



AGENDA

**Children’s Health Consultant Advisory Committee Meeting
Board of Governors**

Friday, June 26, 2020, 1:00 p.m.
L.A. Care Health Plan, 1055 W 7th Street, 10^t Floor, Los Angeles, CA 90017

California Governor issued Executive Order N-25-20, N-29-20, which among other provisions amends the Ralph M. Brown Act and Executive Order N 33-20, ordering all residents to stay in their homes, except for specific essential functions. Accordingly, members of the public should now listen to this meeting via teleconference or videoconference as follows:

To join the meeting via videoconference please register by using the link below:
<https://lacare.webex.com/lacare/onstage/g.php?MTID=e6d0c7d8a8959abd95182d7ec01892e4c>

To join the meeting via teleconference please dial:
+1-415-655-0002
Meeting Number: 146 419 3298

Members of the Board of Governors or staff may also participate in this meeting via videoconference or teleconference. *The public is encouraged to submit its public comments or comments on Agenda items in writing by e-mail to boardservices@lacare.org, or by a text or voicemail to 213 628 6420.*

The text, voicemail, or email should indicate if you wish to be identified or remain anonymous, and should also include the name of the item to which your comment relates.

Comments received by voicemail, email or text by 1:00 pm on June 26, 2020 will be provided in writing to the members of the Children’s Health Consultants Advisory Committee at the meeting.

Once the meeting has started, emails and texts for public comment should be submitted before the item is called by the meeting Chair. If you wish to submit public comment on an item, you must submit it at any time prior to the time the Chair starts consideration of the item. The Chair will ask for public comment and will announce the item. The Chair will announce when public comment period is over.

Public comments will be read for up to 3 minutes at the meeting.

All votes in a teleconferenced meeting shall be conducted by roll call.

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Welcome

Tara Ficek, MPH
Chair

- 1. Approve today’s Agenda *Chair*
- 2. Public Comment *Chair*
- 3. Approve January 21, 2020 meeting minutes P.3 *Chair*
- 4. Chairperson Report *Chair*
- 5. Chief Medical Officer Report Richard Seidman, MD, MPH
 - COVID-19 Update *Chief Medical Officer*

DRAFT

6. Preventive Care for Women & Children in the COVID-19 Era P.9 Katrina Miller Parrish, MD, FAAP,
*Chief Quality and Information Executive,
Health Services*
Jacqueline Kalajian, MPH,
*Health Education Program Manager II,
Health Education*
Keren Mahgerefteh, MPP,
QI Project Manager II
Sinthu Kumar, MPH,
*Quality Improvement Project Manager II,
Quality Improvement*
Grace Mhi Kim Crofton, MPH,
Advisor Quality Performance Informatics

ADJOURNMENT

The next meeting is scheduled on August 18, 2020 at 8:30 a.m.

Please keep public comments to three minutes or less.

The order of items appearing on the agenda may change during the meeting.

If a teleconference location is listed at the top of this agenda, the public can participate in the meeting at that location or by calling the teleconference call in number provided. If teleconference arrangements are listed at the top of this Agenda, note that the arrangements may change prior to the meeting. To confirm details with L.A. Care Board Services staff prior to the meeting call (213) 694-1250, extension 4183 or 4184.

THE PUBLIC MAY ADDRESS THE BOARD OF GOVERNORS BEFORE DISCUSSION OF EACH ITEM LISTED ON THE AGENDA BY FILLING OUT A “REQUEST TO ADDRESS” FORM AND SUBMITTING THE FORM TO L.A. CARE STAFF PRESENT AT THE MEETING BEFORE THE AGENDA ITEM IS ANNOUNCED. YOUR NAME WILL BE CALLED WHEN THE ITEM YOU ARE ADDRESSING WILL BE DISCUSSED. THE PUBLIC MAY ALSO ADDRESS THE BOARD ON OTHER L.A. CARE MATTERS DURING PUBLIC COMMENT.

NOTE: THE CHILDREN’S HEALTH CONSULTANT ADVISORY COMMITTEE CURRENTLY MEETS ON THE THIRD TUESDAY EVERY TWO MONTHS AT 8:30 A.M. POSTED AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION AT Board Services, 1055 W. 7th Street – 10th Floor, Los Angeles, CA 90017.

Any documents distributed to a majority of the Board Members regarding any agenda item for an open session after the agenda has been posted will be available for public inspection at Board Services, L.A. Care Health Plan, 1055 W. 7th Street, 10th Floor, Los Angeles, CA 90017, during regular business hours, 8:00 a.m. to 5:00 p.m., Monday – Friday.

AN AUDIO RECORDING OF THE MEETING MAY BE MADE TO ASSIST IN WRITING THE MINUTES AND IS RETAINED FOR 30 DAYS.

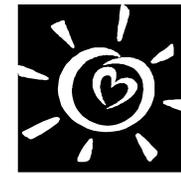
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BOARD OF GOVERNORS

Children’s Health Consultant Advisory Committee

Meeting Minutes – January 21, 2020

1055 W. Seventh Street, Los Angeles, CA 90017



L.A. Care
HEALTH PLAN

Members

Tara Ficek, MPH, *Chair*
Linda Aragon, MPH *
Edward Bloch, MD *
Maria Chandler, MD, MBA **
Tanya Dansky, MD
Rebecca Dudovitz, MD, MS

Lyndee Knox, PhD
Rosina Franco, MD
Toni Frederick, PhD
Gwendolyn Ross Jordan *
Nayat Mutafyan*
Maryjane Puffer, BSN, MPA*

Management

John Baackes, *CEO*

Diana Ramos, MD *
Richard Seidman, MD, MPH
Diane Tanaka, MD *
James Kyle, MD
Hilda Perez

*Absent **Via Teleconference

***Via Teleconference (Not posted - not counted as Quorum)

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Tara Ficek, MPH, <i>Chair</i> called the meeting to order at 8:35 a.m. without quorum.	
APPROVAL OF MEETING AGENDA	The Committee reached a quorum at 8:55 a.m. The Agenda for today’s meeting was approved as submitted.	Approved unanimously. 10 AYES (Chandler, Dansky, Dudovitz, Ficek, Franco, Frederick, Knox, Kyle, Perez, Seidman)
APPROVAL OF THE MEETING MINUTES	The minutes of the November 19, 2019 meeting were approved as submitted.	Approved unanimously. 10 AYES
CHAIRPERSON REPORT	There was no report from the Chairperson.	
CHIEF MEDICAL OFFICER REPORT Richard Seidman, MD, MPH	Richard Seidman, MD, MPH, <i>Chief Medical Officer</i> , reported on the following: <u>Flu Season</u> January is peak influenza season in Los Angeles. As of one week ago emergency room visits were declining, but are still significantly elevated over prior years. The first week of January 2020, 8.3% of deaths in Los Angeles county were attributed to flu and	

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	<p>pneumonia as a complication. Vaccines are still available to members at their doctor offices and at contracted pharmacies.</p> <p><u>Lead Screening</u> The State Auditor released a report on lead screening in January 2020. He noted that California does not do as well as other states with lead screening. The overall screening rate in California was 36% for children who are covered by Medi-Cal. The national average is 45%. L.A. Care’s screening rate is just under 66%. This puts L.A. Care in the 25th percentile of health plans reporting. He believes L.A. Care can do better. About 5% of all screenings have elevated levels. There are about six census tracks with the highest rates of positive screenings, in the southern areas of the County, west of Long Beach. The Department of Public Health and L.A. Care’s quality team are developing new interventions to increase screening rates.</p>	
<p>LAUSD Wellness & School-based health clinics Rosina Franco, MD</p>	<p>Member Rosina Franco, MD, presented information on Los Angeles Unified School District (LAUSD) Wellness & School-based health clinics. <i>(A copy of the presentation can be obtained from Board Services.)</i></p> <p>There are 14 clinics located inside 14 different LAUSD schools that provide free services to students including vision and reproductive health services. Free services are also provided to siblings living in L.A. County. Services are not provided to adults or other community members. Some visits are billable, many are not. Services are billed to Children’s Health and Disability Prevention program, Health Net, and L.A. Care. This allows them to recover some costs for the services that are provided.</p> <p>Other services include helping students apply on site for temporary Medi-Cal, physical exams for sports and school entry, follow-up visits, vaccines, and referrals to specialists as needed. Many times LAUSD are the first services that immigrants access when they enter the country, and the first medical care services.</p> <p>Non-billable services include:</p> <ul style="list-style-type: none"> • Non-urgent care visits • Nutrition counseling • Obesity management • Case management • Vision Services. 	

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	<p>Vision Services include:</p> <ul style="list-style-type: none"> • Three clinics that provide optometry services (Foshay Health Center, Telhair Elementary School Clinic, San Pedro Vision Clinic) • Optometry exams for glasses • Dispense glasses • Foshay Health Center provides Ophthalmology exams depending on need <p>Member Tanya Dansky, MD, asked if there are statistics on how many students need glasses. Member Franco responded that she does not have those numbers, because they provide services to students and children from other school districts and she doesn't have that data. There are services provided by other community organizations in L.A. County.</p> <p>Reproductive Health:</p> <ul style="list-style-type: none"> • Partnerships with Valley Community Healthcare and Planned Parenthood Los Angeles • Partners provide: medical assistance, medications and dispensing on site, equipment for lab collection, on site lab tests, equipment for electronic health record documentation <p>Other Partnerships:</p> <ul style="list-style-type: none"> • LAUSD District Nursing Communicable Disease Team: Telfair Elementary School Clinic, Roosevelt/Hollenbeck Clinic, School Enrollment Placement and Assessment Center Clinic, Zelzah Wellness Clinic • LAUSD Healthy Start • Mental Health Providers include LAUSD School Mental Health, Department of Mental Health, and other community agencies • Kaiser Sunset Community Medicine Fellowship Program: Hollywood High School Wellness Center • Kurka Foundation assists with vision clinic costs <p>Member Toni Frederick, MD, asked if a clinic is located at Kaiser on Sunset. Member Franco responded that the clinic is located at Hollywood High School and the Kaiser Sunset Community Medicine Fellowship Program sends medical staff to provide services there.</p>	

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	<p>Member James Kyle, MD, asked if they are able to keep up with the needs of students. Member Franco responded that they work to capacity and sometimes past capacity. They try their best to keep up. In regard to vision care, because other entities do provide vision services they are able to meet the needs of students that require vision services.</p> <p>Member Seidman asked the percentage of students with Medi-Cal who receive services. Member Franco responded that 90% of students receive Medi-Cal benefits, most of the students that are seen are eligible and so they are enrolled. Member Seidman also asked what percentage of students are undocumented. Member Franco responded that the number is close to 30%-40%. Many times LAUSD clinics are the first medical providers that immigrant students see.</p> <p>Member Franco noted that they do not turn away students based on their health insurance status or insurance coverage.</p> <p>Partner with 15 wellness centers in L.A. County that provide the following services:</p> <ul style="list-style-type: none"> • Primary health care, physical exams, sports physicals, immunizations, reproductive health, health education, STD/HIV testing, health insurance enrollment, vision screening and referral • Individual mental health counseling, group counseling, parent education, evidence based practice • Routine dental services including cleaning, fluoride treatment, cavity prevention, fillings, education <p>Member Lyndee Knox, PhD, asked if there is a strategic plan for LAUSD to have these services at every facility. Member Franco responded that this question is more for the Superintendent. There currently is no plan available to the public. She noted that Member Maryjane Puffer, BSN, is more involved in those conversations.</p> <p>Member Hilda Perez asked what method LAUSD is using to get the information to students and parents. She is unaware that the services are available. Member Franco responded that it is difficult to reach everyone because it is a large school district. She stated that LAUSD reaches out to administrators by email and also has a website, but it is a challenge to get everyone on board.</p> <p>John Baackes, <i>Chief Executive Officer</i>, asked if they provide services to students in Charter schools. Member Franco responded that they do not turn patients away. They serve</p>	

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	LAUSD students and their siblings, and Charter school students that live in the area and go to a clinic will receive services.	
<p>Trauma Informed Care Karen Gross</p>	<p>Mr. Baackes introduced Karen Gross. He and Ms. Gross were colleagues and friends prior to his position with L.A. Care. He noted that Ms. Gross is an attorney by training, and she practiced and taught law. She made a career change and became the President at a southern Vermont college that focused on first generation college students. When she retired and moved to Washington she became an author. She wrote a book called “Lady Lucy’s Quest,” and is about empowerment for young children. It was meant to develop a child’s self-awareness and comprehension. The books were distributed through L.A. Care’s community resource centers.</p> <p>Ms. Gross thanked Mr. Baackes and the committee for inviting her to speak, and she presented information on Trauma Informed Care.</p> <p>Her focus is to improve student success from early childhood through early adulthood. She is deeply interested in the work proposed by California Surgeon General and Governor with respect with Adverse Childhood Experience Scores (ACES). She noted that many of the changes proposed are at a micro level. Medical providers can give a test to children and their families then link the children with high scores to other resources.</p> <p>The psychological and physiological response to trauma should not be left untreated. There should be an assessment of the effectiveness of interventions. She noted that people carry trauma with them even if it is not visible. Sometimes trauma can be carried for an entire life. If not treated promptly it can affect their early childhood education into adulthood. In the short term it can affect educational success and, in the long term physical and psychological wellbeing.</p> <p>She suggested the following to treat trauma:</p> <ul style="list-style-type: none"> • Reading • Talking and expressing traumatic experiences • Engage all senses • Play tables with toys and figures to help children free their minds and trigger signals • Two adults outside of the family who care about the child (can be a religious figure, doctor, nurse, teacher, etc.) 	

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	<p>Trauma takes away:</p> <ul style="list-style-type: none"> • Safety, safe places (a place where children can find comfort) • Structure • Stability • Subtlety • Someone (people who can help with Trauma) <p>Ms. Gross suggested that L.A. Care community resource centers become sites that treat childhood trauma. Mr. Baackes responded that he thinks it would be a good idea to add that service in the future.</p> <p><i>(Ms. Gross shared sensory toys and items used to engage children's senses and trigger signals.)</i></p>	
COMMITTEE ISSUES		
Review Committee Charter Richard Seidman, MD, MPH	This agenda item was tabled for a future meeting.	
Committee Membership Richard Seidman, MD, MPH	Member Seidman presented the following motion to the committee: <u>Motion CHC 100.0320</u> To appoint Ilan Shapiro Strygler, MD, FAAP as member of Children's Health Consultant Advisory Committee (CHCAC), for the Children's Health Care Providers representative seat for the Board of Governors of L.A. Care Health Plan.	Approved unanimously. 10 AYES
ADJOURNMENT	The meeting was adjourned at 10:02 a.m.	

Respectfully submitted by:

Malou Balones, *Board Specialist III, Board Services*
Victor Rodriguez, *Board Specialist II, Board Services*
Linda Merkens, *Senior Manager, Board Services*

APPROVED BY:

Tara Ficek, MPH, *Chair*. _____

Date Signed: _____

Promoting Preventive Services for Women and Children in the COVID Era



L.A. Care
HEALTH PLAN®

For All of L.A.



**ELEVATING
HEALTHCARE**
IN LOS ANGELES COUNTY
— SINCE 1997 —

Presenters (in order of Presenting)



Dr. Katrina Miller
Parrish MD, FAAFP
Chief Quality and
Information Executive



Jacqueline Kalajian, MPH
Health Education Program
Manager II



Keren Mahgerefteh MPP
QI Project Manager II



Sinthu Kumar, MPH
QI Project Manager II



Brigitte Bailey, MPH
Health Education Program
Manager II



Grace Crofton, MPH
Advisor Quality
Performance
Informatics



Nai Kasick, MPH
Chair of the PPC
Committee



Agenda

Topic	Presenter	Slide #	PDF#
Background	Dr. Katrina Miller Parrish MD, FAAFP	4	12
Maternal/Infant Health	Jacqueline Kalajian, MPH	5-8	13-16
Child & Adolescent Health	Keren Mahgerefteh MPP	9-13	17-21
Women's Health	Sinthu Kumar, MPH Brigitte Bailey, MPH	14-16	22-24
Guidance to Provider Groups and Practitioners	Grace Crofton, MPH	17-18	25-26
Questions & Comments	Dr. Katrina Miller Parrish MD, FAAFP	19	27



Background

Quality Improvement Initiatives

- **In a typical year, the organization develops various initiatives for members and providers to promote:**
 - Well Care Visits
 - Cancer Screenings
 - Immunizations for adults & children
- **Initiatives are developed by cross functional teams and may originate in various departments across the organization**
 - A TEAM EFFORT!
- **Types of initiatives include:**
 - Member Outreach – automated calls, mailers
 - Provider Outreach – reports, incentives
 - Community Outreach – social media campaigns
- **COVID has led to some modifications, but women and children's health continue to be a priority**



Healthy Pregnancy Program (Prenatal Care)

Method	Intervention	Target Population	COVID-19 Modifications	Status & Timeline
	Live agent outreach calls to assist with prenatal appointment scheduling	PE MCLA members identified through state eligibility file	Health Education Advocate educates members about the availability of telehealth visits and assists with scheduling	Placed on hold from 3/19/20-6/1/20 per DHCS. Calls have resumed
	Monthly member mailing of trimester specific health education materials (Text4Baby, WIC, nutrition, breastfeeding, postpartum depression, Newborn Referral Form, etc.)	Existing and new PE MCLA members identified through state eligibility file	N/A	Continued throughout the program pause.
	N/A	L.A. Care network OB/GYNs and family medicine practitioners (n=758)	COVID-19 guidelines provider fax blast	Distributed 6/15/20-6/16/20

Healthy Mom Program (Postpartum Care)

Method	Intervention	Target Population	COVID-19 Modifications	Status & Timeline
	Live agent outreach calls to assist with postpartum appointment scheduling	MCLA, LACC, & CMC members who have had a recent live delivery using eConnect data	Health Education Advocate educates members about the availability of telehealth visits and assists with scheduling	Placed on hold from 3/19/20-6/1/20. Calls have resumed
	N/A	Women residing in top 20 zip codes for delivery rates, recently had a baby, or selected "pregnancy" as one of their interests	Facebook ad of the state DPH COVID-19 Maternal Health Resources site	5/4/20-7/4/20
	L.A. Care's maternal health landing site with health education information	L.A. Care female members ages 18-45	L.A. Care's maternal health landing site includes the state DPH COVID-19 Maternal Health Resources	Launched on 4/23/20



NEW OFFERING in response to COVID-19

Direct Network and DHS Members - Healthy Pregnancy

- Expansion of the HP activities to support transition to Telehealth services
 - The availability of blood pressure monitor & cuff and weight scale to pregnant members for remote monitoring and reporting
 - Providers are able to refer pregnant members to receive the durable medical equipment. No prior authorization required
 - Medical equipment vendor to send the DME to member after validating mailing address. The turnaround time is less than 48 hours after the order
 - Provider fax blast sent on May 1, 2020
 - L.A. Care direct network OB/GYN and family medicine providers
 - DHS OB/GYN and family medicine providers
 - Program will be evaluated



Healthy Baby Program (Iz for 0-24 months)

Method	Intervention	Target Population	COVID-19 Modifications	Status & Timeline
	Monthly health education mailing (childhood developmental milestones and Iz schedule, Text4Baby, DHCS Newborn Referral Form, etc.)	Parent/guardian of members who are 0-6 months old. Members are identified through enrollment data	In June, DHCS COVID-19 guideline on safety and continuation of care in Healthy Baby mailing cover letter.	Continued throughout the program pause
	Iz preventive health reminder IVR calls	Parent/guardian of members who are 0-6, 8, 11, and 14 months old. Members are identified through enrollment data	N/A	Placed on hold from 3/5/20-4/29/20. Calls have resumed
	N/A	L.A. Care network pediatricians and family medicine practitioners (n=1,804)	COVID-19 guidelines provider fax blast	Distributed 6/10/20-6/14/20



Childhood Immunization Status Combo-10 (CIS-10)

Target population: The percentage of children 2 years of age who had Combination 10 vaccines by their second birthday.

Combination **10** includes: DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV and Influenza vaccinations

Method	Intervention	Target Population	Status & Timeline
	Four separate social media campaigns to remind and increase the rates of childhood vaccines during COVID-19.	Parents/guardians of children aged 2 and under.	May- July 2020 Two campaigns have been completed and two will launch end of June and go into the end of July.
	CIS-10 Performance Improvement Project with St. John's Well Child and Family Center-Possible "Curbside" Vaccine Drive	Children in SPA 6 who are under the age of 2 years old and are assigned to St. John's Well Child and Family Center.	In development Ongoing into 2021
	Missing Vaccine(s) Report + Recording	Providers who have children under 2 in their patient panel.	Launch July 2020



Immunizations for Adolescents Combo 2 (IMA-2)

Target population: Assesses adolescents 13 years of age who had one dose of meningococcal vaccine, one Tdap vaccine and the complete human papillomavirus vaccine series by their 13th birthday.

Method	Intervention	Target Population	Status & Timeline
	Adolescent Social Media Campaign- pre teen vaccine week	Parents/guardians in L.A. County as well as women eligible for cervical cancer screenings.	March 2020-completed
	Missing Vaccine(s) Report + Recording	Providers who have adolescents aged 11-13 in their patient panel.	Launch July 2020



Well Child Visits and Adolescent Well Care Visits (W34 and AWC)

Target population for W34: Assess children 3-6 years of age who received one or more well-child visits with a primary care practitioner during the measurement year.

Target population for AWC: Assesses adolescents and young adults 12-21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.

Method	Intervention	Target Population	Status & Timeline
	Robo Call	Members aged 3-6 and 12-21 who are non compliant for their well check visit.	October 2020 (tentative)
	Bus Shelter and Social Media Paid Ads	Community Members in Specific zip codes in L.A. County	November 2020



Childhood Lead Screening (LSC)

Target population: The percentage of children 2 years of age who had one or more capillary or venous lead blood test to screen for lead poisoning by their second birthday.

Method	Intervention	Target Population	Status & Timeline
	Social Media paid Ads in nine zip	Parents/guardians of children in need of lead screening.	Launch September 2020
	Webinar Speaker from California Department Public Health regarding Lead Screening	Providers in L.A County	Launch October 2020
	Brochures on the Health Education Portal	Providers	June/July 2020
	Provider Opportunity Report (POR)-LSC to be added	Providers	July 2020



Fluoride Varnish

Target population: Children in L.A. County

Method	Intervention	Target Population	Status & Timeline
	Webinar Speaker from UCLA School of Dentistry regarding Oral Health	Providers in L.A. County	September 2020
	Oral Health video	Community Members in L.A. County	Currently on the Community Resource Page



BCS – Breast Cancer Screening Campaign

Target population: women 50-74 who were identified as not having received their breast cancer screening.

Method	Intervention	Target Population	Status & Timeline
	Robo Call #1	Members in CMC, MCLA, LACC LOB	Scheduled for July 2020 - Cancelled
	Mailer	Members in Regional Community Advisory Committee (RCAC) 8 and 9 – South Bay and Long Beach	Scheduled for October 2020 – planning in progress
	Robo Call #2	Members in CMC, MCLA, LACC LOB	Scheduled for October 2020 – planning in progress
	Provider Pay Per Event Program	Providers located in RCAC 9	On hold due to COVID-19



CCS – Cervical Cancer Screening Campaign

Target population: women 21-64 who were identified as not having received their cervical cancer screening

Method	Intervention	Target Population	Status & Timeline
	Social Media Campaign (HPV/CCS)	Community outreach	Completed – March 2020
	Robo Call #1	Members in CMC, MCLA, LACC LOB	Scheduled for June 2020 - Cancelled
	Mailer	RCAC 5 – West Side will receive mailer RCAC 9 – Long Beach will receive letter	Scheduled for September 2020 – planning in progress
	Robo Call #2	Members in CMC, MCLA, LACC LOB	Scheduled for September 2020 – planning in progress



CHL – Youth Empowerment for Chlamydia Screening Campaign (YES)

Target population: women 16-24 years of age who were identified as sexually active.

Method	Intervention	Target Population	Status & Timeline
	Letter to Parent/Guardian(s)	Parent/guardian(s) of non-compliant LACC & MCLA female and male members 16-17 years old	On hold due to COVID-19
	Provider Fax Blast	Providers specializing in general medicine, family practice, pediatrics and obstetrics/gynecology Additional fax blast targeting providers practicing in areas of low-compliance	Scheduled for July/August 2020 – planning in progress
	Social Media Campaign	18-24 year old females living in zip codes with a high volume of non-compliant members	On hold due to COVID-19



Quality/HEDIS Guidance to Provider Groups and Practitioners

Distribution of letter and info to practitioners and PPGs providing guidance on alternate care and telehealth options:

- Underscored importance of maintaining care for newborns and infants
- Letter accompanied by grid of HEDIS measures including those for children and women's health. Information included hyperlinks to reference sources –AAP, AAFP, ACOG, etc.
- Earlier letter indicated that LA Care is monitoring impact of COVID-19 and continuing with P4P program with potential modification to policy if warranted

Internet radio – lacare.org/internet-radio – for providers, streaming content on:

- Delivery of care with guidance on managing and containing COVID-19
- Info on Teladoc, Minute Clinic, and Nurse Advice Lines
- Recommendations on managing prenatal and postpartum care
- In development – detailed information and guidance on the State MCAS (Managed Care Accountability Set) quality measure set



Quality/HEDIS Guidance to Provider Groups and Practitioners

Excerpt from HEDIS grid of alternate care and telehealth options

HEDIS Quality Metrics - Description and Telehealth Guidance for Measurement Year 2020 Please be advised that as of May 2020, NCQA's revised guidance and Technical Specification for HEDIS Reporting during the COVID-19 pandemic is still in development			
Measure	Category	Description	Appropriate for Telehealth or Remote Care?
Child Health			
Well-Child Visits in the First 30 Months of Life	Child	Members who turned 30 months old during the measurement year and who had well-child visits with a provider during their first 30 months of life. 0-15 mos: 6 visits or more; 15 - 30 mos: 2 or more visits	<p>YES. Well visits for children may be conducted through telehealth, recognizing that some elements of the well exam should be completed in clinic once community circumstances allow. These elements include, at a minimum: the comprehensive physical exam; office testing, including laboratory testing; hearing, vision, and oral health screening; fluoride varnish; and immunizations.</p> <p>URL for additional information: http://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/guidance-on-providing-pediatric-ambulatory-services-via-telehealth-during-covid-19/</p>
Childhood Immunization Status	Child	Children who turned 2 years old during the measurement year who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	<p>NO. Wherever possible, scheduled appointments for routine childhood immunizations should not be deferred or canceled. Prioritize newborn care and vaccination of infants and young children (through 24 months)</p> <p>Balance the benefit of attending a well visit and receiving necessary immunizations and screenings with the risk of exposure to other children and adults with potential contagious diseases.</p> <p>URL for additional information: https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/guidance-on-providing-pediatric-ambulatory-services-via-telehealth-during-covid-19/</p>

Questions or Comments





Inquires may be sent to quality@lacare.org





June 2, 2020

RE: L.A. Care Pay for Performance and New Medi-Cal Patients During the COVID-19 Pandemic

Dear Participating Physician Group (PPG),

Recently, L.A. Care Health Plan (L.A. Care) received a number of questions related to how PPGs like yourself and your primary care providers can deliver high value quality care and whether there are any changes with L.A. Care's quality incentive programs during this time of the pandemic.

In an effort to maintain focus where possible on good patient care, we will continue to work with you to collect clinical data and encounters to better understand the present care provided and needs of our members. In the meantime, we will review our Pay-for-Performance Programs (P4P) and will inform you of our decision should changes occur. Additionally, we will continue to distribute provider opportunity reports throughout the year as originally scheduled. We also provided a grid (please see "HEDIS MY 2020_General Guidance" attachment) of the current P4P Healthcare Effectiveness Data and Information Set (HEDIS) measures and the current guidance from National Committee for Quality Assurance (NCQA) as it relates to Telehealth.

L.A. Care would like to emphasize the care for two (2) groups of new Medi-Cal patients (new Medi-Cal members) that should be of concern for all of us. First, there is a great deal of health and public health concern that during this pandemic, newborns and infants are missing their well-visits and vaccinations. If you provide pediatric care and are challenged by circumstances related to COVID-19, please prioritize newborn care and vaccination of infants and young children through 24 months of age when possible. The American Academy of Pediatrics (AAP) has developed guidance on the provision of pediatric ambulatory services during the pandemic. Guidance suggests that well-child care should occur in-person whenever possible.

Secondly, with the economic downturn, there will be a number of new Medi-Cal enrollees. We understand that many primary care providers discount the value of the Initial Health Assessment (IHA). However, during this pandemic, it is even more important to get a complete history, physical and appropriate screening and assessment of preventive care services. We want to note that much of the health assessment (such as the patient history, behavioral assessment, health education, etc.) can be completed telephonically and by video. You can, then, schedule an in-person visit for the comprehensive physical along with preventive tests and screenings. This way, the duration of the in-person IHA visit can be shortened to limit exposure.

You and your primary care providers can always check L.A. Care's web site at <https://www.lacare.org> and click on the orange banner for COVID-19 up to date guidance and resources. If you prefer to listen to recorded information and guidance on managing COVID-19, please visit L.A. Care's internet radio streaming page at <https://www.lacare.org/internet-radio>.

For questions or clarifications regarding our P4P or VIIP programs, please contact us via one of the following emails listed below:

- If you are PPG and have a PPG-related question, please email VIIP@lacare.org
- If you are an individual physician or a PPG with questions on behalf of a physician, please email Incentive_Ops@lacare.org

We appreciate your support for our providers and (new) members. Take care and be safe as services resume in L.A. County.

Sincerely,

L.A. Care's Quality Improvement Department

HEDIS Quality Metrics - Description and Telehealth Guidance for Measurement Year 2020 Please be advised that as of May 2020, NCQA's revised guidance and Technical Specification for HEDIS Reporting during the COVID-19 pandemic is still in development				
Meas Abbr	Measure	Category	Description	Appropriate for Telehealth or Remote Care?
Newborn and Child Health				
	Well-Child Visits in the First 30 Months of Life	Child	Members who turned 30 months old during the measurement year and who had well-child visits with a provider during their first 30 months of life. 0-15 mos: 6 visits or more; 15 - 30 mos: 2 or more visits	YES. Well visits for children may be conducted through telehealth, recognizing that some elements of the well exam should be completed in clinic once community circumstances allow. These elements include, at a minimum: the comprehensive physical exam; office testing, including laboratory testing; hearing, vision, and oral health screening; fluoride varnish; and immunizations. URL for additional information: https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/guidance-on-providing-pediatric-ambulatory-services-via-telehealth-during-covid-19/
CIS	Childhood Immunization Status	Child	Children who turned 2 years old during the measurement year who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HIB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	NO. Wherever possible, scheduled appointments for routine childhood immunizations should not be deferred or canceled. Prioritize newborn care and vaccination of infants and young children (through 24 months) Balance the benefit of attending a well visit and receiving necessary immunizations and screenings with the risk of exposure to other children and adults with potential contagious diseases. URL for additional information: https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/guidance-on-providing-pediatric-ambulatory-services-via-telehealth-during-covid-19/
	Child and Adolescent Well Care Visits	Child	Members 3–21 years of age who had at least one comprehensive well care visit in the measurement year. Services should include health, physical developmental, mental developmental, physical exam, health education and anticipatory guidance	YES. If community circumstances require limiting in-person visits, the guidance urges pediatricians to continue well visits for children through telehealth, with the acknowledgement that some elements of the well exam will need to be completed in clinic once community circumstances allow. Complete in-person elements when circumstances permit. These elements include, at a minimum, the comprehensive physical exam; office testing, including laboratory testing; hearing, vision and oral health screening; fluoride varnish; and immunizations. URL for additional information: https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/guidance-on-providing-pediatric-ambulatory-services-via-telehealth-during-covid-19/
IMA	Immunizations for Adolescents	Child	Adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates	NO. Because of personal, practice, or community circumstances related to COVID-19, some providers may not be able to provide well child visits, including provision of immunizations, for all patients in their practice. If a practice can provide only limited well child visits, healthcare providers are encouraged to prioritize newborn care and vaccination of infants and young children (through 24 months of age) when possible. URL for additional information: https://www.cdc.gov/vaccines/schedules/hcp/schedule-changes.html
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Child	Members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation during the measurement year	No. Documentation requires measurement of height and weight to calculate the BMI percentile.
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Child	Members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity documentation during the measurement year	YES. Documentation requires counseling on physical activity - info, education and/or referral
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Child	Members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of nutritional counseling documentation during the measurement year	YES. Documentation requires counseling on nutrition - info, education and/or referral
Women's Health				
PPC	Prenatal and Postpartum Care	Woman	Women who had deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.	NO. Obstetrician-gynecologist and other obstetric care clinicians should continue to provide medically necessary prenatal care, referrals and consultations. Consider grouping components of care together (e.g. vaccinations, glucose screenings, etc.) to reduce the number of in-person visits. Refer to www.acog.org/clinical-information/physician-faqs/covid-19-faqs-for-ob-gyns-obstetrics page for examples of modified care. YES, for remote monitoring of weight, blood pressuring, fetal heart rate
PPC	Prenatal and Postpartum Care	Women	Women who have had deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	YES. Obstetrician-gynecologist and other obstetric care clinicians should continue to provide medically necessary postpartum care, referrals and consultations. Refer to www.acog.org/clinical-information/physician-faqs/covid-19-faqs-for-ob-gyns-obstetrics page for examples of modified care. Also refer to L.A. Care's compilation of low risk postpartum visit guidance in the accompanying Word document under section III, Prenatal and Postpartum. Telehealth and remote monitoring of vaginal and C-Section Delivery check, assessment of mood, depression
CCS	Cervical Cancer Screening	Women	Women 21–64 years of age who were screened for cervical cancer using either of the following criteria: • Women 21–64 years of age who had cervical cytology performed within the last 3 years. • Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. • Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.	NO. The American Society for Colposcopy and Cervical Pathology (ASCCP.org) recommends the following action during the pandemic: 1. Individuals with low-grade cervical cancer screening tests may have postponement of diagnostic evaluations up to 6-12 months. 2. Individuals with high-grade cervical cancer screening tests should have documented attempts to contact and diagnostic evaluation scheduled within 3 months. 3. Individuals with high-grade cervical disease without suspected invasive disease should have documented attempts to contact and procedures scheduled within 3 months. 4. Individuals with suspected invasive disease should have contact attempted within 2 weeks and evaluation within 2 of that contact (4 weeks from the initial report or referral).
CHL	Chlamydia Screening in Women	Women	Women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	NO. If STD clinic services have not been disrupted, providers should continue to follow recommendations in CDC's 2015 STD Screening and Treatment Guidelines. The URL for the guidelines is https://www.cdc.gov/std/tg2015/tg-2015-print.pdf
BCS	Breast Cancer Screening	Women	Women 50–74 years of age who had a mammogram to screen for breast cancer	NO. According to the American Society of Breast Surgeons, routine screening mammograms can be deferred for up to 12 months in the general population without a likely impact on overall survival, and patients with previous abnormal screenings can wait for six months before pursuing imaging again. In addition, all screenings with other modalities, including MRI and breast ultrasound, should also be postponed.
Medication Management				
SPD	Statin Therapy for Patients With Diabetes	Rx	Members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported: 1. Received Statin Therapy. Members who were dispensed at least one statin medication of any intensity during the measurement year. 2. Statin Adherence 80%. Members who remained on a statin medication of any intensity for at least 80% of the treatment period.	YES. Advise telephonic assessments and electronic prescriptions. Consider mail order option and switching from 30 days to 90 days supply
PDC	Proportion of Days Covered (PDC-RASA)	Rx	Individuals 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80 percent or more during the measurement period for Renin Angiotensin System (RAS) Antagonists	YES. Advise telephonic assessments and electronic prescriptions. Consider mail order option and switching from 30 days to 90 days supply
PDC	Proportion of Days Covered (PDC-DR)	Rx	Individuals 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80 percent or more during the measurement period for Diabetes All Class	YES. Advise telephonic assessments and electronic prescriptions. Consider mail order option and switching from 30 days to 90 days supply
PDC	Proportion of Days Covered (PDC-STA)	Rx	Individuals 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80 percent or more during the measurement period for Statins	YES. Advise telephonic assessments and electronic prescriptions. Consider mail order option and switching from 30 days to 90 days supply

<p align="center">HEDIS Quality Metrics - Description and Telehealth Guidance for Measurement Year 2020</p> <p align="center">Please be advised that as of May 2020, NCQA's revised guidance and Technical Specification for HEDIS Reporting during the COVID-19 pandemic is still in development</p>				
Meas Abbr	Measure	Category	Description	Appropriate for Telehealth or Remote Care?
SPC	Statin Therapy for Patients With Cardiovascular Disease	Rx	Males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported: 1. Received Statin Therapy. Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year. 2. Statin Adherence 80%. Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period	YES. Advise telephonic assessments and electronic prescriptions. Consider mail order option and switching from 30 days to 90 days supply
Chronic Care Management				
CBP	Controlling High Blood Pressure	Chronic	Members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year	YES for diagnosis, assessment and medication management. BP readings from remote monitoring devices that are digitally stored and transmitted to the provider is acceptable for blood pressure measurement and documentation. Note that the American Journal of Hypertension cites that specific comorbidities associated with increased risk of infection and worse outcomes with development of increased severity of lung injury and mortality have been reported. The most common comorbidities in one report were hypertension (30%), diabetes (19%), and coronary heart disease (8%).
CDC	Comprehensive Diabetes Care	Chronic	Members 18–75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c test result was less than 8.	YES, if result from glucometer can be transmitted to the doctor's office. NCQA usually does not accept patient's self-reported results and as of May 2020, has not released definitive guidance on this. YES, for assessment and medication management. Documentation for HbA1c requires screening and result. From the April 2020 issue of Lancet: Evidence from epidemiological observations in regions heavily affected by SARS-CoV-2 and reports from the Centers for Disease Control and Prevention (CDC) and other national health centres and hospitals showed that the risk of a fatal outcome from COVID-19 is up to 50% higher in patients with diabetes than in those who do not have diabetes.
CDC	Comprehensive Diabetes Care	Chronic	Members 18–75 years of age with diabetes (type 1 and type 2) who had a dilated retinal eye exam (DRE) during the measurement year or had a negative DRE in the year prior to the measurement year.	NO. Eye exam requires dilation of the eyes by an optometrist or ophthalmologist.
CDC	Comprehensive Diabetes Care	Chronic	Members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:	YES. For assessment and medication management. BP readings from remote monitoring devices that are digitally stored and transmitted to the provider is acceptable for blood pressure measurement and documentation.
AMR	Asthma Medication Ratio	Chronic	Members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	YES. Advise telephonic assessments and electronic prescriptions. Consider mail order option and switching from 30 days to 90 days supply
COL	Colorectal Cancer Screening	Adult	Members 50–75 years of age who had appropriate screening for colorectal cancer. gFOBT, FIT, FIT DNA	YES, mail out of FOBT Kits
Behavioral Health				
AMM	Antidepressant Medication Management	BH	Members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 84 days (12 weeks) .	YES. Advise telephonic assessments and electronic prescriptions. Consider mail order option and switching from 30 days to 90 days supply
AMM	Antidepressant Medication Management	BH	Members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication for at least 180 days (6 months) .	YES. Advise telephonic assessments and electronic prescriptions. Consider mail order option and switching from 30 days to 90 days supply
ADD	Follow-Up for Children Prescribed ADHD Medication	BH	Children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Members 6–12 years of age as of the ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase	NO. Must be in-person visit billed by practitioner with prescribing authority
ADD	Follow-Up for Children Prescribed ADHD Medication	BH	Children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Members 6–12 years of age as of the ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	YES, one of two visits after 30 days of prescription of ADHD meds can be a telehealth visit.
FUH	Follow-Up After Hospitalization for Mental Illness	BH	Members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 7 days after discharge .	YES, a telehealth visit with a mental health practitioner acceptable.
FUH	Follow-Up After Hospitalization for Mental Illness	BH	Members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 30 days after discharge .	YES, a telehealth visit with a mental health practitioner acceptable.

Additional Resources

Additional Resources	
Professional Associations	
California Medical Association:	https://www.cmadocs.org/covid-19/faq/CategoryID/48
Family Medicine:	https://www.aafp.org/dam/AAFP/documents/patient_care/public_health/AAFP-COVID-Non-Urgent-Care-Statement.pdf
Internal Medicine:	https://www.acponline.org/clinical-information/clinical-resources-products/coronavirus-disease-2019-covid-19-information-for-internists
Pediatrics:	https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/
OB/GYN:	https://www.acog.org/clinical-information/physician-faqs/covid-19-faqs-for-ob-gyns-obstetrics
Public Health Resources for Healthcare Professionals	
Centers fo Disease Control:	https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html
California Department of Public Health:	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx
L.A. County Department of Public Health:	http://publichealth.lacounty.gov/acd/ncorona2019/index.htm
L.A. County Department of Public Health Guidance on Serology Testing:	http://publichealth.lacounty.gov/media/Coronavirus/docs/about/FAQ-SerologyTests.pdf
In-Person Care Visits	
California Department of Public Health:	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/ResumingCalifornia%E2%80%99sDeferredandPreventiveHealthCare.aspx
Health Plan Support	
Telehealth and Nurse Advice Line Resources:	www.lacare.org/teladoc
Anthem Blue Cross Virtual Services:	https://livehealthonline.com/
Nurse Advice Lines	
L.A. Care Health Plan:	1-800-249-3619 (TTY 711)
Anthem Blue Cross:	1-800-224-0336 or TTY/TDD 1-800-368-4424
Blue Shield of California Promise Health Plan:	1-800-609-4166 (TTY 711)
Newborn and Infant Care	
American Academy of Pediatrics:	https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/guidance-on-providing-pediatric-well-care-during-covid-19/
Department of Health Care Services:	http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_30339_44.asp
Prenatal and Postpartum Care	
World Health Organization:	https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-on-covid-19-pregnancy-and-childbirth
American College of Obstetricians and Gynecologists:	https://www.ACOG.org/clinical-information/physician-faqs/covid-19-faqs-for-ob-gyns-obstetrics/
Home Prenatal Monitoring:	https://www.acog.org/patient-resources/faqs/pregnancy/coronavirus-pregnancy-and-breastfeeding

Telehealth Reimbursement Guide For California

Spring 2020

Compiled by the California Telehealth Resource Center and Includes:

Medi-Cal
Denti-Cal
Medicare
Managed Care Health Plans
FQHC/RHC Billing Scenarios



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This document is intended as a guide to assist providers in obtaining information on telehealth reimbursement. This document does not constitute legal advice. Many factors affect the appropriateness of submitting a particular claim for reimbursement. The information should be used in consultation with your billing specialist and other advisers in initiating telehealth billing.

Reimbursement information can become outdated quickly and is subject to change without notice. We recommend review of this material on a regular basis to assure the information is up to date. Please visit www.caltrc.org to download the latest version. CTRC does not guarantee payment for any service.

The California Telehealth Resource Center is a leading source of expertise and comprehensive knowledge on the development and operation of telemedicine and telehealth programs. CTRC has received national recognition since 2006 as one of fourteen federally designated Telehealth Resource Centers in the country.

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INTRODUCTION

What Is Telehealth?

Telehealth is a collection of means or methods for enhancing health care, public health, and health education delivery and support using telecommunications technologies.

As state and federal policymakers, private payers, practitioners, and consumers realize telehealth's potential benefits, there is a growing need to create a consistent framework for understanding what is meant by "telehealth," and how the term is accurately applied.

First and foremost, telehealth is a collection of means or methods, not a specific clinical service, to enhance care delivery and education. Ideally, there should not be any regulatory distinction between a service delivered via telehealth and a service delivered in person. Both should be held to the same quality and practice standards. The "tele-" descriptor should ultimately fade from use as these technologies seamlessly integrate into health care delivery systems.

While "telemedicine" has been more commonly used in the past, "telehealth" is a more universal term for the current broad array of applications in the field. Its use crosses most health service disciplines, including dentistry, counseling, physical therapy, home health, and many other domains. Further, telehealth practice has expanded beyond traditional diagnostic and monitoring activities to include consumer and professional education.

While the State of California now uses the term "telehealth", some providers and payer organizations still use the term "telemedicine" when referring to the provision of clinical care over a distance.

Note that while a connection exists between health information technology (HIT), health information exchange (HIE), and telehealth, neither HIE nor HIT are considered to be telehealth.

What Is Telemedicine?

Telemedicine generally refers to the provision of clinical services from a distance. The Institute of Medicine of the National Academy of Science defines telemedicine as "the use of electronic information and communication technologies to provide and support health care when distance separates the participants". Telemedicine is a component of telehealth.

How Does Telehealth Work?

Today, telehealth encompasses many distinct domains of applications. Note, however, that each state's Medicaid program and private insurers vary in their use and reimbursement of these applications. These are commonly known as:

- **Synchronous Live Videoconferencing:** Live, two-way interaction between a person and a provider using audiovisual telecommunications technology.
- **Asynchronous Store-and-Forward:** Store and Forward services provides for the review of medical information at a later time by a physician or optometrist at a distant site without the patient being present in real time.
- **eConsult:** E-consult services fall under the auspice of store and forward services. Electronic messages are exchanged (including clinical question and related diagnostic data) initiated by the primary care physician to a specialist. Specialist can convert an eConsult to a referral if necessary.
- **Remote Patient Monitoring (RPM):** Personal health and medical data collection from an individual in one location via electronic communication technologies, which is transmitted to a provider in a different location for use in care and related support.
- **Mobile Health (mHealth):** Health care and public health practice and education supported by mobile communication devices such as cell phones, tablet computers, and PDAs. Applications can range from targeted text messages that promote healthy behavior to wide-scale alerts about disease outbreaks, to name a few examples.

Is Telehealth a Billable Service?

In many cases telehealth services are covered benefits and are billable by government programs and private payers. This guide provides information on major telehealth reimbursement programs in California. As the field is rapidly expanding, it should be noted that more and more public, private and commercial payers may begin to cover telemedicine. It is important that you check with your payers on a regular basis to see if additional services have been added for reimbursement. CTRC can provide updates on many of the major payers but may not be aware of all payer policies.

Reimbursement Information By Program Disclaimer

The following pages provide details on reimbursement for many of the major payers within the state of California. It should be noted that telehealth is a rapidly expanding field and changes in telehealth covered services and reimbursement occur every year. It will be necessary for programs to review new reimbursement provisions on a regular basis. CTRC publishes changes to this reimbursement guide as often as possible. This document can be found on our website and is distributed to those on the CTRC email list.

To sign up for the CTRC email list, please visit <http://caltrc.org/about-us/contact-us/>

Traditional Medicare

Reimbursement for Traditional Medicare telehealth has five criteria for payment:

1. **The patient was seen from an “originating site” as defined by CMS.** An originating site is the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. Originating sites authorized by law are:
 - Physician and practitioner offices
 - Hospitals
 - Critical Access Hospitals (CAHs)
 - Rural Health Clinics (RHC)
 - Federally Qualified Health Centers (FQHC)
 - Hospital-based Renal Dialysis Centers (including satellites)
 - Skilled Nursing Facilities
 - Community Mental Health Centers (CMHCs)
 - Renal Dialysis Facilities
 - Patient Homes w/ End-Stage Renal Disease (ESRD) getting home dialysis
 - Mobile Stroke Units
2. **The Originating Site is located in one of the following geographic areas:**
 - a. Rural Health Professional Shortage Areas (HPSAs) located in a rural census tract;
-OR-
 - b. Counties located outside Metropolitan Statistical Areas (MSA),

Determining an eligible Originating Site location:

HRSA has developed a tool that will help providers determine geographic eligibility for Medicare telehealth services. This tool, the Medicare Telehealth Payment Eligibility Analyzer, is available at <https://data.hrsa.gov/tools/medicare/telehealth>

NOTE: Medicare does not apply originating site geographic conditions to hospital-based and CAH-based renal dialysis centers, renal dialysis facilities, and beneficiary homes when practitioners furnish monthly home dialysis ESRD-related medical evaluations. Independent Renal Dialysis Facilities are not eligible originating sites. Independent Renal Dialysis Facilities are not eligible originating sites.

NOTE: Beginning January 1, 2019, the Bipartisan Budget Act of 2018 removed the originating site geographic conditions and added eligible originating sites to diagnose, evaluate, or treat symptoms of an acute stroke.

3. **The encounter was performed at the “distant site” as defined by CMS as the site where the health care provider is located. Eligible distant site practitioners are as follows:**
 - Physicians
 - Nurse practitioners (NPs)
 - Physician assistants (PAs)
 - Nurse-midwives
 - Clinical nurse specialists (CNSs)
 - Certified registered nurse anesthetists
 - Clinical psychologists (CPs) and clinical social workers (CSWs)*
 - Registered dietitians or nutritional professionals
 - Opioid Treatment Programs (OTP)

*CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838

4. **The patient was present, and the encounter involved interactive audio and video telecommunications** that provides real-time communication between the practitioner and the Medicare beneficiary.
5. **Type of Service provided** as specified in the Medicare Eligible Services located in Table 1.

Billing and Reimbursement

Originating Site Fee

The originating site is eligible to receive a facility fee for providing services via telehealth. As of January 2020, the payment amount is “80% of the lesser of the actual charge or \$26.65”. The site receives a flat reimbursement rate, outside of any other reimbursement arrangements such as inpatient DRGs or RHC per-visit payments.

- Originating sites are to use **Q3014** when submitting facility fee claims.
- The type of service is 9 - other items and services.
- The place of service code is 02 - Telehealth
- Bill the MAC for the originating site facility fee which is a separately billable Part B payment.

Traditional Medicare provides specific instructions for different originating facility types:

- For FQHC and RHCs: the originating site facility fee for Medicare telehealth services is not an FQHC or RHC service. When an FQHC or RHC serves as the originating site, the originating site facility fee must be paid separately from the center or clinic all-inclusive rate.
- For Critical Access Hospitals, the payment amount is 80 percent of the originating site facility fee.
- For CMHC, the originating site facility fee does not count toward the number of services used to determine payment for partial hospitalization services.
- In addition to FQHCs, RHCs and CAHs, Chapter 12 of the Medicare Claims Processing Manual, Section 190.6 describes payment methodologies for hospital outpatient departments, hospital inpatient, physicians’ and practitioners’ offices, renal dialysis centers, skilled nursing facilities and community mental health centers.

Distant Site Clinical Services Fees

Reimbursement to the health professional delivering the clinical service is the same as the current fee schedule amount for the service provided without telemedicine.

Distant site claims for reimbursement should be submitted with the appropriate CPT code or HCPCS code for the professional services provided.

Distant sites will submit the appropriate CPT code and use Place of Service 02 (Telehealth) for all encounters.

*Distant site practitioners billing telehealth services under the CAH Optional Payment Method (Method II) will continue to submit institutional claims using the GT modifier.

***NOTE: FQHCs and RHCs are not authorized to serve as a distant site for telehealth consultations. A distant site is the location of the practitioner at the time the telehealth service is furnished. The cost of a visit may not be billed or included on the cost report.**

The table below provides a listing of all eligible services with CPT and HCPCS codes effective January 2020.

Synchronous Live Video Service	CPT or HCPCS Code
Telehealth consultations, emergency department or initial inpatient	G0425–G0427
Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs	G0406–G0408
Office or other outpatient visits	99201–99215
Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days	99231–99233
Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days	99307–99310
Individual and group kidney disease education services	G0420, G0421
Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training	G0108, G0109
Individual and group health and behavior assessment and intervention	96150–96154
Individual psychotherapy	90832–90838
Telehealth Pharmacologic Management	G0459
Psychiatric diagnostic interview examination	90791, 90792
End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment	90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	90963
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	90964
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	90965
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 20 years of age and older	90966
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age	90967
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 2-11 years of age	90968
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 12-19 years of age	90969
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 20 years of age and older	90970
Individual and group medical nutrition therapy	G0270 or 97802–97804
Neurobehavioral status examination	96116
Smoking cessation services	G0436–G0437 99406–99407
Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services	G0396 G0397
Annual alcohol misuse screening, 15 minutes	G0442
Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	G0443
Annual depression screening, 15 minutes	G0444
High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes	G0445
Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	G0446
Face-to-face behavioral counseling for obesity, 15 minutes	G0447
Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)	99495

Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)	99496
Advance Care Planning, 30 minutes	99497
Advance Care Planning, additional 30 minutes (effective for services furnished on and after January 1, 2017)	99498
Psychoanalysis	90845
Family psychotherapy (without the patient present)	90846
Family psychotherapy (conjoint psychotherapy) (with patient present)	90847
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour	99354
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes	99355
Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; first hour (list separately in addition to code for inpatient evaluation and management service)	99356
Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; each additional 30 minutes (list separately in addition to code for prolonged service)	99357
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) first visit	G0438
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) subsequent visit	G0439
Telehealth Consultation, Critical Care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth	G0508
Telehealth Consultation, Critical Care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth	G0509
Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (service is for eligibility determination and shared decision making)	G0296
Interactive Complexity Psychiatry Services and Procedures	90785
Health Risk Assessment	96160 and 96161
Comprehensive assessment of and care planning for patients requiring chronic care management	G0506
Psychotherapy for crisis	90839 and 90840
Prolonged preventative services	G0513-G0514

- Clinical psychologists (CPs) and clinical social workers (CSWs). CPs and CSWs cannot bill for codes 90792, 90833, 90836, and 90838
- For ESRD-related services, a physician, NP, PA, or CNS must furnish at least one “hands on” visit (not telehealth) each month to examine the beneficiary’s vascular access site.

CMS Expansion of Telehealth – Advancing Virtual Care

In 2019 CMS put forth new regulations to help advance virtual care. The intent of these regulations is to support access to care using communication technologies. Please note that none of these services are considered “traditional telehealth” for Medicare, therefore, they do not have the same restrictions as traditional telehealth services.

CMS will reimburse for the following under the Virtual Care programs:

- Opioid Use Disorder and MAT treatment
- Virtual Check-Ins
- Remote evaluation of patient submitted photos or recorded video
- Interprofessional Internet Consultation

FQHCs and RHCs will be reimbursed for Virtual Visits and Remote Evaluation services that are furnished by an FQHC or RHC practitioner when there is no associated billable visit. They are not eligible for reimbursement of Interprofessional Internet Consultations (eConsult), as the PPS includes all costs associated with a billable visit, including consultations with other practitioners.

Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT)

Beginning July 1, 2019, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act removed the originating site geographic conditions and adds an individual's home as a permissible originating telehealth services site for treatment of a substance use disorder or a co-occurring mental health disorder via live video.

In the finalized Physician Fee Schedule for 2020, Medicare added three bundled payments for MAT treatment. The codes are:

- G2086: Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month.
- G2087: Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month.
- G2088: Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure).

Brief communication technology-based service, e.g. Virtual Check-In

Virtual Check-Ins are billed with code **G2012**. *

These interactions are patient initiated telephone or live video interactions. They involve a physician or non-physician practitioner having a brief, at least 5-minute, check-in with an established patient to assess whether the patient needs to come in for an office visit. The practitioner may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.

The virtual check-in must be for a condition not related to an E/M service provided within the previous 7 days and does not lead to an E/M service or procedure within the next 24 hours or soonest available appointment. There are no frequency limitations at this time.

Billable providers are physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, and clinical social workers. If the discussion could be conducted by a nurse, health educator, or other clinical personnel, it would not be billable as a virtual communication service.

* FQHCs and RHCs are allowed to bill for a Virtual Check-In. Virtual Check-Ins at an FQHC or RHC are billed with code **G0071**. The rate charged will be the physician fee schedule rate, not the all-inclusive rate (AIR) or prospective payment system (PPS).

Remote Evaluation of Pre-Recorded, Patient Submitted Photos or Recorded Video

Remote Evaluation Services are billed with code **G2010**. *

Remote evaluation services are patient initiated and consist of a practitioner evaluating an established patient's transmitted information via pre-recorded video or image. The practitioner may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.

The services can only be billed if the condition is not related to a service provided within the previous 7 days and does not lead to a service provided within the next 24 hours or soonest available appointment. There are no frequency limitations at this time.

Billable by physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, and clinical social workers. If the discussion could be conducted by a nurse, health educator, or other clinical personnel, it would not be billable as a virtual communication service.

*FQHCs/RHCs will be allowed to bill for Remote Evaluation services when an established patient sends recorded video or images to the FQHC/RHC. Remote Evaluation Services are billed with code **G0071**.

Interprofessional Internet Consultation (eConsult)

Interprofessional Internet Consultation is defined by CMS as “Assessment and management services conducted through telephone, internet, or electronic health record consultations furnished when an established patient’s treating physician or other qualified healthcare professional requests the opinion and/or treatment advice of a consulting physician or qualified healthcare professional with specific specialty expertise to assist with the diagnosis and/or management of the patient’s problem without the need for the patient’s face-to-face contact with the consulting physician or qualified healthcare professional.” Interprofessional internet consultations covers consultations between professionals performed by a communications technology such as telephone or internet.

Verbal consent and acknowledgement of cost sharing from the patient is required.

Interprofessional Internet Consultations are limited to practitioners that can independently bill Medicare for E/M visits and are billed using the following codes:

99446: Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review

99447: Same as 99446, but 11-20 minutes of medical consultative discussion and review

99448: Same as 99446, but 21-30 minutes of medical consultative discussion and review

99449: Same as 99446, but 31 minutes or more of medical consultative discussion and review

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 or more minutes of medical consultative time

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

FQHCs and RHCs are not allowed to bill for interprofessional internet consultations because the AIR and PPS includes all costs associated with a billable visit, including consultations with other practitioners.

Chronic Care Management: Remote Physiological Monitoring

The definition for remote physiological monitoring under the Chronic Care Management Program is “a collection of physiological data (for example; ECG blood pressure glucose monitoring) digitally stored and/or transmitted by the patient or caregiver or both to the Home Health agency”.

Under this definition remote patient monitoring will only be reimbursable when reported as a service in the provision of another skilled service.

Home visits for the purpose of supplying, or maintaining, remote physiological monitoring equipment without the provision of another skilled service will not be separately billable but will constitute an allowable administrative cost under the amendments to 42 CFR 409.46.

The Remote Physiological Monitoring CPT codes are as follows:

- CPT Code 99453: Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment
- CPT Code 99454: Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days
- CPT Code 99457: Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month
- CPT Code 99458: Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; additional 20 minutes

Principal Care Management Service

Beginning January 1, 2020, CMS finalized a new Principal Care Management Program payment and coding structure, recognizing that there is considerable time needed to manage one chronic condition.

- G2064: CCM for a single high-risk disease, e.g. PCM, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities.
- G2065: CCM for a single high-risk disease, e.g. PCM, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional time per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities.

CMS also added a requirement that ongoing communication and care coordination between all practitioners furnishing care to the beneficiary must be documented by the practitioner billing for PCM in the patient's medical record.

Additional Resources

CMS Telehealth Services Fact Sheet

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctstht.pdf>

CMS Rural Health Center Fact Sheet

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralHlthClinfctstht.pdf>

CMS Federally Qualified Health Center Fact Sheet

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fqhcfactsheet.pdf>

CMS Virtual Visits FAQ for Federally Qualified Health Centers

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf>

CMS MLN Matters number: MM10583, Revised September 6, 2018

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10583.pdf>

UnitedHealthcare

Medicare and Medicaid Plans

UnitedHealthcare offers telemedicine and telehealth services to UnitedHealthcare patients. Telemedicine and telehealth services are covered for patients under this plan when Medicare coverage criteria are met.

Originating site requirements and allowable practitioners listed in the Medicare section of this manual apply to all telemedicine visits. UnitedHealthcare uses the same billing codes as Medicare for services.

See Medicare section of this manual for detail information on program restrictions.

Virtual Visits – HMP, EPO, POS Plans

The Virtual Visit benefit is designed to reimburse for telemedicine services rendered to a patient who is located at a location that is not a clinical Originating Site, (i.e. their home or workplace). Such services would not normally be covered under the existing telemedicine benefit. However, the addition of the Virtual Visit benefit provides coverage for those services when the member is not at a clinical Originating Site and uses a Designated Virtual Visit provider.

Conditions Required for Virtual Visits

Virtual visits are provided for the diagnosis and treatment of low acuity medical conditions. Examples include, but are not limited to:

Bronchitis

- Seasonal Flu
- Pink Eye
- Sore Throat
- Sinus Problems

The diagnosis and treatment is provided through the use of interactive audio and visual telecommunication and transmissions and audio visual communication technology. The virtual visit must provide communication of medical information in real-time between the patient and a distant physician or health

specialist through the use of interactive audio and video communications equipment outside of a medical facility.

The virtual visit must be provided by a UnitedHealthcare Designated Virtual Network Provider. Services are currently provided by AmWell and Doctor on Demand.

Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person physician contact is necessary.

Patient Consent

Prior to the delivery of health care via telehealth, the health care provider initiating the use of telehealth shall inform the patient 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 and public health. The consent shall be documented.

Nothing shall preclude a patient from receiving in-person health care delivery services during a specified course of health care and treatment after agreeing to receive services via telehealth.

Telemedicine/Telehealth services are covered only when all of the following criteria are met:

- Member requires services that are usually provided by direct contact with the provider
- Services are authorized by the member's contracting/participating medical group or UnitedHealthcare
- The health care provider has determined telehealth services are appropriate
- Provider obtains verbal consent from member to provide telehealth services

Exclusions

This section shall not apply to a patient under the jurisdiction of the Department of Corrections and Rehabilitation or any other correctional facility.

Additional Resources

UnitedHealthcare Telehealth Policy

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-reimbursement/COMM-Telehealth-and-Telemedicine-Policy.pdf>

UnitedHealthcare Advantage Plans – Telehealth Policy

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medadv-coverage-sum/telemedicine-telehealth-services.pdf>

UnitedHealthcare Community Plan – Medicaid – Telehealth Policy

[https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan-reimbursement/UHCCP-Telehealth-and-Telemedicine-Policy-\(R0046\).pdf](https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan-reimbursement/UHCCP-Telehealth-and-Telemedicine-Policy-(R0046).pdf)

UnitedHealthcare Policy Number: BIP181.E: TELEMEDICINE/TELEHEALTH SERVICES/
VIRTUAL VISITS

<https://www.uhcprovider.com/content/dam/provider/docs/public/policies/signaturevalue-bip/telemedicine-telehealth-ca.pdf>

UnitedHealthcare Virtual Visits FAQ

<http://uhcvirtualvisits.com/FAQs>

Medi-Cal Fee-For-Service

Please note: Most of the information in this section does not apply to FQHC or RHC provider types. Please refer to the FQHC/RHC section starting on page 34 for FQHC/RHC Medi-Cal fee-for-service information.

Medi-Cal Coverage of Telehealth

In-person contact between a health care provider and a patient is not required for services provided through telehealth.

Provider Requirements

The health care provider rendering Medi-Cal covered benefits or services provided via telehealth must meet the requirements of Business and Professions Code (B&P Code), Section 2290.5(a)(3), or equivalent requirements under California law in which the provider is considered to be licensed. *For example, BCBA and BCaBA providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission for Certifying Agencies.*

Covered Service: Synchronous - Live Video

1. Health care providers must use interactive audio, video, or data telecommunications system that permits real-time communication between the health care provider at the distant site and the patient at the originating site.
2. 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.
3. The presence of a health care provider is not required at the originating site as a condition of payment unless the health care provider at the originating site is medically necessary as determined by the health care provider at the distant site.
4. The E&M service must be in real-time or near real-time (delay in seconds or minutes) to qualify as an interactive two-way transfer of medical data and information between the patient and health care provider.
5. 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.
6. 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.

Covered Service: Asynchronous - Store and Forward

Store and forward is defined as the transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient. Store and forward includes, but is not limited to teleophthalmology, teledermatology, teledentistry, teleradiology and must meet the following requirements:

1. The images must be specific to the patient's condition and adequate for meeting the procedural definition of the code that is billed.
2. Teleophthalmology and teledermatology by store and forward must be rendered by a physician who has completed training in an Accreditation Council for Graduate Medical Education (ACGME)-approved residency in ophthalmology or dermatology respectively.

Covered Service: eConsult

E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions, and recommendations of care. A health care provider at the distant site may bill for an e-consult when the benefits or services delivered meet the procedural definition and components of the CPT code. eConsult is not applicable for FQHCs, RHCs or IHS-MOA clinics.

eConsult is not reimbursable more than once in a seven-day period for the same patient and provider.

Providers should note that eConsult is not separately reportable, or reimbursable, if any of the following are true:

1. The distant site provider (consultant) saw the patient within the last 14 days.
2. 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.
3. 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.

Documentation Requirements

Documentation for benefits or services delivered via telehealth should be the same as for a comparable in-person service. All documentation should be maintained in the patient's medical record. 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.

Providers should note the following:

1. Health care providers at the distant site must determine that the covered service or benefit meets the procedural definition and components of the CPT or HCPCS code.
2. Health care providers are no longer required to document a barrier to an in-person visit (W&I Code, Section 14132.72[d]).
3. Health care providers at the distant site are no longer required to document cost effectiveness of telehealth to be reimbursed.

For eConsult, Medi-Cal has specific documentation requirements:

The health care provider at the **originating site** must create and maintain the following:

1. 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
2. A record of a request for an e-consult by the health care provider at the originating site.

The health care provider at the **distant site** must create and maintain the following:

1. A record of the review and analysis of the transmitted medical information with written documentation of date of service and time spent; and
2. A written report of case findings and recommendations with conveyance to the originating site.

Conditions Required for Telehealth Use

Patient Consent

Health care providers (either at the Originating or Distant Site) must inform the patient 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. The consent shall be documented in the patient's medical record and should include:

- 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
- No dissemination of any patient images or information to other entities without further written consent

If a health care provider, whether at the Originating or Distant site, maintains a general consent 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.

For benefits delivered via asynchronous store and forward: health care providers must also meet the following requirements:

- A patient receiving teleophthalmology, teledermatology, or teledentistry by store and forward shall be notified of the right to receive interactive communication with the distant specialist physician, optometrist, or dentist and shall receive an interactive communication with the distant specialist physician, optometrist, or dentist, upon request.
- If requested, communication with the distant specialist physician, optometrist, or dentist may occur either at the time of the consultation or within 30 days of the patient's notification of the results of the consultation.

Eligible Originating Sites (Patient Site)

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. The type of setting may include, but is not limited to, a hospital, medical office, community clinic or the **patient's home**.

The presence of a health care provider is not required at the originating site as a condition of payment unless the health care provider at the originating site is medically necessary, as determined by the health care provider at the distant site.

Eligible Distant Site Practitioners (Provider Site)

There are no restrictions on provider types; however, a distant site provider must:

1. Be licensed in the State of California
2. Enrolled as a Medi-Cal provider
3. Be located in California or reside in a border community *
 - a. A health care provider who is part of a group, with an office physically located in California, may reside outside California.

* Border communities (see source citation under additional information):

Oregon: Ashland, Brookings, Cave Junction, Grants Pass, Jacksonville, Klamath Falls, Lakeview, Medford, Merrill

Nevada: Carson City, Henderson, Incline Village, Las Vegas, Minden, Reno, Sparks, Zephyr Cove

Arizona: Bullhead City, Kingman, Lake Havasu City, Parker, Yuma

Billing and Reimbursement

Place of Service

Health care providers are required to document Place of Service code 02 on the claim, which indicates that services were provided or received through a telecommunications system. The Place of Service code 02 requirement is not applicable for FQHCs or RHCs.

Modifiers

Only services rendered from the distant site are billed with modifiers. Claims for reimbursement should be submitted with the appropriate CPT code or HCPCS code for the professional services provided and one of the following Telemedicine modifiers:

- 95 for Synchronous live video services.
- GQ for Asynchronous store and forward services, including eConsult.

Originating Site Fee

Sites are instructed to use **Q3014**. Sites fee are limited to once per day, same recipient, same provider. The originating site fee is applicable to sites utilizing synchronous live video, asynchronous store and forward, and eConsult. As of January 2020, the payment amount is \$22.94.

FQHCs or RHCs may not bill for an originating site fee.

Transmission Fee: Live Interactive

Sites are instructed to use code **T1014**: telehealth transmission, per minute. This fee can be paid to originating and distant sites. It is limited to a maximum of 90 minutes per day, same recipient, and same provider. One unit of service is equal to one minute of transmission cost. Transmission fees are not applicable to asynchronous store and forward or eConsult services.

FQHCs or RHCs may not bill for a transmission fee.

Synchronous Live video and Asynchronous Store & Forward:

Medi-Cal covered benefits or services, as 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, 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; and
- 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, associated with the Medi-Cal covered service or benefit, as well as any extended guidelines as described in this section of the Medi-Cal provider manual; and

- The benefits or services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to his or her medical information.

Medi-Cal has removed all CPT and HCPC codes from their policy, instead allowing providers the ability to utilize telehealth as an appropriate modality for care for any clinical condition deemed appropriate by the provider.

eConsult:

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

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

Additional Resources

Medi-Cal Telehealth Guidelines

http://files.medi-cal.ca.gov/pubsdoco/DocFrame.asp?wURL=publications%2Fmasters-mtp%2Fpart2%2Fmednetele_m01o03.doc

Medi-Cal & Telehealth: Resources

<http://www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx>

CCHP Medi-Cal Telehealth Policy Fact Sheet

https://www.cchpca.org/sites/default/files/2019-08/Medi-Cal%20Fact%20Sheet%20FINAL_0.pdf

Border Communities: Medi-Cal SPA 09-004

<https://www.dhcs.ca.gov/formsandpubs/laws/Documents/09-004packageRAI.pdf>

Border Communities: Medi-Cal MHSUDS Informational Notice 18-041

https://www.dhcs.ca.gov/services/MH/Documents/MHSUDS_IN18-041enclosure_MEDI.pdf

Denti-Cal

The Department of Health Care Services has opted to permit the use of teledentistry as an alternative modality for the provision of select dental services. Therefore, enrolled Denti-Cal billing providers may submit documents for services rendered utilizing teledentistry.

The goal of teledentistry is to:

1. Allow Medi-Cal providers to practice teledentistry, as defined to mean the transmission of medical information to be reviewed at a later time, or in real time, by a licensed dental provider at a distant site; and
2. Authorize modest scope of practice expansions.

Please note that allied dental professionals may render limited services via teledentistry so long as such services are within their scope of practice and are rendered under the general supervision of a licensed dentist.

Documentation Requirements

Providers may use CDT Code **D9999** for reimbursement of live transmission costs associated with teledentistry. Written documentation is required and must include the number of minutes the transmission occurred.

Conditions Required for Use

Patient Consent

Providers must inform the patient about the use of teledentistry and obtain verbal or written consent from the patient for the use of teledentistry as an acceptable mode of delivering dental services. The consent shall be documented in the patient's dental record.

A beneficiary receiving teledentistry services by store and forward may also request to have real-time communication with the distant dentist at the time of the consultation or within 30 days of the original consultation.

Billing and Reimbursement

Asynchronous Store and Forward services

Teledentistry claims are identified CDT code **D0999** ("Unspecified diagnostic procedure, by report") with a date of service on or after July 1, 2015. Claims are billed with D0999 and any additional services provided in the table below.

Providers may bill for teledentistry on the same claim form as other types of procedure codes unless they are in conflict with the Denti-Cal Manual of Criteria (MOC).

The table below provides a listing of all eligible store and forward services with CPT codes effective 2018

Asynchronous Store and Forward Service	CDT Codes
Unspecified diagnostic procedure, by report	D0999
Periodic oral evaluation — established patient	D0120
Comprehensive oral evaluation – new or established patient	D0150
Intraoral — complete series of radiographic images	D0210
Intraoral — periapical first radiographic image	D0220
Intraoral — periapical each additional radiographic image	D0230
Intraoral — occlusal radiographic image	D0240
Bitewing — single radiographic image	D0270
Bitewings — two radiographic images	D0272
Bitewings — four radiographic images	D0274
Panoramic radiographic image	D0330
Oral/Facial photographic images	D0350

Synchronous Live Video Services

Traditionally, teledentistry is conducted by asynchronous store and forward. However, at the beneficiaries request or if health care provider believes the service is clinically appropriate, live transmissions can be conducted and are reimbursable. Teledentistry claims are identified using Current Dental Terminology (CDT) code **D0999** (“Unspecified diagnostic procedure, by report”) with a date of service on or after July 1, 2015.

Please note: CDT D0999 is the same code used as Asynchronous Store and forward. However, in this instance, D0999 is used as a stand alone code, or in conjunction with the live transmission code, D9999.

Providers may use CDT Code **D9999** for reimbursement of live transmission costs associated with teledentistry.

When submitting a claim for reimbursement of live transmission costs, CDT Code D9999 will only be payable when CDT Code D0999 has been rendered. The reimbursed rate is 24 cents per minute, up to a maximum of 90 minutes. Procedure D9999 may only be used once per date of service per beneficiary, per provider. Written documentation is required and must include the number of minutes the transmission occurred.

If the live transmission cannot occur at the precise time of the beneficiary request, then a subsequent agreed upon time may be scheduled between the beneficiary and provider within a 30 day time period.

Additional Resources

Denti-Cal Provider Handbook

https://www.denti-cal.ca.gov/DC_documents/providers/provider_handbook/handbook.pdf

Denti-Cal Quick Reference Guide

https://www.denti-cal.ca.gov/DC_documents/providers/teledentistry_quick_reference_guide.pdf

Denti-Cal Teledentistry Tutorial

https://www.denti-cal.ca.gov/DC_media/providers/teledentistry_tutorial.mp4

California Children’s Services (CCS) and Genetically Handicapped Persons Program (GHPP)

CCS and GHPP programs follow Medi-Cal policies and procedures concerning coverage and reimbursement of telemedicine services.

Additional Resources

CCS Numbered Letter No. 14-123 Telehealth Services for CCS and GHPP Programs

<https://www.dhcs.ca.gov/services/ccs/Documents/ccsn141213.pdf>

CCS Numbered Letter No. 16-1217 Telehealth Services Code Update for CCS and GHPP Programs.

<https://www.dhcs.ca.gov/services/ccs/Documents/ccsn161217.pdf>

Anthem Blue Cross Telehealth Programs

Anthem Blue Cross has telehealth services available through a variety of programs administered and operated by Anthem Blue Cross. This section outlines the Anthem Blue Cross Telehealth Program provisions and benefits.

Coverage of Telehealth

- Live interactive
- Store and forward

For telehealth services to be eligible for reimbursement, the provider’s services must be rendered from one of the following locations:

- | | |
|------------------------|--|
| a. Provider’s office | d. Federally Qualified Health Center |
| b. Hospital | e. Other location with prior plan approval |
| c. Rural Health Clinic | |

Conditions Required for Telehealth Use

Verbal and Written Patient Consent

All telehealth encounters require that verbal informed consent be obtained and documented by the Originating Site. This documentation is part of the medical record to be kept with other documentation.

Exclusions

A telephone conversation, email, fax are not considered live interactive or store and forward telehealth visits and are specifically excluded from the definition of telemedicine.

Eligible Member Populations

- | | |
|--|--|
| a. Anthem Blue Cross Medi-Cal Managed Care Plans | d. California’s Valued Trust (CVT) |
| b. CalPERS Basic Plan | e. Self-Insured Schools of California (SISC) |
| c. Butte Schools Self-funded Program | f. University of California (UC) |

Eligible Originating and Distant Sites

Anthem Blue Cross limits participation in its telemedicine program to members of the Blue Cross Open Access Network. All originating (patient) and distant (provider) sites must be a member of this network.

Billing and Reimbursement

Anthem Blue Cross of California uses standardized billing procedures when submitting claims.

Modifiers

To be used by the distant site

- 95 for live interactive telemedicine encounters
- GQ for store and forward telemedicine encounters

Originating Site Fee – Synchronous Live Video and Asynchronous Store and Forward

Specialty sites (also known as distant sites) may not bill for an originating site fee.

Presentation site (also known as originating sites): **Q3014**

Transmission Fees

- Anthem Blue Cross will pay claims for Blue Cross members' telecommunication charges for live interactive consultations only.
- Only the site that initiates the live interactive telemedicine encounter may bill.
- Sites are instructed to bill with code **T1014**
- Each minute (or part thereof) is equal to one (1) unit of occurrence with a maximum of 90 minutes of occurrence (1.5 hours billable maximum).

Synchronous Live Video

Reimbursement to the health professional delivering the clinical service is the same as the current fee schedule amount for the service provided without telemedicine.

The table below provides a listing of all eligible live interactive services with CPT codes, effective 2019

Synchronous Live Video Service	CPT Codes
Primary Care Providers	
New patient office visit	99201-99205
Established patient office visit	99211-99215
Specialist	
Consultations	99241-99245
Follow-up visits	99211-99215
Psychiatry	
Psychiatric diagnosis	90801-90809
Individual psychotherapy	90810-90815
Individual psychotherapy (inpt)	90816-90819
Individual psychotherapy (inpt)	90821-90829
Medical psychoanalysis	90853
Pharmacological psychiatric mgt	90862
Consultations	99241-99245
Established member office visits	99211-99215

Asynchronous Store and Forward

Anthem Blue Cross pays for claims for the review of patient files for store and forward under codes:

- **99241-99245** Consultants only

The preparation of the store and forward consult should be billed as part of the primary care provider's office visit.

Store and forward is accomplished via secured email communication. As such, there are no telecommunication charges applicable. Therefore, there is no telecommunication reimbursement offered by Anthem Blue Cross.

Live Health Online (LHO)

LiveHealth Online (LHO) is a website and mobile application that gives patients 24/7 access to on-demand video visits (medical). It has an urgent care focus and provides convenient access anytime, anywhere in California, even at home, via smartphone, tablet or computer.

LHO connects patients with board-certified physicians supporting physical and behavioral health. Physicians can electronically prescribe to the member's pharmacy. **Note: Only noncontrolled substances can be prescribed.**

It is available at no cost for Anthem Blue Cross (Anthem) members enrolled in Medi-Cal Managed Care (Medi-Cal) beginning September 1, 2018.

Bright Heart Health

Now available to Anthem Medi-Cal members at no cost: Bright Heart Health Medication Assisted Treatment (MAT) program for opioid use disorder and alcohol use disorder.

Bright Heart Health is a website and mobile application that gives members 24/7 access to opioid addiction programs using virtual Substance Use Disorder (SUD) treatment programs. Bright Heart Health provides discrete outpatient treatment programs using your smart phone, tablet or computer.

Patients can access care by utilizing one of the following options:

1. Call Bright Heart Health to complete intake and get an appointment. Phone available 24x7
PHONE: (844) 884-4474
2. Complete Referral Form on Bright Heart Health website.
<https://www.brighthearthealth.com/intake-forms/patient-referral/>
3. Member's doctor or an emergency room can fax patient information to Bright Heart Health:
FAX: (415) 458-2691

Members will be referred to a BHH services coordinator who will work with them to explore MAT and other treatment options.

Additional Resources

Anthem Blue Cross: Telemedicine Program Provider Operations Manual
https://mediproviders.anthem.com/Documents/CACA_CAID_ProviderManual.pdf

Anthem Blue Cross Telemedicine Website
http://w2.anthem.com/bcc_state/tm/info/index.asp

California Health & Wellness

This section outlines the California Health & Wellness Telehealth Program provisions and benefits.

Coverage of Telehealth

- Live interactive
- Store and forward

Conditions Required for Telehealth Use

Verbal and Written Patient Consent

Prior to each encounter of the delivery of health care services via telehealth, the licensed provider at the originating site must verbally inform the member that telehealth may be used and obtain verbal or written consent from the member. The verbal or written consent must be documented in the member's medical record, including the following elements:

- a. A description of the risks, benefits, and consequences of telemedicine
- b. The member retains the right to withdraw at any time
- c. All existing confidentiality protections apply
- d. The member has access to all transmitted medical information
- e. No dissemination of any member images or information to other entities without further written consent

Store and Forward Patient Consent

The health care provider shall comply with the informed consent provision of Section 2290.5 of the Business and Professions Code when a member receives teleophthalmology and teledermatology by store and forward.

Members receiving teledermatology or teleophthalmology services by store and forward must be notified of the right to interactive communication with the distant specialist if requested. If requested, the communication may occur at the time of the consultation or within 30 days of the member's notification of the results of the consultation.

Exclusions

Telehealth does not include email, telephone (voice only), text, inadequate resolution video, written communication between the providers, or between patients and providers.

Eligible Member Populations

Live interactive (synchronous) telehealth services can be provided to Plan members by any Plan-credentialed licensed provider.

Store and forward (asynchronous) telehealth services can be provided to Plan members by any Plan-credentialed licensed provider. The following licensed providers may provide store and forward services:

- a. Ophthalmologists
- b. Dermatologists
- c. Optometrists (licensed pursuant to Chapter 7 (commencing with Section 3000 of Division 2 of the Business and Professions Code)

Eligible Originating and Distant Sites

For purposes of reimbursement for covered treatment or services provided through telehealth, the type of setting where services are provided for the member or by the licensed provider is not limited (Welfare and Institutions Code [W&I Code], Section 14132.72[e]).

Billing and Reimbursement

California Health and Wellness uses standardized billing procedures when submitting claims.

Modifiers

To be used by the distant site

- GT for live interactive telemedicine encounters
- GQ for store and forward telemedicine encounters

Originating Site Fee – Live Video and Store and Forward

Q3014 - May be billed with or without a provider present

Transmission Fees

T1014 - (per minute for a maximum of 90 minutes per day, same recipient, same provider). Each minute (or part thereof) is equal to one (1) unit of occurrence.

Synchronous Live Video

There are two synchronous models of telehealth services available to Plan members.

- Live interactive (synchronous) telehealth services, connects the patient with a distant licensed provider through audio-video equipment on a real-time basis.
- Live interactive (synchronous) patient to provider telehealth services, connects a single licensed provider (primary care or specialty provider) to a member using audio-visual equipment on a real-time basis. The member can be in a health facility, residential group home or private residence or other setting, provided the appropriate equipment is used.

Table 10 provides a listing of all eligible live interactive services with CPT codes.

Synchronous Live Video Service	CPT Codes
Office or other outpatient visit (new or established patient)	99201-99215
Initial hospital care or subsequent hospital care (new or established patient)	99221-99233
Consultations: Office or other outpatient, initial or follow-up inpatient, and	99241-99275
Interactive complexity (List separately in addition to the code for primary	90785
Psychiatric diagnostic evaluation	90791
Psychiatric diagnostic evaluation with medical services	90792
Psychotherapy, 30 minutes with patient/or family member	90832
Psychotherapy, 45 minutes with patient/or family member	90834
Psychotherapy, 60 minutes with patient/or family member	90837
Psychotherapy for crisis; first 60 minutes	90839
Additional 30 minutes	90840
Pharmacologic management, including prescription and review of medication, when performed with psychotherapy	90863

Asynchronous Store and Forward

Asynchronous telehealth services or store and forward services, connects a member with a distant licensed provider of ophthalmology, dermatology or certain optometry services using audio-video equipment, but not on a real-time basis. Generally an image or picture is taken and forwarded to the distant licensed provider to review at a later time.

The table below provides a listing of all eligible store and forward services with CPT codes.

Asynchronous Store and Forward Service	CPT Codes
Office consultation, new or established patient	99241-99243
Initial inpatient consultation	99251-99253
Office or other outpatient visit	99211-99214
Subsequent hospital care	99231-99233
Retinal Photography: with interpretation for services provided by optometrists or ophthalmologists (should not be used if the originating site is submitting claims with this code)	92250

Additional Resources

California Health & Wellness Telehealth Policy

http://caltrc.org/wp-content/uploads/2020/02/CA_CHW_Telehealth_Services_SHP_11.11.19.pdf

Central California Alliance for Health

This section outlines the Central California Alliance for Health (CCAH) Telehealth Program provisions and benefits. The goal of telehealth with the Alliance is to improve both access and quality health services provided in rural and other medically underserved areas through the use of information and telecommunications technologies.

In order to support timely access to care, especially in specialties and regions in which access is limited, the Alliance promotes the use of telehealth when appropriate for the provision of specialty services.

Coverage of Telehealth

- Synchronous Live Video
- Asynchronous Store and forward including eConsult

Conditions Required for Telehealth Use

The health care provider at the originating site must inform the member that telehealth services will be used and obtain the member's verbal or written consent, which will be documented in the member's medical record. The health care provider will disclose to enrollees the use telehealth in the delivery of specialty or other care and, if applicable, directions for how enrollees can elect to use telehealth services for their care. In all circumstances, providers will abide by HIPAA laws, including not disclosing a member's personal health information to any third party without written consent.

Exclusions

The Alliance will not reimburse under this policy for routine e-mail, telephone (voice only), text, written communication between providers or between members and providers, or images with inadequate resolution.

Eligible Member Populations

Live interactive (synchronous) telehealth services can be provided to Alliance members by any Alliance credentialed health care provider with the member's verbal consent, as documented in the patient's medical record.

The Alliance will pay for asynchronous store and forward services in teledermatology, teleoptometry and teleophthalmology, as long as they meet federal and state guidelines for medical necessity and are covered benefits according to the Alliance member's Evidence of Coverage (EOC).

Eligible Originating and Distant Sites

Telehealth services may be provided at a physician office, clinic setting, hospital, skilled nursing facility, residential care setting or patient home, or other settings as necessary. The Alliance does not require face-to-face contact between a member and a provider for reimbursement to occur.

Billing and Reimbursement

Modifiers and Place of Service Code

Place of Service code 02 is to be used on the claim. This is not applicable to FQHCs and RHCs.

Modifiers to be used by the distant site:

- 95 for live interactive telemedicine encounters
- GQ for store and forward telemedicine encounters

Originating Site Fee – Live Video and Store and Forward

Q3014: If a licensed provider is not present at the originating site, a site facility fee may be billed in lieu of the provider fee for the visit.

Transmission Fees

T1014: Transmission cost fees may be billed whether or not a licensed provider is present.

Synchronous Live Video

The table below provides a listing of all eligible live interactive services with CPT codes.

Synchronous Live Video Service	CPT Codes
Office or other outpatient visit (new or established patient)	99202-99215
Initial hospital care or subsequent hospital care, critical care (new or established patient)	99221-99233, 99291, 99292
Extended Inpatient Care	99356 – 99357
Consultations: Office or other outpatient, initial or follow-up inpatient, Inpatient, and confirmatory	99241-99275
Genetic Counseling	96040, S0265
Nutrition Counseling per PHC Guidelines (See Policy MCUP3052)	97802, 97803, 97804, 99539
Interactive complexity (List separately in addition to the code for primary	90785
Psychiatric diagnostic evaluation	90791
Psychiatric diagnostic evaluation with medical services	90792
Psychotherapy, 30 minutes with patient/or family member	90832
Psychotherapy, 45 minutes with patient/or family member	90834
Psychotherapy, 60 minutes with patient/or family member	90837
Psychotherapy for crisis; first 60 minutes	90839
Additional 30 minutes	90840
Pharmacologic management, including prescription and review of medication, when performed with psychotherapy	90863
Originating Site Fee	Q3014
Transmission Fee	T1014

Asynchronous Store and Forward

Store and forward (asynchronous) services, connects a member with a distant licensed provider of ophthalmology, dermatology or certain optometry services using audio-video equipment, but not on a real-time basis. Generally, an image or picture is taken and forwarded to the distant licensed provider to review at a later time. The following Medi-Cal certified health care providers may provide store and forward services:

- a. Ophthalmologists
- b. Dermatologists
- c. Optometrists (licensed pursuant to Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code)
- d. Specialist groups contracted with the Alliance to provide eConsult services

The table below provides a listing of all eligible store and forward services with CPT codes.

Asynchronous Store and Forward Service	CPT Codes
Office or other outpatient visit (new or established patient)	99202-99215
Consultations: Office or other outpatient, initial or follow-up inpatient, Inpatient, and confirmatory	99241-99243, 99231-99233
eConsult, electronic consultation	99451
Retinal Photography: with interpretation for services provided by optometrists or ophthalmologists	92250
Originating Site Fee	Q3014
Transmission Fee	T1014

Managed Behavioral Health Organization (MBHO)

The Alliance contracts with a Managed Behavioral Health Organization (MBHO) to provide mild to moderate mental health services and BHT for eligible members from licensed/certified behavioral health providers.

Additional Resources

CCAH Provider Manual

https://www.ccah-alliance.org/providerspdfs/PM/Provider_Manual_Chapters/Provider_Manual.pdf

CCAH Provision of Telehealth Services to Alliance Members Policy 404-1727

<http://www.ccah-alliance.org/providerspdfs/pm/20190101/404-1727-Telehealth-Services.pdf>

Partnership Health Plan of California

This section outlines the Partnership HealthPlan of California (Partnership) Telehealth Program provisions and benefits. The goal of telehealth with Partnership is to improve both access and quality health services provided in rural and other medically underserved areas through the use information and telecommunications technologies.

Telemedicine services may also be used to provide mild-moderate severity Mental Health Services to Partnership members. Such services are provided through Partnership's contracted Managed Behavioral Health Organization (MBHO).

Partnership Coverage of Telehealth

- Synchronous live video
- Asynchronous store and forward including eConsult

Conditions Required for Telehealth Use

Verbal and Written Patient Consent

Prior to the delivery of health care services via telehealth, the health care provider at the presentation site must verbally inform the patient that telehealth may be used and obtain verbal consent from the patient for this use. The verbal consent must be documented in the patient's medical record.

Store and Forward Patient Consent

Members receiving teledermatology or teleophthalmology services by store and forward must be notified of the right to interactive communication with the distant specialist if requested. If requested, the communication may occur at the time of the consultation or within 30 days of the member's notification of the results of the consultation.

eConsult

Verbal consent for telehealth services is a requirement and must be documented by both the originating and distant site in the patient medical record.

Exclusions

PHC does not cover communication between providers outside that described as E-Consult. PHC does not cover patient-provider communication via email, text, or written communication. Video communication of poor resolution and phone communication are only covered if such telephone visits last at least 5 minutes and be documented in the medical record.

Certain types of services cannot be appropriately delivered via telehealth. These include services that would otherwise require the in-person presence of the patient for any reason, such as services performed in an operating room or while the patient is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices.

Eligible Originating and Distant Sites

For purposes of reimbursement for covered treatment or services provided through telehealth, the type of setting where services are provided for the member or by the licensed provider is not limited. Telehealth services may be provided at a physician office, clinic setting, hospital, skilled nursing facility, residential care setting or patient home or

other setting and must be in compliance with all laws regarding the confidentiality of health care information and a patient's rights to his or her medical information.

Live interactive (synchronous) telehealth services can be provided to Partnership members by any PHC credentialed health care provider with the member's verbal consent, as documented in the patient's medical record.

Store and forward (asynchronous) telehealth services can be provided by the following Medi-Cal providers:

- | | |
|---------------------|--|
| a. Ophthalmologists | c. Optometrists |
| b. Dermatologists | d. Specialists participating in PHC's eConsult Program |

Billing and Reimbursement

Partnership uses standardized billing procedures when submitting claims.

Modifiers and Place of Service Code

Place of Service code 02 is to be used on the claim. This is not applicable to FQHCs and RHCs.

Modifiers to be used by the distant site:

- 95 for live interactive telemedicine encounters
- GQ for store and forward telemedicine encounters

Originating Site Fee – Live Video and Store and Forward

Q3014 – May be billed without a provider present. This is not applicable to FQHCs and RHCs.

Transmission Fees

T1014 - (per minute for a maximum of 90 minutes per day, same recipient, same provider). Each minute (or part thereof) is equal to one (1) unit of occurrence. This is not applicable to FQHCs and RHCs.

Synchronous Live Video Services

There are two synchronous models of telehealth services available to Plan members:

1. Live interactive (synchronous) Telehealth Services connects the patient with a distant provider of health services through audio-video equipment on a real-time basis. This model is commonly used between specialty centers such as UCSF or UCD with outlying physician offices or community health centers.
2. Live interactive (synchronous) Patient to Provider Telehealth Services connects a single provider (primary care or specialty provider) to a patient using audio-visual equipment on a real-time basis. The patient can be in a health facility, residential group home or private residence or other setting, provided the appropriate equipment is used.

The table below provides a listing of all eligible live interactive services with CPT codes.

Synchronous Live Video Service	CPT Codes
Office or other outpatient visit (new or established patient)	99201-99215
Initial hospital care or subsequent hospital care, critical care (new or established patient)	99221-99233, 99291, 99292, G0508, G0509
Extended Inpatient Care	99356 – 99357

Consultations: Office or other outpatient, initial or follow-up inpatient, Inpatient, and confirmatory	99241-99275
Genetic Counseling	96040, S0265
Nutrition Counseling per PHC Guidelines (See Policy MCUP3052)	97802, 97803, 97804, 99539
Interactive complexity (List separately in addition to the code for primary)	90785
Psychiatric diagnostic evaluation	90791
Psychiatric diagnostic evaluation with medical services	90792
Psychotherapy, 30 minutes with patient/or family member	90832
Psychotherapy, 45 minutes with patient/or family member	90834
Psychotherapy, 60 minutes with patient/or family member	90837
Psychotherapy for crisis; first 60 minutes	90839
Additional 30 minutes	90840
Pharmacologic management, including prescription and review of medication, when performed with psychotherapy	90863
Video Visit with provider in office and patient off-site (in lieu of office visit)	G0071 (FQHC/RHC) or G2012 (other providers)
Originating Site Fee	Q3014
Transmission Fee	T1014

Other Covered Procedures that can be provided by Synchronous Live Video

All CPT codes except for these excluded codes: Anesthesia: 00100-01999 and 99100-99157; Surgery: 10021-69990; Speech/Occupational/Physical Therapy: 96101 to 97546, and 97750 to 97799; Wound care: 97597 to 97610; Acupuncture, osteopathic manipulation, chiropractic manipulation: 97810 to 98943) are potentially allowed if they meet requirements as noted*

* Each telehealth provider must be licensed in the State of California, enrolled as a Medi-Cal provider, and must reside in California (or a border community).

PHC covered services, identified by CPT or HCPC codes, and subject to any existing treatment authorization requirements, may be provided via a telehealth modality if all of the following criteria are satisfied:

1. The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment;
2. The services delivered via telehealth meet the procedural definition and components in the CPT-4 or HCPCS code(s) associated with the covered service; and
3. The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to the patient's own medical information.

Note for FQHCs and RHCs: An FQHC, RHC, or Tribal health site may choose to sub-contract with a specialist and pay them directly. Under these circumstances, the FQHC/RHC would bill for the originating site and the specialty service on two separate claims. The Partnership system would need to be set up for the specific specialty and if not, the Provider Relations Department should be contacted.

Asynchronous Store and Forward Services

Store and forward (asynchronous) services, model connects a patient with a distant provider of radiology, electrocardiography, ophthalmology, dermatology or certain optometry services using audio-video equipment, but not on a real-time basis. Generally, an image or picture is taken and forwarded to the specialty provider to review at a later time. This also includes specialty services provided via eConsult, or electronic consultations, which consist of an electronic exchange of information through the E-Consult platform and may include images or photos, labs, and other relevant patient information.

The table below provides a listing of all eligible store and forward services with CPT codes.

Asynchronous Store and Forward Service	CPT Codes
Office consultation (new or established patient)	99201-99215
Consultations: Office or other outpatient, initial or follow-up inpatient, Inpatient, and confirmatory	99241-99243, 99231-99233
Remote evaluation of recorded video and/or images submitted by the patient.	G2010
eConsult, electronic consultation	99451
Retinal Photography: with interpretation for services provided by optometrists or ophthalmologists	92250 (no modifier)
Remote imaging for detection of retinal disease with analysis and report under physician supervision, unilateral or bilateral	92227 (no modifier)
Originating Site Fee	Q3014
Transmission Fee	T1014

Special Billing Guidelines for Asynchronous Retinal Photography - Originating Site Providers:

If a provider uses asynchronous telehealth for diabetic eye exam screenings, through the use of a retinal camera located at the originating site, special billing guidelines apply, when the originating site is paying the specialist directly for reading the results of the retinal photographs. A licensed provider does not need to be present for retinal photography service to be reimbursable. If provider is present during the visit, E&M codes can also be billed as usual. If no provider is present at visit, bill using one of the following CPT codes:

92250: Retinal photography with interpretation for services provided by optometrists or ophthalmologists

92227: Remote imaging for detection of retinal disease with analysis and report under physician supervision, unilateral or bilateral

eConsult

Only approved specialists participating in PHC's E-Consult Program can bill. The specialist provider at the distant site must:

1. Create and maintain record of the review and analysis of the transmitted information with written documentation of data of service and time spent (between 5-30 minutes)
2. Record of preparing a written report of case findings and recommendations with conveyance to the originating site
3. Record of maintenance of transmitted medical records in patient's medical record.

Telephone visits

Any clinician eligible to bill for office visits may conduct a telephone visit with a patient in lieu of an office visit. Such telephone visits must last at least 5 minutes, and be documented in the medical record. Note that these are the same codes used for video visits with the patient at home.

G0071 – FQHCs and RHCs G2012 – Other Providers

Additional Resources

Partnership Health Plan Telehealth Policy

<http://www.partnershiphp.org/Providers/Policies/Documents/Utilization%20Management/MCUP3113.docx>

Partnership Health Plan Telehealth Service Website

<http://www.partnershiphp.org/Providers/Quality/Pages/Telehealth-Services.aspx>

Beacon Health Options

Beacon is a Managed Behavioral Health Organization (MBHO). Beacon manages the behavioral health benefits for some of the Medi-Cal Managed Care Plans in California. Specifically, they offer behavioral health, including psychiatry and therapy, substance use disorder, and specialty programs for autism. The services that Beacon offers will vary by Managed Care Plan. Below are a few of the guidelines you should be aware of.

Coverage of Telehealth

Live interactive only

Eligible Member Populations

Live interactive (synchronous) telehealth services can be provided to Beacon members with the following health plan affiliations:

- Alameda Alliance for Health
- Central California Alliance for Health
- Gold Coast Health Plan
- Health Plan of San Joaquin
- LA Care
- Partnership Health Plan
- Promise Health Plan
- San Francisco Health Plan

Billing and Reimbursement

Beacon uses standardized billing procedures when submitting claims.

Modifiers

To be used by the distant site

- 95 for live interactive telehealth encounters

Originating Site Fee

Q3014 – May be billed without a provider present

Transmission Fees

T1014 - (per minute for a maximum of 90 minutes per day, same recipient, same provider). Each minute (or part thereof) is equal to one (1) unit of occurrence.

Eligible Originating and Distant Sites

For purposes of reimbursement for covered treatment or services provided through telehealth, the type of setting where services are provided for the member or by the licensed provider is not limited.

The table below provides a listing of **potential** live interactive services with CPT codes, based on your individual contract.

Synchronous Live Video Service	CPT Codes
Psychiatric diagnostic evaluation	90791
Psychiatric diagnostic evaluation with medical services	90792
Psychotherapy, 30 minutes with patient/or family member	90832
Psychotherapy, 45 minutes with patient/or family member	90834
Psychotherapy, 60 minutes with patient/or family member	90837
Psychotherapy for crisis; first 60 minutes	90839
Additional 30 minutes	90840
Family psychotherapy (without the patient present), 50 minutes	90846
Family psychotherapy (conjoint therapy) (with the patient present), 50 minutes	90847
New Patient, office or other outpatient visit	99205
Established patient, office or other outpatient visit	99212 - 99215
Behavioral health day treatment, per hour	H2012
Skills training and development, per 15 minutes	H2014
Therapeutic behavioral services, per 15 minutes	H2019
Home care training; family, per session	S5111
Originating Site Fee	Q3014
Transmission Fee	T1014

Direct to Consumer Option

Beacon offers several platforms for members to be seen in their homes, by a licensed clinician, using their smart phone, laptop, or tablet.

Members must be screened first by a member services representative before they can be referred for services.

This option is not available to all members or all plans that Beacon manages the benefit for. Please check with member services or Provider Relations for availability.

Additional Resources

Beacon Telehealth Program Description

<https://www.beaconhealthoptions.com/material/telehealth-program-description/>

Beacon Telehealth Program Specifications

<https://www.beaconhealthoptions.com/material/telehealth-program-specs/>

Beacon Telehealth FAQ

<https://www.beaconhealthoptions.com/material/telehealth-faqs/>

Beacon Telehealth Site Coordination

<https://www.beaconhealthoptions.com/material/telehealth-site-coordination/>

Federally Qualified Health Centers and Rural Health Clinics

Federally Qualified Health Centers (FQHC) And Rural Health Clinics (RHC) play a critical role in the provision of primary care to our rural and underserved populations. Many FQHC/RHCs are patient and / or provider sites for the delivery of telehealth services. Telehealth can improve patient access to specialty care, primary care, and reduce travel hardships when needed services are far away. These valuable healthcare resources have played an important role in the development of telehealth in California.

One of the questions most commonly asked of the CTRC is about allowable billing for telehealth services by an FQHC/RHC. CTRC has worked with many rural clinic administrators and payers to clearly identify the different reimbursement scenarios and the payment rules that surround each scenario. This document has been developed with input from many different stakeholders, health plans, and clinics themselves.

This portion of the guide is designed to assist in maximizing allowable billing for telemedicine and to assist in determining the type of provider relationship that will best meet programmatic needs. It is written for FQHCs and RHCs operating in California under the Prospective Payment System (PPS). Please note that rules for other states may differ.

There are several factors that determine how to bill for telemedicine services. Two principles form the foundation:

- The place determined to be the Distant or provider site is the billing site
- A provider can, under certain circumstances, enter the four walls virtually using telehealth

The factors that determine the billing scenario are:

- Where the patient is physically located at the time of the visit
- Characteristics of the specialty provider site
- Payment arrangement with the distant site provider
- If there is medical reason for a provider to be present with the patient

Fee-For-Service Medi-Cal

Fee-For-Service Medi-Cal has developed specific policies for FQHCs and RHCs that differ from the other provider types. First, let's address a few definitions that will help to clarify the policies we will be diving in to in a bit.

HHMS: Homeless, Homebound, Migratory, or Seasonal Worker.

Homebound: means the patient must have a normal inability to leave home and leaving home must require considerable and taxing effort due to either:

1. An illness or injury where
 - a. There is a need for the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; or
 - b. The use of special transportation; or
 - c. The assistance of another person in order to leave their place of residence.
2. Having a documented condition such that leaving his or her home is medically contraindicated.

Homeless: Shall include all individuals who do not reside in a permanent residence, who do not have a fixed home, or mailing address.

Migratory or seasonal worker: An individual who meets the definition of migratory agricultural worker in Section 330(g)(3)(A) of the Public Health Service Act or seasonal agriculture worker in Section 330(g)(3)(B) of the Public Health Service Act.

Established Patient: is a Medi-Cal eligible recipient who meets one or more of the following conditions:

1. The patient has a health record with the FQHC or RHC that was created, or updated, during a visit that occurred in the clinic within the previous 3 years; or
 - a. During a synchronous telehealth visit in a patient's home with a clinic provider and a billable provider at the FQHC or RHC. The patient's health record must have been created or updated within the previous three years.
2. The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit, occurring within the last three years, that was provided outside the FQHC or RHC clinic, but within the FQHCs or RHCs service area. All consent for telehealth services for these patients must be documented.
3. The patient is assigned to the FQHC or RHC by their Managed Care Plan (MCP) pursuant to a written agreement between the plan and the FQHC or RHC.
4. When a health record is maintained among multiple FQHCs or RHCs within the same organization, the patient is an established patient of the organization's FQHCs or RHCs.

Synchronous Live Video Telehealth Services:

Services provided through synchronous, live video telehealth for an established patient are subject to the same program restrictions, limitations and coverage that exist when the service is provided in-person.

1. FQHCs and RHCs may bill for an office visit if it is medically necessary for a billable provider to be present with a patient during the telehealth visit.
2. An FQHC or RHC billable provider furnishes services as a distant site.
3. FQHCs and RHCs must submit claims for telehealth services using the appropriate all-inclusive billing code sets and related claims submission requirements.

Telehealth to the patient's home:

FQHCs/RHCs are allowed to provide live video telehealth services to the patient home, however, the following conditions will be in place:

1. The patient must be an established patient and either homeless, homebound, or a migratory or seasonal worker.
2. The FQHC or RHC may bill its PPS rate for services provided outside the Four Walls. The FQHC or RHC must maintain documentation demonstrating that the person is homeless, homebound, or a migratory or seasonal worker. The FQHC or RHC shall meet all of the following requirements:
 - a. The visit must be at the patient's residence or current location for homeless patients. For RHCs, a patient's residence is the only location outside the Four Walls of an RHC that is eligible for visits to be reimbursed at the RHC's PPS rate.
 - b. The person rendering the service must be employed or under contract with the FQHC or RHC at the time the services are rendered.
 - c. Services must be rendered within the FQHC's Health Resources and Services Administration's (HRSA) approved service area.

Asynchronous Store and Forward Services:

Reimbursement is permitted for an established patient for teleophthalmology, teledermatology and teledentistry, and furnished by a billable provider at the distant site.

Billing and Reimbursement

Originating site and transmission fees:

FQHCs and RHCs are not eligible to bill an originating site fee, or transmission charges. The cost of these services should be included in the PPS rate.

Synchronous Live Video:

1. If the Originating Site and the Distant Site are FQHCs or RHCs that are part of the same organization, only one site may bill for the visit, even if a billable provider participates at each location.
2. If the Originating Site and the Distant Site are both FQHCs or RHCs but are not part of the same organization, both the Originating Site and Distant Site may each bill for the services at their respective PPS rates if both organizations use medically necessary billable providers. The Originating Site shall not compensate the Distant Site for the Telehealth Services rendered.
3. If the Originating Site is an FQHC or RHC and the Distant Site is not an FQHC or RHC, only the Originating Site can be reimbursed for the Telehealth Service at the PPS rate if a medically necessary billable provider is used. The Originating Site is responsible for reimbursing the Distant Site for the Telehealth Service rendered to its Established patient if a payment arrangement exists.
4. If the Originating Site is not an FQHC or RHC and the Distant Site is a FQHC or RHC, the Distant Site can be reimbursed for the Telehealth Service at the PPS rate. The Originating Site shall not compensate the Distant Site for the Telehealth Services.

Asynchronous Store and Forward:

An FQHC or RHC may bill at its PPS rate for store and forward ophthalmology, dermatology, and dentistry services provided to its established patient, if it meets all of the following requirements:

- a. The Originating Site FQHC or RHC shall comply with the informed consent provision for store and forward prior to its established patient receiving ophthalmology, dermatology and dentistry Store and Forward Services
- b. If the Distant Site providing Store and Forward Services is also an FQHC or RHC, the Originating Site may only bill for one visit at its PPS rate, even if the services provided at the Distant Site occurred on a different day. Under no circumstances can two visits be billed for a single Store and Forward Service
- c. If the Distant Site is not an FQHC or RHC, the following requirements must be met for the Originating Site FQHC or RHC to be reimbursed at the PPS rate:
 - i. Only one visit can be reimbursed at the PPS rate regardless of the services rendered at the Originating Site
 - ii. The Originating Site FQHC or RHC must have an arrangement or current written agreement with the Distant Site to furnish the Store and Forward Services
 - iii. The Originating Site FQHC or RHC must compensate the Distant Site for the Store and Forward Services furnished to its patients
 - iv. The Distant Site must not directly bill Medi-Cal for the Store and Forward Services.

Medi-Cal Managed Care

Not all Medi-Cal Managed Care Plans in the state reimburse for telehealth services. You can find the policies for a few of these plans in other sections of the Reimbursement Guide. The CTRC strives to include as many Managed Care Plan policies as possible. In the absence of a policy, please reach out to your specific plans Provider Relations department to inquire about telehealth services.

For those Managed Care Plans that do reimburse for telehealth services, many of them do not have the same restrictions for FQHCs and RHCs as Fee-For-Service Medi-Cal. For example, an FQHC may be able to see a patient who is located in their home, via telehealth, and bill their PPS rate to the plan, regardless of the patient being HHMS.

Keep in mind that if a Managed Care Plan allows an FQHC to provide telehealth services to the patient's home without restrictions, Fee-For-Service Medi-Cal will NOT pay the wrap unless the patient is HHMS!

It is also important to keep contracting in mind when working with your Managed Care Plan around telehealth. As an FQHC, some Managed Care Plans will allow you to be both Distant Site and Originating Site. It is important to be sure that your FQHC is contracted correctly with the plan and that your rates are loaded in to the claims system correctly.

FQHC and RHC Reimbursement Models

The application of some of the factors we have discussed are described in the following fourteen scenarios. While this section has addressed Med-Cal specifically, Medicare scenarios have been added to help FQHC and RHC providers understand their billing options.

Medicare – Traditional Telehealth Live Video Visit

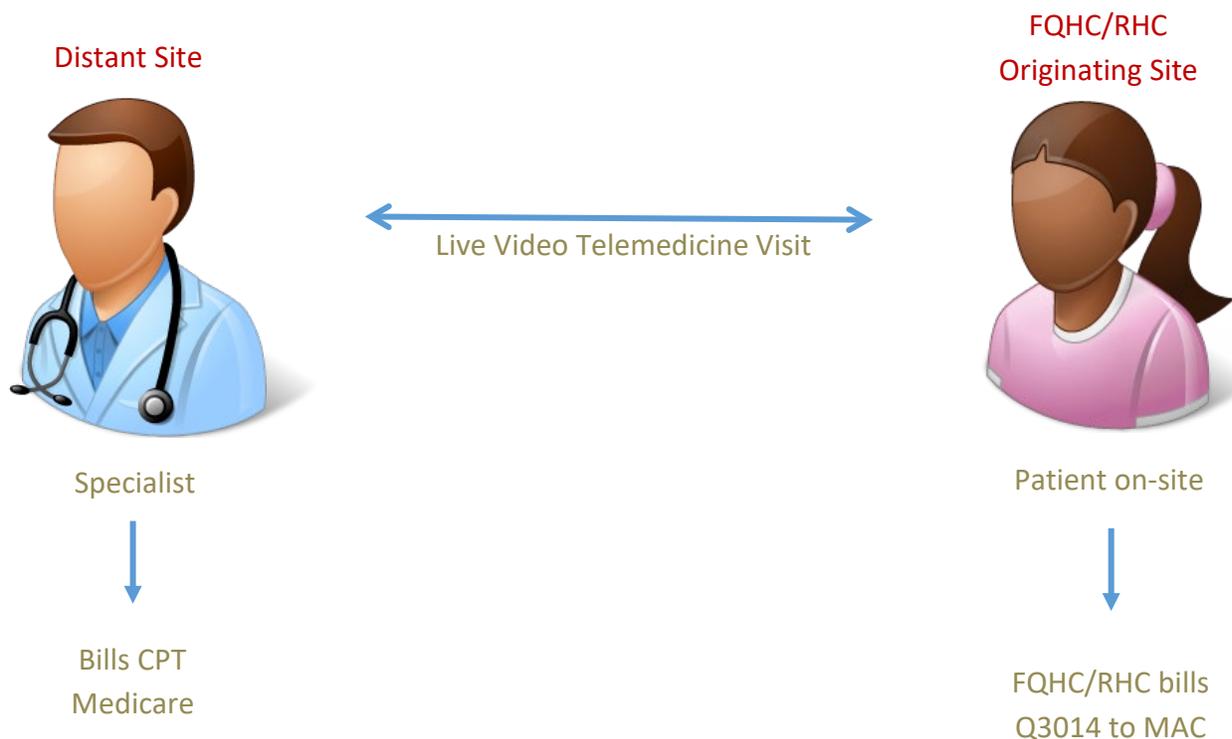
Scenario 1

FQHC/RHC Originating Site to a Distant Site

- Patient is physically present at the FQHC/RHC located **in an eligible location**.
- Specialist is a Medicare provider not physically present at the FQHC/ RHC.
- FQHC/RHC and specialist have an agreement to provide services, but the FQHC/RHC does not compensate the specialist.
- No medical reason for a provider to be present with the patient at the FQHC/RHC Site.

Outcome

- Medicare specialist is the Distant Site and can bill Medicare for a visit.
- FQHC/RHC is the Originating Site, did not provide an in person medical service, and cannot bill PPS for a face-to-face. However, the FQHC/RHC can bill an Originating Site fee to the Medicare Administrative Contractor (MAC).



Medicare Virtual Visit

Scenario 2

Patient (off-site) to an FQHC/RHC

- Provider is physically located at and receives compensation from FQHC/RHC.
- Patient is not physically present at FQHC/RHC. In this example we will use the patient's home.
- Patient is an established patient and initiates a live video or phone call to see if they need to come in to the FQHC/RHC for an in person visit.
- FQHC billable provider spent at least 5 minutes talking to patient.
- Patient has NOT been seen for an E/M code in the previous 7 days, and the appointment does not lead to an in person visit within the next 24 hours or soonest available appointment.

Outcome

- FQHC or RHC can bill for the Virtual Visit Service.

Off-Site Location
(such as the patient's home)



Patient

Patient initiated phone call
or live video call

FQHC or RHC



Provider
(Physician, NP, PA, CNM,
Psychologist, and CSW)

FQHC/RHC bills
G0071 to Medicare

Medicare Remote Evaluation

Scenario 3 Patient (off-site) to an FQHC/RHC

- Provider is physically located at and receives compensation from FQHC/RHC.
- Patient is not physically present at FQHC/RHC. In this example we will use the patient's home.
- Patient is an established patient and initiates an asynchronous transmission of photos or video to the FQHC/RHC.
- FQHC billable provider evaluated the patient transmitted images or video.
- Patient has NOT been seen for an E/M code in the previous 7 days, and the appointment does not lead to an in person visit within the next 24 hours or soonest available appointment.

Outcome

- FQHC or RHC can bill for the Remote Evaluation service.

Off-Site Location
(such as the patient's home)



Patient

Patient initiated phone call
or live video call

FQHC or RHC



Provider
(Physician, NP, PA, CNM,
Psychologist, and CSW)

FQHC/RHC bills
G0071 to Medicare

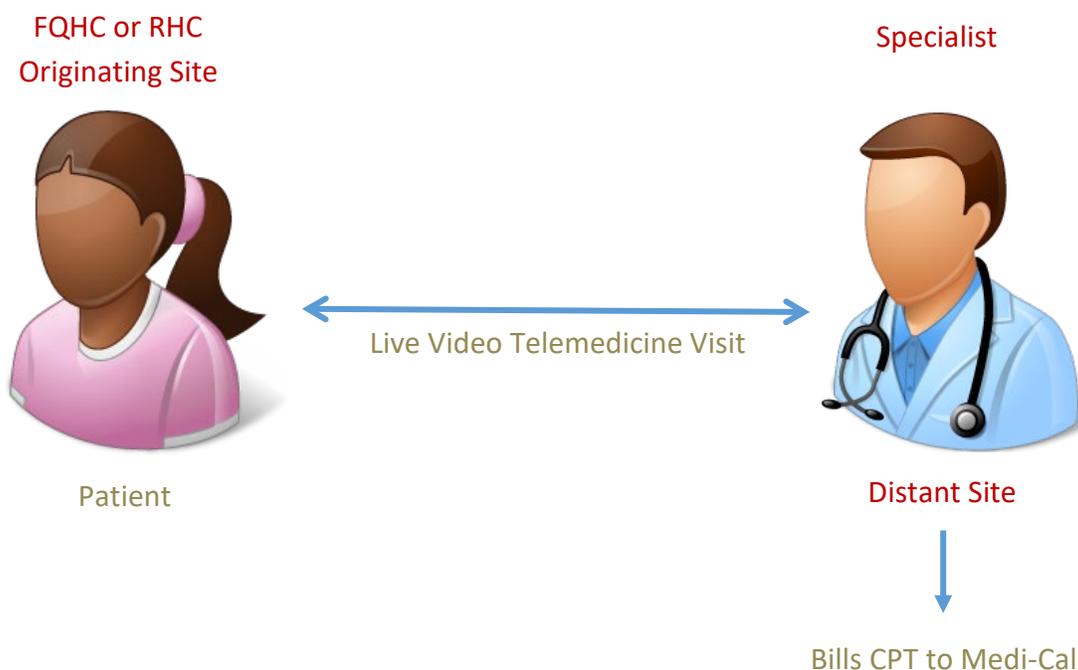
Medi-Cal Fee-For-Service

Scenario 4 FQHC/RHC Originating Site to a Fee-For-Service Distant Site

- Patient is physically present at the FQHC or RHC.
- Specialist is a Medi-Cal fee-for-service provider not physically present at the FQHC or RHC.
- FQHC or RHC and specialist have an agreement to provide services, however the FQHC or RHC does not compensate the specialist.
- No medical reason for a provider to be present with the patient at the FQHC or RHC Site.

Outcome

- Medi-Cal specialist is the Distant Site and can bill fee-for-service rate.
- FQHC or RHC is the Originating Site, did not provide a medical service, and cannot bill PPS for a face-to-face.



*Per the Medi-Cal handbook:
FQHCs, RHCs, and IHS clinic PPS sites may not bill for originating site or transmission fees.

Medi-Cal Fee-For-Service

Scenario 5

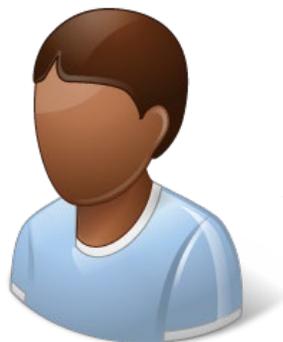
FQHC/RHC to FQHC/RHC (Two Different Organizations)

- Patient is physically present at FQHC/RHC 1.
- Specialist is physically present at and receives compensation from FQHC/RHC 2.
- FQHC/RHC 1 and FQHC/RHC 2 have an agreement to provide services, however FQHC/RHC 1 cannot compensate FQHC/RHC 2.
- No medical reason for a provider to be present with the patient at FQHC/RHC 1.

Outcome

- FQHC/RHC 2 is the Distant Site and can bill PPS for a face-to-face visit.
- FQHC/RHC 1 is the Originating Site, did not provide a medical service, and cannot bill PPS for a face-to-face visit.

FQHC/RHC 1
Originating Site



Patient

← Live Video Telemedicine Visit →

FQHC/RHC 2
Distant Site



Specialist

↓
Bills PPS

*Per the Medi-Cal handbook: FQHCs, RHCs, and IHS clinic PPS sites may not bill for originating site or transmission fees.

*Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.

Medi-Cal Fee-For-Service

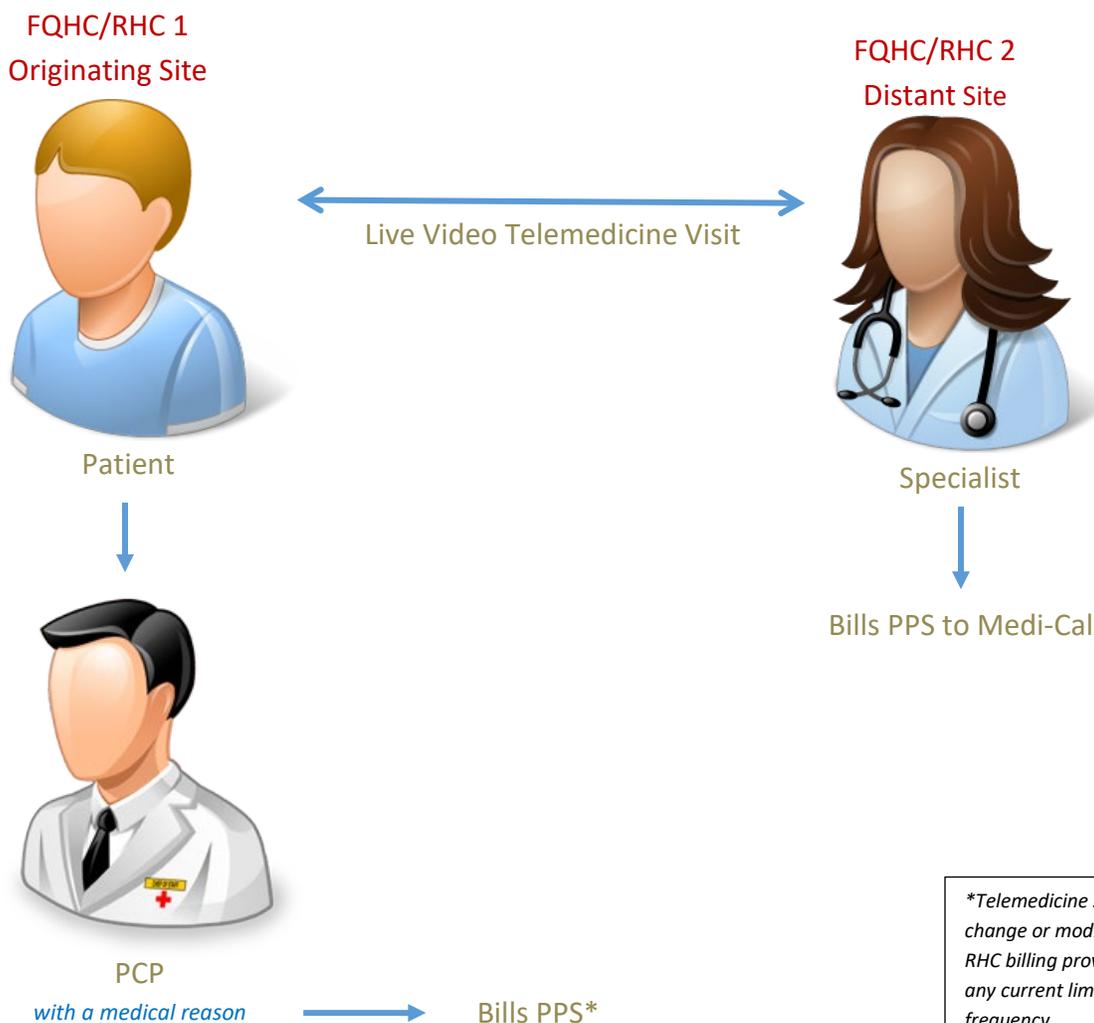
Scenario 6

FQHC/RHC (Provider Present) to FQHC/RHC (Two Different Organizations)

- Patient is physically present at FQHC/RHC 1.
- Specialist is physically present at and receives compensation from FQHC/RHC 2.
- FQHC/RHC 1 and FQHC/RHC 2 have an agreement to provide services, but FQHC/RHC1 cannot compensate FQHC/RHC 2.
- Medical reason for a provider to be present with the patient at FQHC/RHC 1.

Outcome

- FQHC/RHC 2 specialist is the Distant Site and can bill PPS for a face-to-face visit.
- FQHC/RHC 1 is the Originating Site, provided a medically necessary service, and can bill PPS for a face-to-face visit.



**Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.*

Medi-Cal Fee-For-Service

Scenario 7

FQHC/RHC to FQHC/RHC (Within Same Organization)

- Patient is physically present at FQHC/RHC 1.
- Distant Site Provider is physically at, and receives compensation from, FQHC/RHC 2.
- FQHC/RHC 1 and FQHC/RHC 2 have an agreement to provide services and are part of the same organization.
- No medical reason for a provider to be present with the patient at the FQHC/RHC 1 Site.

Outcome

- FQHC/RHC 2 is the Distant Site.
- FQHC/RHC 1 is the Originating Site.
- In this scenario, only one FQHC/RHC site may bill since they are part of the same organization.

FQHC/RHC 1
Originating Site

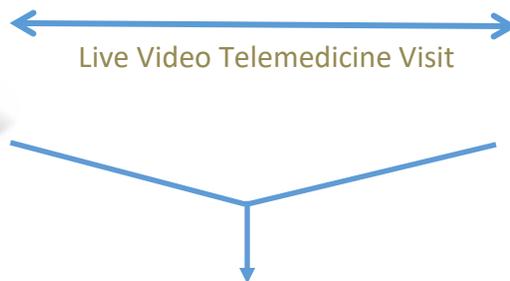


Patient

FQHC/RHC 2
Distant Site



Specialist



Only one site may bill PPS

*Per the Medi-Cal handbook: FQHCs, RHCs, and IHS clinic PPS sites may not bill for originating site or transmission fees.

*Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.

Medi-Cal Fee-For-Service

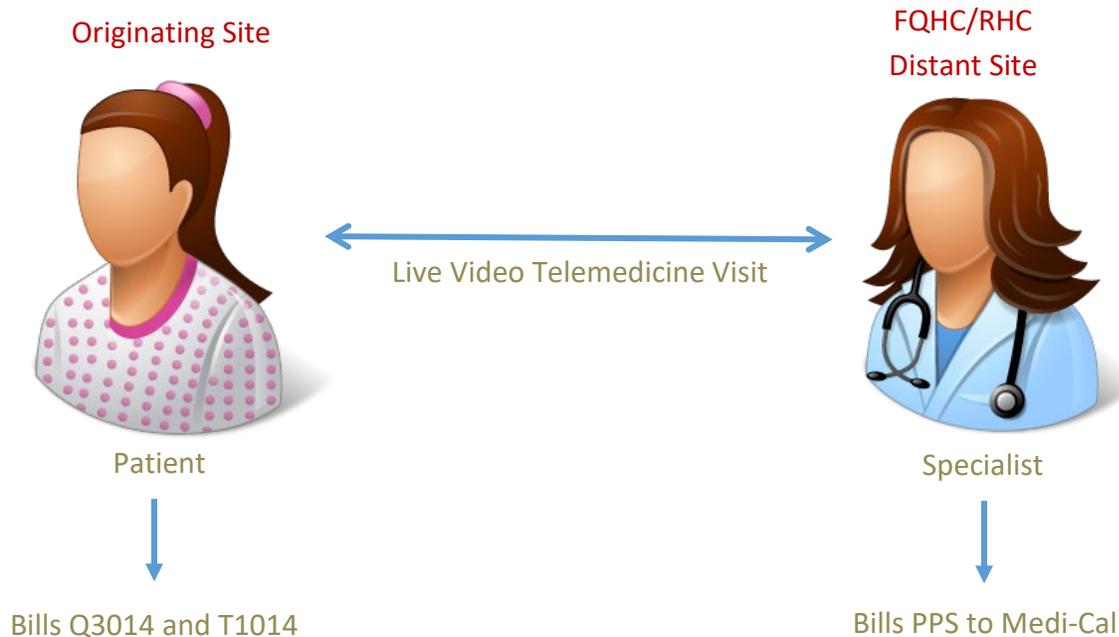
Scenario 8

Non FQHC/RHC Originating Site to FQHC/RHC Distant Site

- Patient is physically present at Originating Site (non FQHC/RHC).
- Specialist is physically located at and receives compensation from FQHC/RHC.
- Originating Site and FQHC/RHC have an agreement to provide services, however Originating Site does not compensate FQHC/RHC.
- No medical reason for a provider to be present with the patient at the Originating Site.

Outcome

- FQHC/RHC is the Distant Site and can bill PPS for a face-to-face visit.
- Non FQHC/RHC Clinic site is the Originating Site, did not provide a medical service, and cannot bill for a face-to-face visit. However, the clinic site can bill an Originating Site fee and transmission fee.



Medi-Cal Fee-For-Service

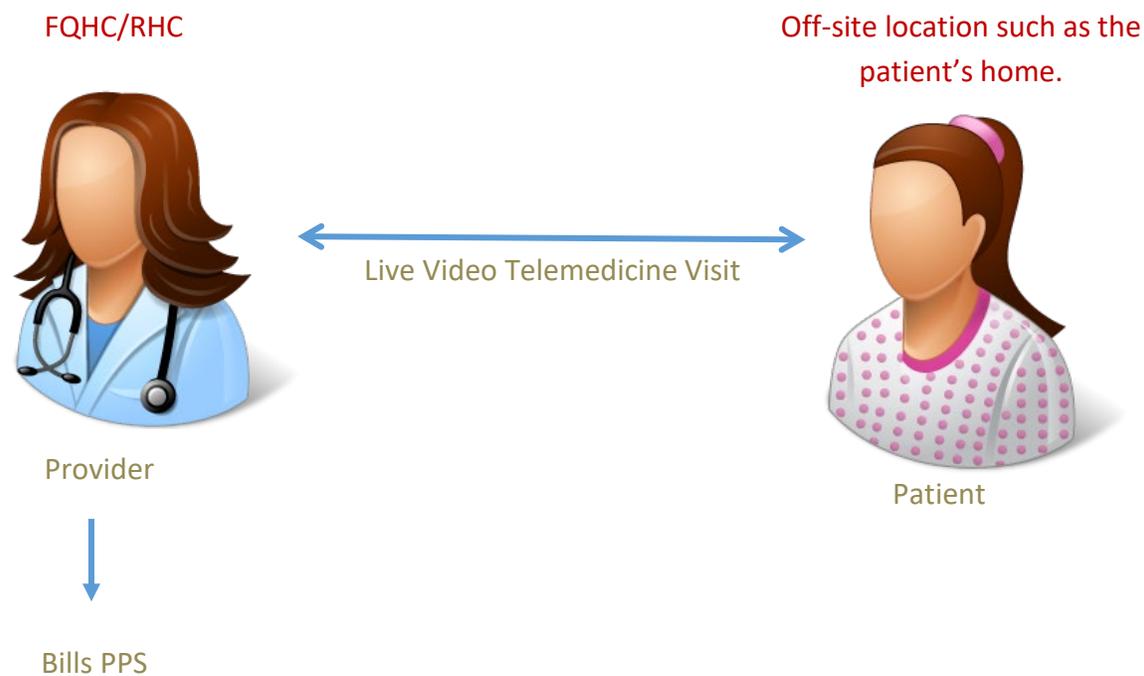
Scenario 9

FQHC/RHC to HHMS Patient Home

- Provider is physically located at and receives compensation from FQHC/RHC.
- Patient is an established patient, and either **homebound, homeless, or a migratory or seasonal worker**.
- Patient is not physically present at FQHC/RHC. In this example we will use the patient's home.

Outcome

- FQHC/RHC is the Distant Site (or Provider Site) and can bill PPS for a face-to-face visit.



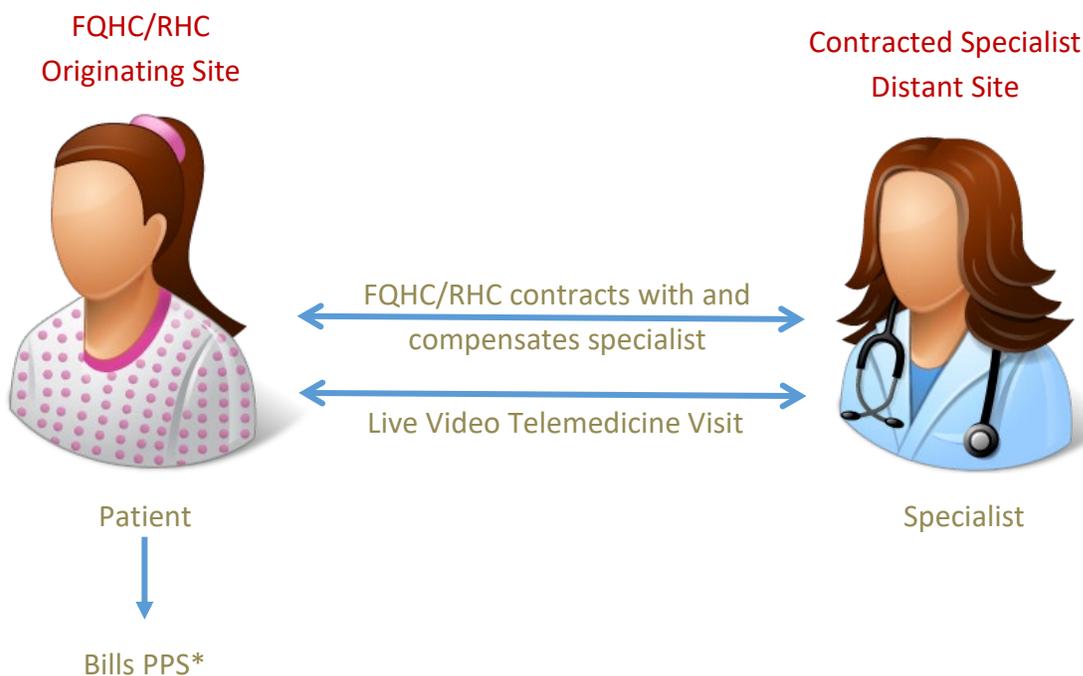
Medi-Cal Fee-For-Service and Multiple Managed Care Plans

Scenario 10 FQHC/RHC Originating Site to Contracted Distant Site

- Patient is physically present at FQHC/RHC Site.
- Specialist is not physically at the FQHC/RHC.
- FQHC/RHC and specialist have a written agreement to provide services. FQHC/RHC compensates specialist outside of an insurance plan.
 - *The agreement should be in writing and clearly state: The time period during which the agreement is in effect; the specific services it covers; any special conditions under which the services are to be provided; and the terms and mechanisms for billing and payment. (See BPHC Policy Information notice 98-23)*
- FQHC or RHC has credentialed the contracted provider in house and with the health plan (if applicable)
- Specialist virtually enters FQHC site via telemedicine.

Outcome

- FQHC/RHC becomes the Distant Site and can bill PPS for a face-to-face visit.



*Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.

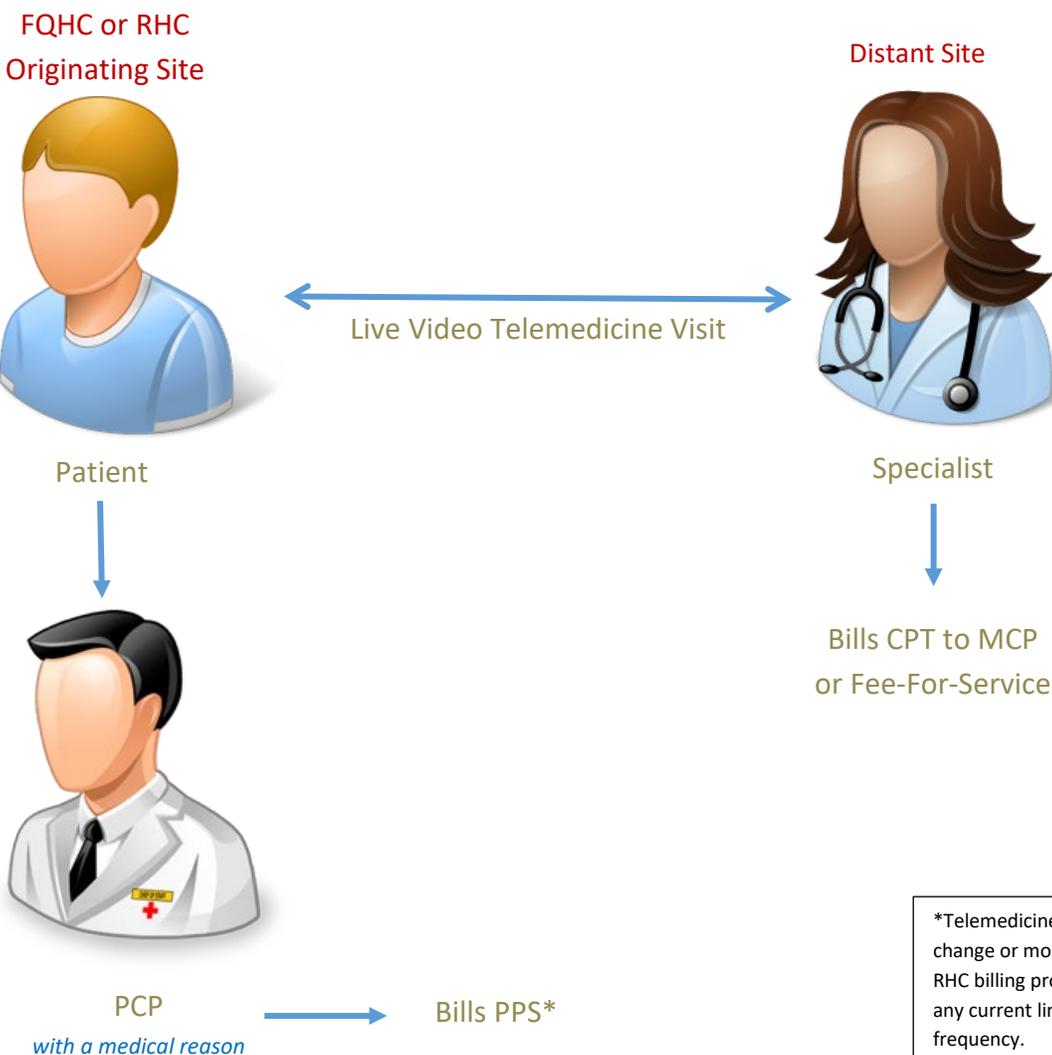
Medi-Cal Fee-For-Service and Multiple Managed Care Plans

Scenario 11 FQHC/RHC Originating Site (Provider Present) to a Distant Site

- Patient is physically present at the FQHC/RHC.
- Specialist is a Medi-Cal fee-for-service provider not physically present at the FQHC/RHC.
- FQHC or RHC and specialist have an agreement to provide services, however the FQHC/RHC does not compensate the specialist.
- Medical reason for a provider to be present with the patient at the FQHC/RHC Site.

Outcome

- Medi-Cal specialist is the Distant Site and can bill fee-for-service.
- FQHC/RHC is the Originating Site, provided a medically necessary service, and can bill PPS for a face-to-face visit.



*Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.

Medi-Cal Managed Care Plan (MCP)

Scenario 12 FQHC/RHC to HHMS Patient Home

- Provider is physically located at and receives compensation from FQHC/RHC.
- Patient is an established patient, and either **homebound, homeless, or a migratory or seasonal worker**.
- Patient is not physically present at FQHC/RHC. In this example we will use the patient's home.

Outcome

- FQHC/RHC is the Distant Site (or Provider Site) and can bill MCP.
- Patient is homebound, homeless, or a migratory or seasonal worker, therefore the code 18 wrap CAN be billed to the state.

FQHC/RHC



Provider



Bills PPS to MCP



Bills code 18 wrap to FFS Medi-Cal

Off-site location such as the
patient's home.



Live Video Telemedicine Visit

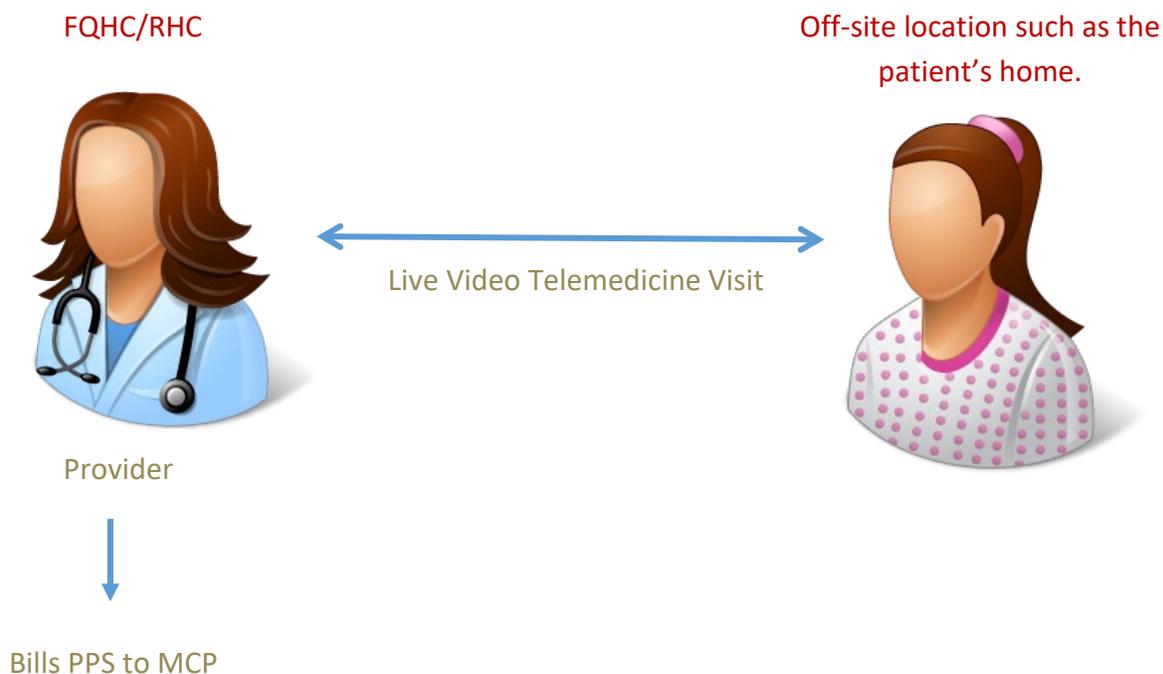
Medi-Cal Managed Care Plan (MCP)

Scenario 13 FQHC/RHC to Non-HHMS Patient Home

- Provider is physically located at and receives compensation from FQHC/RHC.
- Patient is an established patient but is NOT homebound, homeless, or a migratory or seasonal worker.
- Patient is not physically present at FQHC/RHC. In this example we will use the patient's home.

Outcome

- FQHC/RHC is the Distant Site (or Provider Site) and can bill MCP.
- Patient is not homebound, homeless, or a migratory or seasonal worker, therefore the code 18 wrap CANNOT be billed to the state.



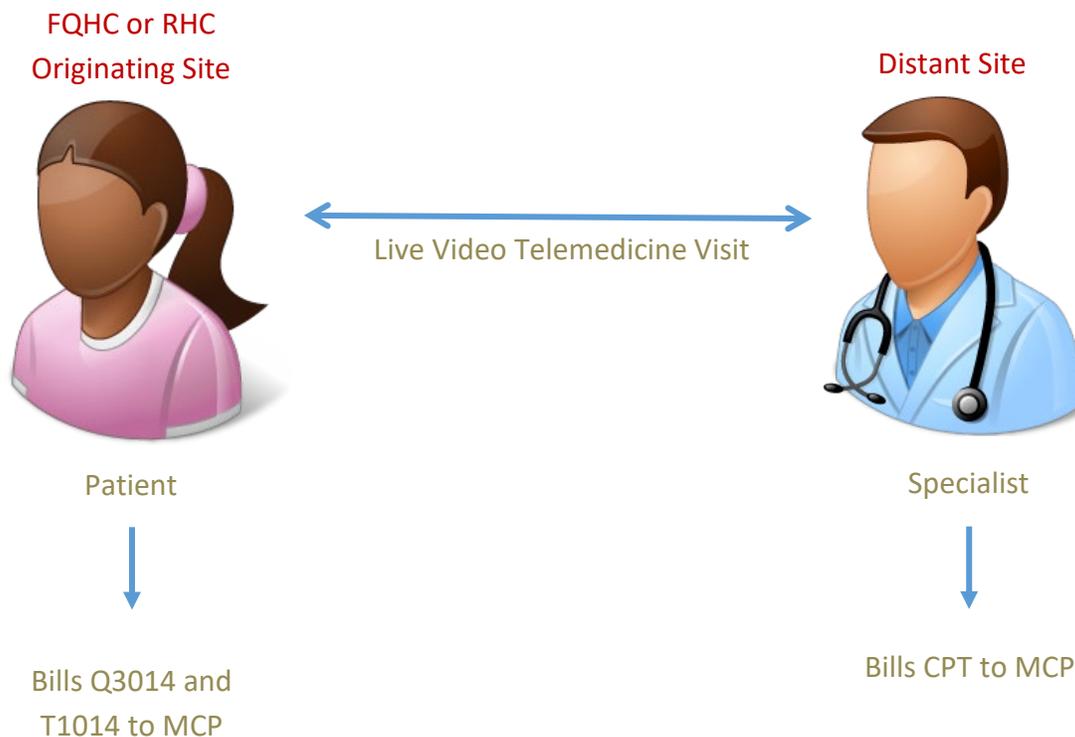
Medi-Cal Managed Care Plan (MCP)

Scenario 14 FQHC/RHC Originating Site to an MCP Contracted Distant Site

- Patient is physically present at the FQHC/RHC.
- Specialist is a MCP contracted provider not physically present at the FQHC/RHC.
- FQHC or RHC and specialist have an agreement to provide services, but the FQHC/RHC does not compensate the specialist.
- No medical reason for a provider to be present with the patient at the FQHC/RHC Site.

Outcome

- MCP contracted specialist is the Distant Site and can bill MCP.
- FQHC/RHC is the Originating Site, did not provide a medical service, and cannot bill PPS for a face-to-face. However, the FQHC/RHC, *in most instances*, can bill an Originating Site fee and Transmission fee to the MCP.



Useful References

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