

MEDI-CAL FEE-FOR-SERVICE TELEHEALTH POLICY CHANGES – A comparison of the previous Medi-Cal Telehealth Policy, the original proposed changes and the final policy.

In October 2018, the California Department of Health Care Services (DHCS), released a draft proposal to update the state Medicaid (Medi-Cal) telehealth policies for fee-for-service, FQHCs/RHCs, IHS, and FPACT. These proposals went into effect on July 1, 2019, though final publication of the document will not be until August 2019 when the Department will also issue an All Plan Letter. However, DHCS did release a copy of the final policies for fee-for-service (though it is still labeled as “DRAFT”). Below is a comparison of the previous Medi-Cal telehealth policy, the October 2018 Proposed Changes and the Final Policy. Several things to note regarding the final policy:

- Providers decide what modality, live video or store-and-forward, will be used to deliver eligible services to a Medi-Cal enrollee as long as the service is covered by Medi-Cal and meets all other Medi-Cal guidelines and policies, can be properly provided via telehealth and meets the procedural and definition components of the appropriate CPT or HCPCS code.
- What constitutes as an originating site includes the home and no requirement that a provider be with the patient at the time of the telehealth interaction.
- Addition of e-consult as a subset of store-and-forward and reimbursement for one specific code.
- Provider must be licensed in CA, enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community.

SECTION	PRE-CHANGE POLICY	PROPOSED POLICY (OCT 2018)	FINAL POLICY (JULY 2019)
DEFINITIONS	Definitions for terms were not in the previous manual.	<p>Asynchronous store-and-forward means the transmission of a patient’s medical information from an originating site to the health care provider of a distant site without the presence of the patient.</p> <p>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</p>	<p>Made changes to definitions for:</p> <p>“Asynchronous store-and-forward” – Added: “Consultations via asynchronous electronic transmission initiated directly by patients, including through mobile phone applications, are not covered under this policy.”</p> <p>“E-consults” – “E-Consults are asynchronous health record consultation services that provide an assessment and management service in which the patient’s treating health care practitioner (attending or primary) requests the</p>

		<p>permissible only between health care providers. Consultations via asynchronous electronic transmission initiated directly by patients do not constitute e-consults under this policy.</p> <p>Originating site – The type of setting may include, but is not limited to, a hospital, medical office, community clinic or the patient’s home.</p> <p>Distant site means a site where a health care provider who provides health care services is located while providing these services via a telecommunication system.</p>	<p>opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the patient’s health care needs without patient face-to-face contact with the consultant.”</p> <p>“Distant site” – Added “The distant site for purposes of telehealth can be different from the administrative location.”</p>
PROVIDER REQUIREMENTS	<p>Requirements listed only under “Guidelines for Psychiatric Procedures” – “The health care provider 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. The provider performing services via telemedicine whether from California or out of state, must be licensed in California and enrolled as a Medi-Cal provider.”</p> <p>While not in the provider manual, DHCS has stated that an enrolled Medi-Cal provider must be located within the state’s borders.</p>	<p>The billing provider who has ultimate responsibility for the care of the patient must be licensed in CA and enrolled as Medi-Cal provider. The billing provider must be located in and licensed in CA, 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 of CA.</p>	<p>The provider rendering covered benefits or services must meet the requirements of B&P 2290.5(a)(3) or equivalent requirements under CA law in which the provider is considered licensed (ex: Behavior Analyst Certification Board). Provider must be licensed in CA, enrolled as Medi-Cal rendering provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community.</p>
DOCUMENTATION REQUIREMENTS	<p><u>Under Guidelines for Psychiatric Procedures:</u></p> <p>The health care provider at the originating site must first obtain oral consent from the patient prior to providing service via telehealth and shall document oral consent in the patient’s medical record, including the following:</p> <ul style="list-style-type: none"> • A description of the risks, benefits and consequences of telemedicine 	<p>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 CPT or HCPCS codes associated with the covered benefit/service. In-person contact is not required subject to the reimbursement policies</p>	<p>Language was changed to:</p> <p>“All health care practitioners providing covered benefits or services to Medi-Cal recipients must maintain appropriate documentation to substantiate the corresponding technical and professional components of billed CPT or HCPCS codes. Documentation for benefits or services delivered via telehealth should be the same as</p>

	<ul style="list-style-type: none"> • 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 <p>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.</p> <p>Health care providers at the “distant site” are not required to document medical necessity or cost effectiveness to be reimbursed for telehealth services or store and forward services.</p>	<p>adopted by DHCS. Providers are not required to document a barrier to an in-person visit.</p> <p>Health care providers at the “distant site” are not required to document medical necessity or cost effectiveness to be reimbursed for telehealth services or store and forward services.</p>	<p>for a comparable in-person service. The distant site provider can bill for Medi-Cal covered benefits or services delivered via telehealth using the appropriate CPT or HCPCS codes with the corresponding modifier and is responsible for maintaining appropriate supporting documentation. The documentation should be maintained in the patient’s medical record.</p> <p>Health care providers at the distant must determine that the covered Medi-Cal service or benefit being delivered via telehealth meets the procedural definition and components of the CPT or HCPCS code(s) associated with the Medi-Cal benefit/service.</p>
<p>CONSENT & MEDICAL RECORD: TECHNICAL & PROFESSIONAL COMPONENTS</p>	<p><u>Under Guidelines for Psychiatric Procedures:</u></p> <p>The health care provider at the originating site must first obtain oral consent from the patient prior to providing service via telehealth and shall document oral consent in the patient’s medical record, including the following:</p> <ul style="list-style-type: none"> • 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 	<p>Labeled as “Informed Consent”</p> <p>Provider must inform the patient about the use of telehealth and obtain verbal consent. The consent must be documented in the patient’s medical file and available to DHCS upon request. For Asynchronous teleophthalmology, teledermatology or teledentistry, requirements under WIC 14132.725(b) must be met.</p> <p><u>Under Medical Record: Technical & Professional Components</u></p> <p>All medical information transmitted during the delivery of Medi-Cal covered benefits or services via a telehealth modality must become part of</p>	<p>Placed the “Technical & Professional Components” section under “Consent”; Changed “Informed Consent” to “Consent”</p> <p>Specified consent can be verbal or written. Added:</p> <p>“If a health care provider, whether at the originating or distant site, maintains a general consent agreement that specifically mentions use of telehealth as an acceptable modality for delivery of services, then this is sufficient for documentation of patient consent and should be kept in the patient’s medical file.”</p>

	<ul style="list-style-type: none"> No dissemination of any patient images or information to other entities without further written consent <p>A patient receiving teleophthalmology or teledermatology by store and forward shall be notified of the right to receive interactive communication with the distant specialist physician consulted through store and forward, upon request. If requested, communication with the distant specialist physician may occur either at the time of consultation or within 30 days of the patient’s notification of the results of the consultation.</p> <p>The health care provider shall comply with the informed consent provision of Section 2290.5 of the Business and Professions Code when a patient receives teleophthalmology and teledermatology by store and forward.</p> <p>NOTE: Medical Record: Technical & Professional Components Section does not exist here.</p>	<p>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 the 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 ex-rays and electrocardiograms performed via asynchronous store and forward – for including in the patient’s medical record.</p>	<p><u>Changed the “Technical & Professional Components” language to now read:</u></p> <p>All health care practitioners providing covered benefits or services to Medi-Cal recipients must maintain appropriate documentation to substantiate the corresponding technical and professional components of billed CPT or HCPCS codes. Document for benefits or services delivered via telehealth should be the same as for a comparable in-person service. The distant site provider can bill for Medi-Cal covered benefits or services delivered via telehealth using the appropriate CPT or HCPCS codes with the corresponding modifier and is responsible for maintaining appropriate supporting documentation. This documentation should be maintained in the patient’s medical record.</p>
PLACE OF SERVICE CODE 02	Not mentioned	Required to use Place of Service Code 02	Same as proposal.
REIMBURSABLE SERVICES	Specific language regarding psychiatric services and asynchronous teleophthalmology, teledermatology and teledentistry.	<p>Medi-Cal covered benefits or services, identified by CPT or HCPCS codes and subject to all existing Medi-Cal coverage and reimbursement policing including any treatment authorization requirements, may be provided via a telehealth modality, either live video or store-and-forward, if all of the following are satisfied:</p> <ul style="list-style-type: none"> Treating provider at the distant site believes that the benefits or services are clinically appropriate based upon 	Same as proposal.

		<p>evidenced-based medicine and best practices to be delivered via telehealth;</p> <ul style="list-style-type: none"> • The benefits or services meet the procedural definition and components of the CPT/HCPCS code as well as any extended guidelines in this section of the Medi-Cal manual; and • The benefits or services meet all laws regarding confidentiality of health care information and patient’s rights to their information. 	
BILLING REQUIREMENTS	<p>Use GT modifier for live video Use GQ modifier for store-and-forward Specific list CPT/HCPCS codes provided but is not a complete list.</p>	<p>Use of the 95 modifier if providing services via live video. Use of the GQ modifier for store-and-forward.</p> <p>For store-and-forward, the following language was included: “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.”</p>	<p>Same as the proposal, however the store-and-forward language regarding email, phone and fax was removed.</p>
E-Consult	<p>Not included.</p>	<p>Billing included two codes that could be used:</p> <p>99358 – Prolonged evaluation and management service before and/or after direct patient care; first hour</p> <p>99359 – Each additional 30 minutes</p> <p>Requirements and guidelines for e-consults:</p> <ul style="list-style-type: none"> • The health care provider at the originating site must create and maintain the following: 	<p>Billing code to use for e-consults:</p> <p>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.</p> <p>99451 is not separately reportable or reimbursable if any of the following is true:</p>

		<ul style="list-style-type: none"> - 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: <ul style="list-style-type: none"> - 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 recommendation with conveyance to the originating site; and - Record of maintenance of transmitted medical records in patient's medical record. 	<ul style="list-style-type: none"> • The distant site provider saw the patient within the last 14 days. • The e-consult results in a transfer of care or other face-to-face service with the distant site provider within the next 14 days or next available appointment date of the distant site provider. • The distant site provider did not spend at least five minutes of medical consultative time, and it did not result in a written report. <p>If more than one contact or encounter is required to complete the e-consult request, the entirety of the service and cumulative discussion and information review time should be reported only once using 99451.</p> <p>99451 is not reimbursable more than once in a seven-day period for the same patient and health care provider.</p> <p>BOTH originating and distant site providers must document the following and maintain in the patient's medical record and make available to DHCS upon request:</p> <p>Originating Site Provider:</p> <ul style="list-style-type: none"> • Record that the e-consult is the result of patient care that has occurred or will occur and relates to ongoing patient management; and • Record of a request for an e-consult by the health care provider at the originating site.
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ORIGINATING SITE AND TRANSMISSION FEE	<p>Q3014 – Originating Site – Once per day, same recipient, same provider</p> <p>T1014 – Originating site and Distant site – Maximum of 90 minutes per day (1 unit = 1 minute), same recipient, same provider.</p>	<p>Contains same language as previous policy. Adds:</p> <p>“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.”</p>	Same as the proposal.