
Medicine: Telehealth

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«The policy in this section is established pursuant to Welfare and Institutions Code 14132.725.» All health care practitioners rendering Medi-Cal covered benefits or services under this policy must comply with all applicable state and federal laws.

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. 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. Consultations via asynchronous electronic transmission initiated directly by patients, including through mobile phone applications, are not covered under this policy.

E-Consults

“E-consults” fall under the auspice of store and forward. 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 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. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers.

E-Visits

“E-visits” are communications between a patient and their provider through an online patient portal.

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. The distant site for purposes of telehealth can be different from the administrative location.

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* [W&I Code], Section 14132.72[e]). The type of setting may include, but is not limited to, a hospital, medical office, community clinic or the patient’s home.

For originating site policy and billing information specific to Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) or Indian Health Services – Memorandum of Agreement (IHS-MOA) 638, Clinics, refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* and *Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics* sections in the appropriate Part 2 manual.

Establishing New Patients via Telehealth

Providers may establish a relationship with new patients via synchronous video telehealth visits.

Providers may establish a relationship with new patients via audio-only synchronous interaction only if one or more of the following applies:

- «The visit is related to sensitive services as defined in subsection (s) of Section 56.05 of the Civil Code. Section 56.05 (s) of the Civil Code defines “sensitive services” as all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender-affirming care, and intimate partner violence, and includes services described in Sections 6924 through 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.»
- The patient requests an audio-only modality.
- The patient attests they do not have access to video.

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 must be otherwise designated by the Department of Health Care Services (DHCS) pursuant to Welfare and Institutions Code (WIC) 14132.725 (b)(2)(A).

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

For policy and billing information specific to FQHCs, RHCs or IHS-MOA clinics, providers may refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* and *Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics* sections in the appropriate Part 2 manual.

«Doula, Community Health Worker (CHW), and Asthma Preventive Services

- Doulas may provide services described in the [Doula Services](#) manual via telehealth.
- Community Health Workers (CHWs) may provide services described in the [Community Health Worker \(CHW\) Preventive Services](#) manual via telehealth
- Asthma preventive education and training services described in the [Asthma Preventive Services \(APS\)](#) manual may be provided via telehealth by unlicensed asthma preventive service providers. In-home environmental trigger assessments for asthma may not be conducted via telehealth and must be conducted in-person.»

Documentation Requirements

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. Documentation 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.

Providers should note the following:

- Health care providers at the distant site 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 covered service or benefit as well as any other requirements described in this section of the Medi-Cal provider manual.
- Health care providers are not required to document a barrier to an in-person visit for Medi-Cal coverage of services provided via telehealth (W&I Code, 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.

«Payment Parity

The amount paid by DHCS and Medi-Cal managed care plans for a service rendered via telehealth is the same as the amount paid for the applicable service when rendered in-person.»

Consent

«Health care providers must inform the patient prior to the initial delivery of telehealth services 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.

If a health care provider, whether at the originating site or distant site, maintains a general consent agreement that specifically mentions use of telehealth as an acceptable modality for delivery of services and includes the required information, as explained below, then this is sufficient for documentation of patient consent and should be kept in the patient's medical file. Providers also need to document when a patient consents to receive services via audio-only prior to initial delivery of services.

The consent shall be documented in the patient's medical file and be available to DHCS upon request.

Providers are required to share additional information with beneficiaries regarding:

- Right to in-person services
- Voluntary nature of consent
- Availability of transportation to access in-person services when other available resources have been reasonably exhausted
- Limitations/risks of receiving services via telehealth, if applicable
- Availability of translation services

Consent requirements may be found in Business and Professions Code, Section 2290.5 [b] and Welfare and Institutions Code, Section 14132.725 [d]. Model patient consent language may be found on the DHCS website.»

Health care providers who bill using the *CMS-1500 Health Insurance Claim Form* are required to report the most applicable Place of Service (POS) code on the claim.

«Patient Choice of Telehealth Modality

Medi-Cal providers can offer a variety of telehealth modalities for covered Medi-Cal services to the extent that the service can be appropriately rendered via the allowable telehealth modalities.

For Medi-Cal providers who do offer telehealth modalities, they are required to offer Medi-Cal recipients the ability to choose whether they want to receive covered Medi-Cal services via:

- Synchronous, interactive audio/visual telecommunication systems (for example, video) or
- Synchronous, telephone or other interactive audio-only telecommunications systems.

While Medi-Cal providers are required to offer both video and telephone telehealth modalities, Medi-Cal recipients may freely choose, and change at any time, their desired telehealth modalities, which includes the ability to decline video modalities and select audio-only (telephone) modalities if preferred and/or necessary given the recipient's needs.

For example, if the visit is related to sensitive services as defined in subsection (s) of Section 56.05 of the Civil Code, then the Medi-Cal recipient may prefer to utilize an audio-only (telephone) modality.

Medi-Cal recipients shall be given the choice of how they receive their covered Medi-Cal services.

Exception to Telehealth Modalities Provider Requirement

Since broadband is necessary to ensure quality and effective communication between Medi-Cal providers and recipients, Medi-Cal providers are exempt from the requirement to offer both telehealth modalities if the Medi-Cal provider does not have access to broadband.

Note: Broadband refers to high-speed internet access that is always on and faster than traditional dial-up access. Broadband includes several high-speed transmission technologies, such as fiber, wireless, satellite, digital subscriber line, and cable. For the purposes of delivering telehealth services to patients, DHCS uses the Federal Communications Commission's (FCC) definition of broadband and the FCC minimum mbps upload/download speeds.

Medi-Cal providers claiming this exception must maintain appropriate supporting documentation, which should be made available to DHCS upon request. For example, supporting documentation might include confirmation from an internet services provider regarding the lack of broadband service in a particular coverage area.››

«Right to In-person Services

Medi-Cal providers furnishing services to Medi-Cal recipients through telehealth modalities must also either offer services in-person or have a documented process in place to link Medi-Cal recipients to in-person care within a reasonable time if in-person services are unavailable from the provider.

If the Medi-Cal provider chooses to link the Medi-Cal recipient to in-person care to satisfy this requirement, then they must provide a referral to and facilitation of in-person care that does not require a recipient to independently contact a different Medi-Cal provider to arrange for such care. The Medi-Cal provider may initiate a process by which a different Medi-Cal provider in their office or an affiliated in-person care site contacts the Medi-Cal recipient directly to schedule an in-person visit.

The referring Medi-Cal provider or a member of their staff must confirm the referred Medi-Cal provider has at least attempted to contact the recipient to schedule an in-person appointment. However, the Medi-Cal referring provider is not required to schedule an appointment with a different provider on behalf of the Medi-Cal recipient. The Medi-Cal provider must offer referral and facilitation support that is minimally burdensome to the Medi-Cal recipient.

Medi-Cal providers must maintain documentation of their process to link Medi-Cal recipients to in-person care, which should be made available to DHCS upon request.»

Reimbursable Telehealth Services

Medi-Cal covered benefits or services, 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, as outlined in this section, only 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;
- 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 (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 meet all laws regarding confidentiality of health care information and a patient's right to his or her medical information.

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 visual 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.
- For services or benefits provided via synchronous telephone or other real-time interactive **audio-only** telecommunications systems, the health care provider bills with modifier 93.

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 otherwise require the in-person presence of the patient for any reason.

Billing Requirements

The following provides information about billing requirements for specific telehealth services.

Synchronous, Telephone or Other Interactive Audio-only Telecommunications Systems: Modifier 93

Modifier 93 must be used for Medi-Cal covered benefits or services delivered via synchronous, telephone or other interactive audio-only telecommunications systems. Only the portion(s) of the telehealth service rendered at the distant site are billed with modifier 93. The use of modifier 93 does not alter reimbursement for the CPT or HCPCS code.

Health care providers must use an interactive audio-only telecommunications system that permits real-time communication between the provider at the distant site and the patient at the originating site. The audio 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 totality of the communication of information exchanged between the provider and the patient during the audio-only service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.

Providers must document in the patient's medical file that the patient has given a written or verbal consent to the audio-only telehealth encounter.

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 or HCPCS code.

Health care providers must use an interactive audio, video or data telecommunications system that permits real-time communication between the health care provider at the distant site and the patient at the originating site. 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.

Under federal regulations (*Code of Federal Regulations*, Title 42, Section 410.78), the presence of a health care provider at the originating site is not required as a condition of payment for the telehealth service unless the health care provider at the distant site determines it is medically necessary.

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 modifier 95). The E&M service must be in real-time or near real-time (delay in seconds) 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, teledentistry and teleradiology, delivered via asynchronous store and forward telecommunications systems, including e-consults. Only the service(s) rendered from the distant site must be billed with modifier GQ.

The use of modifier GQ does not alter reimbursement for the CPT or HCPCS code billed. For additional information about policy and billing requirements relating to teledentistry, providers may refer to “Teledentistry” in the *Medi-Cal Dental 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 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.

E-Consults

For the definition of “e-consult,” providers may refer to the “Definitions” heading previously in this section.

A health care provider at the distant site may bill for an e-consult with the CPT code listed below when the benefits or services delivered meet the procedural definition and components of the CPT code as defined by the AMA as well as any requirements described in this section of the Medi-Cal provider manual.

When billing for e-consults, health care providers at the originating and distant sites must clearly document the following information relating to previous and/or pertinent health care services, maintain this information in the patient's medical record and make it available to DHCS upon request:

- A health care provider at the originating site must create and maintain the following:
 - A record that the e-consult is the result of patient care that has occurred or will occur and relates to ongoing patient management; and
 - A record of a request for an e-consult by the health care provider at the originating site.
- In order to bill for e-consults, 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; and
 - A written report of case findings and recommendations with conveyance to the originating site.

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

Table of CPT and HCPCS Codes for E-Consults»»

«CPT/HCPCS Code»	Description
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
«G9037	Interprofessional telephone/internet/electronic health record clinical question/request for specialty recommendations by a treating/requesting physician or other qualified health care professional for the care of the patient (i.e., not for professional education or scheduling) and may include subsequent follow up on the specialist's recommendations; 30 minutes»»

In accordance with the AMA requirements, CPT code 99451 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 e-consult results in a transfer of care or other face-to-face service with the distant site provider (consultant) within the next 14 days or next available appointment date of the consultant.
- The distant site provider did not spend at least five minutes of medical consultative time, and it did not result in a written report.

If more than one contact or encounter is required to complete the e-consult request, the entirety of the service and cumulative discussion and information review time should be reported only once using CPT code 99451.

CPT code 99451 is not reimbursable more than once in a seven-day period for the same patient and health care practitioner.

Medi-Cal covered benefits or services provided at the originating site (in-person) with the patient in connection with an e-consult are billed according to standard Medi-Cal policies (without modifier GQ).

The e-consult policy is not applicable for FQHCs, RHCs or IHS-MOA clinics. For policy and billing information specific to FQHCs, RHCs or IHS-MOA clinics, providers may refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* and *Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics* sections in the appropriate Part 2 manual.

Brief Virtual Communications and Check-Ins

Virtual or telephonic communication includes a brief communication with an established patient not physically present (face-to-face). Medi-Cal providers may be reimbursed using 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.

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 to 10 minutes of medical discussion. G2012 can be billed when the virtual communication via a telephone call.

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 fees and transmission fees are not available for audio-only synchronous services.

Originating Site and Transmission Fee Restrictions

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

HCPCS Codes with Restrictions for Billing

HCPCS Code	Transmission Site	Frequency Limit
Q3014	Originating site	Once per day, same patient, same provider
T1014	Originating site and distant site	Maximum of 90 minutes per day (1 unit = 1 minute), same patient, 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 IHS-MOA clinics. For policy and billing information specific to FQHCs, RHCs or IHS-MOA clinics, providers may refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* and *Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics* sections in the appropriate Part 2 manual.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
«	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
»	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.