Telehealth Advisory Workgroup Meeting #1

September 22, 2021

DHCS

Agenda

- Purpose and Scope of Workgroup
- Medi-Cal Telehealth Coverage: Background & Data
- Guiding Principles, Policy Approaches, Considerations & Examples
- Public Comment

Purpose and Scope of Workgroup

Workgroup Context and Charge

Workgroup Context

- Telehealth utilization has dramatically increased in California and nationally in response to the COVID-19 pandemic. In response to COVID-19, coverage and reimbursement for telehealth services was expanded in the Medi-Cal program.
- As directed under a telehealth-related provision of a health-related trailer bill to the 2021-22 Budget Act, Assembly Bill 133 (AB-133), the California Department of Health Care Services (DHCS) will:
  - ➢ Seek to continue telehealth flexibilities through December 31, 2022 (pending CMS approval); and,
  - ➢ Convene a Telehealth Advisory Workgroup* to inform DHCS in establishing and adopting billing and utilization management protocols for telehealth modalities starting January 1, 2023.

Workgroup Charge

- Provide recommendations to inform DHCS in policies for telehealth modalities that preserve access, quality, and patient choice.
- Discuss and assess the impact of telehealth in increased access for patients, changes in health quality outcomes and utilization, best practices for the appropriate mix of in-person visits and telehealth, and the benefits or liabilities of any practice or care model changes that have resulted from telephonic visits.

Telehealth Advisory Workgroup Membership in Appendix

Workgroup Engagement Timeline: Session 1

Workgroup Discussions

Session 1:
September 22, 2021

- Level set on:
  - ✓ Purpose and scope of workgroup
  - ✓ Medi-Cal telehealth coverage: background and data
  - ✓ Coding and billing issues
- Review and validate guiding principles
- Review policy approaches aligned with guiding principles, begin to discuss issues and considerations

HOMEWORK: Deeper review and feedback on policy approaches, issues, and considerations

To support Workgroup, Manatt to synthesize feedback, bring additional national landscape research and analysis

Workgroup Engagement Timeline: Session 2

Workgroup Discussions

Session 2:
October 6, 2021

- Assess issues and considerations for policy approaches under 2-3 guiding principles
- Refine policy approaches based on discussion
- Identify areas for further research and evaluation to better understand telehealth utilization, access, and quality

HOMEWORK: Validate refined policy approaches; additional TBD.

To support Workgroup, Manatt to synthesize feedback, bring additional national landscape research and analysis

Workgroup Engagement Timeline: Session 3

Workgroup Discussions

Session 3:
October 20, 2021

- Assess issues and considerations for policy approaches under remaining 2-3 guiding principles
- Finalize recommendations on policy approaches that will best help DHCS meet its stated goals and guiding principles
- Finalize recommendations on areas for further research and evaluation to better understand telehealth utilization, access, and quality

To support Workgroup, Manatt to synthesize feedback, bring additional national landscape research and analysis

Workgroup Engagement Timeline: Policy & Budget Process

DHCS Policy & Budget Process

DHCS Policy and Budget Deliberations

A **stakeholder recommendations report,** developed in **November,** will include a qualitative summary of the Telehealth Advisory Workgroup Meeting proceedings; key themes and feedback on policy approaches, issues and considerations; and recommendations on policy approaches and research and evaluation agenda.

This report will inform DHCS telehealth policy making for the 2022-2023 proposed Governor's Budget.

To support Workgroup, Manatt to synthesize feedback, bring additional national landscape research and analysis

Out of Scope for Workgroup Discussion

To focus our conversations throughout this process, it's important to recognize and acknowledge the topics that are out of scope for this workgroup.

Out of Scope

The workgroup will not focus on:

- Telehealth beyond existing covered benefits
- Payment parity and reimbursement rates
- Additional telehealth modalities (e.g., RPM)

Ground Rules for Participation

Today's Schedule

9:30 - 11:30am: Workgroup Discussion

11:30 - 11:45am: Public Comment

Please

✓ Allow one person to speak at a time
✓ Actively listen and seek to understand
✓ Be mindful of time

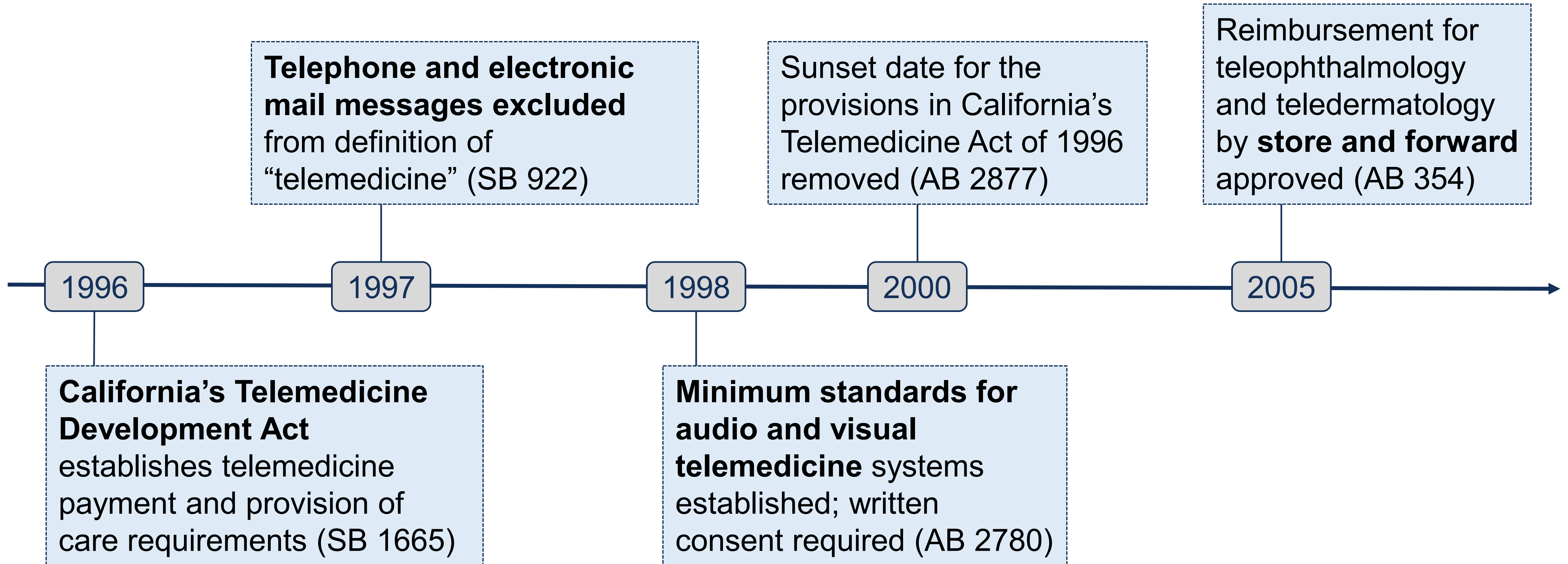
Please Do Not

× Speak over others
× Monopolize discussion
× Multitask

All parties were invited to participate in this important workgroup because of your expertise. Your attention, engagement, and collective consideration are important and appreciated – we look forward to learning from you.

Medi-Cal Telehealth Coverage:
Background & Data

History of Telehealth Coverage in California (Part 1)



History of Telehealth Coverage in California (Part 2)

In response to the COVID-19 pandemic, DHCS temporarily expanded telehealth flexibilities: **providers can render all applicable services** that can be appropriately provided via telehealth modalities; most telehealth modalities can be **provided for new and established patients**; many covered services can be provided via **telephone/audio-only for the first time**; payment parity between in-person face-to-face, by synchronous telehealth, and by **audio-only when the service met the requirements of the billing code**; **waiving site limitations**; allowing for expanded access to telehealth through **non-public technology platforms** (DHCS 2/2021)

2011

2019

2020

Telehealth Advancement Act replaces "telemedicine" with "telehealth"; **eliminates ban on email or telephone-delivered services**; **allows for verbal patient consent** to telehealth; enables all CA-licensed providers to practice via telehealth; removes Medi-Cal regulation mandating documentation of patient 'barrier' to in-person visit (AB 415)

Face-to-face contact is not required in an enrolled community clinic for Medi-Cal beneficiaries during or immediately following a state of emergency; **telehealth services and telephonic services will be reimbursable** when provided by another enrolled FFS Medi-Cal provider, clinic, or facility (AB 1494).

Medi-Cal Telehealth Policy in Today's PHE

The 2021-22 Budget Act extends pandemic-era flexibilities until December 31, 2022.
DHCS is planning for permanent extension of many flexibilities.

- ✓ Payment parity between telehealth modalities (video and audio-only) and in-person services, so long as those services meet billing code requirements (payment parity does not include e-consults and virtual communications)
- ✓ Allow video and audio-only visits, and remove site limitations, for Federally Qualified Health Centers/Rural Health Centers (FQHC/RHC)
- ✓ Expand synchronous and audio-only telehealth to additional delivery systems and allow reimbursement for additional physical health codes
- ✓ Expand virtual check-ins to additional delivery systems (e.g., 1915c waivers, LEA BOP, among others)

Current Coding Issues and Limitations

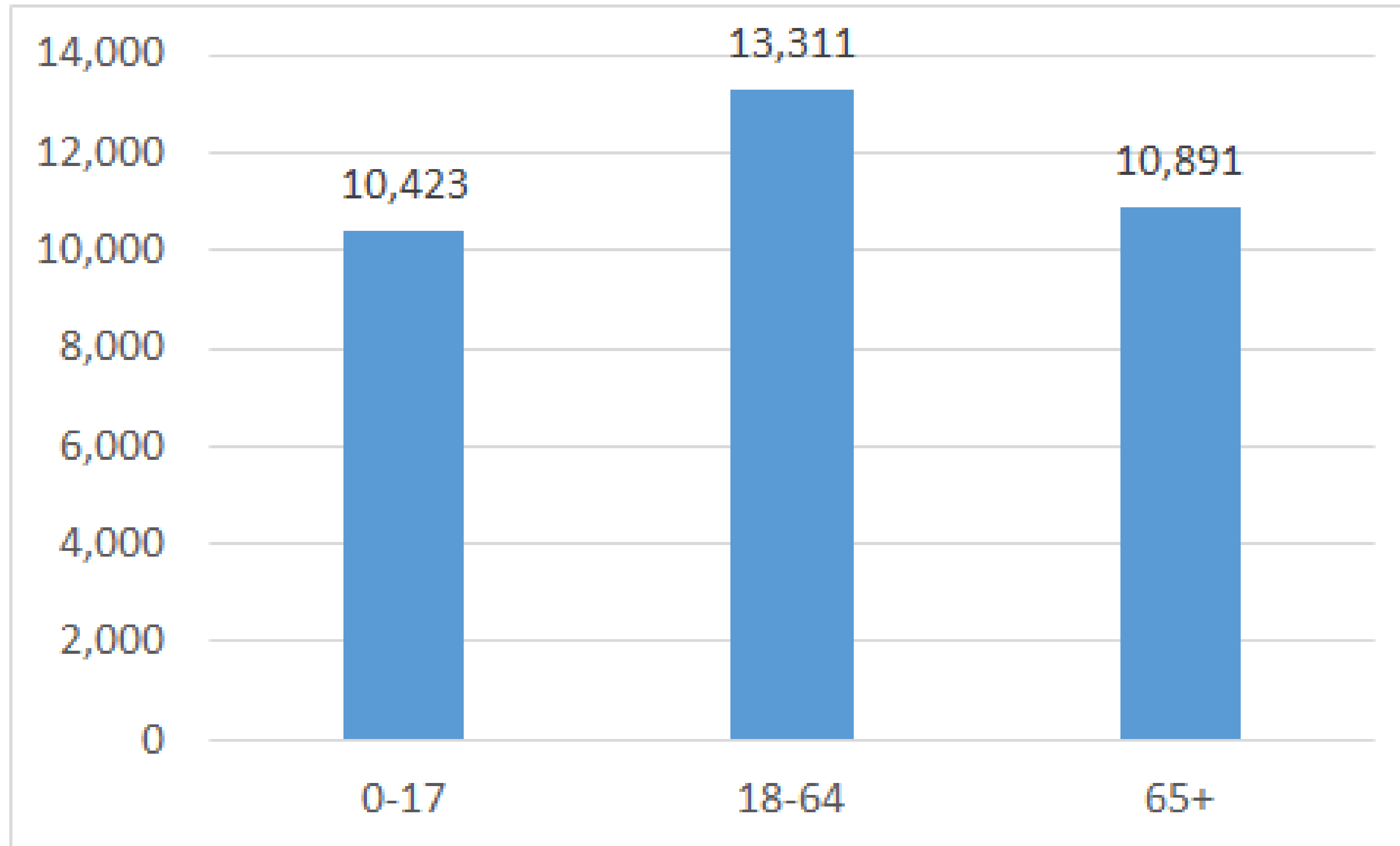
- 2019 coding guidance to FQHCs/RHCs did not require use of telehealth modifier, limiting ability to track telehealth claims and resulting in underrepresented telehealth claims
- Telehealth modifiers have also been optional for specialty mental health providers (will be required starting November 2021) and county systems may lack technical capacity to accept telehealth modifiers, resulting in underrepresented telehealth claims when included in analyses
- Current telehealth modifiers do not distinguish between types of telehealth visits (e.g., video vs. audio)

Telehealth Claims Utilization Analysis

- DHCS analyzed paid claims for the total number of outpatient telehealth visits for every 100,000 beneficiaries for March 2021
- These outpatient visits include outpatient medical and non-specialty mental health services. These data do not include specialty mental health services
- Source - DHCS Medi-Cal Data Warehouse
- These analyses are preliminary

Adults 18-64 were more likely to have a telehealth visit than children, youth or seniors

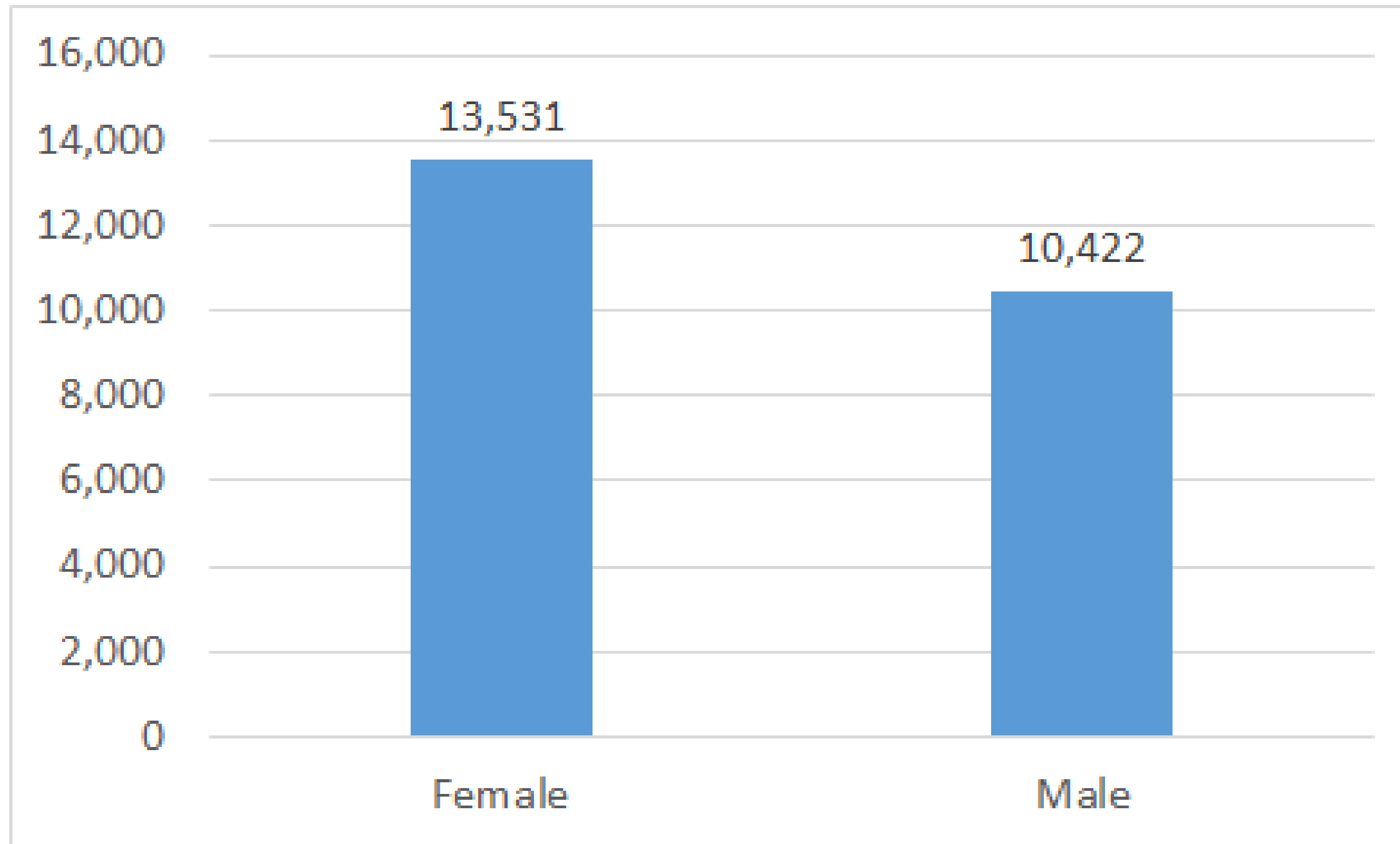
Telehealth Visits per 100,000 Beneficiaries, By Age Group, March 2021



Preliminary analyses

Female beneficiaries were more likely to have a telehealth visit than males

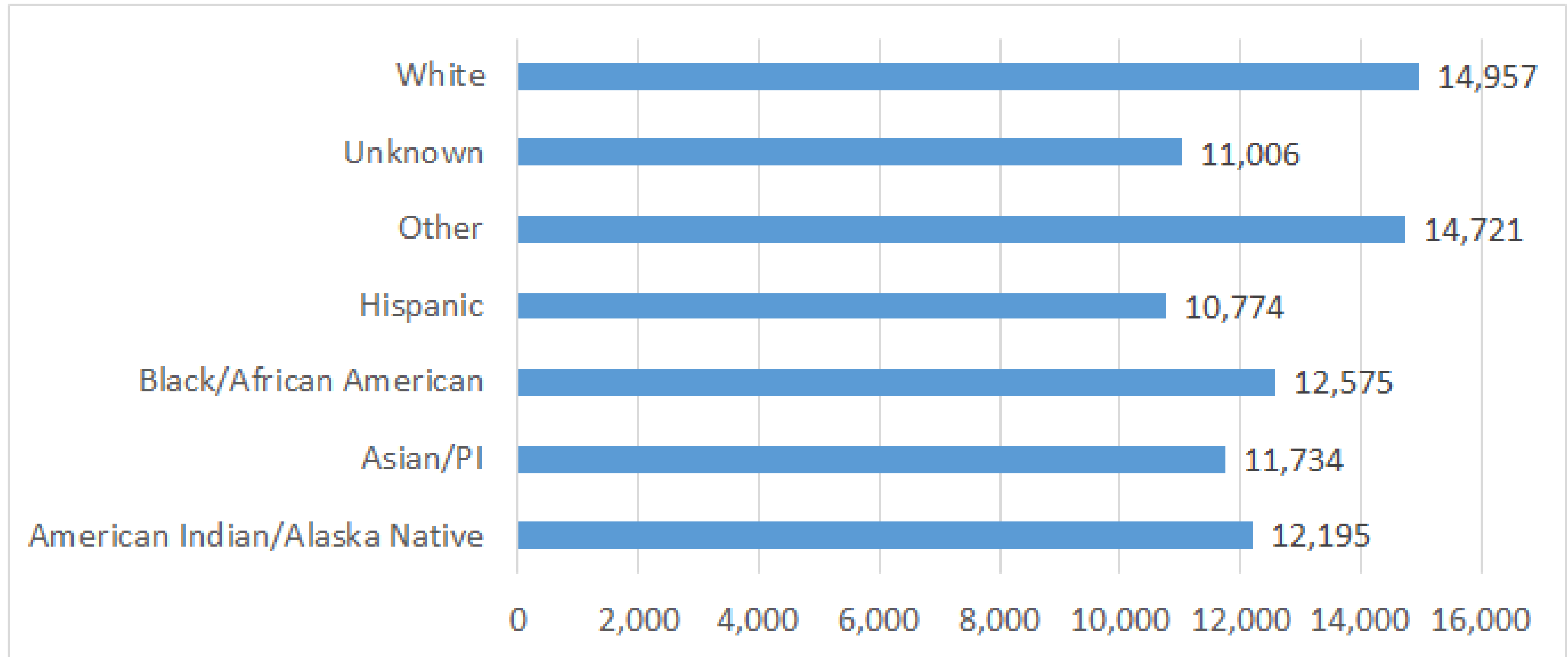
Telehealth Visits per 100,000 Beneficiaries, By Sex, March 2021



Preliminary analyses

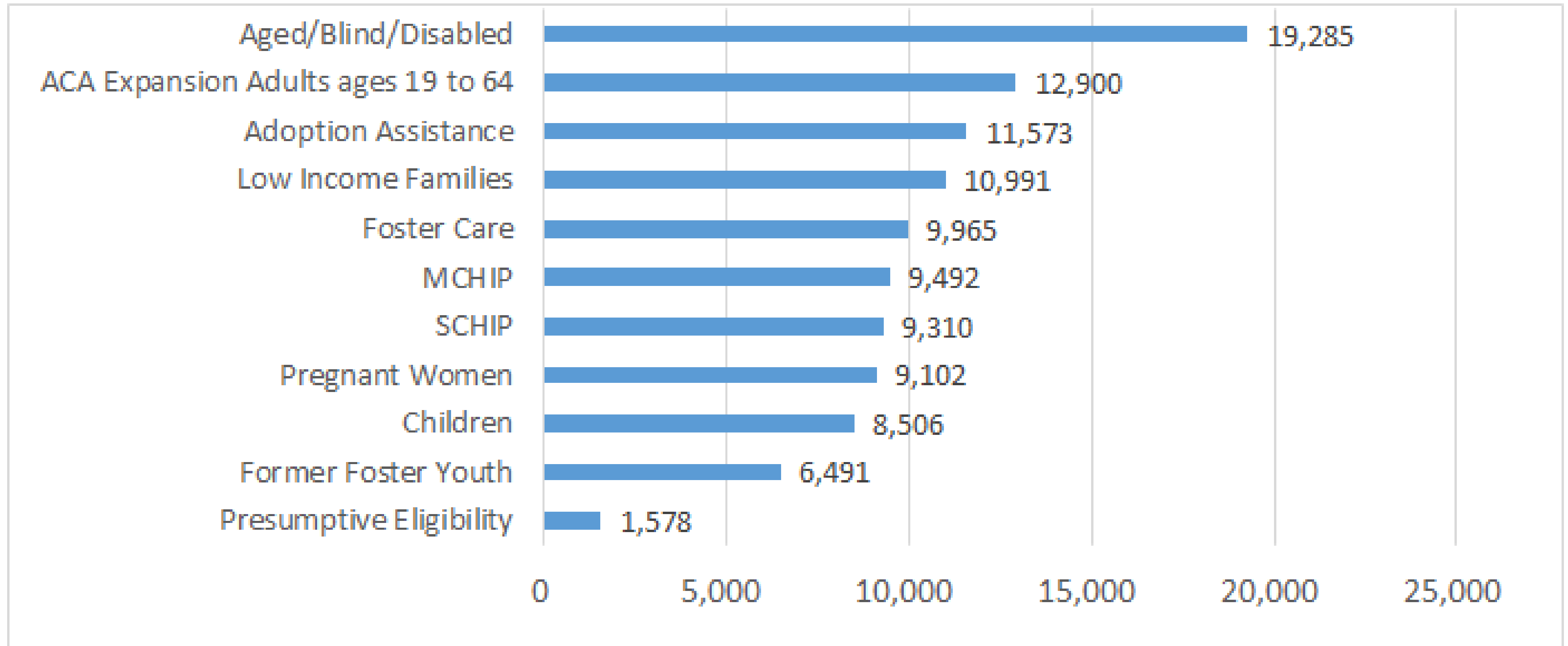
Hispanic beneficiaries had the lowest rate of telehealth visits; White race/ethnicity had the highest rate

Telehealth Visits per 100,000 Beneficiaries, By Race/Ethnicity, March 2021



Preliminary analyses

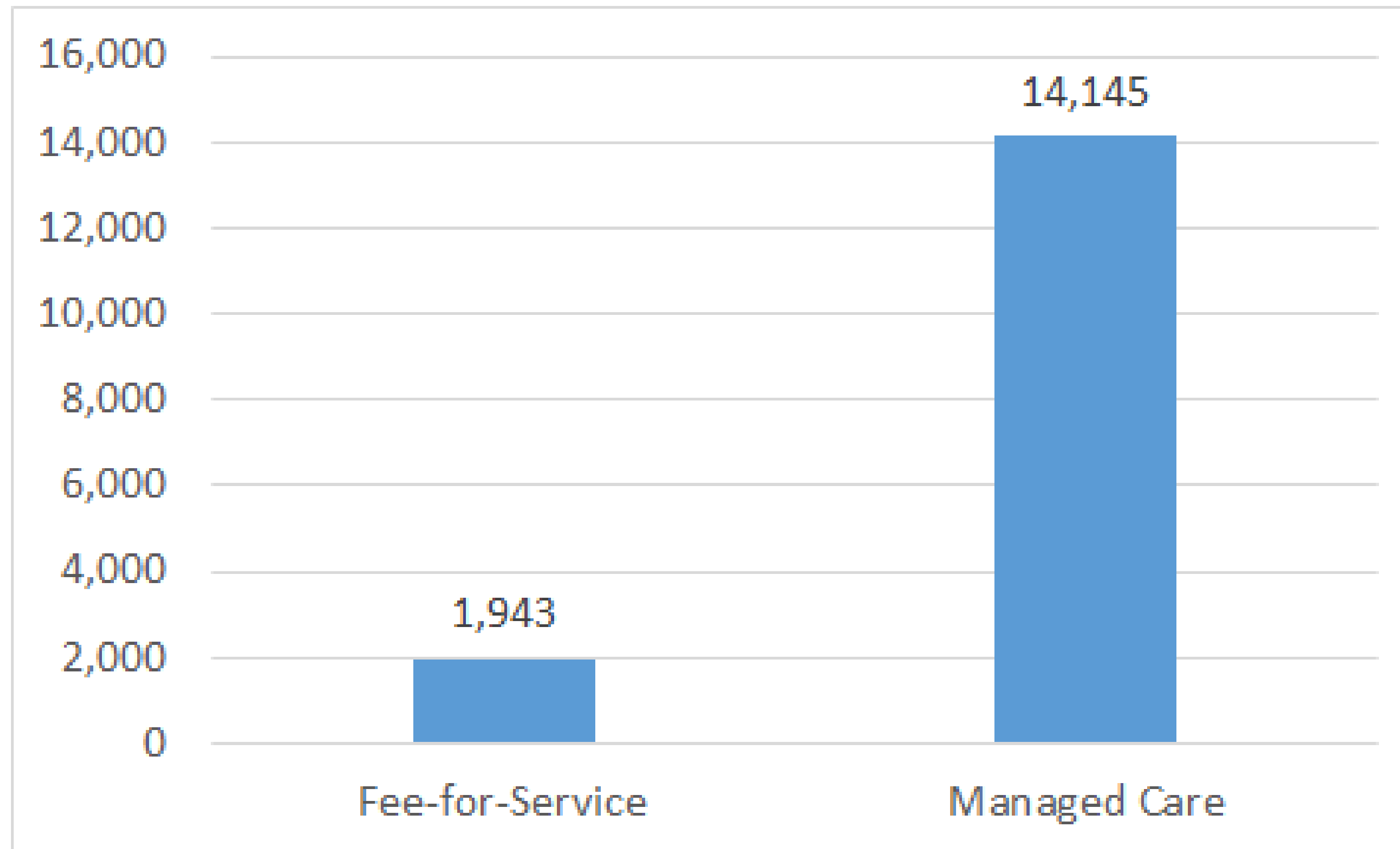
Aged, blind and disabled beneficiaries were among the most likely to use telehealth; former foster youth were among the least likely



Preliminary analyses

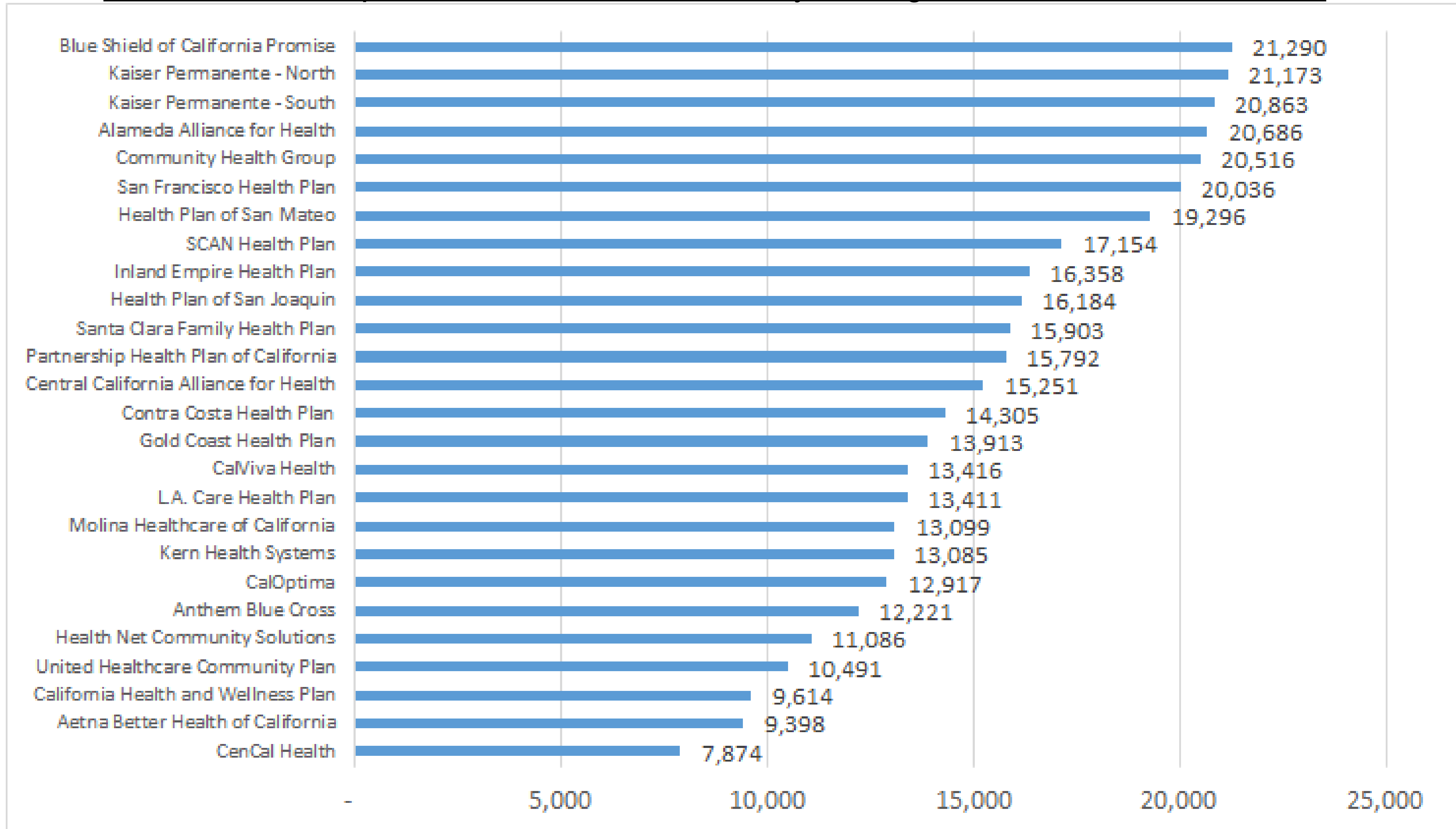
The rate of telehealth visits in managed care was far higher than in fee-for-service

Telehealth Visits per 100,000 Beneficiaries, By Delivery System, March 2021



Preliminary analyses

Telehealth Visits per 100,000 Beneficiaries, By Managed Care Plan, March 2021



Preliminary analyses

Possible Areas for Future Data Analysis

» Ratio of in-person to telehealth visits

» Categories of services through telehealth

» Others TBD

Medi-Cal Telehealth: Guiding Principles, Policy Approaches, and Considerations

Inherent Tradeoffs in Enabling Care Via Telehealth

- **Expanded Access to Telehealth Could Perpetuate Health Inequities and Disparities**
  - Expansive telehealth policies could benefit only a subset of the Medi-Cal population (younger, urban adults with low acuity conditions) who can easily access digital care
  - Older adults, lower-income individuals, communities of color, individuals with low digital literacy or who require interpreter services or other accommodations may not be able to access care via video or audio-only
- **Improved Access Could Lead to Unnecessary or Duplicative Care**
  - Convenient access to telehealth could result in unnecessary or duplicative visits

Inherent Tradeoffs in Enabling Care Via Telehealth – Sources

Sources: MedPAC Report to Congress, Chapter 14: Telehealth in Medicare after the Coronavirus Public Health Emergency (March 2021); J S Ashwood, A Mehotra, D Cowling, L Uscher-Pines, "Direct-to-Consumer Telehealth May Increase Access to Care But Does Not Decrease Spending," *Health Affairs* 36, No. 3 (2017), pp: 485–491, doi: 10.1377/hlthaff.2016.1130; A Mehotra, B Wang, G Snyder, "Telemedicine: What Should the Post-Pandemic Regulatory and Payment Landscape Look Like?" The Commonwealth Fund, Issue Brief (August 2020); Totten AM, Womack DM, Eden KB, et al. "Telehealth: Mapping the Evidence for Patient Outcomes From Systematic Reviews," Agency for Healthcare Research and Quality (AHRQ); 2016; Graber ML, Hunte HE, Smith KM, "Telediagnosis for Acute Care: Implications for the Quality and Safety of Diagnosis," Agency for Healthcare Research and Quality; August 2020. AHRQ Publication No. 20-0040-2-EF; R O'Reilly et al., "Is Telepsychiatry Equivalent to Face-to-Face Psychiatry? Results from a Randomized Controlled Equivalence Trial," *Psychiatric Services* 58, no. 6 (2007): 836–43.

Inherent Tradeoffs in Enabling Care Via Telehealth

- **Inability of Telehealth Providers to Conduct Physical Exams or Diagnostic Testing Could Pose Quality and Patient Safety Risks Without Appropriate Guardrails**
  - Video and audio-only visits are limited by their inability to complete a full physical exam or obtain ancillary testing.
  - Inappropriate use of telehealth generally, or specific modalities, could risk patient safety and result in lower quality of care.
- **Expansive Coverage of Telehealth Could Increase Risks of Fraud and Abuse**
  - » Digital technologies have enabled some bad actors to take advantage of new coverage of telehealth care
  - » Medicare and the Dept. of Justice have recently reported and are seeking to charge telehealth companies that have submitted false and fraudulent claims

Inherent Tradeoffs in Enabling Care Via Telehealth, Continued

- **Limited Research Exists Regarding the Quality of Care for Individuals Who Receive Telehealth + In-Person Care**
  - Available research suggests equivalency in quality of care delivered in-person vs. telehealth, yet findings are not generalizable because:
    - Equivalency research is limited and tends to focus on older adults with mental health or chronic conditions
    - Most patients receive a combination of telehealth + in-person care (i.e., hybrid care)
  - Not yet sufficient evidence that examines quality or cost outcomes for patients who receive hybrid care

Inherent Tradeoffs in Enabling Care Via Telehealth, Continued – Sources

Sources: MedPAC Report to Congress, Chapter 14: Telehealth in Medicare after the Coronavirus Public Health Emergency (March 2021); J S Ashwood, A Mehotra, D Cowling, L Uscher-Pines, "Direct-to-Consumer Telehealth May Increase Access to Care But Does Not Decrease Spending," *Health Affairs* 36, No. 3 (2017), pp: 485–491, doi: 10.1377/hlthaff.2016.1130; A Mehotra, B Wang, G Snyder, "Telemedicine: What Should the Post-Pandemic Regulatory and Payment Landscape Look Like?" The Commonwealth Fund, Issue Brief (August 2020); Totten AM, Womack DM, Eden KB, et al. "Telehealth: Mapping the Evidence for Patient Outcomes From Systematic Reviews," Agency for Healthcare Research and Quality (AHRQ); 2016; Graber ML, Hunte HE, Smith KM, "Telediagnosis for Acute Care: Implications for the Quality and Safety of Diagnosis," Agency for Healthcare Research and Quality; August 2020. AHRQ Publication No. 20-0040-2-EF; R O'Reilly et al., "Is Telepsychiatry Equivalent to Face-to-Face Psychiatry? Results from a Randomized Controlled Equivalence Trial," *Psychiatric Services* 58, no. 6 (2007): 836–43; Lori Uscher-Pines et al., "Access and Quality of Care in Direct-to-Consumer Telemedicine," *Telemedicine and E-Health* 22, no. 4 (2016): 282–87.

DHCS Telehealth Guiding Principles

Access: Promote adequate, culturally responsive, patient-centered, equitable access to health care, and strengthen provider network adequacy.

Standard of Care: Apply standard of care to all services and information provided via telehealth, including quality, utilization, cost, medical necessity, and clinical appropriateness.

Patient choice: Offer patient, and their providers, choice of service delivery mode and retain patient right to receive health care in-person.

Equity: Improve equitable access to providers, address inequities and disparities in care to every member, and ensure compliance with civil rights law.

Stewardship: Exercise responsible stewardship of public resources, including mitigating and addressing fraud, waste, discriminatory barriers, and abuse.

Confidentiality: Protect patient confidentiality.

Note: On the following slides we will discuss potential telehealth policy approaches that may support the guiding principles above, except for confidentiality, which is supported by existing federal and state regulations.

Guiding Principle: Access

Promote adequate, culturally responsive, patient-centered, equitable access to health care, and strengthen provider network adequacy.

Policy Approach(es)

Allow the use of synchronous telehealth to meet network adequacy standards for in Medi-Cal managed care health plans, County Mental Health Plans, Dental Managed Care plans and Drug Medi-Cal-Organized Delivery System (DMC-ODS)

Open Issues for Discussion

- How should telehealth providers be accounted for in meeting network adequacy standards or requirements?
- If telehealth can be used to meet network adequacy standards or requirements, what guardrails should be put in place to ensure that beneficiaries still have appropriate access to in-person care?
- What are other policy approaches that achieve this principle?

Guiding Principle: Access

Promote adequate, culturally responsive, patient-centered, equitable access to health care, and strengthen provider network adequacy.

Policy Approach(es)

Allow the use of synchronous telehealth to meet network adequacy standards for in Medi-Cal managed care health plans, County Mental Health Plans, Dental Managed Care plans and Drug Medi-Cal-Organized Delivery System (DMC-ODS)

This policy approach informed by Medicare example below

Examples

- **Medicare:** "To encourage and account for telehealth providers in contracted networks, we provide MA plans a 10% credit towards the percentage of beneficiaries that must reside within required time and distance standards when the plan contracts with telehealth providers for Dermatology, Psychiatry, Cardiology, Otolaryngology, Neurology, Ophthalmology, Allergy and Immunology, Nephrology, Primary Care, Gynecology/ OB/GYN, Endocrinology, and Infectious Diseases."- Contract Year 2021 Medicare Advantage and Part D Final Rule
- **State Example – Colorado**: In 2015 Colorado passed HB 15-1029, which allows insurers to offer access to specialty services via telehealth as a way of meeting the state's network adequacy requirement, as long as the specialty service can be delivered appropriately through telemedicine.

Guiding Principle: Standard of Care

Apply standard of care to all services and information provided via telehealth, including quality, utilization, cost, medical necessity, and clinical appropriateness.

Policy Approach(es)

Allow new patients to be established via telehealth subject to certain guardrails

Open Issues for Discussion

- Under what circumstances, if any, should audio-only services be allowed for new patient visits?
- Should audio-only services be allowed if a patient has not had an in-person visit with the rendering telehealth provider within a given timeframe (e.g., past 6 months? past 12 months?)
- What are other policy approaches that achieve this principle?

Guiding Principle: Standard of Care

Apply standard of care to all services and information provided via telehealth, including quality, utilization, cost, medical necessity, and clinical appropriateness.

Policy Approach(es)

Allow new patients to be established via telehealth subject to certain guardrails

Examples

- **Medicare:** Within the FY22 Proposed Medicare Physician Fee Schedule, CMS proposes that when tele-mental health care is provided to a patient in their home, there be an in-person, non-telehealth service with the patient's provider within 6 months prior to the initial telehealth service and thereafter at least once every 6 months
- **State Example – North Carolina**: North Carolina's Medicaid program
  - Limits coverage of telehealth to certain services per specialty-specific clinical coverage policies (e.g., family planning services, select outpatient behavioral health services, etc.);
  - Limits audio-only coverage to select behavioral services; and,
  - Encourages providers to send documentation of telehealth service to the patient's primary care or medical home within 48 hours of a telehealth encounter
- **State Example – Tennessee**: Tennessee's legislature passed SB 429, which allows for HIPAA-compliant audio-only conversations for the provision of behavioral health services when no other options are available

Guiding Principle: Patient Choice

Offer patient, and their providers, choice of service delivery mode and retain patient right to receive health care in-person

Policy Approach(es)

Require all telehealth providers furnishing health care services via the video or audio-only modality to offer both modalities

Open Issues for Discussion

- Given the developing evidence base, what guidelines are helpful to ensure audio-only preserves quality of care?
- Are there services where audio-only does not meet standard of care?
- Should the default telehealth modality for providers be video, with audio-only available if patients requests?
- Should providers be required to document a reason for delivering care via audio-only (e.g., no access to broadband for video visit)?
- What types of frequency limits on audio-only visits would ensure audio-only preserves quality of care?
- What are other policy approaches that achieve this principle?

Guiding Principle: Patient Choice

Offer patient, and their providers, choice of service delivery mode and retain patient right to receive health care in-person

Policy Approach(es)

Require all telehealth providers furnishing health care services via the video or audio-only modality to offer both modalities

Examples

- **Medicare:** Within the FY22 Proposed Medicare Physician Fee Schedule, CMS proposes requiring coverage of audio-only services if "the patient is not capable of, does not wish to use, or does not have bandwidth/access to use interactive audio-video modality."
- **State Example – Vermont**: Vermont's legislature passed S.117*, which enables Medicaid providers to deliver services via audio-only if the patient elects to receive services via that modality and it is clinically appropriate to do so. Providers must document in the patient record:
  - Patient's informed consent for receiving services via audio-only; and,
  - The reason(s) that the provider determined that it was clinically appropriate

Note: S.117 extends audio-only flexibilities through March 2022

Guiding Principle: Equity

Improve equitable access to providers, address inequities and disparities in care to every member, and ensure compliance with civil rights law.

Policy Approach(es)

Require all telehealth providers to also offer such services via in-person, face-to-face contact

DHCS believes telehealth should offer additional options for care and all Medi-Cal beneficiaries should retain the choice to have access to in-person care

Open Issues for Discussion

- Are there instances where ‘telehealth only’ providers be able to meet this requirement through a referral to a provider who offers in-person services?
- Are there instances where a provider should not be required to offer in-person services?
- What other guardrails can be put in place to ensure that DHCS beneficiaries are not inappropriately ‘steered’ to telehealth as opposed to in-person services?
- What are other policy approaches that achieve this principle?

Guiding Principle: Equity

Improve equitable access to providers, address inequities and disparities in care to every member, and ensure compliance with civil rights law.

Policy Approach(es)

Require all telehealth providers to also offer such services via in-person, face-to-face contact

DHCS believes telehealth should offer additional options for care and all Medi-Cal beneficiaries should retain the choice to have access to in-person care

Examples

- **State Example – North Carolina**: North Carolina's Medicaid program telehealth policy states that "beneficiaries are not required to seek services through telehealth, virtual communications, or remote patient monitoring, and shall be allowed access to in-person services, if the beneficiary requests."

Guiding Principle: Stewardship

Exercise responsible stewardship of public resources, including mitigating and addressing fraud, waste, discriminatory barriers, and abuse.

Policy Approach(es)

- Require telehealth providers to be located in California (with limited exceptions for specialty care)
- Implement post-visit monitoring protocols to facilitate oversight of telehealth services

Open Issues for Discussion

- What guardrails should be put in place for out-of-state providers who deliver services via telehealth to Medi-Cal beneficiaries?
- What monitoring protocols should DHCS consider adopting to facilitate oversight of telehealth services?
- What are other policy approaches that achieve this principle?

Guiding Principle: Stewardship

Exercise responsible stewardship of public resources, including mitigating and addressing fraud, waste, discriminatory barriers, and abuse.

Policy Approach(es)

- Require telehealth providers to be located in California (with limited exceptions for specialty care)
- Implement post-visit monitoring protocols to facilitate oversight of telehealth services

Examples

- **Medicare:** A recent MedPAC report regarding the future of telehealth coverage policies within Medicare proposed the following post-telehealth visit monitoring policies to address program integrity concerns:
  - Targeted Review of Outlier Providers Based on Volume: Monitor and audit providers who are outliers in terms of the volume of telehealth services they bill relative to other providers
  - Targeted Review of Outlier Providers Based on Time: Monitor and review providers who are outliers in terms of the time spent delivering care via telehealth relative to other providers
  - Red Flag Reviews: Review claims from providers that trigger specific “red flags” (e.g., more than 80% audio-only visits, regular pattern of high-cost DMS/diagnostic tests following telehealth visits)

Public Comment

*During this time, should you wish to be unmuted to comment, click “Raise Hand” in the Zoom window, and if selected, you’ll be asked to unmute your microphone. For those joining by phone-only, you may press *9 to raise your hand. If selected, you will hear an operator say “the host would like to unmute your microphone.” To unmute, press *6. Once unmuted, please state your name and pose your question. Commenters will be given two minutes to speak.*

Additional Comments

Should you have additional questions or comments, please email **Medi-Cal_Telehealth@dhcs.ca.gov**.

Appendix

Stakeholder Participation (Legislatively-Mandated Organizations)

Legislatively-Mandated Organizations

AB-133 mandated the advisory group include representatives of:

- ❖ California Association of Public Hospitals
- ❖ California Medical Association
- ❖ California Primary Care Association
- ❖ Essential Access Health
- ❖ Local Health Plans of California
- ❖ California Behavioral Health Directors Associations (represented by Los Angeles County Department of Mental Health)
- ❖ Planned Parenthood Affiliates of California

Stakeholder Participation (DHCS-Identified Organizations)

DHCS-Identified Organizations

DHCS put out a solicitation, received ~90 responses, and selected organizations and individuals that represent a diverse cross-sector of stakeholders:

- ❖ AARP California
- ❖ Association of California Healthcare Districts (ACHD)
- ❖ Blue Shield of California
- ❖ California Children's Trust
- ❖ California Emerging Technology Fund
- ❖ Paul Glassman, DDS, California Northstate University College of Dental Medicine
- ❖ California Pan-Ethnic Health Network
- ❖ CenCal Health
- ❖ Center for Connected Health Policy
- ❖ Jennifer Raymond, MD, Children's Hospital of Los Angeles
- ❖ Contra Costa Health Plan
- ❖ County of Los Angeles Department of Health Services
- ❖ Disability Rights of California
- ❖ Downey Unified School District

Stakeholder Participation (DHCS-Identified Organizations, cont'd)

DHCS-Identified Organizations

DHCS put out a solicitation, received ~90 responses, and selected organizations and individuals that represent a diverse cross-sector of stakeholders:

- ❖ Indian Health Council, Inc
- ❖ Insure the Uninsured Program
- ❖ Justice in Aging
- ❖ Kids and Caregivers
- ❖ National Health Law Program
- ❖ OCHIN & California Telehealth Network
- ❖ Promesa Behavioral Health
- ❖ Anthony Magit, MD, Rady Children's Hospital & Children's Specialty Care Coalition
- ❖ Seneca Family of Agencies
- ❖ Service Employees International Union California State Council
- ❖ Shasta Community Health Center
- ❖ Carol Yarbrough, UCSF MC
- ❖ Lisa Moore, University of California Health
- ❖ James Marcin, MD, UC Davis Health

DHCS Telehealth Definitions (Page 1)

Term	DHCS Definition
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers. (Telehealth includes telemedicine and virtual check-ins.)
Telemedicine	Two-way, real time interactive communication between the patient and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.
Virtual Check-Ins	Virtual check-ins (or brief communication technology-based services) are for patients to communicate with their physicians, health care practitioners, or other skilled and trained individuals such as Community Health Workers. Virtual communication services consists of at least five minutes of technology-based communication or remote evaluation services to conduct e-visits (e.g., web- based modalities, such as web-based interfaces, live chats, etc.) furnished by an applicable provider.

Source: DHCS Telehealth Definitions

DHCS Telehealth Definitions (Page 2)

Term	DHCS Definition
E-Consults	Asynchronous health record consultation services that provide an assessment and management service in which the patient's treating health care practitioner (i.e., attending or primary) requests the opinion and/or treatment advice of another health care practitioner (i.e., consultant) with specific specialty expertise to assist in the diagnosis and/or management of the patient's health care needs without patient face-to-face contact with the consultant. E-consults between health care providers are designed to offer a coordinated multidisciplinary case reviews, advisory opinions, and recommendations of care.
Asynchronous store and forward	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.
Synchronous interaction	A real-time interaction between a patient and a health care provider located at a distant site.

Source: DHCS Telehealth Definitions

DHCS Telehealth Definitions (Page 3)

Term	DHCS Definition
Originating site	A site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.
Originating site fee	An amount paid to the originating site when providing service by two-way, real-time interactive communication or store and forward, when billed with HCPCS Code Q3014.
Distance site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Transmission fees	An amount paid to both the originating site and distant site when providing service by a two-way, real-time interactive communications system, when billed with HCPCS code T1014.
Interactive telecommunications system	Multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time interactive communication between the patient and distant site physician or practitioner. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system.
Consent	Health care providers must also 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.

Source: DHCS Telehealth Definitions