D0350: Oral/Facial photographic images

Originating Site and Transmission Fee

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

- HCPCS code Q3014 – Billable by originating site; once per day; same patient, same provider.
- HCPCS code T1014 – Originating site and distant site; maximum of 90 minutes per day (1 unit = 1 minute), same patient, same provider
- Originating site fee and transmission costs are not available for telephonic services.

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. Please note, the originating site and transmission fee restrictions are not applicable for FQHCs, RHCs or Tribal 638 clinics.

Other Virtual/Telephonic Communication

For enrolled Medi-Cal providers, including but not limited to physicians, nurses, mental health practitioners, substances use disorder practitioners, dentists, etc., the below policy applies.

Virtual/telephonic communication includes a brief communication with another practitioner or with a patient, who in the case of COVID-19, cannot or should not be physically present (face-to-face). Medi-Cal providers may be reimbursed using the below Healthcare Common Procedure Coding System (HCPCS) codes G2010 and G2012 for brief virtual communications.

- HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 hours, not originating from a related evaluation and management (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.
 - Medi-Cal Fee-For-Service (FFS) Rate: \$10.87
- 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. G2012 can be billed when the virtual communication occurred via a telephone call.
 - Medi-Cal FFS Rate: \$12.48

SECTION II: CURRENT MEDI-CAL POLICY FOR FQHCs, RHCs, TRIBAL 638 CLINICS

Traditional Telehealth (Synchronous or Asynchronous)

For FQHCs, RHCs, and Tribal 638 Clinics, billable providers may provide Medi-Cal covered benefits or services via synchronous telehealth (audio-visual, two-way communication) to “established” patients.

- **Synchronous Telehealth:** Synchronous telehealth is available to everyone within the four walls of the clinic. For purposes of FQHCs, RHCs, and Tribal 638 Clinics, “established patients” are defined as follows:
 - In FFS, “established patients” are those who have been seen at the FQHC, RHC, or Tribal 638 Clinic within the last three (3) years.
 - In Managed Care, if the patient is “assigned” by the Medi-Cal managed care plan (MCP) to a particular clinic, then the patient is considered to be “established” even if s/he has never been seen in the FQHC, RHC, or Tribal 638 Clinic. Please note that the majority of clients are MC, so the majority would be assigned and eligible to receive Medi-Cal covered benefits and services via a synchronous telehealth modality.

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Medi-Cal covered benefits or services that may be provided via synchronous telehealth, FQHCs, RHCs, and Tribal 638 Clinics would bill using HCPCS code T1015 (medical, per visit), which would be paid at the Prospective Payment System (PPS) or All-Inclusive Rate (AIR), respectively.

Please note that outside of the four walls of the FQHC, RHC, or Tribal 638 Clinic, Medi-Cal covered benefits or services may be provided via synchronous telehealth for certain populations pursuant to applicable federal law, including migrant/seasonal workers, homeless individuals, and homebound individuals.

- **Asynchronous Store and Forward:** For FQHCs, RHCs, and Tribal 638 Clinics, billable providers may provide Medi-Cal covered benefits or services via asynchronous store and forward to “established” patients, as defined above. Asynchronous store and forward can be used to provide teledermatology, teledoctorology, teledentistry via store and forward, using applicable HCPCS or CPT codes. FQHCs, RHCs, and Tribal 638 Clinics cannot bill for e-consult or telephonic visits.

SECTION III: DHCS’ SECTION 1135 WAIVER REQUEST RELATED TO COVID-19

Overview

DHCS has requested additional flexibilities in terms of the available modalities for delivering Medi-Cal covered benefits and services, as part of its Section 1135 Waiver. DHCS recognizes that in addition to traditional telehealth/telemedicine modalities (i.e., synchronous two-way interactive, audio-visual communication, and/or asynchronous store and forward/e-consults), as outlined in existing Medi-Cal coverage policy, there are extraordinary circumstances under which both face-to-face visits as well as traditional telehealth modalities are not an option.

Under these limited and extraordinary instances (such as COVID-19), DHCS recognizes the need for Medi-Cal providers – including but not limited to physicians, nurses, mental health practitioners, substance use disorder practitioners, FQHCs, RHCs, and Tribal 638 Clinics – to utilize other methods such as telehealth and virtual/telephonic communication to provide medically necessary health care services.

Unless otherwise agreed to by the MCP and provider, DHCS and Managed Care Plans (MCPs) must reimburse Medi-Cal providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider’s description of the service on the claim. DHCS and Managed Care Plans (MCPs) must provide the same amount of reimbursement for a service rendered via telephone or virtual communication, as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the member.

Other Virtual/Telephonic Communications

Medi-Cal providers, – including but not limited to physicians, nurses, mental health practitioners, substance use disorder practitioners, FQHCs, RHCs, and Tribal 638 Clinics, will provide and bill for visits consistent with in person visits using the appropriate and regular CPT or HCPCS codes that would correspond to the visit being done in-person, and include POS 02 and Modifier 95. The virtual/telephonic visit must meet all requirements of the billed CPT or HCPCS code and must meet the following conditions:

- There are documented circumstances involved that prevent the visit from being conducted face-to-face, such as the patient is quarantined at home, local or state guidelines direct that the patient remain at home, the patient lives remotely and does not have access to the internet or the internet does not support Health Insurance Portability and Accountability Act (HIPAA) compliance, etc.
- The treating health care practitioner is intending for the virtual/telephone encounter to take the place of a face-to-face visit, and documents this in the patient’s medical record.
- The treating health care practitioner believes that the Medi-Cal covered service or benefit being provided are medically necessary.
- The Medi-Cal covered service or benefit being provided is clinically appropriate to be delivered via virtual/telephonic communication, and does not require the physical presence of the patient.
- The treating health care practitioner satisfies all of the procedural and technical components of the Medi-Cal covered service or benefit being provided except for the face-to-face component, which would include but not be limited to:
 - a detailed patient history
 - a complete description of what Medi-Cal covered benefit or service was provided

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- an assessment/examination of the issues being raised by the patient
- medical decision-making by the health care practitioner of low, moderate, or high complexity, as applicable, which should include items such as pertinent diagnosis(es) at the conclusion of the visit, and any recommendations for diagnostic studies, follow-up or treatments, including prescriptions

Sufficient documentation must be in the medical record that satisfies the requirements of the specific CPT or HCPCS code utilized. The provider can then bill DHCS or the managed care plan as appropriate.

For virtual/telephonic visits that do not meet the requirements above, the billing entity should bill the corresponding virtual/telephonic visit CPT or HCPC listed in Section I and will be reimbursed the Medi-Cal fee-for-service (FFS) rate on file for the applicable procedure code or bill their managed care plan as appropriate.

The information below is specific to FQHCs, RHCs and Tribal 638 clinics that had additional restrictions related to their ability to provide telehealth or virtual/telephonic services.

Traditional Telehealth (Synchronous / Asynchronous) for FQHCs, RHCs and Tribal 638 Clinics

For Medi-Cal covered benefits and services provided via traditional telehealth (synchronous, two-way interactive, audio-visual communication, or asynchronous store and forward), DHCS has proposed to waive through its Section 1135 Waiver request existing restrictions/requirements in Medi-Cal’s current telehealth policy due to various federal laws/Medicaid State Plan language, relative to “new” and “established” patients, “face-to-face”/in-person, and “four walls” requirements. Waiving these limitations will allow FQHCs, RHCs, and Tribal 638 Clinics greater flexibility under DHCS’ existing telehealth policy, which is described above.

Billing & Procedure Coding Requirements for Virtual/Telephonic Communications

Where FQHCs, RHCs, and Tribal 638 Clinics satisfy the above guidelines/criteria, those entities will be able to bill the Prospective Payment System (PPS) rate or All-Inclusive Rate (AIR), as applicable. Below is a chart that outlines the associated procedure codes (i.e., HCPCS or CPT codes) for purposes of billing either the Medi-Cal FFS rate or PPS/AIR rate, as applicable.

Satisfies Guidance/Criteria		Does not Satisfy Guidance/Criteria
PPS/AIR Rate		FFS Rate
HCPCS code T1015*/T1015 SE	+ CPT code 99201–99205 (new patient) CPT code 99211–99215 (established patient)	HCPCS code G0071** (\$13.69)

*Clinic visit/encounter, for PPS and AIR; T1015 SE for PPS Wrap

**Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an FQHC/RHC/Tribal 638 Clinic practitioner and new or established patient, or 5 minutes or more of remote evaluation of recorded video and/or images

- **Medi-Cal FFS:** For the PPS/AIR rate, FQHCs, RHCs, and Tribal 638 Clinics would need to list HCPCS code T1015 in the “payable” claim line in conjunction with one of the appropriate corresponding CPT codes (i.e., 99201-99203 for “new” patients, and 99212-99214 for “established patients”) on the “informational” line relative to the complexity of the virtual/telephonic communication. Please note that the corresponding CPT codes are not separately reimbursed, but instead will be used to identify the virtual/telephonic communication visit as well as by DHCS for tracking and reporting purposes related to COVID-19. Clinics should review the billing guidelines in the Indian Health or FQHC/RHC provider manual. For the Medi-Cal FFS rate when billing with the HCPCS code G0071, clinics should only list the HCPCS code on the “payable” claim line and should not include a corresponding CPT code.
- **Medi-Cal Managed Care:** FQHCs, RHCs, and Tribal 638 Clinics would receive the PPS rate or AIR, as applicable, for rendering a Medi-Cal covered benefit or service – whether provided through telehealth or virtual/telephonic communication – if they meet the above established criteria/guidance. DHCS will ensure the FQHCs and RHCs are made whole with an appropriate wrap payment, consistent with existing DHCS policy. Likewise, Tribal 638 Clinics will be reimbursed the AIR consistent with existing DHCS policy.

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