

DATE: April 10, 2023

ALL PLAN LETTER 23-007
SUPERSEDES ALL PLAN LETTER 19-009

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: TELEHEALTH SERVICES POLICY

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care health plans (MCPs) on the Department of Health Care Services' (DHCS) policy on Covered Services offered through Telehealth modalities as outlined in the Medi-Cal Provider Manual.¹ This includes clarification on those Covered Services which can be provided via Telehealth and the expectations related to documentation for Telehealth.²

BACKGROUND:

Since the California Telehealth Advancement Act of 2011 (Logue, Chapter 547, Statutes of 2011) codified requirements and definitions for the provision of Medi-Cal services via Telehealth, several changes in state and federal law have occurred. These changes made permanent some of the Telehealth flexibilities granted during the COVID-19 Public Health Emergency. The resulting DHCS Telehealth policy is pursuant to Health and Safety Code (HSC) section 1374.13, and Welfare and Institutions Code (WIC) sections 14132.72, 14132.100, and 14132.725.³ For more information regarding definitions of the terms used in this APL, see the "Medicine: Telehealth" section of the Medi-Cal Provider Manual. Additional information and announcements regarding Telehealth are available on the "Telehealth" web page of DHCS' website. For further information about how Telehealth may be used for purposes of meeting DHCS' Network adequacy standards, refer to APL 21-006 or any future iterations of the APL, as well as any applicable DHCS guidance.⁴

POLICY:

Provider Requirements

A Provider rendering Covered Services via a Telehealth modality must be licensed in

¹ The "Medicine: Telehealth" section of the Medi-Cal Provider Manual is available [here](#).

² More information on this policy clarification can be found on the "Telehealth" web page of the DHCS website, available at: <https://www.dhcs.ca.gov/provgovpart/pages/telehealth.aspx>.

³ State law is searchable at: <https://leginfo.legislature.ca.gov/>.

⁴ APLs are available at: <https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx>.

the State of California and enrolled as a Medi-Cal Provider or Non-Physician Medical Practitioner affiliated with an enrolled Medi-Cal Provider group. If the Provider is not located in California, they must be affiliated with a Medi-Cal enrolled Provider group in California or a border community as outlined in the Medi-Cal Provider Manual. Providers who do not have a path to enroll in Medi-Cal, please refer to APL 22-013 Provider Credentialing/Re-Credentialing and Screening/Enrollment.

Each Provider providing Covered Services to a Member via a Telehealth modality must also meet the requirements of Business and Professions Code (BPC) section 2290.5(a)(3), or otherwise be designated by DHCS as able to render Medi-Cal services via Telehealth.

Pursuant to WIC section 14132.725 (b)(2)(A), DHCS will periodically update the Covered Services and Provider types and requirements that may be appropriately delivered through Telehealth. MCPs should refer to the Medi-Cal Provider Manual for the most updated information.

Reimbursable Services

Existing Covered Services, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing treatment authorization requirements, may be provided via a Telehealth modality only if all of the following criteria are satisfied:

1. The treating Provider at the distant site believes the Covered Services being provided are clinically appropriate to be delivered via Telehealth based upon evidence-based medicine and/or best clinical judgment.
2. The Member has provided verbal or written consent.
3. The Medical Record documentation substantiates that the Covered Services delivered via Telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the Covered Service. Providers are not required to:
 - a. Document a barrier to an in-person visit for Covered Services provided via Telehealth (WIC section 14132.72(d)); or
 - b. Document the cost effectiveness of Telehealth to be reimbursed for Covered Services provided via a Telehealth modality.
4. The Covered Services provided via Telehealth meet all state and federal laws

regarding confidentiality of health care information and a Member's right to their own medical information.

Certain types of Covered Services cannot be appropriately delivered via Telehealth. These include Covered Services that would otherwise require the in-person presence of the Member for any reason, such as those that are performed in an operating room or while the Member 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. A Provider must assess the appropriateness of the Telehealth modality to the Member's level of acuity at the time of the service. A Provider is not required to be present with the Member at the originating site unless determined Medically Necessary by the Provider at the distant site.

All Providers, with the exception of Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Tribal Health Providers (THPs), are allowed to be reimbursed for consultations provided via a Telehealth modality. These electronic consultations (e-consults) are permissible using the appropriate CPT-4 code, modifier(s), and Medical Record documentation defined in the Medi-Cal Provider Manual. Members cannot initiate e-consults as they are interprofessional interactions, and therefore only permissible between Providers. Providers, including FQHCs, RHCs, and THPs are permitted to be reimbursed for brief virtual communications that consist of a brief communication with a Member who is not physically present (face-to-face) at the FFS rate. The virtual communications reimbursement for FQHCs, RHCs, and THPs discontinues with the end of the COVID-19 Public Health Emergency on May 11, 2023.

Effective no sooner than January 1, 2024, all Providers furnishing applicable Covered Services via audio-only synchronous interactions must also offer those same services via video synchronous interactions as to preserve Member choice. Also effective no sooner than January 1, 2024, to preserve a Member's right to access Covered Services in-person, a Provider furnishing services through video synchronous interaction or audio-only synchronous interaction must do one of the following:

1. Offer those same services via in-person, face-to-face contact.
2. Arrange for a referral to, and a facilitation of, in-person care that does not require a Member to independently contact a different Provider to arrange for that care.

Member Consent

Providers must inform Members prior to the initial delivery of Covered Services via Telehealth about the use of Telehealth and obtain verbal or written consent from

Members for the use of Telehealth as an acceptable mode of delivering services.

If a Provider, whether at the originating site or distant site, retains a general consent agreement that specifically mentions the use of Telehealth as an acceptable modality for the delivery of Covered Services and includes the required information below, this is sufficient for documentation of consent. Providers also need to document when a Member consents to receive Covered Services via Telehealth prior to the initial delivery of the services. Consent must be documented in the Member's Medical Record and made available to DHCS upon request.

In addition to documenting consent prior to initial delivery of Covered Services via Telehealth, Providers are also required to explain the following to Members:

- The Member's right to access Covered Services delivered via Telehealth in-person.
- That use of Telehealth is voluntary and that consent for the use of Telehealth can be withdrawn at any time by the Member without affecting their ability to access Medi-Cal Covered Services in the future.
- The availability of Non-Medical Transportation to in-person visits.
- The potential limitations or risks related to receiving Covered Services through Telehealth as compared to an in-person visit, if applicable.

DHCS has created model Member consent language for MCPs and Providers to use, which can be found on the DHCS website.⁵

Establishing New Patients via Telehealth

Members may be established as new patients by Providers via Telehealth through the following ways:

1. All Providers may establish new patient relationships via synchronous video Telehealth visits.
2. All Providers may establish new patient relationships via audio-only synchronous interaction only if one or more of the following criteria applies:

⁵ The Model Telehealth Patient Consent Language is available at:
<https://www.dhcs.ca.gov/provgovpart/Pages/Patient-Consent.aspx>.

- a. The visit is related to sensitive services, which is defined in Civil Code section 56.06(n) as all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender-affirming care, and intimate partner violence, and includes services described in Family Code sections 6924 - 6930, and HSC sections 121020 and 124260, obtained by a Member at or above the minimum age specified for consenting to the service specified in the section.
 - b. The Member requests an audio-only modality.
 - c. The Member attests they do not have access to video.
3. FQHCs, including Tribal FQHCs, and RHCs may establish new patient relationships through an asynchronous store and forward modality, as defined in BPC section 2290.5(a), if the visit meets all of the following conditions:
- a. The Member is physically present at a Provider's site, or at an intermittent site of the Provider, at the time the Covered Service is performed.
 - b. The individual who creates the patient's Medical Records at the originating site is an employee or Subcontractor of the Provider, or other person lawfully authorized by the Provider to create a patient Medical Record.
 - c. The Provider determines that the billing Provider is able to meet the applicable standard of care.
 - d. A Member who receives Covered Services via Telehealth must otherwise be eligible to receive in-person services from that Provider.

Payment

To ensure proper payment and record of Covered Services provided via Telehealth, all Providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered through both synchronous interactions and asynchronous store and forward telecommunications.

Regarding the rate of reimbursement, unless otherwise agreed to by the MCP and Provider, MCPs must reimburse Network Providers at the same rate, whether a Covered 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. For example, if an MCP reimburses a Provider \$100 for an in-person visit, the MCP must reimburse the Provider \$100 for an equivalent visit done via Telehealth unless otherwise agreed to by the MCP and Provider. Likewise, MCPs must reimburse Providers for a Covered Service rendered via telephone or video at the same rate for in-person visits, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the Member.

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's contractually required policies and procedures (P&Ps), the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCPD) Contract Manager within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an email confirmation to its MCPD Contract Manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are further responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.⁶ These requirements must be communicated by each MCP to all Subcontractors and Network Providers. DHCS may impose Corrective Action Plans (CAP), as well as administrative and/or monetary sanctions for non-compliance. For additional information regarding administrative and monetary sanctions, see APL 22-015, and any subsequent iterations on this topic. Any failure to meet the requirements of this APL may result in a CAP and subsequent Sanctions.

If you have any questions regarding this APL, please contact your MCPD Contract Manager.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief

⁶ For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic.

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Managed Care Quality and Monitoring Division