



Medi-Cal Payment for Telehealth and Virtual/Telephonic Communications Relative to the 2019-Novel Coronavirus (COVID-19)

January 5, 2021 (*Supersedes June 23, 2020, Guidance*)

*Note: Changes are denoted with ****

Overview

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

- **Section I: Current Medi-Cal Policy for Enrolled Medi-Cal Providers:** As outlined in the Medi-Cal Provider Manual ([Medicine: Telehealth](#)) and/or posted to the [Medi-Cal Rates Information Page](#):
 - Traditional telehealth modalities, i.e., synchronous two-way interactive, audio-visual communication and asynchronous store and forward, inclusive of e-consults
 - Other virtual/telephonic communication modalities
- **Section II: Current Medi-Cal Policy for FQHCs, RHCs, Tribal 638 Clinics:** As outlined in various sections of the Medi-Cal Provider Manual ([Federally Qualified Health Centers/Rural Health Clinics](#), and [Indian Health Services Memorandum of Agreement 638 Clinics](#)), and/or posted to the [Medi-Cal Rates Information Page](#):
 - Traditional telehealth modalities, i.e., synchronous two-way interactive, audio-visual communication and asynchronous store and forward.
- **Section III: Waiver and State Plan Amendment (SPA) [20-0024](#) Related to the Novel Coronavirus Disease (COVID-19), approved on May 8, 2020 and May 13, 2020 respectively**
 - Additional flexibilities and options relative to traditional telehealth modalities, i.e., synchronous two-way, audio-visual communication and asynchronous store and forward, inclusive of e-consults

- Additional flexibilities and options relative to other virtual/telephonic communication modalities

Frequently Asked Questions (FAQ)

DHCS compiled a list of “Frequently Asked Questions” (FAQ) with responses below to provide additional guidance and clarification to Medi-Cal providers regarding both the current telehealth and virtual/telephonic communications outlined in Sections I and II as well as the Section 1135 Waiver temporary flexibilities relative to telehealth and virtual/telephonic communications outlined in Section III. As DHCS receives additional questions, the FAQ section will continue to be updated.

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

Traditional Telehealth - Overview

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

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

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

Behavioral health exception: As described in [Behavioral Health Information Notice 20-009](#), Specialty Mental Health providers should add the modifier GT for SMHS services provided via a telehealth or telephone modality. Drug Medi-Cal Organized Delivery System (DMC-ODS) services provided via a telehealth or telephone modality do not require a modifier.

Synchronous Telehealth

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

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

For Medi-Cal dental benefits or services, Medi-Cal enrolled dentists and allied dental professionals (under the supervision of a dentist) may render limited services via synchronous/live transmission teledentistry, so long as such services are within their scope of practice, when billed using Current Dental Terminology (CDT) code D9999 for dates of service on or before May 15, 2020. For dates of service on or after May 16, 2020, CDT code D9999 is being replaced with CDT code D9995. The following is Medi-Cal's teledentistry policy for synchronous/live transmissions.

- CDT code D9999 is reimbursed at 24 cents per minute, up to a maximum of 90 minutes, i.e., up to \$21.60 maximum reimbursement. CDT code D9999 may only be used once per date of service per beneficiary, per provider. As noted above, CDT code D9999 is being replaced with CDT code D9995, as of May 16, 2020.

Asynchronous Store and Forward, inclusive of E-Consults

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

- Health care practitioners must ensure that the documentation, typically images, sent via store and forward be specific to the patient's condition and adequate for meeting the procedural definition and components of the CPT

or HCPCS code that is billed.

E-Consults

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

- CPT Code 99451: Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time

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

- D0120: Periodic oral evaluation — established patient
- D0150: Comprehensive oral evaluation – new or established patient
- D0210: Intraoral — complete series of radiographic images
- D0220: Intraoral — periapical first radiographic image
- D0230: Intraoral — periapical each additional radiographic image
- D0240: Intraoral — occlusal radiographic image
- D0270: Bitewing — single radiographic image
- D0272: Bitewings — two radiographic images
- D0274: Bitewings — four radiographic images
- D0330: Panoramic radiographic image
- D0350: Oral/Facial photographic images

Originating Site and Transmission Fee

The originating site facility fee is reimbursable only to the originating site when billed with HCPCS code Q3014 (telehealth originating site facility fee).

Effective March 6, 2020, CMS provided blanket approval to for the patient's home to serve as originating site during the COVID-19 PHE. Medi-Cal is adhering to this flexibility. Transmission costs incurred from providing telehealth services via audio/video communication is reimbursable when billed with HCPCS code T1014 (telehealth transmission, per minute, professional services bill separately).

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

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

If billing asynchronous store and forward, including e-consult, providers at the originating site may bill the originating site fee with HCPCS code Q3014, but may not bill for the transmission fee. Please note, the originating site, and transmission fee restrictions are not applicable for FQHCs, RHCs or Tribal 638 clinics.

Other Virtual/Telephonic Communication

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

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

- HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 hours, not originating from a related evaluation and management (E/M) service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.
 - Medi-Cal Fee-For-Service (FFS) Rate: \$10.87
- HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion. G2012 can be billed when the virtual communication occurred via a telephone call.
 - Medi-Cal FFS Rate: \$12.48

Behavioral health exception: As described in [Behavioral Health Information Notice 20-009](#), Specialty Mental Health providers should add the modifier GT for SMHS services provided via a telehealth or telephone modality. DMC-ODS services provided via a telehealth or telephone modality do not require a modifier.

******Home health services:*** Effective January 1, 2021, and consistent with a CMS final rule (CMS-1730-F), Medi-Cal will expand how home health agencies (HHA) can use telehealth to care for patients. Details will be published in the Medi-Cal Provider Bulletin and NewsFlash in mid-to-late January.

*********Effective January 1, 2021, the [American Medical Association](#) will implement changes to a series of E/M codes used by providers to bill for an office or outpatient visit and prolonged services. These changes will not impact Medi-Cal's telehealth billing policies, providers will continue to bill telehealth as they do today. DHCS will release additional information in mid-to-late January 2021 with the annual code update.

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

Traditional Telehealth (Synchronous or Asynchronous)

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

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

For Medi-Cal covered benefits or services that may be provided via synchronous telehealth, FQHCs, RHCs, and Tribal 638 Clinics would bill using the applicable Revenue Code and HCPCS code, as described below in detail, which would be paid at the Prospective Payment System (PPS) or All-Inclusive Rate (AIR), respectively. Below is a non-exhaustive list of examples based upon the type of service being provided:

- For medical visits and mental health visits, FQHCs and RHCs bill using

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Revenue Code 0521 and T1015 for Medi-Cal FFS and T1015SE for managed care.

- For medical visits, Tribal 638 Clinics bill using Revenue Code 0520 and T1015 for Medi-Cal FFS. Managed care visits should be billed consistent with existing DHCS policy.
- For mental health visits, Tribal 638 Clinics bill with Revenue Code 0561 and the appropriate modifier corresponding to the practitioner providing the services.
- For drug and alcohol visits, Tribal 638 Clinics bill using Revenue Code 0520 and HCPCS code H0047.

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

Note: Tribal 638 Clinics can provide services outside of the four walls to homeless individuals only.

- **Asynchronous Store and Forward:** For FQHCs, RHCs, and Tribal 638 Clinics, billable providers may provide services via asynchronous store and forward to “established” patients, as defined above. Asynchronous store and forward can be used to provide teledermatology, teleophthalmology, teledentistry via store and forward, using the applicable Revenue Code and HCPCS or CPT codes.

E-Consults and Other Virtual/Telephonic Communication

FQHCs, RHCs, and Tribal 638 Clinics cannot bill for e-consult or virtual/telephonic communication visits.

Originating Site and Transmission Fee

FQHCs, RHCs, and Tribal 638 Clinics are not eligible to bill an originating site fee or transmission charges. The costs of these services should be included in the PPS/AIR rate, as applicable.

SECTION III: DHCS' SECTION 1135 WAIVER AND SPA 20-0024 REQUESTS RELATED TO COVID-19

Overview

DHCS received flexibilities in terms of the available modalities for delivering Medi-Cal covered benefits and services, as part of its Section 1135 Waiver and SPA 20-0024. DHCS recognizes that in addition to traditional telehealth/telemedicine modalities (i.e., synchronous two-way interactive, audio-visual communication, and/or asynchronous store and forward/e-consults), as outlined in existing Medi-Cal coverage policy and above, there are extraordinary circumstances under which both face-to-face visits as well as traditional telehealth modalities are not an option.

Under these limited and extraordinary instances (such as COVID-19), DHCS recognizes the need for Medi-Cal providers – including, but not limited to physicians, nurses, mental health practitioners, substances use disorder practitioners, FQHCs, RHCs, and

Tribal 638 Clinics – to utilize other methods such as telehealth and virtual/telephonic communication to provide medically necessary health care services, regardless of originating or distant site. This affords providers the flexibility to safely and expeditiously render necessary care for people.

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

Other Virtual/Telephonic Communications

Medi-Cal providers – including, but not limited to, physicians, nurses, mental health practitioners, substances use disorder practitioners, as well as FQHCs, RHCs, and Tribal 638 Clinics, and other clinics, will provide and bill for virtual/telephonic visits consistent with in person visits as follows:

- For Medi-Cal providers, including, but not limited to, physicians, nurses, mental health practitioners, substances use disorder practitioners, bill using the appropriate and regular CPT or HCPCS codes that would correspond to the visit being done in-person, and include POS 02 and Modifier 95.
- *******Virtual/telephonic communication services billed using HCPCS codes G2010 and G2012 may be used for “new” as well as “established” patients. These codes may be billed by all providers except FQHCs, RHCs, Tribal 638 clinics during the COVID-19 PHE. FQHCs, RHCs, and Tribal 638 clinics would bill virtual/telephonic communication with HCPCS code G0071 for “new” as well as “established” patients during the COVID-19 PHE.
- For FQHCs, RHCs, and Tribal 638 Clinics, bill using the applicable revenue code and HCPCS code, as per standard billing procedure, as well as the corresponding CPT code on the “informational line”, as described below in detail. Below is a non-exhaustive list of examples based upon the type of service being provided:
 - For medical visits and mental health visits, FQHCs and RHCs bill using Revenue Code 0521 and T1015 for Medi-Cal FFS and T1015SE for managed care.
 - For medical visits, Tribal 638 Clinics bill using Revenue Code 0520 and T1015 for Medi-Cal FFS. Managed care visits should be billed consistent with existing DHCS policy.
 - For mental health visits, Tribal 638 Clinics bill with Revenue Code 0561 and the appropriate modifier corresponding to the practitioner providing the services.

- For drug and alcohol visits, Tribal 638 Clinics bill using Revenue Code 0520 and HCPCS code H0047

Please note that for all services, the virtual/telephonic visit must meet all requirements of the billed CPT or HCPCS code and must meet the following conditions:

- There are documented circumstances involved that prevent the visit from being conducted face-to-face, such as the patient is quarantined at home, local or state guidelines direct that the patient remain at home, the patient lives remotely and does not have access to the internet or the internet does not support Health Insurance Portability and Accountability Act (HIPAA) compliance, etc.
- The treating health care practitioner is intending for the virtual/telephone encounter to take the place of a face-to-face visit, and documents this in the patient's medical record.
- The treating health care practitioner believes that the Medi-Cal covered service or benefit being provided are medically necessary.
- The Medi-Cal covered service or benefit being provided is clinically appropriate to be delivered via virtual/telephonic communication, and does not require the physical presence of the patient.
- The treating health care practitioner satisfies all of the procedural and technical components of the Medi-Cal covered service or benefit being provided except for the face-to-face component, which would include, but not be limited to:
 - a detailed patient history
 - a complete description of what Medi-Cal covered benefit or service was provided
 - an assessment/examination of the issues being raised by the patient
 - medical decision-making by the health care practitioner of low, moderate, or high complexity, as applicable, which should include items such as pertinent diagnosis(es) at the conclusion of the visit, and any recommendations for diagnostic studies, follow-up or treatments, including prescriptions

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

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

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

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

For Medi-Cal covered benefits and services provided via traditional telehealth (synchronous, two-way interactive, audio-visual communication, or asynchronous store and forward), DHCS has proposed to waive through its Section 1135 Waiver request existing restrictions/requirements in Medi-Cal’s current telehealth policy due to various federal laws/Medicaid State Plan language, relative to “new” and “established” patients, “face-to-face”/in-person, and “four walls” requirements. Waiving these limitations will allow FQHCs, RHCs, and Tribal 638 Clinics greater flexibility under DHCS’ existing telehealth policy, which is described above. Please note that the Centers for Medicare and Medicaid Services (CMS) clarified they will not seek recovery of payments for services provided outside the clinics four walls during the public health emergency for Tribal 638 clinics.

Billing & Procedure Coding Requirements for Virtual/Telephonic Communications

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

Satisfies Guidance/Criteria				Does not Satisfy Guidance/Criteria
PPS/AIR Rate				FFS Rate
Applicable Revenue Code*	+	HCPCS code T1015* (FFS)/ T1015 SE (Managed Care)**	+	CPT code 99201-99205 (new patient) CPT code 99211-99215 (established patient)
				HCPCS code G0071**** (\$24.76)

*Corresponding to the type of service being provided, e.g., medical, mental health, alcohol and drug, etc., and whether by an FQHC/RHC or Tribal 638 Clinic

** T1015 Clinic visit/encounter, for PPS and AIR

***T1015 SE for PPS Wrap for FQHCs and RHCs only.

****Payment for communication technology-based services for 5 minutes or more between an FQHC/RHC/Tribal 638 Clinic practitioner and new or established patient, irrespective of date of last visit, that does not meet the criteria of a face-to-face visit and results in a determination that a face-to-face visit is unnecessary, will be reimbursed with HCPCS code G0071 at the Medicare reimbursement rate.

Medi-Cal FFS: For the PPS/AIR rate, FQHCs, RHCs, and Tribal 638 Clinics would need to list HCPCS code T1015 in the “payable” claim line in conjunction with one of the appropriate corresponding CPT codes (i.e., 99201-99203 for “new” patients, and 99212-99214 for “established patients) on the

“informational” line relative to the complexity of the virtual/telephonic communication. Please note that the corresponding CPT codes are not separately reimbursed, but instead will be used to identify the virtual/telephonic communication visit as well as by DHCS for tracking and reporting purposes related to COVID-19. Clinics should review the billing guidelines in the Indian Health or FQHC/RHC provider manual. For the Medi-Cal FFS rate when billing with the HCPCS code G0071, clinics should only list the HCPCS code on the “payable” claim line and should not include a corresponding CPT code.

- Medi-Cal Managed Care: FQHCs, RHCs, and Tribal 638 Clinics would receive the PPS rate or AIR, as applicable, for rendering a Medi-Cal covered benefit or service – whether provided through telehealth or virtual/telephonic communication – if they meet the above-established criteria/guidance. DHCS will ensure the FQHCs and RHCs are made whole with an appropriate wrap payment, consistent with existing DHCS policy. Likewise, Tribal 638 Clinics will be reimbursed the AIR consistent with existing DHCS policy.

Please note: DHCS is aware that FQHCs, RHCs, and Tribal 638 Clinics do not include CPT codes as part of traditional claim submission. That said, for purposes of the temporary flexibilities under this policy and to allow DHCS to track that services were provided via virtual/telephonic communication modalities, DHCS is requesting this modified billing structure relative to the Section III guidance, i.e., including the CPT codes on the “information line” of the claim form. The selected CPT codes will also allow DHCS to also track the level of complexity (low, medium, high, etc.) of the visit and whether it is a new or established patient.

Frequently Asked Questions

(Current as of December XX 2020)

CURRENT MEDI-CAL TELEHEALTH AND VIRTUAL/TELEPHONIC COMMUNICATION POLICY

- 1. Does Medi-Cal allow FQHCs, RHCs, and Tribal 638 Clinics to provide covered services via telehealth?**
Yes, billable providers may utilize a telehealth modality to provide FQHC, RHC, or Tribal 638 covered services via synchronous telehealth (audio-visual, two-way communication) to “established” patients. Please see the Provider Manuals provided by telehealth.
- 2. Do FQHCs, RHCs, or Tribal 638 Clinics bill their telehealth claims the same as if the visit was in-person?**
Yes, FQHC, RHC, or Tribal 638 covered services provided via a synchronous telehealth modality to an established patient are subject to the same program restrictions, limitations, and coverage that exist when the service is provided in-person.
- 3. Can FQHCs, RHCs, and Tribal 638 Clinics bill for originating site or transmission fees?**
No, FQHCs, RHCs, and Tribal 638 Clinics may not bill for originating site or transmission fees.
- 4. Can FQHCs, RHCs, and Tribal 638 Clinics bill for e-consults?**
No, FQHCs, RHCs, and Tribal 638 Clinics may not bill for e-consults.
- 5. Can FQHCs, RHCs, and Tribal 638 Clinics submit claims for Medi-Cal covered benefits or services provided via a virtual/telephonic communication modality using HCPCS codes G2012 or G2010 and be paid?**
No, FQHCs, RHCs, and Tribal 638 Clinics cannot bill using HCPCS codes G2012 or G2010.
- 6. *** Are Medi-Cal covered Comprehensive Perinatal Services Program (CPSP) services able to be provided via telehealth?**
Yes, Medi-Cal’s telehealth policy applies to all Medi-Cal providers – which includes enrolled CPSP providers - subject to any specific requirements and/or limitations as articulated in the policy.

ADDITIONAL SECTION 1135 WAIVER AND/OR OTHER TEMPORARY FLEXIBILITIES FOR TELEHEALTH AND VIRTUAL/TELEPHONIC COMMUNICATIONS

PROVIDER TYPES

7. Are Registered Nurses (RNs) able to provide Medi-Cal covered benefits or services via a virtual/telephonic communication modality and bill the Medi-Cal FFS rate?

No, virtual/telephonic communication modalities are billable by FQHCs, RHCs, and Tribal 638 Clinics only when the discussion requires the skill level of an FQHC, RHC, or Tribal 638 practitioner, which includes physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, clinical social workers, and marriage and family therapist. If the virtual/telephonic communication were conducted by a RN, health educator, or other clinical personnel, it would not be billable. Medi-Cal has not changed its policies on billable providers/practitioners.

8. Are licensed Vocational Nurses (LVNs) able to provide Medi-Cal covered benefits or services via a virtual/telephonic communication modality and bill the Medi-Cal FFS rate?

No, virtual/telephonic communication modalities are billable by FQHCs, RHCs, and Tribal 638 Clinics only when the discussion requires the skill level of an FQHC, RHC, or Tribal 638 practitioner, which includes physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, clinical social workers, and marriage and family therapist. If the virtual/telephonic communication were conducted by a LVN, health educator, or other clinical personnel, it would not be billable. Medi-Cal has not changed its policies on billable providers/practitioners.

9. Can FQHCs, RHCs, or Tribal 638 Clinics bill for a RN's telephone visit (Medi-Cal FFS beneficiary) and an eligible PPS/AIR visit with a billable provider for the same patient on the same day?

No, RN visits are not reimbursable in FQHCs, RHCs, or Tribal 638 Clinics. Additionally, physicians/health care practitioners who simply triage a patient-initiated telephone call for a future visit would not satisfy the criteria/guidance for being in lieu of a face-to-face visit, and thus not be eligible for reimbursement at PPS/AIR, as applicable. In that case, FQHCs, RHCs, and Tribal 638 Clinics would bill for services delivered to FFS patient using HCPCS G0071 code, and be reimbursed at \$24.76 for the telephone call. That said, a subsequent physician's visit either face-to-face or via telehealth that meets all of the criteria/guidance for being in lieu of a face-to-face visit, would be eligible for reimbursement at PPS/AIR, as applicable.

BILLING

10. Do FQHCs, RHCs, or Tribal 638 Clinics bill using Place of Service (POS) Code 02 and/or Modifier 95 modifier for telehealth claims?

No, FQHCs, RHCs, and Tribal 638 Clinics do not bill with POS 02 or Modifier 95 for Medi-Cal FFS. For Medical Managed Care, FQHCs, RHCs, or Tribal 638 Clinics should contact the MCPs with which they have contractual arrangements to determine documentation requirements for these encounters.

11. Do FQHCs, RHCs, or Tribal 638 Clinics bill covered services provided via a virtual/telephonic communication modality the same as if it was in-person?

Yes, if the services provided satisfy all of the identified conditions outlined in the above Section III guidance then the FQHC, RHC, or Tribal 638 Clinics provider would submit claims using the applicable Revenue Code, HCPCS T1015 or T1015 SE (managed care patient only), and appropriate CPT code for reimbursement at PPS/AIR. In those instances, FQHC, RHC, or Tribal 638 Clinics covered services provided via a virtual/telephonic communication modality are subject to the same program restrictions, limitations, and coverage that exist when the service is provided face-to-face.

12. How should FQHCs, RHCs, and Tribal 638 Clinics bill for virtual/telephonic communications when the service satisfies criteria/guidance, as outlined in Section III, for being in lieu of a face-to-face visit?

For purposes of the temporary flexibilities under this policy, FQHCs and RHCs would continue to bill with a Revenue Code (0521) in conjunction with a HCPCS code (T1015/T1015 SE), but would also include the appropriate corresponding CPT codes (i.e., 99201-99205 for “new” patients, and 99211-99215 for “established” patients) on the “informational” line relative to the complexity of the virtual/telephonic communication.

Similarly, for purposes of the temporary flexibilities under this policy, Tribal 638 Clinics would continue to bill with a Revenue Code (0520) in conjunction with a HCPCS code (T1015), but would also include the appropriate corresponding CPT codes (i.e., 99201-99205 for “new” patients, and 99211-99215 for “established patients”) on the “informational” line relative to the complexity of the virtual/telephonic communication.

13. * How do FQHCs, RHCs, or Tribal 638 Clinics bill for virtual/telephonic communications when the service does not satisfy the criteria/guidance, as outlined in Section III, for being in lieu of an in-person visit?**

FQHCs, RHCs, and Tribal 638 Clinics may bill for appropriate Medi-Cal covered benefits or services provided via a virtual/telephonic communication modality for Medi-Cal FFS beneficiaries utilizing HCPCS code G0071 when the service does not meet the Section III criteria/guidelines for reimbursement at the PPS/AIR. This method will allow for claiming separate from the PPS/AIR. In Medi-Cal managed care, unless

otherwise agreed to by the MCP and FQHC, RHC, or Tribal 638 Clinic, MCPs must reimburse Medi-Cal providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim. As approved in SPA 20-0024, FQHC, RHC, and Tribal 638 Clinics may use G0071 for "new" and "established" patients during the PHE.

14. Can physicians/health care practitioners in a FQHC, RHC, and Tribal 638 Clinic provide FQHC, RHC, Tribal 638 Clinic covered services via a virtual/telephonic communication and receive the Medi-Cal fee-for-service (FFS) rate for HCPCS code G0071?

Yes, the billing/reimbursement policy for HCPCS code G0071 applies to Medi-Cal FFS. For the Medi-Cal FFS rate when billing with HCPCS code G0071, FQHC, RHC, and Tribal 638 Clinic should only list the HCPCS code on the "payable" claim line and should not include a corresponding CPT code. FQHCs, RHCs, and Tribal 638 Clinics would only bill HCPCS code G0071 when they do not meet the criteria in Section III relative to the services being in lieu of an in-person visit. See FAQ #15 and #16.

15. Can physicians/health care practitioners in FQHCs, RHCs, and Tribal 638 Clinics provide FQHC, RHC, Tribal 638 covered services via a virtual/telephonic communication and receive the Medi-Cal FFS rate for HCPCS code G0071 in the managed care delivery system? For example, if the patient were enrolled in managed care, then the Medi-Cal MCP would be billed.

No, the billing/reimbursement policy for HCPCS code G0071 does not apply to Medi-Cal managed care; however, unless otherwise agreed to by the MCP and the provider, MCPs must reimburse Medi-Cal providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim.

Further, please note that MCPs must offer members and providers the option to utilize telehealth services to deliver care when medically appropriate. In addition, MCPs must act proactively to ensure members can access all medically necessary screening and testing of COVID-19, which includes working with their contracted providers to use telehealth services to deliver care when medically appropriate, as a means to limit members' exposure to others who may be infected with COVID-19, and to increase provider capacity. Additionally, DHCS strongly encourages MCPs to offer covered benefits and services utilizing telehealth and other virtual/telephonic communication modalities, and must be compliant with existing timely access standards. For more information, please refer to Supplement to [All Plan Letter 19-009](#), which discusses reimbursement requirements relative to MCPs, as well as [DHCS' March 16, 2020 Memorandum](#) to all Medi-Cal MCPs, which also discusses telehealth.

16. How should FQHCs, RHCs, and Tribal 638 Clinics bill for a dental visit provided via a virtual/ telephonic communication modality?

For dental services provided via a virtual/telephonic communication modality, FQHCs, RHCs, and Tribal 638 Clinics should bill using HCPCS code G0071 (\$24.76) since dental services provided via virtual/telephonic communication would not meet all requirements of the applicable CDT code that would correspond to the visit being done in-person, and would also not satisfy all of the identified conditions outlined in the guidance. As a result, it would not be appropriate to bill using Local Code 03 (dental visit) and be reimbursed at PPS/AIR.

17. For specialty services, such as prenatal visits, behavioral health, etc., provided via virtual/telephonic communication modalities, how should FQHCs, RHCs, and Tribal 638 Clinics bill?

Please see response to FAQ questions 15 and 16 above. Please note that all Medi-Cal covered benefits/services that are clinically appropriate to be provided via telehealth or other virtual/telephonic communication modality and that satisfy all of the criteria/guidance outlined in Medi-Cal's policy guidance, are included.

18. What preventive CPT billing codes should FQHCs, RHCs, and Tribal 638 Clinics be using for well childcare (Child Health and Disability Prevention (CHDP) visits provided utilizing telehealth and/or other virtual/telephonic communication modalities?

In order for CHDP/well-child services to be provided via virtual/telephonic communication to be billed and reimbursed at PPS/AIR, those visits would have to be rendered by a billable provider, meet all requirements of the corresponding covered CPT/HCPCS codes that would correspond to the visit being done in-person, and satisfy all of the identified conditions outlined in the [Section III guidance](#). If the CHDP/well-child services do not satisfy the conditions for an in-person visit, FQHCs, RHCs, Tribal 638 Clinics can be reimbursed using HCPCS code G0071 (\$24.76) for FFS patients.

In addition, relative to well child visits, during the COVID-19 situation, the American Academy of Pediatrics (AAP) reminds providers that the benefit of attending a well visit and receiving necessary immunizations and screenings should be balanced with the risk of exposure to other children and adults with potential contagious diseases. In particular, the AAP's current guidance includes considering modifications to the structure of your clinic schedule and physical space. For more information, please see the [AAP's website](#), as well as [guidance](#) released by DHCS relative to well child visits. Please also see [DHCS' guidance](#) relative to non-essential, non-urgent procedures during COVID-19.

19. Tribal 638 clinics are only allowed to bill the AIR for services provided within the four walls, except for services provided to homeless individuals. Is there any flexibility to this requirement?

CMS clarified they will not seek recovery of payments for services provided outside the clinic four walls during the public health emergency for Tribal 638 Clinics.

BENEFITS

20. Where can I find information specific to Specialty Mental Health Services (SMHS), i.e. those contracted with county Mental Health Plans, and the Drug Medi-Cal Organized Delivery System (DMC-ODS)?

For information specific to SMHS and DMC-ODS, please see [Behavioral Health Information Notice 20-009](#) and [FAQs](#) on the DHCS COVID-19 Response website.

21. * Can Medi-Cal covered CPSP services be provided via a virtual/telephonic communication modality?**

In order for a CPSP service via virtual/telephonic communication to be billed and reimbursed at PPS/AIR, it would have to be rendered by a Medi-Cal enrolled CPSP practitioner (including a Comprehensive Perinatal Health Worker, LVN, and RN), meet all requirements of the corresponding CPSP-covered HCPCS codes that would correspond to the visit being done in-person, and satisfy all of the identified conditions outlined in the above Section III guidance. If the CPSP visit does not satisfy the conditions for a face-to-face visit, FQHC, RHC, Tribal 638 Clinics can be reimbursed using HCPCS code G0071 (\$24.76) for FFS patients.

22. Specific to Medi-Cal covered dental services, will DHCS be offering any additional flexibilities, outside of the above Section 1135 Waiver flexibilities?

Yes, effective March 25, 2020, DHCS will allow a temporary teledentistry exception for Medi-Cal dental providers who provide consultation services by telephone or video to remote Medi-Cal members. This policy will be in effect until further notice. In utilizing this temporary flexibility, enrolled Medi-Cal dental providers should follow the guidelines below:

- CDT code D9430: Used for live streaming video or telephone with a Medi-Cal patient with oral health issues in lieu of an in-person office visit. Providers would be reimbursed the SMA rate for CDT code D9430, in addition to the teledentistry payment for CDT code D9999 (code D9995 after May 16, 2020).
- Documentation of the consultation should be noted on the claim document in the comments section. For example:
 - Patient is having discomfort

- Patient has a concern that was to be discussed at the recall appointment – but that appointment has now been postponed due to COVID-19.
- CDT code D9430 would only be allowed for an actual conversation between the Medi-Cal member and the Medi-Cal provider about oral health issues as their chief complaint.
- CDT code D9430 should not be billed for conversations with office staff about scheduling or rescheduling appointments.

23. Can providers utilize a hybrid model to deliver well child care (CHDP) visits, i.e., combining a virtual visit where the provider would review all questionnaires, conduct counseling, review anticipatory guidance, and then conduct a brief in-person visit for vitals, weight/height, vision/hearing, point of care tests, vaccines, and basic physical exam, etc.?

To the extent there are components of the comprehensive CHDP/well child visit services provided in-person due to those components not being appropriate to be provided via telehealth (e.g., those requiring direct visualization and/or instrumentation of bodily structures, or that otherwise require the in-person presence of the patient for any reason) and those components that are a continuation of companion services provided via virtual/telephonic communication, the provider should only be billing for one encounter/visit. For more information, please see [DHCS' guidance](#) relative to well child care/CHDP visits.

24. * Can G2010 and G2012 be used for brief virtual/telephonic communication with new patients?**

Medi-Cal providers including, but not limited to, physicians, nurses, mental health practitioners, substances use disorder practitioners, and clinics may bill with HCPCS codes G2010 and G2012 for brief virtual/telephonic communication with “new” patients during the COVID-19 PHE as well as “established” patients. FQHCs, RHCs, and Tribal 638 Clinics do not bill with G2010 and G2012.

25. Can FQHCs, RHCs, and Tribal 638 Clinics bill PPS/AIR, as applicable, for telehealth and telephonic services when the FQHC, RHC, or Tribal 638 Clinic and distant site provider have an agreement to provide services and the FQHC, RHC, or Tribal 638 Clinic compensates the distant site provider? If yes, please clarify how this arrangement should be billed.

Under the Section III guidance, in order to bill for PPS/AIR, as applicable, the billable provider associated with the FQHC, RHC, and Tribal 638 Clinic must be at either at the distant or originating site (i.e., need to have something happening on the front-end or back-end). FQHCs, RHCs, and Tribal 638 Clinics could bill for this scenario if they meet all of the requirements in Section III relative to the temporary waiver flexibilities and if they have a contractual arrangement in place allowing them to reimburse the distant site provider. DHCS would not dictate the compensation relative to that sub-contractual arrangement.

26. Can physicians employed by an FQHC, RHC, and Tribal 638 Clinic provide medical appropriate covered services using virtual/telephonic

communication modalities from their places of residence to a new or established patient located in their home during the COVID-19 declared emergency?

The Section 1135 Waiver approval includes temporary flexibilities for FQHCs, RHCs, and Tribal 638 Clinics to provide medically appropriate covered services using virtual/telephonic communication modalities so long as the service meets all of the criteria of an in-person encounter/visit, absent the in-person component of the visit. Additionally, the provider must be a FQHC, RHC, or Tribal 638 Clinic billable provider, enrolled in the Medi-Cal program, employed by the clinic and all patient health records of the visit must be accessible at the FQHC, RHC, or Tribal 638 Clinic site. If all of these requirements are satisfied, then the FQHC, RHC, and Tribal 638 Clinic would be reimbursed at the PPS/AIR, as applicable.

ELIGIBILITY

27. Where can I find more information about DHCS' recent implementation of a new Presumptive Eligibility (PE) Aid Code relative to COVID-19?

You can find more information on [DHCS' website](#), which includes information about how to render and bill for COVID-19 diagnostic testing, testing-related services, and treatment services, including all medically necessary care for the individual at the time of the individual's visit to the office, clinic, or hospital.

28. When using the new PE Aid Code relative to COVID-19, how should FQHCs, RHCs, and Tribal 638 Clinics bill in order to receive the applicable reimbursement amount, i.e., PPS/AIR, if the Section III guidance above is satisfied?

FQHCs, RHCs, and Tribal 638 Clinics should bill using the COVID-19 specific diagnosis code of U071 in box 66. Claims without the COVID-19 diagnosis code U071 will suspend with error code 644 and will be denied. For more information about the COVID-19 PE aid code, please see the recent [Provider NewsFlash](#) on the DHCS website, as well as the recently released [Frequently Asked Questions](#) document.

MISCELLANEOUS

29. Are any existing Health Insurance Portability and Accountability Act (HIPAA) requirements relaxed during the COVID-19 situation?

Yes, on March 17, 2020, the federal Health and Human Service agency [issued a limited waiver](#) of certain HIPAA sanctions to improve data sharing and patient care during the pandemic. Similarly, on March 18, 2020, HHS' Office for Civil Rights [announced](#) it would not impose penalties for noncompliance with HIPAA regulations against providers leveraging telehealth platforms that may not comply with the privacy rule during the COVID-19 pandemic. DHCS recommends you review that guidance relative to providing services via telehealth and virtual/telephonic communications during the COVID-19 situation.

30. Executive Order (EO) N-43-20 suspends patient consent requirements for telehealth services. How will EO N-43-20 impact current patient consent requirement for telehealth services? Will the telephone and telehealth visits without patient consent meet the documentation requirements for PPS/AIR reimbursement?

DHCS' telehealth policy already allows for both verbal and written consent, consistent with state law. That said, consistent with EO N-43-20 language, this requirement is temporarily waived in light of the COVID-19 situation. Where practicable and as a matter of best practice, DHCS would recommend that providers continue to document verbal patient consent for services provided via telehealth and other virtual/telephonic communication modalities. Lastly, as stated elsewhere, all FQHCs, RHCs, or Tribal 638 Clinics covered services provided via a virtual/telephonic communication modality are subject to the same program restrictions, limitations, and coverage that exist when the service is provided face-to-face, in order to bill PPS/AIR, as applicable.