CONTRA COSTA COUNTY CIVIL GRAND JURY REPORT NO. 2102
"Tele-Mental Health: Expansion of Remote Access to Care"

BOARD OF SUPERVISORS' RESPONSE

RESPONSES TO FINDINGS:

F1. Prior to the Covid-19 pandemic, tele-mental health and audio-only services available through BHS were a small portion of the outpatient services provided (7% in 2018; 8% in 2019).

Response: Respondent disagrees partially with this finding.

Our data indicates that 12% of services in 2018 were tele-mental health and audio-only services, and almost 13% of services in 2019 were tele-mental health and audio-only services.

F2. During the Covid-19 pandemic, BHS did not offer training to prepare clinicians or clients for effective and confidential use of tele-mental health services.

Response: Respondent disagrees wholly with this finding.

The use of telehealth has been the subject of Behavioral Health Services (BHS) staff meetings and BHS has provided a variety of materials and training for both clinicians and clients promoting the effective use of tele-mental health services during the COVID-19 pandemic, including a 14-page telehealth user guide for staff (Attachment A). The user guide includes procedures for identity verification, instructions for using multiple devices (e.g., phone, tablet, computer), instructions to assist patients, and how to use interpreters while using telehealth. There are also training materials for patients in both Spanish and English to assist them with telehealth sessions. Telehealth tools utilized by BHS clinicians are compliant with HIPAA privacy rules.

F3. During the Covid-19 pandemic, BHS tele-mental health services continue to be underutilized. While audio-only increased to 52% of all outpatient services, tele-mental health was 18% of outpatient services delivered.

Response: Respondent disagrees partially with this finding.

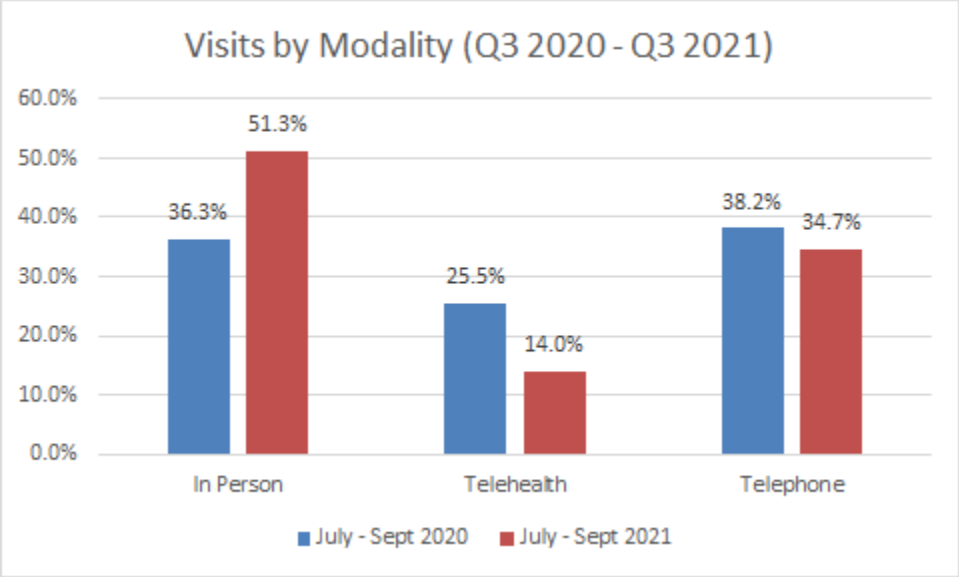
The number of clients who chose to receive telehealth or audio-only services increased significantly during the onset of COVID-19 for obvious reasons of health safety. BHS

rapidly adapted to this need and heavily used both telehealth and phone modalities.

It is important to note that County clients are provided a choice in terms of modality for services provided by BHS.

There has been a shift in preferred modality during COVID-19. With vaccines available, less community spread, and broader acceptance of mitigation measures such as masks and social distancing, there has been an increased demand for in-person services.

Quarter three data comparison between 2020 and 2021 indicates audio-only outpatient services decreased from 38.2% to 34.7% and telehealth outpatient services decreased from 25.5% to 14.0%. The graph below reflects the change in demand: significant increase for in-person services, and lowered demand for telehealth and audio-only services.



F4. At the outset of the Covid-19 pandemic, tele-mental health and audio-only services decreased the number of missed appointments.

Response: Respondent agrees with the finding.

F5. Tele-mental health services are appropriate for clients who are more stable, verbal and insightful.

Response: Respondent agrees with the finding.

F6. Tele-mental health services are appropriate to use with clients displaying symptoms of anxiety and depression.

Response: Respondent agrees with the finding.

F7. The greater use of audio-only services has the limitation of not offering visual cues, which provide clinicians with important clinical information.

Response: Respondent agrees with the finding.

F8. Tele-mental health services are not appropriate for

a. **Homeless populations**
b. **Patients presenting with chronic schizophrenia with a limited capacity to manage the tasks of daily life**
c. **Patients prescribed controlled substances or injectable medication.**

Response: Respondent disagrees partially with this finding.

There could be instances where engagement with homeless populations is more accessible using telehealth or audio-only modalities. In-person services can sometimes be disadvantageous to clients due to logistical barriers such as transportation or timing. In these cases, engagement with clients via telehealth can be the preferred modality, perhaps as an adjunct to in-person services. On the other hand, telehealth and audio-only is likely to be ineffective with patients described in b and c above. In-person service is required for clients who are prescribed controlled substances or injectable medication.

F9. BHS has not incorporated tele-mental health into a comprehensive service delivery model to offer a broad range of opportunities for underserved populations to receive mental health services.

Response: Respondent disagrees wholly with this finding.

Following protocols set forth in the California Department of Health Care Services (DHCS) Behavioral Health Information Notice No: 20-009, tele-mental health is firmly incorporated into the behavioral health service delivery system in Contra Costa. Clients are given the option of service modality, and BHS has the hardware and software necessary to render tele-mental health services to clients electing to receive it.

Services available via tele-mental health include mental health services, crisis intervention services, targeted case management, therapeutic behavioral services, intensive care coordination, intensive home-based services, medication support services, and components of day treatment, intensive day rehabilitation, adult residential treatment services, and crisis residential treatment services.

F10. Access to outpatient mental health services in Contra Costa County suffers from difficulties with transportation to clinics, long wait times for appointments, and insufficient availability of after-hours appointments.

Response: Respondent disagrees partially with this finding.

Transportation issues have been long-standing challenges for mental health clients. Contra Costa is a large county and access to public transportation is a common issue. To address this challenge BHS has been involved in the "Barriers to Transportation Project," hiring two Community Support Workers as Commute Navigation Specialists (CNS) in March 2017. The program is a systematic approach to developing effective family and peer-driven transportation navigation support to the entire mental health system of care.

Regarding long wait times, BHS is well within DHCS standards (70% threshold):

- *Overall clinical timeliness to meeting the first offered appointment standard (10 business days) was at 96.3% for FY 20-21*
- *Overall psychiatric timeliness to meeting the first offered appointment standard (15 business days) was at 92.2% for FY 20-21*

Contra Costa County clients have access to after-hours and weekend services at the Miller Wellness Center.

F11. BHS has a limited number of clinicians who can provide culturally and linguistically sensitive services to diverse minority groups.

Response: Respondent disagrees wholly with this finding.

BHS has devoted considerable resources into ensuring the diversity of clinicians to provide culturally and linguistically sensitive services to diverse minority groups. An in-house Ethnic Services Manager/ Ethnic Services Coordinator who helps ensure that the workforce has the background and training to work with diverse groups and develops the Cultural Humility Workplan, a living document with clear focus areas and goals.

Additional resources include an ongoing training plan, differential pay for bilingual staff, and a Language Line with Health Care Interpreter Network (HCIN) for interpretation services. According to the Network Adequacy Certification Tool (NACT) for documenting network adequacy, the BHS has a 97% compliance rate for cultural competency training, 180 providers who are fluent in Spanish, and fluency by providers in numerous other languages including Farsi, Tagalog, ASL, Vietnamese, and Mandarin.

The latest Consumer Survey (June 2020) indicates that 94% of patients received services in their preferred language, and 91% stated they agreed or strongly agreed that their provider was "respectful and supportive of my culture, values, beliefs, life ways, and lifestyle" (this includes race, religion, language, gender/gender expression, sexual orientation, or disability). Providers are also matched with patients for specialty areas, including LGBTQ, Ethnic Minorities, language, and location.

F12. Increasing access to mental health services is a priority for Contra Costa County BHS.

Response: Respondent agrees with the finding.

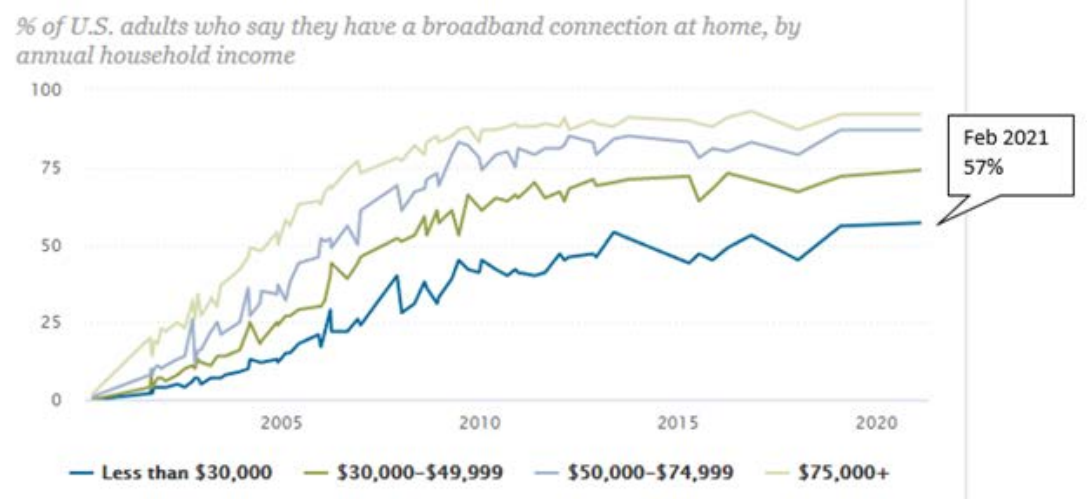
F13. The FCC reported 99.2% of Contra Costa County residents have access to internet broadband for greater use of tele-mental health services.

Response: Respondent disagrees wholly with this finding.

Although 98+% of Contra Costa residents may have access to broadband services, it is not true that 98+% are subscribing to broadband. These are entirely different issues, and there is a significant number of BHS clients who do not have broadband. Access to public computers is not reflective since the use of a public computer is not conductive to receiving telehealth services.

As indicated in the Grand Jury report, in Contra Costa County over 98% of individuals have access to broadband; however, only 72% have broadband as indicated in this article on broadband use across the counties.
https://www.thecalifornian.com/story/news/2021/07/07/gda-broadband-local-ca-psas/47204929/
Interactive Map:
https://datawrapper.dwcdn.net/9LhSS/8/

Moreover, this number is substantially less when considering the demographics of BHS consumers. The mandate for the Mental Health Plan (MHP) is serving Medi-Cal eligible citizens of Contra Costa with serious mental health and/or substance use issues. Individuals and families must be low income to qualify for Medi-Cal, and income is correlated with having broadband access, as shown in the data below from research conducted by Pew Research[1]. In 2021, only 57% of individuals who earned less than $30,000 per year used broadband from home.



F14. BHS has not followed the directives of the California Telehealth Advancement Act of 2011 to develop telehealth services to better meet the needs of underserved populations in the community.

[1] https://www.pewresearch.org/internet/fact-sheet/internet-broadband/?menuItem=2ab2b0be-6364-4d3a-8db7-ae134dbc05cd

Response: Respondent disagrees wholly with this finding.

As mentioned in the response to Finding 9, BHS has a full array of services available to meet the needs of the underserved in the community. The Telehealth Advancement Act of 2011 and several Notices from DHCS (Behavioral Health Information Notice No: 21-047; Behavioral Health Information Notice No: 21-047), have removed telehealth barriers and ensured parity between in-person services and tele-mental health services. BHS has fully embraced tele-mental health. Evidence of the commitment of BHS to tele-mental health is evident in the memo sent to BHS staff and contract providers on March 20, 2020: "Guidance Regarding Provision of Services During COVID-19". The memo is included in this report as Attachment A.

F15. The Congressional Consolidated Appropriations Act of 2021 expands Medicare services to allow tele-mental health services to be integrated with in-person sessions, and to be received by beneficiaries in their home without geographic limitations.

Response: Respondent agrees with the finding.

F16. BHS lacks an adequate electronic data system to evaluate the efficacy of outpatient mental health services provided.

Response: Respondent disagrees partially with this finding.

BHS utilizes the Contra Costa Health Services Electronic Health Record system, which has enabled streamlined documentation, collection of assessment and outcome measures, client-centered medical records, program level aggregate data, reporting tools, and performance dashboards. Current electronic data systems are used for generating reports include Objective Arts for the CANS (Child and Adolescent Needs Assessment), ANSA (Adult Needs and Strengths Assessment), PSC-35 (Pediatric Symptom Checklist), and QLIK for dashboards. However, the current system is bifurcated between two different systems: one for the clinical record (Epic/ccLink) and the second for practice management (Echo/ShareCare). This configuration has been necessary due to unique BHS billing rules, which are due to expire in July 2023. BHS is heavily engaged in finding a solution for a truly integrated system that will capture clinical and practice management data and support evaluation of the effectiveness of mental health services.

F17. BHS does not collect clinical data from network providers, which limits accountability for the outpatient mental health services provided to county residents.

Response: Respondent disagrees partially with this finding.

BHS collects a variety of clinical data from network providers, including the CANS, ANSA, and PSC-35. These are entered into the online Objective Arts system. BHS is working to identify solutions that will have direct entry for other measures from network providers, for a consolidated, centralized data repository available in real time for ensuring accountability and measuring effectiveness.

RESPONSES TO RECOMMENDATIONS: By June 30, 2022, it is recommended that Contra Costa Behavioral Health Services

R1. Develop a hybrid plan to integrate tele-mental health services with in-person services in their clinics.

Response: The recommendation has been implemented.

BHS is currently a hybrid plan that integrates tele-mental health services with in-person services in the clinics. The data shown in the chart provided in response to Finding 3, indicates that as of September 2021, almost one-half of services were delivered via either telehealth or audio-only. The number of in-person versus tele-mental health services is largely driven by client choice and BHS adapts services based on that choice and professional judgment for optimal patient outcomes. The BHS hybrid plan is coupled with the Telehealth Act of 2011 and COVID-related telehealth Information Notices from DHCS highlighted above, and is outlined in the BHS memo to providers issued in March 2020, and included with Attachment A.

R2. Coordinate with network provider groups to integrate tele-mental health services with in-person services.

Response: The recommendation has been implemented.

Network providers are part of the Mental Health Plan (MHP) and were provided the same advice going forward about client choice, implementation of tele-mental health services, training documents, and ongoing updates from DHCS. The Mental Health Division holds a semi-monthly Contract Provider meeting where updates are provided.

R3. Develop a training program for BHS clinicians, network providers, and support staff to facilitate the use of tele-mental health.

Response: The recommendation requires further analysis.

As mentioned above, considerable efforts to facilitate the use of tele-medicine for all staff types have occurred. These include hardware accommodation (e.g., webcams, microphones, laptops), written training guides on the technology, usage protocols, interpreter services when using tele-mental health, use of all types of devices (e.g., smartphone, tablet, computer) when using tele-mental health, and patient educational materials for using videoconferencing.

Tele-mental health for consumers can be used more effectively by fleshing out a more robust training program for BHS clinicians, network providers, and support staff. The training program could include training via video format on the BHS Learning Management System (LMS) platform (Relias), and it could include more in-person trainings at staff meetings and meetings with contract agencies. The program will be developed into a documented training plan by June 30, 2022, with input from staff, managers, and the Office for Consumer Empowerment.

R4. Develop a training program for clients to facilitate and provide support for the use of

tele-mental health.

Response: The recommendation has been implemented.

Clinicians have been trained to assist clients to facilitate and provide support for the use of tele-mental health. Patient training material and implementation guides are available in both English and the BHS threshold language of Spanish.

R5. Collect outcome data from BHS providers and programs to provide feedback to improve mental health services delivered to the community.

Response: The recommendation has been implemented.

Contra Costa BHS collects outcome data for the County's BHS clinic providers and programs and has numerous reports that analyze the data, including benchmarks when available (for example Children's Adolescent Needs and Strengths (CANS), client satisfaction, PHQ9 for depression, GAD 7 for anxiety, & HEDIS medication monitoring measure reports). In addition, Contra Costa BHS is in the process of establishing an evidence-based practices, outcomes data dashboard to include CANS data available to all clinicians and inform practice. Quality Management will begin working with the analytics teams to establish a quality dashboard by June 30, 2022.

Two of the data collections that can support further analysis and mental health programing support include capturing more client race and ethnicity demographic data and establishing a multi-prong client survey approach that includes web-based survey options for clients to report on service satisfaction and quality of care/outcomes.

R6. Collect outcome data from network providers to provide feedback to improve mental health services delivered to the community.

Response: The recommendation has not yet been implemented, but will be implemented in the future.

Contra Costa BHS has begun updating all fee-for-service contract templates with network providers. The contract template revision will include contractor obligations to provide additional outcome measures that will be collected on an annual basis starting with Fiscal Year 2022-23. The revised contract templates will be fully implemented for all necessary network providers effective July 1, 2022.

R7. Increase the use of MyChart health care information system to make clinical information accessible to clients and providers.

Response: The recommendation has been implemented.

Currently, more than 50% of adults have a MyChart account. The use of MyChart has been well-received by clients, and utilization is growing. Clients using MyChart have full access to their medical record. BHS is also increasing the functionality within MyChart to include e-signing forms and other functionality.

R8. Modernize the electronic data collection capabilities of the quality management program to provide meaningful information about mental health services.

Response: The recommendation requires further analysis.

BHS is currently undergoing a systems gap analysis to develop a technology strategy aligned with the direction of healthcare changes. There are major changes underway for major issues such as payment reform, documentation changes, outcome measures, and a long-term goal of value-based care. Integration with Primary Health and within BHS between Mental Health services and Substance Use services is part of the overall landscape of Behavioral Health Plans across California. As mentioned above, BHS currently uses two separate systems, one for clinical documentation and another for practice management. BHS' goal is to consolidate to one unified system. By doing so, data collection will be simplified with a much more robust system. The strategic plan will be completed by June 2022. The following plans are included in the assessment underway:

- *Payment reform*
- *Sunsetting current billing system*
- *Collaborative data exchange with contracting agencies*
- *Meeting CalAIM initiatives such as Enhanced Care Management*

R9. Develop appropriate clinical metrics to evaluate outcomes that improve the effectiveness of mental health services provided.

Response: The recommendation has been implemented.

BHS currently has numerous clinical metrics in use to evaluate outcomes for services provided. BHS uses the Child and Adolescent Needs Assessment (CANS) at intake and 6-month intervals to determine initial needs and track needs (and strengths) over time. The CANS is a treatment planning tool, used on an individual level for treatment planning, and in the aggregate to understand program performance. An equivalent measure used on the adult side is called the Adult Needs and Strengths Assessment (ANSA). There is also the Pediatric Symptom Checklist (PSC-35) used for caregiver input on children and adolescents. The Full-Service Partnership (FSP) Programs have the Partnership Assessment Form (PAF), a quarterly update, and Key Event Tracking (KET). In addition, there are a host of measures used in evidence-based programs, including the PHQ-9 for depression and the GAD-7 for anxiety.

R10. Seek grants and MHSA funding to upgrade the technological resources of the quality management program.

Response: The recommendation has been implemented.

BHS was recently awarded a grant from DHCS that will provide the Quality Management Program statistical tools for analyzing data – Statistical Package for the Social Sciences (SPSS). In addition, new funding for Substance Use services will provide the resources needed to move data into electronic format to facilitate data analysis and measurement of program effectiveness, and quality improvement in general. There is also new funding for the program evaluation associated with new Community Crisis programming that will further supplement the

quality management program.

RESPONSE TO RECOMMENDATION: By June 30, 2022, it is recommended that Contra Costa Board of Supervisors:

R11. Allocate funds for BHS to upgrade its quality management program.

Response: The recommendation will not be implemented because it is not warranted.

By June 30, 2022, BHS will have completed upgrades to its quality management program as stated in the response to Recommendation 10.

Attachment A

ccLink Workflow Guide

ccLink Telehealth Provider Workflows

Contents

Telehealth Visits Audio and Video

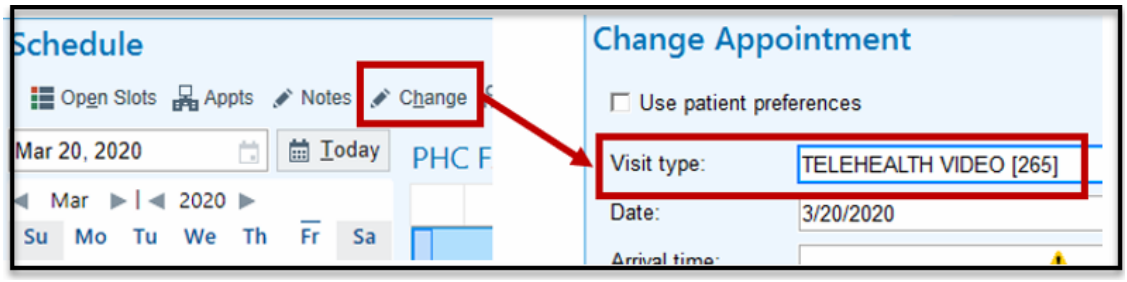
Updates 5/12/20:

- Telehealth Audio visits now require 99441-99443 codes instead of G2012. G2012 will no longer satisfy close visit requirements for Audio Telehealth Encounters.
- MyChart patients no longer need the Telehealth Zoom ID communicated to them, as they will launch Zoom directly from within MyChart.

Change Visit Type to Telehealth – Audio or Telehealth-Video

If a visit is scheduled as in person, and needs to be changed to 'Telehealth Video or Audio, complete this step".

- Appointment Staff: 'Change Appointment' button and update Visit type.
- Clinical Staff: 'Change' button on schedule toolbar, select visit type based on planned communication method for visit.



Note: Leave provider, time/date *as-is* to continue to hold the appointment slot for the patient.

Zoom Integration

If the patient has MyChart, she will be able to launch Zoom directly from within MyChart. If the patient does not have MyChart, call the patient and provide the meeting ID verbally.

To prevent confusion, this should **NOT** be used for standard telehealth-video visits with MyChart active patients. Only send to MyChart patients if the patient knows not to connect through MyChart or a different visit type is being used (for example, group visits)."

"**TeleHealthPatientInstructionSmartphone**", add the provider's personal meeting ID in the ***. This SmartLink will pull in either the English or the Spanish version of the instructions based on the patient's preferred written language. (Note: this SmartLink replaces the SmartPhrase with the same name).

Reviewed 03/20/20 by: Adam Buck, MD Reviewed 04/15/2020 by Troy Kaji, MD

Created 03/20/20 updated 3/27/20, updated 4/15/2020 by: Raymond Patrick, Analyst/Principal Trainer

ccLink Workflow Guide

ccLink Telehealth Provider Workflows

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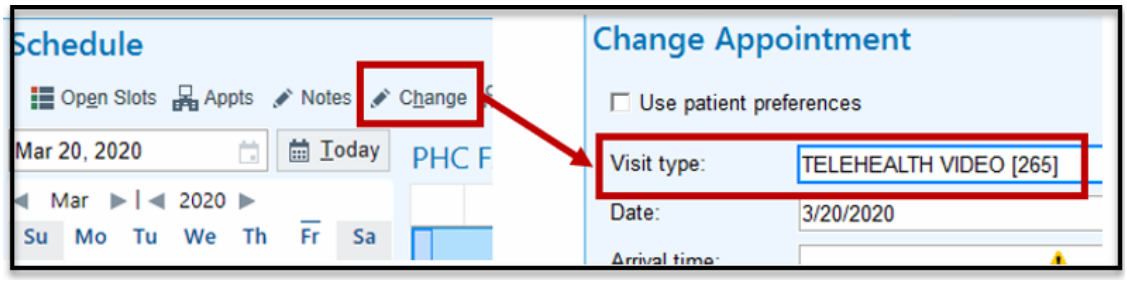

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Reviewed 03/20/20 by: Adam Buck, MD Reviewed 04/15/2020 by Troy Kaji, MD

Created 03/20/20 updated 3/27/20, updated 4/15/2020 by: Raymond Patrick, Analyst/Principal Trainer

Handling No Shows / No Answer (Contacts Section)

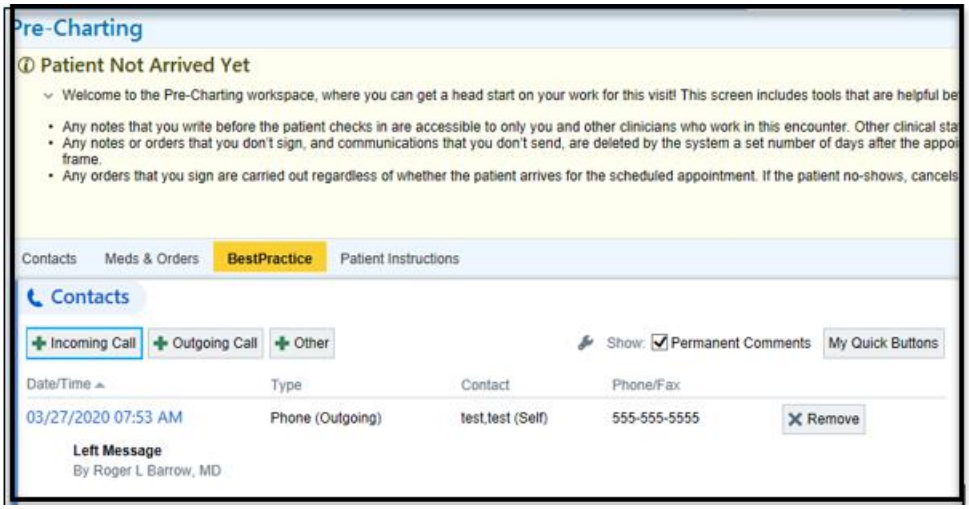
WAIT until you successfully contact the patient before Checking in!

Prior to checking in and starting the visit, document attempts to reach the patient in the **Contacts** section, now available in Pre-Charting. **Do NOT check in** the patient or convert the visit to an encounter until you reach the patient.

If you don't check in the patient and don't start the visit, these will simply be marked as no-shows.

The **Contacts** section is also now in the Rooming Navigator.

If you have already started documentation (converted the encounter), use the Erroneous Encounter SmartSet to close the visit



Check in Visit

WAIT until you successfully contact the patient before Checking In!

Clinical Staff: Use the BPA within the encounter to check in the patient. Clicking Accept completes the check in.

Tip: Using the BPA is a one-click process. Checking in using the 'Check In' button on the schedule is also possible, but that option will require you to also click 'Accept' on the Check-in Activity that opens.

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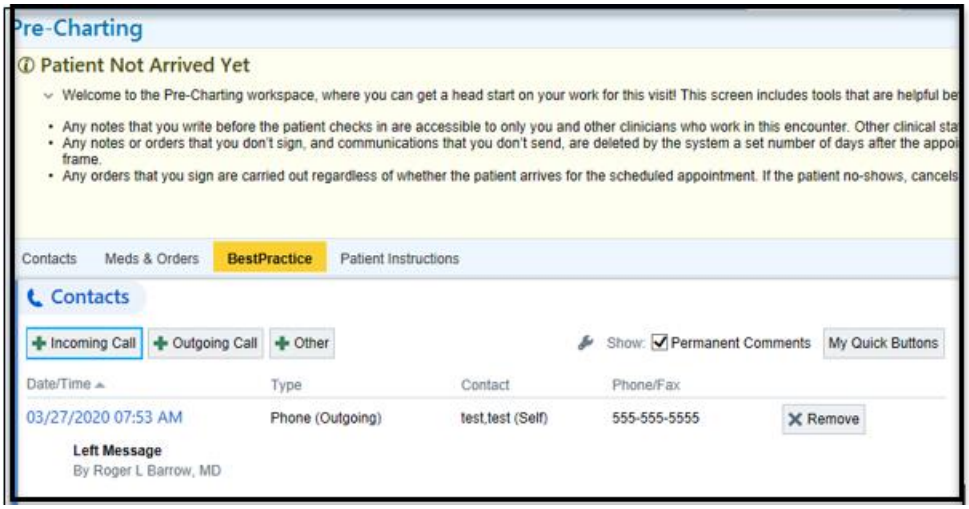

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Clinical Staff: Use the BPA within the encounter to check in the patient. Clicking Accept completes the check in.

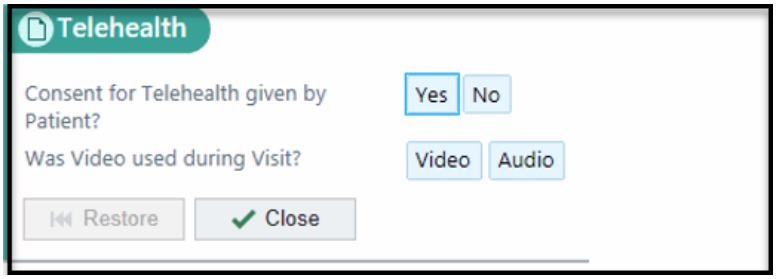
Tip: Using the BPA is a one-click process. Checking in using the 'Check In' button on the schedule is also possible, but that option will require you to also click 'Accept' on the Check-in Activity that opens.

Visit Documentation

Providers default to Rooming Activity to enter required documentation (Reason for Visit, Telehealth form, Launch Video (Video visits w/MyChart Active patients only), and Contacts (optional).

Required Section:

- Consent: Document patient's consent to Telehealth visits (both Audio and Video)
- You must select Video or Audio. If video attempt is unsuccessful, you should select Audio.

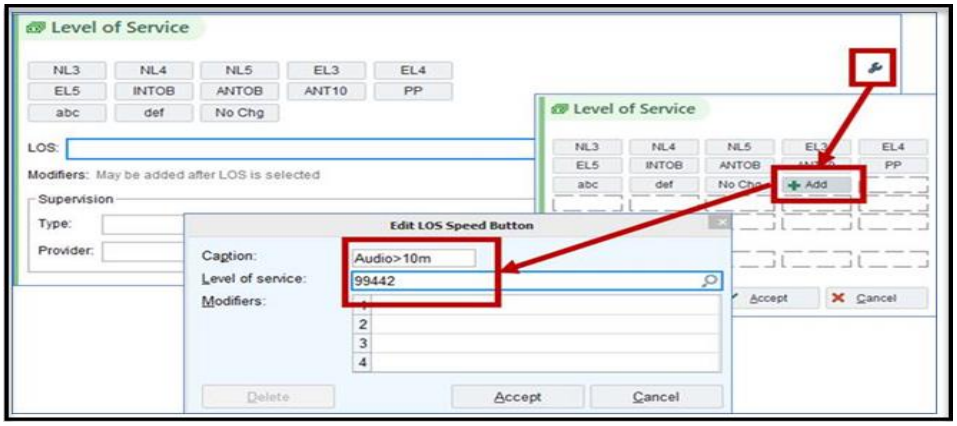


Video Section:

A navigator section which a link to launch video will display for MyChart Active patients with Video visits, allowing the provider to launch Zoom. See the Zoom Integration tip sheet for details on this workflow.

Billing (Make sure to enter a Diagnosis First!)

- **LOS** required if Video is used
- 99441–99443 are now required for Audio encounters, and G2012 will no longer satisfy close visit requirements (use Erroneous Enc if no charge). If you don't see these as a quick button by default in the LOS section, you add by clicking the wrench icon, then adding buttons for applicable codes
  - 99441: PR TELEPHONE E&M BY MD 5-10 MIN ESTABLISHED PATIENT
  - 99442: PR TELEPHONE E&M BY MD 11-20 MIN ESTABLISHED PATIENT
  - 99443: PR TELEPHONE E&M BY MD 21-30 MIN ESTABLISHED PATIENT
- Healthy Start and some Behavioral Health will require Charge Capture for Telehealth instead of LOS.



FAQs

Close Visit Validations:

Required — Telehealth - Video or Audio AND Consent Questions Required	Telehealth Navigator section (2 questions) must both be answered for every Telehealth visit
Required — Audio Visit MUST have charge: 99441-99443. (Use 99999 if no charge. Use Err Enc SmartSet if erroneous.)	If 'Audio' selected in Telehealth navigator section, a Charge of 99441-99443 (or 99999= no charge or Err1= erroneous) must be entered.
Required — Video MUST have LOS. If only Audio used, update Telehealth form	If 'Video' selected in Telehealth navigator section, a LOS must be entered.
Required — Check In incomplete. Use 'Check In' button (schedule toolbar) to check in patient	Check in not yet completed. Access the schedule and click the 'Check In' button.
Required — Only 99441-99443 or 99999 LOS allowed for Audio-Only Visits.	Only 99441-99443, 99999, or Err1 LOS codes are allowed in Audio-only visits.

- **What should I do if I see "This type of encounter cannot be closed?**

  Required — This type of encounter cannot be closed

  - The appointment hasn't been converted to a visit yet. Entering a Reason for Visit or LOS will convert the appointment and display the appropriate close visit requirements.

- **Why do I have to check in the patient?**
  - Checking in the patient will auto-create a HAR to capture charges for the encounter.

- **Is this visit type available to schedule directly?**
  - Yes!

- **What if I'm missing one of these tools?**
  - Please contact the help desk with patient example and login department information.

- **Other questions?**
  - Please contact the help desk with patient example and login department information.

Appendix A – Handling Unscheduled Patients On-The-Fly Telehealth Encounters

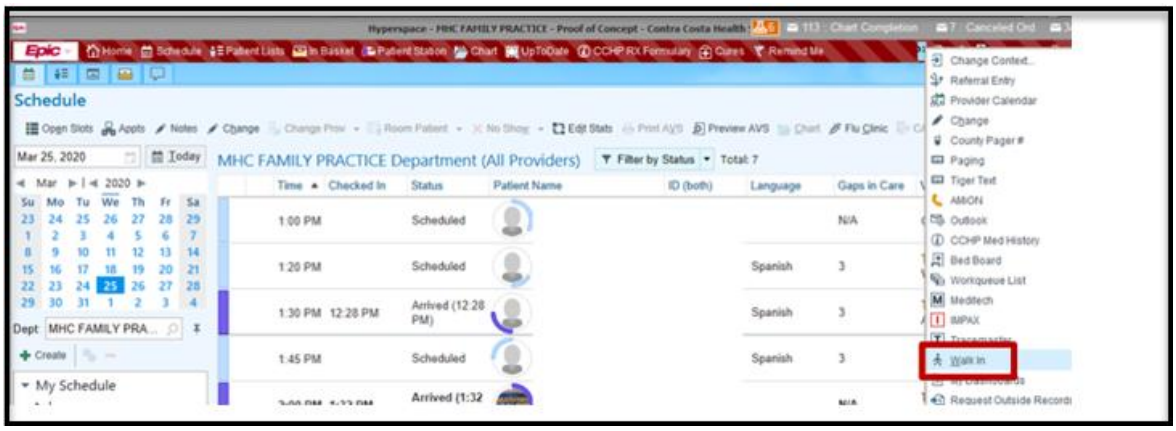
Overview

Many of you are used to creating telephone encounters on-the-fly to document phone calls to your patients.
For these visits to be billable, they actually need to be scheduled visits. This tip sheet will instruct you how to schedule these encounters on-the-fly.
Keep in mind, that telehealth audio visits require a full evaluation; including documentation of a chief complaint, history, assessment, and medical decision making.

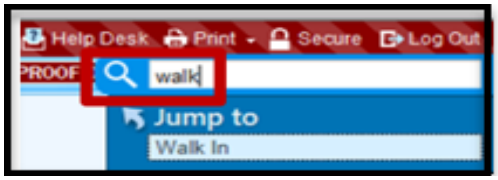
Schedule a Patient

You can schedule on the fly telehealth encounters from either the walk-in button on the epic toolbar or from the appt desk button on the Inbasket toolbar (available in various Inbasket folders)

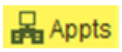
- Click **'Walk-In'** button on the Toolbar



- If there is no Walk-In button use the search field type in **"Walk-In"**

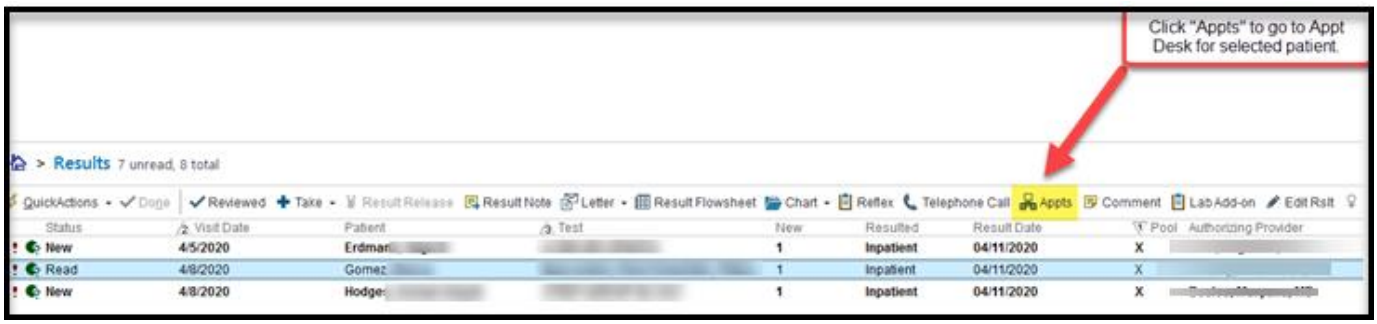


- Access **Appt** or **Walk-In** buttons from **Inbasket** folder to facilitate Telehealth workflows

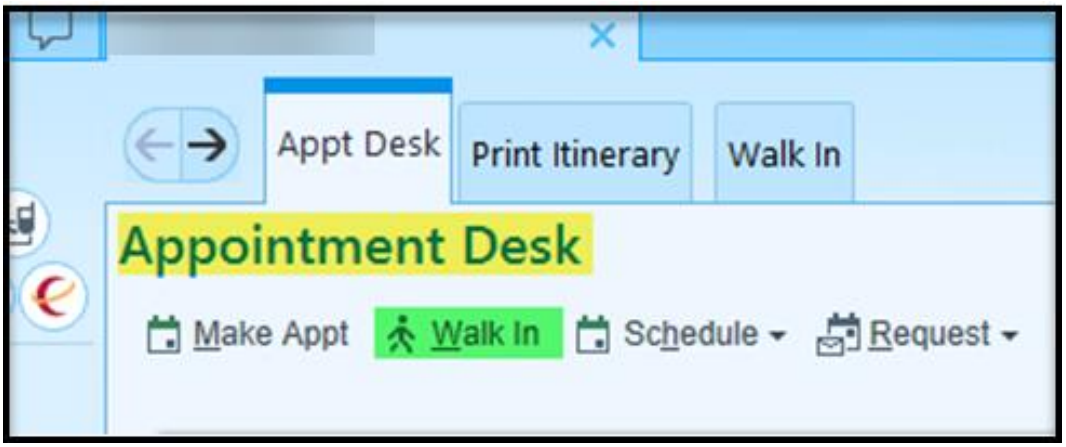
1. InBasket Toolbar now shows Appts  and Appointment Desk now shows Walk-in  Buttons. You may need to log in and out a couple of times before seeing the new position.

2. Provider may schedule a Walk-In directly from the following IB folders:
    - Results Notes
    - Results
    - Patient Calls
    - CC'd Chart
    - Staff Messages
    - MyChart Patient Advice Requests

3. From the Inbasket select the patient and click the “Appts” icon.

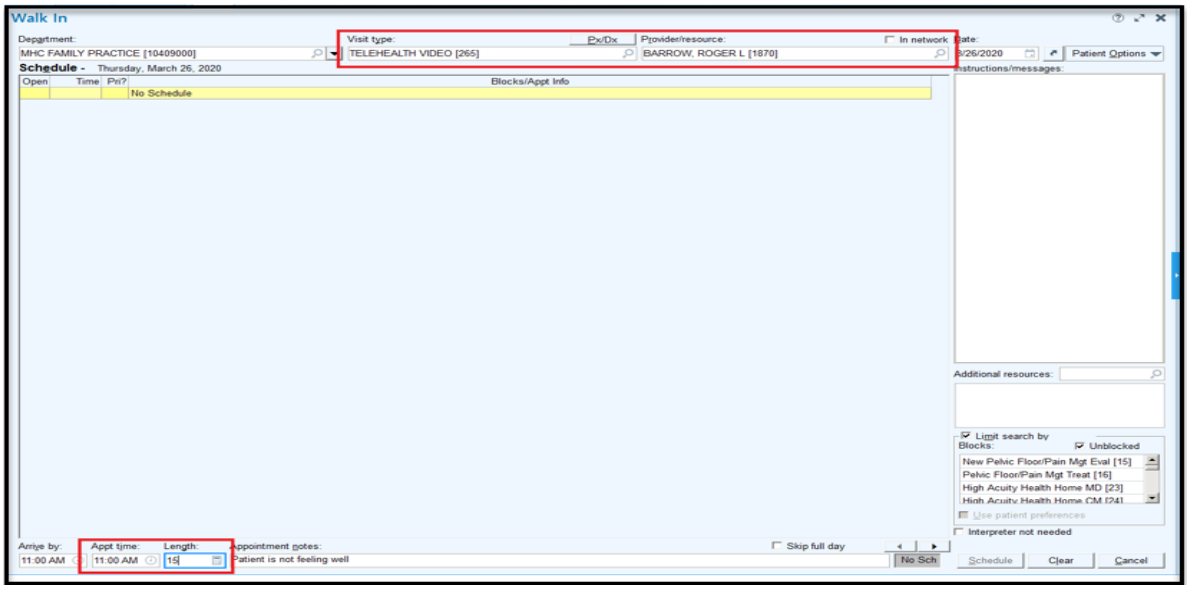


4. In Appt Desk click “Walk-In”



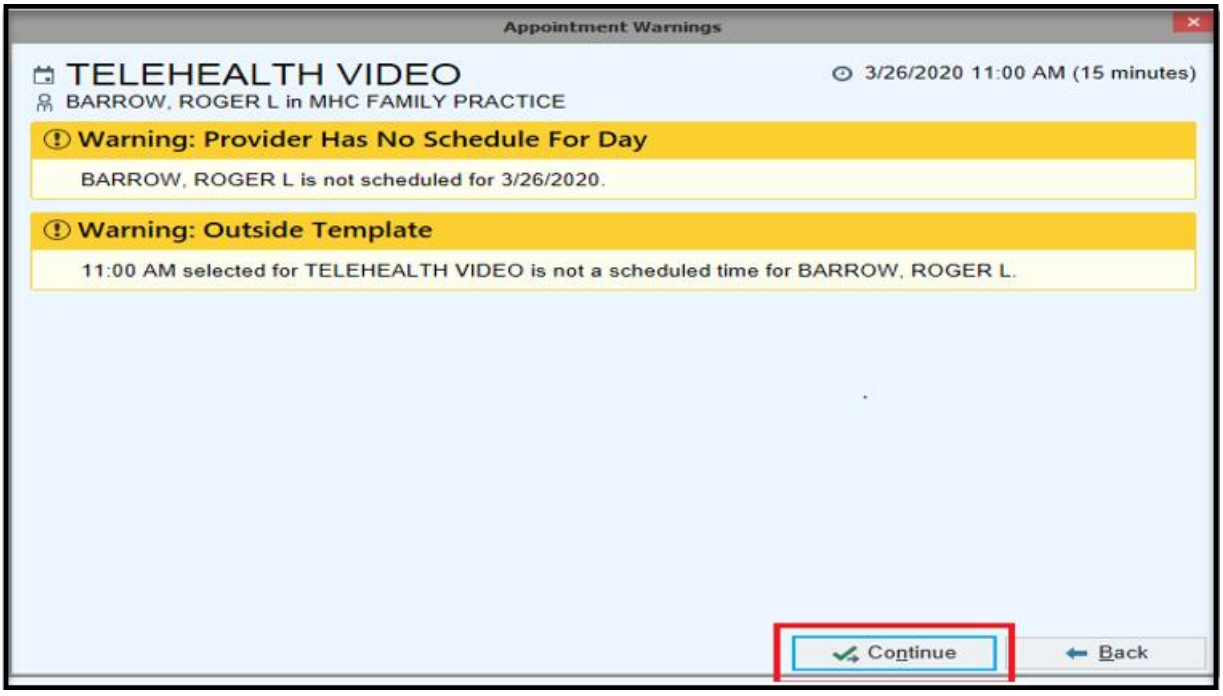
Select a patient and the Walk-In activity will open

- Choose a Visit Type (Telehealth Video or Telehealth Audio)
  - If required, enter provider’s name
- Manually enter the desired appointment time and duration in the Appt time and Length fields located in the bottom left-hand corner



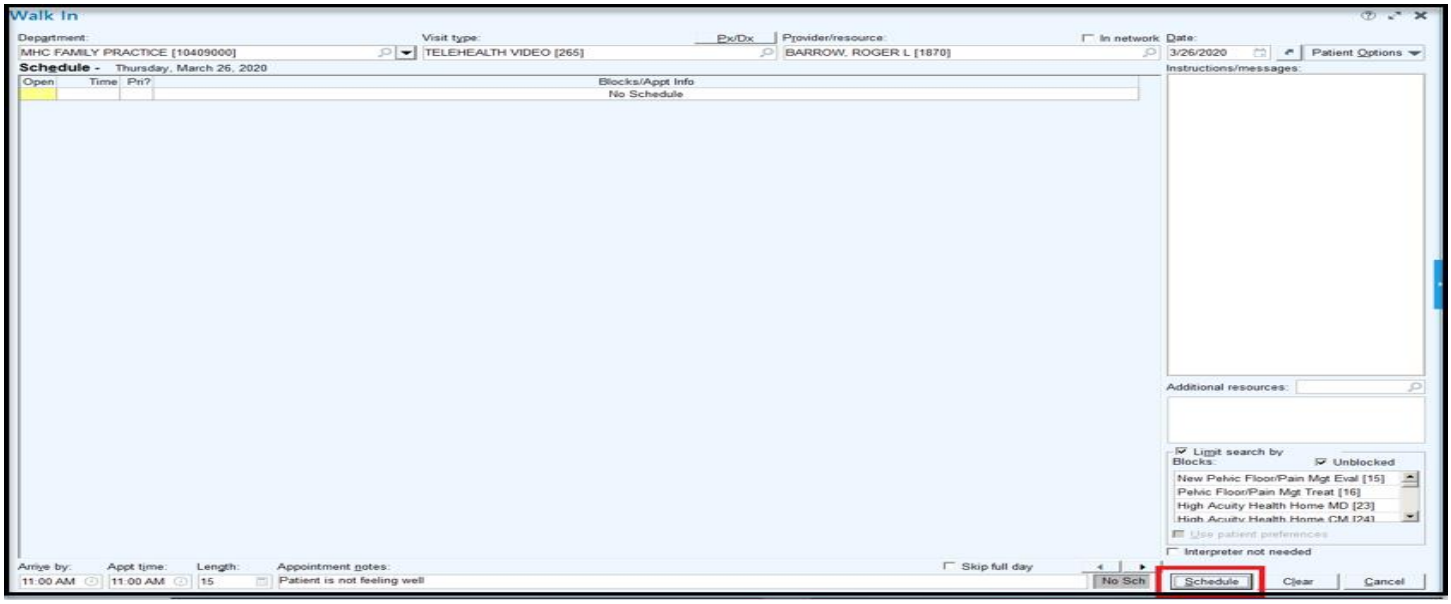
Continue Through Warnings

- After the Length and Appt time fields are filled in, you will see the following warnings:
    - To bypass the warnings click Continue.

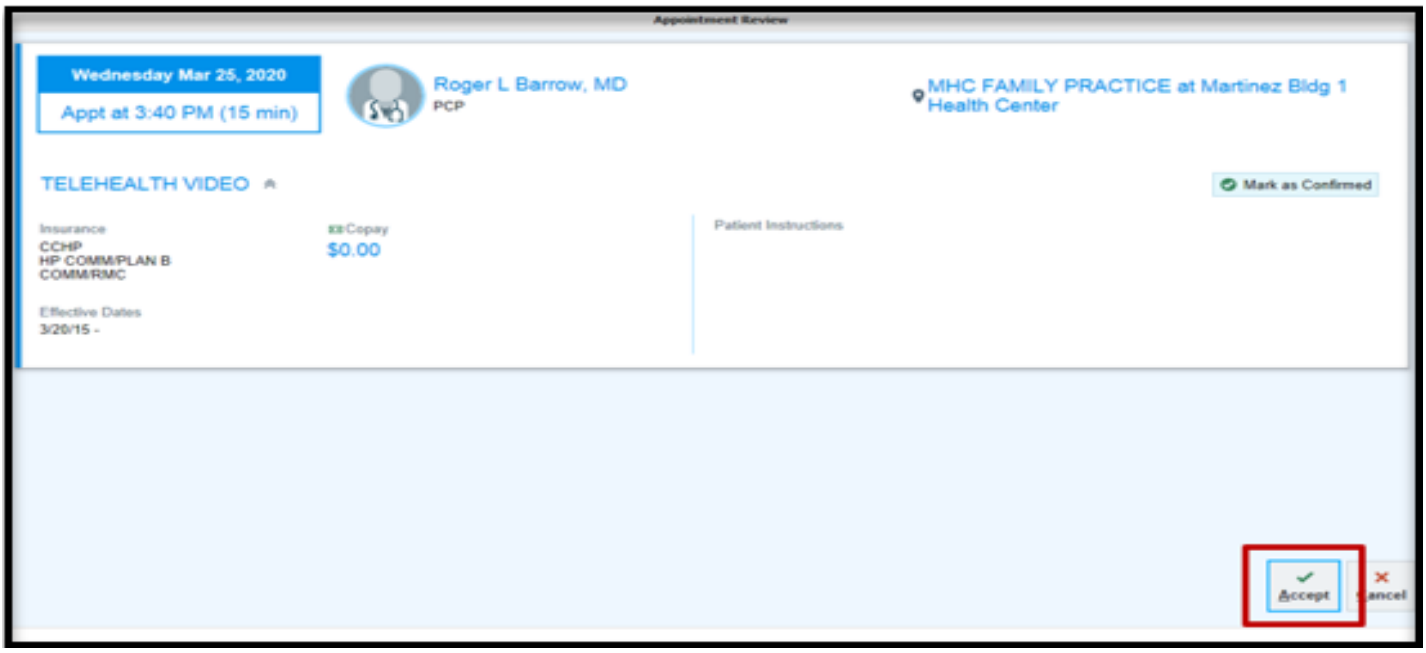


Schedule the Appointment

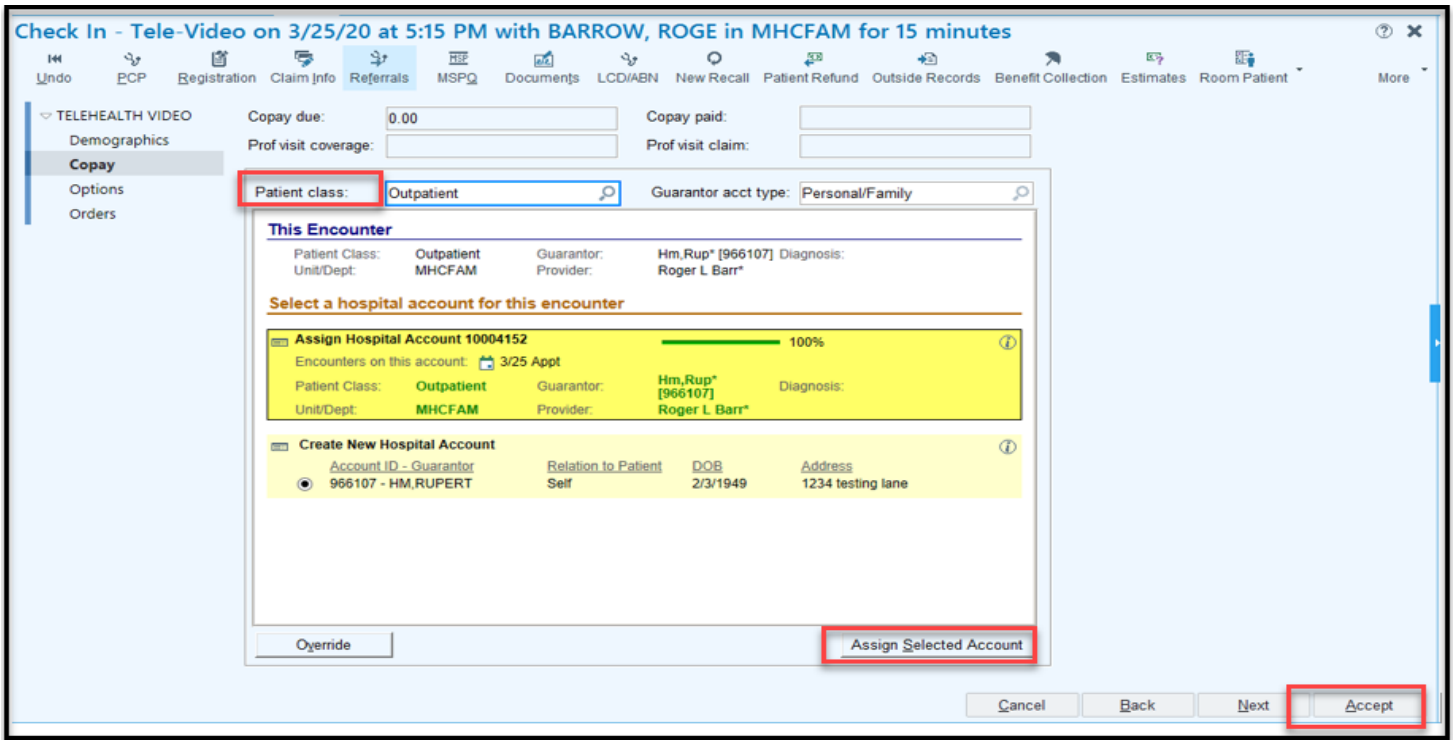
- After you bypass the warnings, click Schedule in the bottom right hand corner



- When the Appointment Review window appears, click Accept in the bottom right hand corner



In some cases, the **Patient Class field** may be blank, if so, select "**Outpatient**". Click "Assign Selected Account" to create a new HAR for the visit.
If Check-In opens, click Accept to complete the check-in process.



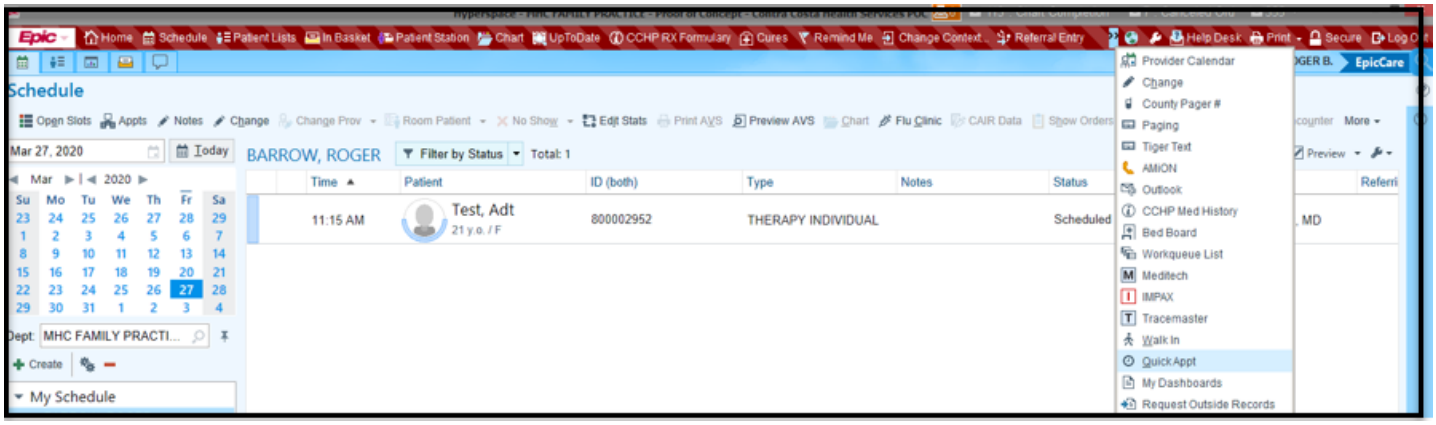
Appendix B -Scheduling Future Appointments with the Quick Appointment activity

Overview

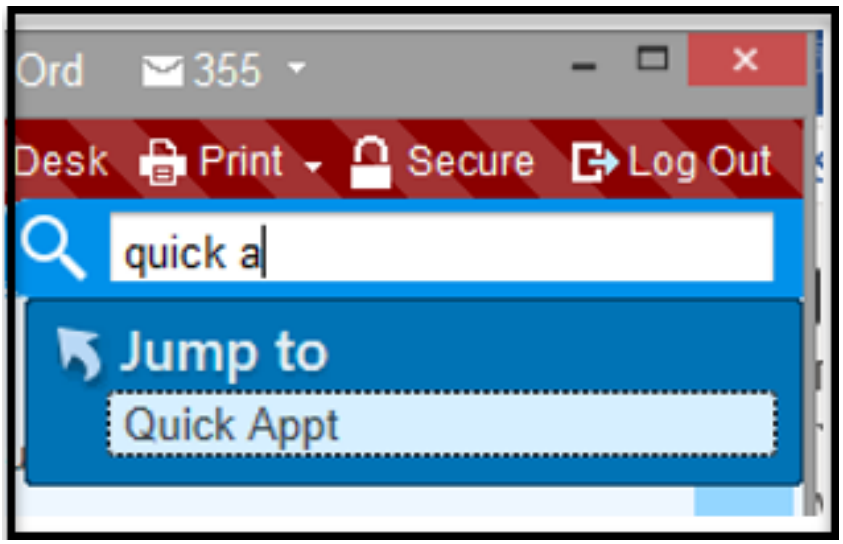
Physicians can now use the Quick Appointment activity to easily schedule future encounters within their clinic. This activity is intended for booking appointments that will occur and be checked in on a later date.

Schedule a Patient

- Click '**Quick Appt'** button on the Toolbar

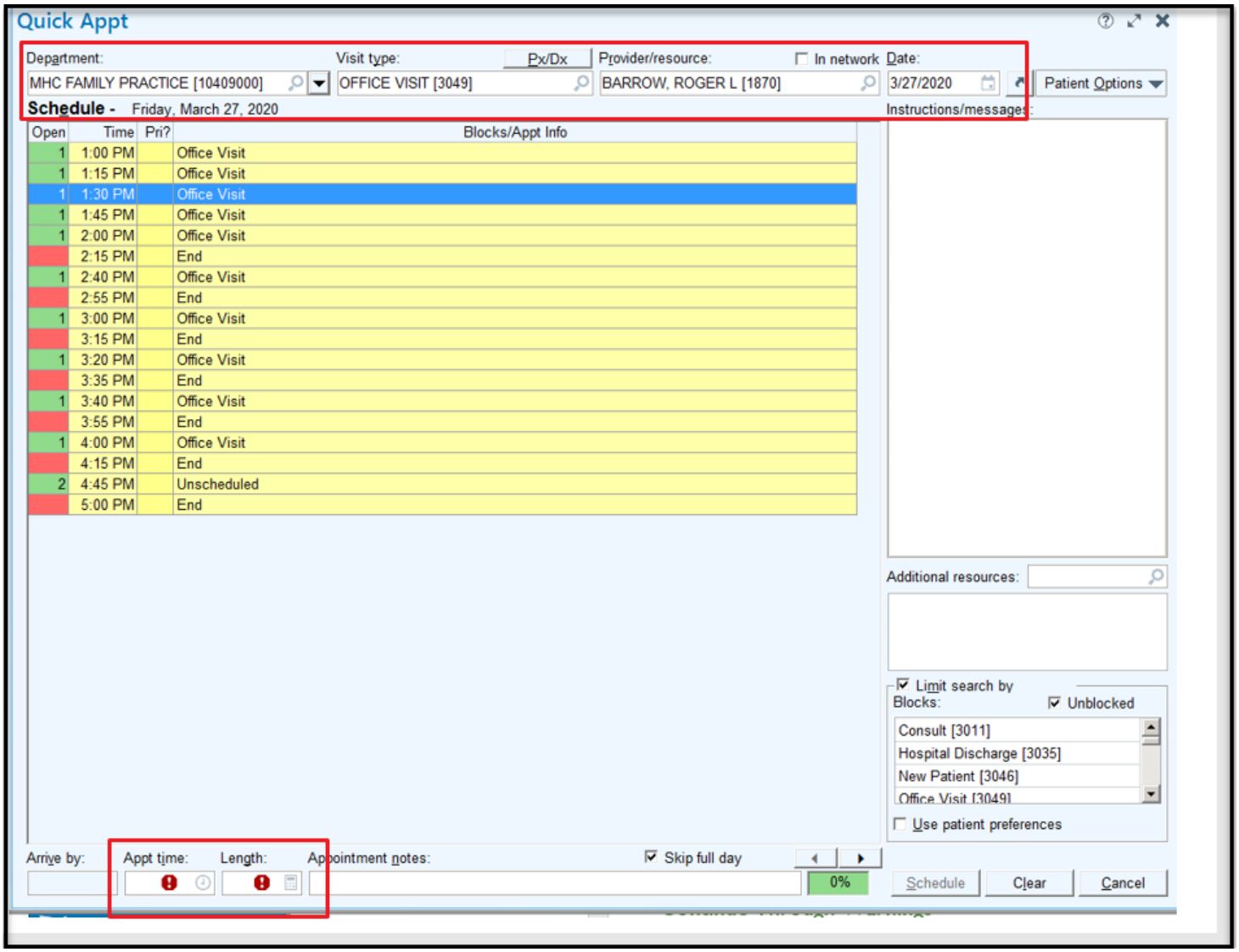


- If there is no Quick Appt button, use the search field type in **"Quick Appt"**



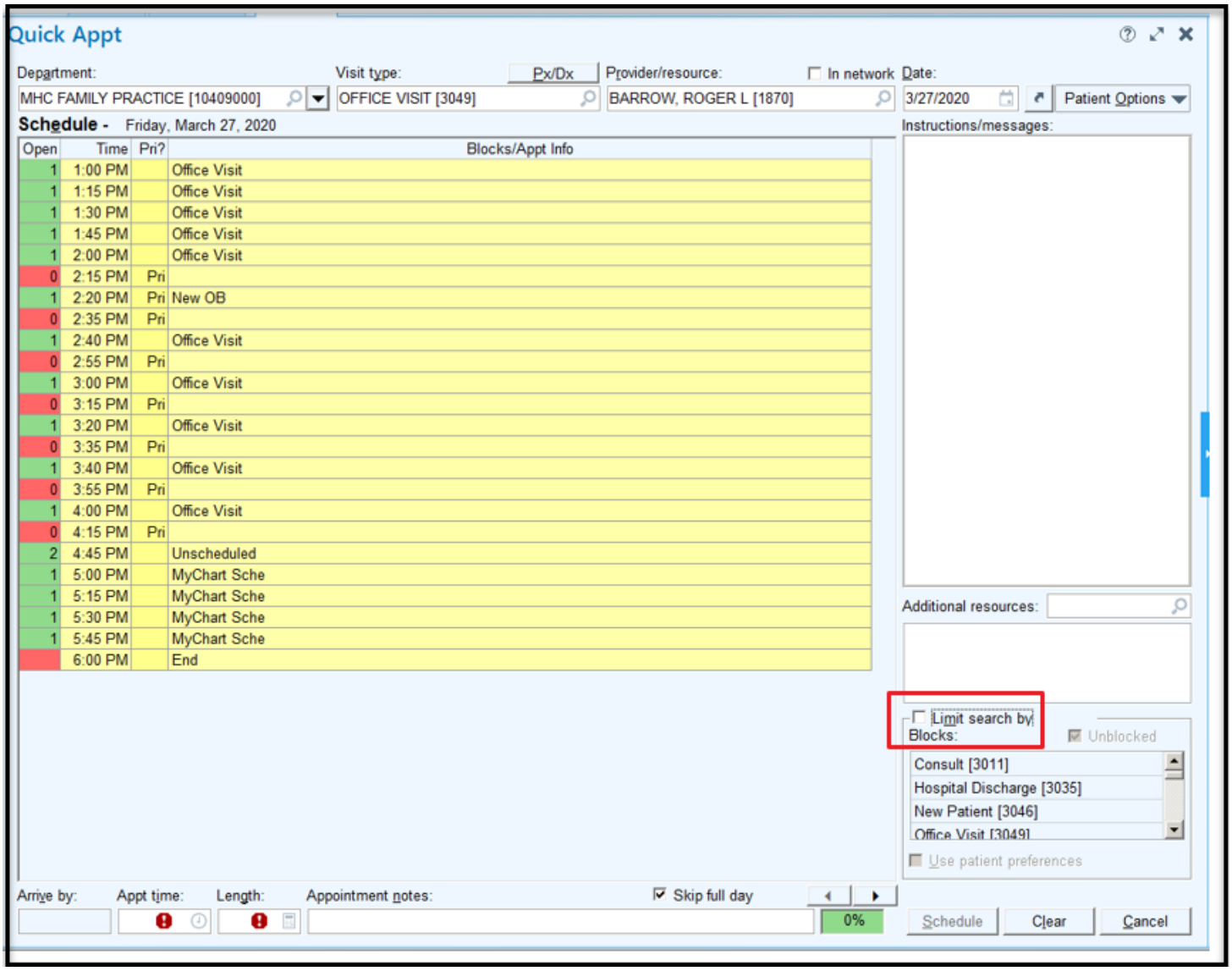
Select a patient and the Quick Appointment activity will open

- Update or confirm the Department, Visit Type, and Provider appropriate for the type of visit you wish to schedule
- You can adjust the date you are scheduling for with the Date field in the upper-right.
- Double-click the slot you wish to place the appointment in, or, if you wish to book the appointment outside of the defined slots, manually enter the Appt time and length.



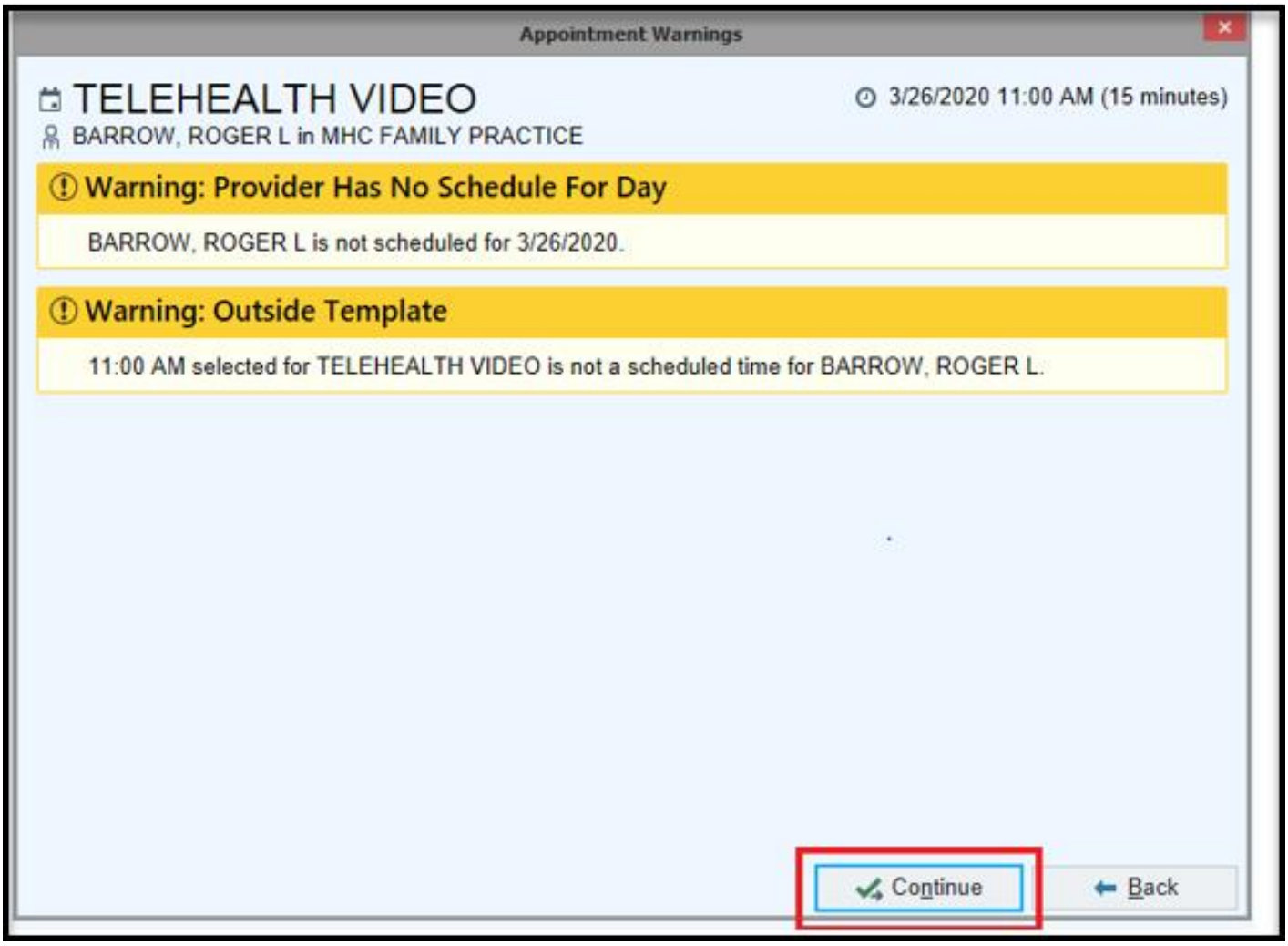
Expanding the Search to include Non-matching Slots (optional)

- Sometimes, you may wish to schedule a visit type in one of your scheduled slots that was not originally built for that visit type. If so, you can uncheck the "Limit search by" checkbox to display all the slots available, even if they do not match the visit type's blocks.



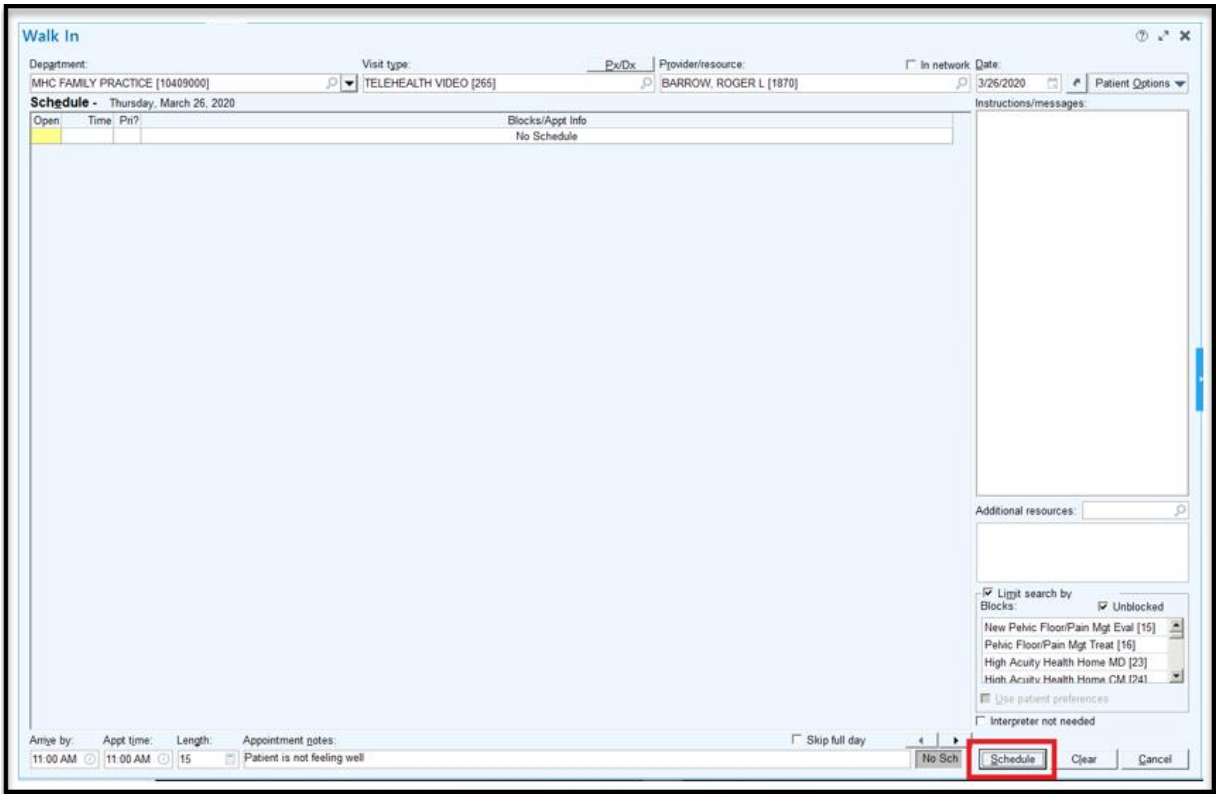
Continue Through Warnings

- If you are scheduling an appointment that uses overbook slots, is outside your defined scheduling template, and does not match the scheduling blocks in a chosen slot, Epic may display informational warnings for your review.
    - You can acknowledge the warnings and continue the scheduling process by clicking Continue.



Schedule the Appointment

- After you review any warnings, click Schedule in the bottom right hand corner



- When the Appointment Review window appears, click Accept in the bottom right hand corner.

ANNA M. ROTH, RN, MS, MPH
HEALTH SERVICES DIRECTOR

SUZANNE K. TAVANO, PHD
BEHAVIORAL HEALTH DIRECTOR

CONTRA COSTA HEALTH SERVICES

CONTRA COSTA
BEHAVIORAL HEALTH SERVICES

1340 ARNOLD DRIVE, SUITE 200
MARTINEZ, CA 94553
(925) 957-5150

MEMORANDUM

DATE: March 20, 2020
TO: CCMHP Staff and Contract Providers
FROM: Suzanne Tavano, PhD, Behavioral Health Director
SUBJECT: Guidance Regarding Provision of Services During COVID-19

In light of both the federal Health and Human Services (HHS) Secretary's January 31, 2020 public health emergency declaration, as well as the President's March 13, 2020 national emergency declaration, Department of Health Care Services (DHCS) has issued guidance to counties and Medi-Cal providers to assist them in providing medically necessary health care services in a timely fashion for patients impacted by COVID-19.

GUIDANCE:

DHCS is encouraging counties and providers to take all appropriate and necessary measures to ensure beneficiaries can access all medically necessary services while minimizing community spread. As such, the following guidance is given:

- Telehealth is not a distinct service, but an allowable mechanism to provide clinical services. The standard of care is the same whether the patient is seen in-person, by telephone, or through telehealth.
- DHCS does not restrict the location of services via telehealth. Patients may receive services via telehealth in their home, and providers may deliver services via telehealth from anywhere in the community, outside a clinic or other provider site.
- DHCS does not have requirements about which live video platform can be used, as long as it is HIPAA-compliant. The Office of Civil Rights (OCR) has exercised its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during COVID-19 nationwide public health emergency.
- Under this Notification of Enforcement Discretion, covered health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, to provide telehealth without risk that OCR might seek to impose a penalty for the lack of a BAA with video communication vendors or for noncompliance with HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency. **Under this Notice, however, Facebook Live, Twitch, TikTok, and similar video communication applications are public facing, and <u>should not</u> be used in the provision of telehealth by covered health care providers**.
- County staff will use Zoom when providing services through telehealth.
- OCR has published a bulletin advising covered entities of further flexibilities available to them as well as obligations that remain in effect under HIPAA as they respond to crises or emergencies at

https://www.hhs.gov/sites/default/files/february-2020-hipaa-and-novel-coronavirus.pdf - PDF.

Covered Services:

The following services can be provided via telehealth or telephone; mental health services, crisis intervention services, targeted case management, therapeutic behavioral services, intensive care coordination, intensive home-based services, and medication support services. For Contra Costa Mental Health Plan (CCMHP) this will include the following procedure codes:

- **Mental Health Services**

  311 – Collateral
  313 – Evaluation
  315 – Plan development
  317 – Rehab
  331 – Assessment
  341 – Individual Therapy
  351 – Group Therapy
  355 - Group Rehab

- **Crisis Intervention**

  371 – Crisis Intervention

- **Case Management**

  541 – Placement
  561 – Linkage
  571 – Plan development

- **Katie A**

  564 – ICC
  565 – ICC-CFT
  358 – IHBS

- **Medication Support Services**

  361 – Eval/RX
  363 – Education
  364 – Plan development
  369 – Medication Group

- **Therapeutic Behavioral Services**

  391, 393, 395, 397 – TBS Licensed
  392, 393, 396 – TBS Unlicensed

- **Non-billables**

  300 – No Show
  400 – Client Cancel
  700 – Staff Cancel

Documentation:

- Licensed staff as well as unlicensed staff may provide services via telephone and telehealth, as long as the service is within their scope of practice.
- Services provided via telehealth are subject to the same privacy and security laws and regulations as services provided in-person, and providers must ensure that they comply with HIPAA, the California Medical Information Act, and, if applicable, 42 CFR part 2 or California Welfare & Institutions Code section 5328.
- Service documentation should be completed in the patient record in the same way as in-person visit, and a patient's verbal or written consent for the telephone or telehealth visit should be noted (Business and Professions Code section 2290.5(a)(6)
- Documentation should begin with the following phrase : "This service was provided through telehealth (or telephone) with consent of the beneficiary and as a response to national public health emergency declaration regarding COVID-19 and CCC Health Officer's order to shelter in place."
- For Treatment Plans please indicate the following in your documentation: "The treatment plan was discussed with the beneficiary and verbal agreement was given".
- In ShareCare please select "telehealth" or "phone" from the location drop down menu.
- In ccLink, county staff can use location code 20 for "telehealth" and 03 for "phone".
- You may begin billing for telehealth services in ShareCare as of Monday March 23, 2020.

Billing – Medi-Cal, Medicare & Other OHC:

- Medi-Cal services provided through telehealth or telephonically will bill through ShareCare as before.
- For those serving Medicare or Medi-Medi patients, CMS has broadened access to Medicare telehealth services so that beneficiaries can receive a wider range of services from their providers without having to travel to a healthcare facility. The provider must use an interactive audio and video telecommunications system that permits real-time communication between the distant site and patient at home.
- These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.
- For the duration of COVID-19 public health emergency, Medicare will make payment for professional services furnished to beneficiaries in all areas of the country in all settings.
- If patients have other health coverage (OHC), you must contact the entity to inquire about their telehealth policy and reimbursement.

- CCC Mental Health Plan is waiving share of cost during the COVID-19 public health emergency period.

What You Need to Do:

We recognize the importance of having access to telehealth services so you can continue to provide care to beneficiaries while safeguarding the health of all involved. We ask that each organization provides us with the following information:

- Will you be providing services through telehealth and if so what platform your staff will be using to provide these services?
- Interim procedures to address emergencies such as assessing risk for suicide, homicide, and 5150s.
- Interim procedures on how to serve patients that ask or need to be seen in person.

Please send this information to Ziba.Rahimzadeh@cchealth.org. We like to thank you for your continued partnership and wish you all good health.

ANNA ROTH, RN, MS, MPH
Health Services Director
SUZANNE TAVANO, PHN, PhD
Behavioral Health Services Director
MATTHEW P. WHITE, MD
Medical Director

CONTRA COSTA
HEALTH SERVICES

CONTRA COSTA
BEHAVIORAL HEALTH SERVICES
UTILIZATION REVIEW
2400 Bisso Lane Suite #D1
Concord, CA 94520
Ph: (925) 608-6760
Fax: Inpatient (925) 608-6793
Outpatient (925) 608-6792

March 24, 2020

Dear Providers,

During this period of heightened COVID-19 concern, there has been significant disruption in the provision of Mental Health Services, and more broadly in the lives of our clients/beneficiaries, staff, and communities.

The Utilization Review/Management (UR) Unit is making every effort to ensure that the needs and services of our client/beneficiaries will not be affected by the current health alert situation. The UR unit will continue to receive requests for authorization of services and authorize accordingly in a timely manner.

The unit is responsible to ensure that the health risks to our providers and staff are minimized. Effective immediately, we ask the providers to not hand-deliver any documentation to our unit.

As some of our staff work remotely off-site, we are requesting that providers please scan and send their UR paperwork via secured/encrypted e-mail to the UR Clerk Specialist assigned to your program. Please include the following staff when sending your secured/encrypted e-mail:

Kathryn Seib, Clerical Supervisor: Kathryn.Seib@cchealth.org
Scott Alexander, UR Supervisor: Scott.Alexander@cchealth.org
Bles M. Surio, UR Manager: Blesilda.Surio@cchealth.org

If secured email is not available from the provider, please fax them to the UR Clerical Specialist assigned to your program. Providers assigned to send their requests for authorization that are handled in the main UR unit office in Concord, please use the fax numbers as follows according to your regional offices. As we will be receiving a high volume of faxes, please consider faxing during non-business hours.

Providers from East County: 925/608-9791
Providers from West County: 925/608-6792
Providers from Central County: 925/608-6799

In response of Contra Costa County to the order of the federal and state mandates regarding social distancing and shelter in place, CCBHS encourages all its providers to utilize telehealth or telephone services to provide continued services to our clients/beneficiaries. This ensures that all services remain available to our most vulnerable populations without the risk of direct contact. Included is the MEMORANDUM from Suzanne Tavano, PhD, Behavioral Health Services Director dated March 20, 2020 for all services and guidance.

CCBHS is working closely with DHCS regarding the required compliance with our needed services. Therefore, the client/beneficiary signature requirements for consents and treatment plan have been considered and modified temporarily. The following verbiage is recommended to be documented as required in replacement of the actual client/beneficiary signature when obtaining consents and treatment plan signature.

Via telephone/video:

"This service was provided through telehealth (or telephonically) with consent of the beneficiary and as a response to national public health emergency declaration regarding COVID-19 and CC Health Officer's shelter in place".

Partnership/Treatment Plan:

"The beneficiary has participated in the development of the treatment plan, the treatment plan was discussed and verbal agreement was given". (Please document on the Treatment Plan form).

Medication Consent:

"I have discussed the alternatives, risks, side effects, and therapeutic effects of the medication with the beneficiary, who verbally gave consent to proceed with prescription of identified medication". (Please document directly on the Medication Consent form).

The Utilization Review/Management Unit is here to provide you with guidance and to support the needs of our provider in this difficult time. Should you have any questions regarding documentation standards please feel free to email us at the addresses identified above.

Sincerely,

Bles M. Surio, BSN, RN
Utilization Review Manager
Behavioral Health Division

Scott Alexander, LMFT
Acting Supervisor Utilization Review Unit
Behavioral Health Division

CC: Matthew Luu, LCSW
Deputy Director
Behavioral Health Division

Enclosure: Memorandum from Behavioral Health Director Suzanne Tavano, PhD. Dated March 20, 2020

Contra Costa County Health Services Department **Behavioral Health Services Division** **Mental Health Services**	POLICY NO. 511-MH
POLICY: **TELEPSYCHIATRY SERVICES**	Date Reviewed/Revised: January 6, 2020 Date Initially Approved: March 28, 2018 Next Review Date: January 6, 2023
	By: Suzanne Tavano Suzanne Tavano, PhD Behavioral Health Director

POLICY: TELEPSYCHIATRY SERVICES

I. PURPOSE:

The purpose of this policy is to describe the appropriate protocol for use of Telepsychiatry services for consultation and coordination of care for mental health services as allowed by the Telemedicine Development Act of 1996 (SB 1665) and the Telehealth Advancement Act of 2011 (AB 415), which authorizes telemedicine as a treatment practice appropriate for reimbursement and stipulates that face-to-face in person contact between a patient and a health care provider is no longer required.

II. REFERENCES:

- 42 CFR Part 2, Confidentiality of Substance Use Disorder Patients
- Welfare and Institutions Code Section 14132.72[c]
- SB 1665, Telemedicine Development Act of 1996
- AB 415, Telehealth Advancement Act of 2011

III. POLICY:

It is the policy of Behavioral Health Services Division to follow all applicable Federal and State laws in the use of Telepsychiatry services to improve patient access to mental health services and to provide consultation and coordination of care.

IV. AUTHORITY/RESPONSIBILITY:

Behavioral Health Director
Behavioral Health Medical Director
Nurse Program Manager
Clinic Program Managers
Psychiatrists
Quality Improvement Coordinator
Clinical Support Staff

V. PROCEDURE:

A. At the time of scheduling a telepsychiatry appointment with a client, the client shall be informed that the appointment is a telepsychiatry appointment and must give verbal consent.

B. Clinic staff shall offer the client a Consent for Telepsychiatry Services form before, or at the time of, their initial telepsychiatry visit. The client shall have the option to decline the form.

C. Clinic staff, including telepsychiatry staff, shall follow the instructions in the *Clinic Protocol for Telepsychiatry Visits* document.

D. Clinic staff shall be available to the client for any needs at all times during telepsychiatry appointments.

E. Clinic staff shall coordinate with Health Services IT Staff for all of the following as needed.

1. Perform periodic checks to telepsychiatry hardware and software in order to maintain quality control related to audio and video clarity.
2. Perform periodic updates to telepsychiatry hardware and software as required by vendor/licensing party.
3. Resolve any problems with telepsychiatry hardware and software in order to maintain timely access to patient care.
4. Ensure ongoing equipment connectivity between service provider and client.
5. Ensure that equipment meets industry standards and that transmission of audio and visual interaction between patient and provider is HIPAA-compliant.
6. Provide all appropriate clinic staff with appropriate training on how to use telepsychiatry equipment.

F. Quality Improvement/Quality Assurance Unit Responsibilities.

1. Collect client care data.
2. Maintain a log of issues identified by client/family and service providers.
3. Identify and document patterns or trends as well as areas of concern.
4. Ensure client safety and timely access to client care.
5. Report findings and trends to the Quality Improvement Committee and Behavioral Health Executive Team.

VI. ATTACHMENT:

Behavioral Health Services Division, *Clinic Protocol for Telepsychiatry Visits*

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A Division of Contra Costa Health Services

Clinic Protocol for Telepsychiatry Visits

1. **Clinic Support Staff Responsibilities.**
   a. Welcome client and general check-in.
   b. If high-risk behavior is identified, alert nursing or licensed clinical staff to assess for the need for a more urgent intervention.
   c. Offer client a copy of the Telepsychiatry consent to be discussed with Psychiatrist. The client has the option to decline the consent.
   d. Alert Psychiatrist of any possible concerns before Telepsychiatry visit.
   e. Assist with any/all Psychiatrist orders after Telepsychiatry visit.
2. **Psychiatrist Responsibilities at Initial Assessment.**
   a. Assess for need of a more urgent intervention, such as a 5150 for danger to self or danger to others, and take appropriate action if necessary.
   b. Complete initial assessment.
   c. Review/update client's selected pharmacy.
   d. Complete partnership plan (Treatment Plan).
   e. Assess client's Mental Status Exam
   f. Review and obtain medication consent(s) from client.
   g. Obtain verbal or written consent regarding Telepsychiatry Services from client.
3. **Psychiatrist Responsibilities for followup or return appointments.**
   a. Assess for need of a more urgent intervention, such as a 5150 for danger to self or danger to others, and take appropriate action if necessary.
   b. Assess client's Mental Status Exam
   c. Complete progress notes.
   d. Review and update all relevant information in ccLink.
   e. Review and order lab tests if appropriate.
   f. Review medication consent(s) and order medications via electronic prescription.

Contra Costa County Health Services Department **Behavioral Health Services Division** **Drug Medi-Cal Organized Delivery System** **POLICY:** **USE OF TELEHEALTH SERVICES FOR SUBSTANCE USE DISORDER TREATMENT**	POLICY NO. 511-AOD Date Reviewed/Revised: July 30, 2021 Date Initially Approved: March 28, 2018 Next Review Date: July 30, 2024 Policy Expires On: July 30, 2025 By: _____ Suzanne Tavano, PhD Behavioral Health Director

POLICY: USE OF TELEHEALTH SERVICES FOR SUBSTANCE USE DISORDER TREATMENT

I. PURPOSE:

The purpose of this policy is to describe the appropriate protocol for use of telehealth (synchronous audio and video) or telephone services for consultation and coordination of care for Substance Use Disorder (SUD) treatment services, as allowed by the Telemedicine Development Act of 1996 (SB 1665) and the Telehealth Advancement Act of 2011 (AB 415), which authorizes telemedicine as a treatment practice appropriate for reimbursement and stipulates that face-to-face, in-person contact between a patient and a health care provider is no longer required.

II. REFERENCES:

- 42 CFR Part 2, Confidentiality of Substance Use Disorder Patient Records
- Welfare and Institutions Code Section 14132.72[c]
- SB 1665, Telemedicine Development Act of 1996
- AB 415, Telehealth Advancement Act of 2011

III. POLICY:

It is the policy of Behavioral Health Services Division to follow all applicable Federal and State laws in the use of telehealth (synchronous audio and video) or telephone services to improve patient access to SUD treatment services and to provide consultation and coordination of care.

IV. AUTHORITY/RESPONSIBILITY:

Behavioral Health Director
Quality Improvement Coordinator
SUD Prevention and Treatment Service Providers

Driving Under the Influence (DUI) Program Staff

V. PROCEDURE:

A. Standards for Providing Telehealth Services.

1. Telehealth or telephone appointments may only be provided when medically appropriate.
2. Clients may receive services via telehealth in their home.
3. Providers may deliver services via telehealth from anywhere in the community, outside a clinic or other provider site as long the Licensed Practitioner of the Healing Arts (LPHA) or Certified Counselor is Licensed/Certified in California.
4. The standard of care provided shall be the same whether the patient is seen in-person, by telephone, or through telehealth.
5. Programs may not require clients to receive services through telehealth only. All clients shall have the right to an in-person appointment, and providers may not restrict in-person appointments in favor of telehealth or telephone appointments, except in cases where health and safety would be compromised due to a pandemic, environmental disaster, etc.

B. Telehealth Visit Process.

1. At the time of scheduling a telehealth or telephone intake appointment with a client, the client shall be informed that the appointment is a telehealth or telephone appointment and must give verbal consent.
2. Program staff shall offer the client a *Consent to Receive Substance Use Treatment Services by Telehealth/Telephone* form before, or at the time of, their intake visit. The client shall have the option to decline the form.
3. Program staff, including staff providing services via telehealth or telephone, shall follow the instructions in the *Protocol for SUD Telehealth Visits* document.
4. Program staff shall be available to the client for any needs at all times during telehealth or telephone appointments.
5. In compliance with 42 CFR Part 2 and to prevent unnecessary disclosure of information, program staff must ensure that the client is located in a private area before a telehealth visit.

C. Program staff shall:

1. Perform periodic checks to all videoconferencing or other telehealth hardware and software used in order to maintain quality control related to audio and video clarity.
2. Perform periodic updates to videoconferencing or other telehealth hardware and software as required by vendor/licensing party.
3. Resolve any problems with videoconferencing or other telehealth hardware and software in order to maintain timely access to patient care.
4. Ensure ongoing equipment connectivity between service provider and client.
5. Ensure that equipment meets industry standards and that transmission of audio and visual interaction between patient and provider is HIPAA-compliant.
6. Provide all appropriate program staff with appropriate training on how to use videoconferencing or other telehealth equipment.

D. Documenting Telehealth or Telephone Visits.

1. Clinical documentation shall be completed in the client's chart following the same standards for an in-person visit.
2. In order to track access to services and measure the proportion of services delivered by telehealth, all Drug Medi-Cal covered services delivered by telehealth or telephone shall be claimed using the most current Department of Health Care Services authorized billing codes.

E. Quality Improvement/Quality Assurance Unit Responsibilities.

1. Collect client care data.
2. Maintain a log of issues identified by client/family and service providers.
3. Identify and document patterns or trends as well as areas of concern.
4. Ensure client safety and timely access to client care.
5. Report findings and trends to the Quality Improvement Committee and Behavioral Health management team.

VI. ATTACHMENT:

Behavioral Health Services Division, *Clinic Protocol for Telehealth and Telephone Visits for Substance Use (SU) Providers*

CONTRA COSTA
ALCOHOL & OTHER DRUGS SERVICES
A Program of Behavioral Health Services

Clinic Protocol for Telehealth and Telephone Visits for Substance Use (SU) Providers

1. **SU Program Support Staff Responsibilities.**
   a. Welcome client and general check-in.
   b. If high-risk behavior is identified, alert clinical staff to assess for the need for a more urgent in-person intervention.
   c. Offer client a copy of the Telehealth consent to be discussed with counselor. The client has the option to decline the consent.
2. **Clinical Staff Responsibilities at Initial Assessment.**
   a. Complete initial assessment and Intake documentation.
   b. Obtain consent(s) for Release of Information (ROI) and Consent for Treatment from client.
   c. Review client's information on *CBO Portal.*
   d. Complete Initial Treatment Plan
   e. Obtain verbal or written consent regarding Telehealth and Telephone Services from client.
3. **SUD Clinical Staff Responsibilities for follow-up or return appointments.**
   a. Assess for need of a more urgent intervention and take appropriate action if necessary.
   b. Review client's Mental Health and/or Medical Status on CBO Portal or *MyChart*
   c. Complete progress notes.
   d. Review all relevant information in ccLink.
   e. Review all prescribed medications. If Opioid Use Disorders (OUD), ensure that client is effectively linked to treatment services and medication refills have not expired, including Narcan.

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M/C Telehealth Policy

Medicine: Telehealth

Page updated: August 2020

The policy in this section is established pursuant to Assembly Bill 415 (Logue, Chapter 547, Statutes of 2011), known as the Telehealth Advancement Act of 2011. All health care practitioners rendering Medi-Cal covered benefits or services under this policy must comply with all applicable state and federal laws.

Definitions

For purposes of this policy, the following definitions shall apply:

Telehealth

"Telehealth" means 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. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

Asynchronous Store and Forward

"Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the health care provider at a distant site. Consultations via asynchronous electronic transmission initiated directly by patients, including through mobile phone applications, are not covered under this policy.

E-Consults

"E-consults" fall under the auspice of store and forward. E-consults are asynchronous health record consultation services that provide an assessment and management service in which the patient's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (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 coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers.

E-Visits

"E-visits" are communications between a patient and their provider through an online patient portal.

Synchronous Interaction

"Synchronous interaction" means a real-time interaction between a patient and a health care provider located at a distant site.

Distant Site

"Distant site" means 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.

Originating Site

"Originating site" means 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. For purposes of reimbursement for covered treatment or services provided through telehealth, the type of setting where services are provided for the patient or by the health care provider is not limited (*Welfare and Institutions Code* [W&I Code], Section 14132.72[e]). The type of setting may include, but is not limited to, a hospital, medical office, community clinic or the patient's home.

For originating site policy and billing information specific to Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) or Indian Health Services – Memorandum of Agreement (IHS-MOA) 638, Clinics, refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* and *Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics* sections in the appropriate Part 2 manual.

Provider Requirements

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

The health care provider rendering Medi-Cal covered benefits or services via a telehealth modality must be licensed in California, enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP) and affiliated with an enrolled Medi-Cal provider group. The enrolled Medi-Cal provider group for which the health care provider renders services via telehealth must meet all Medi-Cal program enrollment requirements and must be located in California or a border community.

For policy and billing information specific to FQHCs, RHCs or IHS-MOA clinics, providers may refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* and *Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics* sections in the appropriate Part 2 manual.

Documentation Requirements

All health care practitioners providing covered benefits or services to Medi-Cal patients must maintain appropriate documentation to substantiate the corresponding technical and professional components of billed CPT® or HCPCS codes. Documentation for benefits or services delivered via telehealth should be the same as for a comparable in-person service. The distant site provider can bill for Medi-Cal covered benefits or services delivered via telehealth using the appropriate CPT or HCPCS codes with the corresponding modifier and is responsible for maintaining appropriate supporting documentation. This documentation should be maintained in the patient's medical record.

Providers should note the following:

- Health care providers at the distant site must determine that the covered Medi-Cal service or benefit being delivered via telehealth meets the procedural definition and components of the CPT or HCPCS code(s) associated with the Medi-Cal covered service or benefit as well as any other requirements described in this section of the Medi-Cal provider manual.
- Health care providers are not required to document a barrier to an in-person visit for Medi-Cal coverage of services provided via telehealth (W&I Code, Section 14132.72[d]).
- Health care providers at the distant site are not required to document cost effectiveness of telehealth to be reimbursed for telehealth services or store and forward services.

Consent

In addition, 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.

If a health care provider, whether at the originating site or distant site, maintains a general consent agreement that specifically mentions use of telehealth as an acceptable modality for delivery of services, then this is sufficient for documentation of patient consent and should be kept in the patient's medical file.

The consent shall be documented in the patient's medical file (B&P Code, Section 2290.5(b)) and be available to the Department of Health Care Services (DHCS) upon request.

Place of Service Code "02"

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

For policy and billing information specific to FQHCs, RHCs or IHS-MOA clinics, providers may refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* and *Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics* sections in the appropriate Part 2 manual.

«Type of Bill "02"

Health care providers are required to document Type of Bill "02" on the *UB-04* claim form, which indicates that services were provided or received through a telecommunications system.»

Reimbursable Telehealth Services

Medi-Cal covered benefits or services, identified by CPT or HCPCS codes and subject to all existing Medi-Cal coverage and reimbursement policies, including any *Treatment Authorization Request* (TAR) requirements, may be provided via a telehealth modality, as outlined in this section, if all of the following are satisfied:

- The treating health care provider at the distant site believes that the benefits or services being provided are clinically appropriate based upon evidence-based medicine and/or best practices to be delivered via telehealth;
- The benefits or services delivered via telehealth meet the procedural definition and components of the CPT or HCPCS code(s), as defined by the American Medical Association (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; and
- The benefits or services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to his or her medical information.

Covered benefits or services provided via a telehealth modality are reimbursable when billed in one of two ways:

- For services or benefits provided via synchronous, interactive audio and telecommunications systems, the health care provider bills with modifier 95.
- For services or benefits provided via asynchronous store and forward telecommunications systems, the health care provider bills with modifier GQ.

Examples of Services Not Appropriate for Telehealth

Certain types of benefits or services that would not be expected to be appropriately delivered via telehealth include, but are not limited to, benefits or services that are performed in an operating room or while the patient is under anesthesia, require direct visualization or instrumentation of bodily structures, involve sampling of tissue or insertion/removal of medical devices and/or otherwise require the in-person presence of the patient for any reason.

Billing Requirements

The following provides information about billing requirements for specific telehealth services.

Synchronous, Interactive Audio and Telecommunications Systems: Modifier 95

Modifier 95 must be used for Medi-Cal covered benefits or services delivered via synchronous, interactive audio/visual, telecommunications systems. Only the portion(s) of the telehealth service rendered at the distant site are billed with modifier 95. The use of modifier 95 does not alter reimbursement for the CPT or HCPCS code.

Health care providers must use an interactive audio, video or data telecommunications system that permits real-time communication between the health care provider at the distant site and the patient at the originating site. The audio-video telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through telehealth. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

Under federal regulations (*Code of Federal Regulations*, Title 42, Section 410.78), the presence of a health care provider is not required at the originating site as a condition of payment unless the health care provider at the originating site is medically necessary as determined by the health care provider at the distant site.

Evaluation and Management (E&M) and all other covered Medi-Cal services provided at the originating site (in-person with the patient) during a telehealth transmission are billed according to standard Medi-Cal policies (without modifier 95). The E&M service must be in real-time or near real-time (delay in seconds or minutes) to qualify as an interactive two-way transfer of medical data and information between the patient and health care provider.

Asynchronous Store and Forward Telecommunications Systems: Modifier GQ

Modifier GQ must be used for Medi-Cal covered benefits or services, including, but not limited to, teleophthalmology, teledermatology, teledentistry and teleradiology, delivered via asynchronous store and forward telecommunications systems, including through e-consult. Only the service(s) rendered from the distant site must be billed with modifier GQ.

The use of modifier GQ does not alter reimbursement for the CPT or HCPCS code billed. ‹‹For additional information about policy and billing requirements relating to teledentistry, providers may refer to "Teledentistry" in the *Medi-Cal Dental Provider Handbook.*››

For billing purposes, health care providers 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. In addition, all services billed via store and forward, including e-consult, are subject to all existing Medi-Cal coverage and reimbursement policies, including any TAR requirements.

E-Consults

For the definition of "e-consult," providers may refer to the "Definitions" heading previously in this section.

A health care provider at the distant site may bill for an e-consult with the CPT code listed below when the benefits or services delivered meet the procedural definition and components of the CPT code as defined by the AMA as well as any requirements described in this section of the Medi-Cal provider manual.

When billing for e-consults, health care providers at the originating and distant sites must clearly document the following information relating to previous and/or pertinent health care services, maintain this information in the patient's medical record and make it available to DHCS upon request:

- A health care provider at the originating site must create and maintain the following:
  - A record that the e-consult is the result of patient care that has occurred or will occur and relates to ongoing patient management; and
  - A record of a request for an e-consult by the health care provider at the originating site.
- In order to bill for e-consults, the health care provider at the distant site must create and maintain the following:
  - A record of the review and analysis of the transmitted medical information with written documentation of date of service and time spent; and
  - A written report of case findings and recommendations with conveyance to the originating site.

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

CPT Code	Description
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

In accordance with the AMA requirements, CPT code 99451 is not separately reportable or reimbursable if any of the following are true:

- The distant site provider (consultant) saw the patient within the last 14 days.
- The e-consult results in a transfer of care or other face-to-face service with the distant site provider (consultant) within the next 14 days or next available appointment date of the consultant.
- The distant site provider did not spend at least five minutes of medical consultative time, and it did not result in a written report.

If more than one contact or encounter is required to complete the e-consult request, the entirety of the service and cumulative discussion and information review time should be reported only once using CPT code 99451.

CPT code 99451 is not reimbursable more than once in a seven-day period for the same patient and health care practitioner.

Medi-Cal covered benefits or services provided at the originating site (in-person) with the patient in connection with an e-consult are billed according to standard Medi-Cal policies (without modifier GQ).

The e-consult policy is not applicable for FQHCs, RHCs or IHS-MOA clinics. For policy and billing information specific to FQHCs, RHCs or IHS-MOA clinics, providers may refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* and *Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics* sections in the appropriate Part 2 manual.

Originating Site and Transmission Fees

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

Originating Site and Transmission Fee Restrictions

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

‹‹HCPCS Codes with Restrictions for Billing››

HCPCS Code	Transmission Site	Frequency Limit
Q3014	Originating site	Once per day, same patient, same provider
T1014	Originating site and distant site	Maximum of 90 minutes per day (1 unit = 1 minute), same patient, same provider

If billing 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.

The originating site and transmission fee restrictions and billing rules are not applicable for FQHCs, RHCs or IHS-MOA clinics. For policy and billing information specific to FQHCs, RHCs or IHS-MOA clinics, providers may refer to the *Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)* and *Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics* sections in the appropriate Part 2 manual.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
«	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
»	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.

State of California—Health and Human Services Agency
Department of Health Care Services

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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.

<u>Asynchronous Store and Forward, inclusive of E-Consults</u>

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

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 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 communcation 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.

MISCELLANOUS

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.