Telehealth Modalities

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The policy in this section is established pursuant to *Welfare and Institutions Code (WIC)* section 14132.725. All health care providers rendering Medi-Cal covered benefits or services using telehealth modalities must comply with all applicable state and federal laws as well as all policy requirements outlined in this section.

Definitions

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

Telehealth

"Telehealth" means the mode of delivering Medi-Cal covered health care benefits and services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Medi-Cal member's (referred to as member throughout this policy) health care. Telehealth modalities can help facilitate member self-management and caregiver support and include synchronous and asynchronous interactions.

Distant Site

"Distant site" means a site where the rendering health care provider is located while providing Medi-Cal covered benefits or services via a telecommunications system.

Originating Site

"Originating site" means a site where a member is located at the time Medi-Cal covered benefits or services are provided via synchronous interaction using a telecommunications system or where the asynchronous interaction, including store and forward, originates. For purposes of reimbursement for Medi-Cal covered treatment or services provided through telehealth modalities, the originating site is not limited (*WIC* Section 14132.72[e]) and may include, but is not limited to, a hospital, medical office, community clinic, or the member's home.

Note: Refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)*, *Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, or Tribal Federally Qualified Health Center Clinics* sections in the appropriate Part 2 manual for originating site policy and billing information specific to FQHCs, RHCs or IHS-MOA 638, or Tribal FQHC Clinics.

Synchronous Interaction

"Synchronous interaction" means a real-time, two-way interaction between a member located at an originating site and a health care provider located at a distant site. This type of telehealth modality mirrors a traditional, face-to-face interaction and is supported by Health Insurance Portability and Accountability Act (HIPAA)-compliant video conferencing platforms or telephone calls. For more information, see the comparison chart below. Key features of synchronous interactions include, but are not limited to, the following:

- The member and health care provider are communicating in real-time or near real time.
- The member and health care provider can interact in real-time with immediate feedback, ask follow-up questions, and the provider can engage in informed clinical decision-making.

Asynchronous Interaction, including Store and Forward

Asynchronous interaction, including "store and forward," means the transmission of a member's medical information (for example, images, videos, laboratory and medical records, or other documents/information) from an originating site to the health care provider at a distant site. This is commonly used in the areas of teledermatology (for example, skin condition images), teleradiology (for example, X-rays, CT scans, etc.), and teleopthamaology (for example, retina images). It does not include store and forward initiated by the member. See the "Brief Virtual Communication" policy in this section for asynchronous interaction, including store and forward, initiated by the member.

Note: This policy does not include consultations via asynchronous electronic transmission through mobile telephone applications, emails, online questionnaires or fillable forms, chats and text messages.

Synchronous vs. Asynchronous Interaction

Synchronous Interaction	Asynchronous Interaction
Real-time (live interaction)	Not real-time (data or imagine sent for review, may be later)
Two-way, interactive	One-way, non-interactive
Video conferencing or telephone	HIPAA-compliant messaging platform, image upload system
Typically requires advance scheduling by the health care provider and simultaneous communication between member and health care provider.	No advance scheduling required and information can be sent anytime. Interaction initiated by the provider. Member and health care provider have increased flexibility.

E-Consults

“E-consults” are a specific type of asynchronous interaction that falls 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 member’s treating health care provider (attending or primary) requests the opinion and/or treatment advice of another health care provider (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the member’s health care needs without face-to-face contact with the consultant provider. 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 non-face-to-face synchronous communications between members and their health care providers through secure, online portals. E-visits are not allowable telehealth modalities for delivery of health care services covered by Medi-Cal.

Brief Virtual Communications

“Brief virtual communications” are short/limited duration communications with members who already have an established patient relationship with a health care provider using either synchronous telehealth or asynchronous telehealth interactions (for example, recorded videos or images).

Establishing New Patient Relationships via Telehealth

Health care providers may establish new patient relationships with members via two-way, audio-visual synchronous interactions (for example, HIPAA-compliant video conferencing platforms).

In limited circumstances, health care providers may also establish new patient relationships with members via audio-only synchronous interactions 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 member at or above the minimum age specified for consenting to the service specified in the section.
- The member requests an audio-only modality.
- The member attests that they do not have access to secure video conferencing platforms.

Note: Health care providers may not establish new patient relationships with members via asynchronous telehealth interaction, including store and forward, for any Medi-Cal covered benefit or service.

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

Health Care Provider Requirements

Health care providers rendering Medi-Cal covered benefits or services using telehealth modalities 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 WIC Section 14132.725 (b)(2)(A). Health care providers must satisfy all Medi-Cal provider enrollment requirements.

Health care providers rendering Medi-Cal covered benefits or services via a telehealth modality must be licensed in California and enrolled as a Medi-Cal rendering provider or affiliated with an enrolled Medi-Cal provider group that is physically located in California. 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.

Note: Subject to very limited exceptions for some provider types established by DHCS, all health care providers must meet Established Place of Business (EPOB) requirements (*California Code of Regulations*, Title 22, section 51000.60). As a result, the EPOB requirement does not apply to fully remote, non-California based health care providers who offer services exclusively through telehealth modalities or at an administrative location that does not meet all EPOB and/or other Medi-Cal provider enrollment requirements.

For policy and billing information specific to FQHCs, RHCs, IHS-MOA or Tribal FQHC Clinics, providers may refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)*, *Indian Health Services (IHS), Memorandum of Agreement (MOA) 638 Clinics*, and *Tribal Federally Qualified Health Centers (*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 synchronous telehealth.
- CHWs may provide services described in the *Community Health Worker (CHW) Preventive Services* manual via synchronous telehealth. CHWs may not provide services via store and forward.
- Asthma preventive education and training services described in the *Asthma Preventive Services (APS)* manual may be provided via synchronous 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 providers providing Medi-Cal covered benefits or services to members must maintain appropriate documentation to substantiate the corresponding technical and professional components of billed CPT® or HCPCS codes. Documentation for Medi-Cal covered 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 member's medical record.

Health care 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 (*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.

Payment Parity

The amount reimbursed by DHCS to Medi-Cal enrolled fee-for-service health care providers and by Medi-Cal managed care plans to contracted providers for Medi-Cal covered services rendered via telehealth modalities are the same as the amount paid for the applicable service when rendered in-person.

Consent

Health care providers must inform the member prior to the initial delivery of telehealth services about the use of telehealth and obtain verbal or written consent from the member for the use of telehealth as an acceptable mode of delivering Medi-Cal covered benefits or 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 (either synchronous or asynchronous interactions) as an acceptable modality for delivery of Medi-Cal covered benefits or services and includes the required information, as explained below, then this is sufficient for documentation of member consent and should be kept in the member's medical file. Health care providers also need to document when a member consents to receive services via audio-only synchronous interactions prior to initial delivery of Medi-Cal covered benefits or services.

The consent shall be documented in the member's medical file and be available to DHCS upon request. Health care providers are required to share additional information with members regarding the following topics:

- Right to face-to-face/in-person services
- Voluntary nature of consent
- Availability of transportation to access face-to-face/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 *B&P Code*, Section 2290.5 [b] and *WIC*, Section 14132.725 [d]. Model member consent language may be found on the DHCS' Patient Consent 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, which may include POS code 02 for telehealth provided other than in the member's home or POS code 10 for telehealth provided in the member's home.

Patient Choice of Telehealth Modality

Health care providers can offer a variety of telehealth modalities for covered Medi-Cal benefits and services to the extent that the benefit or service can be appropriately rendered via the allowable telehealth modalities under this policy. However, health care providers are not required to offer telehealth modality options, although DHCS strongly encourages them to do so to promote greater access to care and reduce barriers.

Health care providers who choose to offer telehealth modalities are required to offer members 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 health care providers may offer both video and audio-only (telephone) telehealth modalities, members 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 member'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 member may prefer to utilize an audio-only (telephone) modality.

Members shall be given the choice of how they receive their covered Medi-Cal benefits and services that may be delivered appropriately via telehealth modalities.

Exception to Telehealth Modalities Provider Requirement

Since broadband is necessary to ensure quality and effective visual communication between health care providers and members, health care providers are exempt from the requirement to offer both telehealth modalities if the health care 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 members, DHCS uses the Federal Communications Commission's (FCC) definition of broadband and the FCC minimum mbps upload/download speeds.

Health care 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

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

If the health care provider chooses to link the member 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 member to independently contact a different health care provider to arrange for such care. The health care provider may initiate a process by which a different health care provider in their office or an affiliated in-person care site contacts the member directly to schedule an in-person visit.

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

Health care providers must maintain documentation of their process to link members 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) or *Service Authorization Requests* (SAR) 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 Medi-Cal covered benefits or services being provided are clinically appropriate based upon evidence-based medicine and/or best practices to be delivered via telehealth;
- The Medi-Cal covered benefits or services delivered via telehealth modalities 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 Medi-Cal covered benefits or services provided via telehealth modalities meet all laws regarding confidentiality of health care information and a member's right to his or her medical information.

Medi-Cal covered benefits or services provided via a telehealth modality are reimbursable when billed as follows:

- For Medi-Cal covered benefits or services provided via synchronous interactions, interactive audio and visual telecommunications systems, the health care provider bills with modifier 95.
- For Medi-Cal covered benefits or services provided via asynchronous interactions, including store and forward, telecommunications systems, the health care provider bills with modifier GQ.
- For Medi-Cal covered benefits or services provided via synchronous interactions, including 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 Medi-Cal covered benefits or services that would not be expected to be appropriately delivered via telehealth include, but are not limited to, Medi-Cal covered benefits or services that are performed in an operating room or while the member 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 member for any reason.

Billing Requirements

The following provides information about billing requirements for specific Medi-Cal covered benefits or services via telehealth modalities.

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 Medi-Cal covered benefit or service rendered via a telehealth modality at the distant site is 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 health care provider at the distant site and the member 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 to adequately complete all necessary components to document the level of service for the CPT or HCPCS code billed.

The totality of the communication of information exchanged between the health care provider and the member 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.

Health care providers must document in the member's medical file that the member has given 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 service rendered via telehealth at the distant site is 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 member 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 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.

Note: Evaluation and Management (E&M) and all other medically necessary Medi-Cal services provided at the originating site (in-person with the member) during a telehealth encounter are billed according to standard Medi-Cal policies (without modifier 95).

Asynchronous Interactions - 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 interactions, including store and forward telecommunications systems. This includes health care provider 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 member’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

A health care provider at the **distant site** (consultative provider) may bill for an e-consult with CPT code 99451, described 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.

A health care provider at the **originating site** (treating/referring provider) may bill for an e-consult with CPT code 99452, described 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 member's medical record, and make it available to DHCS upon request:

- A health care provider at the originating site (treating/referring provider) must create and maintain the following:
  - A record that the e-consult is the result of member care that has occurred or will occur and relates to ongoing member 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 (consultative provider) 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.

The health care provider at the distant site (consultant) may use the following CPT code to bill for e-consults in conjunction with modifier GQ:

Table of E-Consult CPT Codes for Distant Site (Consultant) Providers

CPT Code	Description
99451	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, 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

The health care provider at the originating site (treating/referring) may use the following CPT code to bill for e-consults in conjunction with modifier GQ:

Table of E-Consult CPT Codes for Originating Site (Treating/Referring) Providers

CPT Code	Description
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes

CPT Code 99451

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

The distant site (consultant) provider may be a physician or other qualified health care professional. For more information, refer to the *Non-Physician Medical Practitioners (NMP)* section in this manual.

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 member and health care provider.

CPT Code 99452

In accordance with the AMA requirements, CPT code 99452 is not separately reportable or reimbursable if the originating site (treating/requesting) provider did not spend at least 16 minutes preparing for the referral and/or communicating with the distant site (consultant) provider.

The originating site (treating/requesting) provider may be a physician or other qualified health care professional. For more information, refer to the *Non-Physician Medical Practitioners (NMP)* section in this manual.

CPT code 99452 is not reimbursable more than once in a 14-day period for the same member and originating site (treating/requesting) provider.

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

The e-consult policy is not applicable to FQHCs, RHCs, IHS-MOA, or Tribal FQHC clinics and they may not separately bill. For policy and billing information specific to FQHCs, RHCs IHS-MOA, or Tribal FQHC 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,* and *Tribal Federally Qualified Health Centers* sections in the appropriate Part 2 manual.

Brief Virtual Communications

Virtual or telephonic communication includes a brief communication initiated by the member between a health care provider and a member when the member is not physically present (in-person). The member must already have an established patient relationship with the health care provider. This code cannot be used to establish a new patient relationship. Health care providers may be reimbursed using HCPCS code G2010 or CPT code 98016 for brief virtual communications.

- **HCPCS code G2010**: Remote evaluation of recorded video and/or images submitted by an established patient (for example, store and forward), including interpretation with follow-up with the patient within 24 hours, not originating from a related E&M service provided within the previous seven days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment.
- **CPT code 98016**: Brief communication technology-based service 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 seven days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment; five to 10 minutes of medical discussion. Code 98016 can be billed when the virtual communication is via a telephone call.

The brief virtual communication policy is not applicable for FQHCs, RHCs, or IHS-MOA , or Tribal FQHC Clinics, and they may not separately bill for it. For policy and billing information specific to FQHCs, RHCs, IHS-MOA, or Tribal FQHCs, 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, Tribal Federally Qualified Health Center Clinics* sections in the appropriate Part 2 manual.

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 equals 1 minute), same patient, same provider

If billing store and forward, including e-consult, health care providers at the originating site may bill the originating site fee with HCPCS code Q3014 when using electronic record (for example, email) transfers, 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, or Tribal FQHC clinics. For policy and billing information specific to FQHCs, RHCs, IHS-MOA.or Tribal FQHC 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, or Tribal Federally Qualified Health Center 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.