CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

Date: August 25, 2023 **Policy Letter 23-03**

To: Program of All-Inclusive Care for the Elderly Organizations

Subject: Telehealth Services

Purpose

The purpose of this Policy Letter (PL) is to provide clarification to the Program of All-Inclusive Care for the Elderly (PACE) Organizations (PO) on the Department of Health Care Services' (DHCS) policy on telehealth services as outlined in the Medi-Cal Provider Manual.[1, 2] This includes clarification on the services that are covered, and the expectations related to documentation for the telehealth modality.[3]

Background

The California Telehealth Advancement Act of 2011 codified requirements and definitions for the provision of telehealth services in Business and Professions Code (BP Code) section 2290.5, Health and Safety Code (H&S Code) section 1374.13, and California Welfare and Institutions Code (W&I Code) sections 14132.72 and 14132.725.

BP Code section 2290.5 requires: 1) documentation of either verbal or written consent for the use of telehealth from the patient; 2) compliance with all state and federal laws regarding the confidentiality of health care information; 3) that a patient's rights to the patient's own medical information apply to telehealth interactions; and 4) that the patient is not precluded from receiving in-person health care services after agreeing to receive telehealth services.

H&S Code section 1374.13 prohibits regulated health plans from implementing a limitation on the type of setting where a health care provider can provide covered services to a patient, so long as the service(s) are appropriately provided through a telehealth modality.

With the passage of Senate Bill 184, W&I Code section 14132.725((j) allows POs the

[1] Medi-Cal Provider Manual, "Medicine: Telehealth", Medicine: Telehealth
[2] For definitions of the terms used in this Policy Letter, 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 the DHCS website.
[3] Clarification on the services that are covered: "Telehealth" web page of the DHCS website.

flexibility to use video telehealth only for enrollment eligibility assessments and reassessments.

Federal Telehealth Waivers
The Centers for Medicare & Medicaid Services (CMS) allows POs to submit a 903 Benefits Improvement and Protection Act (BIPA) Waiver, authority provided under section 1894(f)(2)(B) and 1934(f)(2)(B) of the Social Security Act. BIPA waivers allow states to modify or waive certain regulatory provisions to meet the needs of PACE organizations.

Policy

POs must abide by the Medi-Cal telehealth policy by following the Medi-Cal Provider Manual when providing covered services in the PACE model.

Each telehealth provider must be licensed in the State of California. Each telehealth provider providing Medi-Cal covered services to a PACE participant via a telehealth modality must meet the requirements of BP Code section 2290.5(a)(3), or equivalent requirements under California law the provider is licensed under. For example, providers who are certified by the Behavior Analyst Certification Board, that is accredited by the National Commission on Certifying Agencies.

Existing Medi-Cal covered services, identified by Current Procedural Terminology Revision 4 (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 if all the following criteria, detailed in the Medi-Cal Procedure Manual, Medicine: Telehealth, are satisfied:

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

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

Additionally, current federal regulation requires initial comprehensive care planning

[4] These four criteria are based on the above cited laws that constitute the Telehealth Advancement Act of 2011.

assessments and reassessments be conducted in-person by the full interdisciplinary team (IDT). Subsequent reassessments do not require the full IDT, but must include the: primary care provider, registered nurse, masters level social worker, and other IDT members who are actively involved in the participant's plan of care. Subject to approved federal telehealth waivers, POs can conduct assessments and reassessments via telehealth. The federal telehealth waiver process is detailed in the next section. [5]

In order to provide services to a PACE participant via telehealth, a health care provider must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service. A health care provider is not required to be present with the patient at the originating site unless determined medically necessary by the provider at the distant site.

Health care 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 via telehealth, for both synchronous interactions and asynchronous store and forward telecommunications.[6] Consultations via asynchronous electronic transmission cannot be initiated directly by patients. Electronic consultations (e-consults) are permissible using CPT-4 code 99451, modifier(s), and medical record documentation as defined in the Medi-Cal Provider Manual. E-consults are permissible only between health care providers.

POs are responsible for ensuring that their subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including Policy Letters. These requirements must be communicated by each PO to all delegated entities and subcontractors.

PO Telehealth Waiver Requests

Pursuant to federal regulations and related procedures, DHCS will accept telehealth BIPA waiver requests from POs for review to assess eligibility.[7] DHCS will not accept waiver requests for complete telehealth for all IDT assessments and all IDT members. When requesting a BIPA waiver for telehealth, a PO must state which of the IDT members will be allowed to use telehealth and must include the specific facts and circumstances that would justify the request. POs must submit using the template provided by DHCS. Waiver requests must first be submitted to DHCS for review 60 days ahead of the CMS submission dates. If the waiver request is incomplete, DHCS will provide technical assistance one time to try to facilitate completion of the waiver request so it can be submitted to CMS by the closest submission date. If the waiver request cannot be completed and submitted by this closest submission date, DHCS will submit the PO's waiver request to CMS by the next submission date, regardless of whether the waiver request has been completed.

POs who decide to submit a waiver request related to telehealth services must adhere to

[5] 42 C.F.R. § 460.26.
[6] Medi-Cal Provider Manual, "Medicine: Telehealth - Documentation Requirements"
[7] 42 C.F.R. § 460.26.

the CMS requirements and deadlines. CMS submission deadlines are on a quarterly basis and are on the last business day of the following months: March, June, September, and December. Once DHCS has completed a review of the PO's waiver request, DHCS will submit the waiver request to CMS, along with a letter providing DHCS' assessment of the waiver request, via the PACE portal. CMS has 90 days from the date of receipt to make a determination. If the waiver has been approved by CMS, the waiver will be added to each individual PO's program agreement.

If you have any questions regarding this Policy Letter, please contact your PACE Contract Manager.

Sincerely,

[Original document signed by]

Cortney Maslyn, Chief
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