



Policy and Procedure No: PR 7.1	Revision No: 1
Division: Care Management	
Department: Provider Relations	
Title: PHC-CA Telehealth Services	
Effective Date: 1/1/2019	
Supersedes Policy No: PR 7.0	
Reviewed/Revised by: Michael O'Malley	Review/Revision Date: 12/1/2025
Approving Committee: Member Provider Committee	Date: 12/15/2025
Executive Oversight Committee Date: 12/16/2025	

Purpose:

To clarify the PHC California’s (the Health Plan) and the Department of Health Care Services’ (DHCS) policy regarding covered services offered through telehealth modalities as outlined in the Medi-Cal Provider Manual and those covered services that can be provided via telehealth and the expectations related to documentation for telehealth.

Policy:

1. Provider Requirements

- a. A Provider rendering Covered Services via a Telehealth modality must be licensed in the State of California and enrolled as a Medi-Cal Provider or Non-Physician Medical Practitioner affiliated with an enrolled Medi-Cal Provider group. If the Provider is not located in California, they must be affiliated with a Medi-Cal enrolled Provider group in California or a border community as outlined in the Medi-Cal Provider Manual. Providers who do not have a path to enroll in Medi-Cal, please refer to DHCS APL 22-013 Provider Credentialing/Re-Credentialing and Screening/Enrollment. See Credentialing Policy and Procedure PHC-CA Provider Screening and Enrollment.
- b. Each Provider providing Covered Services to a Member via a Telehealth modality must also meet the requirements of Business and Professions Code (BPC) section 2290.5(a)(3) or otherwise be designated by DHCS as able to render Medi-Cal services via Telehealth.
- c. DHCS will periodically update the Covered Services and Provider types and requirements that may be appropriately delivered through Telehealth. The Plan should refer to the Medi-Cal Provider Manual for the most updated information.

2. Reimbursable Services

- a. Existing Covered Services, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing treatment authorization requirements, may be provided via a Telehealth modality only if all of the following criteria are satisfied:
 - i. The treating Provider at the distant site believes the Covered Services being provided are clinically appropriate to be delivered via Telehealth based upon evidence-based medicine and/or best clinical judgment.
 - ii. The Member has provided verbal or written consent.

- iii. The Medical Record documentation substantiates that the Covered Services delivered via Telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the Covered Service. Providers are not required to:
 - 1. Document a barrier to an in-person visit for Covered Services provided via Telehealth (WIC section 14132.72(d)); or
 - 2. Document the cost effectiveness of Telehealth to be reimbursed for Covered Services provided via a Telehealth modality.
 - iv. The Covered Services provided via Telehealth meet all state and federal laws regarding confidentiality of health care information and a Member's right to their own medical information.
- b. Certain types of Covered Services cannot be appropriately delivered via Telehealth. These include Covered Services that would otherwise require the in-person presence of the Member for any reason, such as those that are performed in an operating room or while the Member is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices.
- i. A Provider must assess the appropriateness of the Telehealth modality to the Member's level of acuity at the time of the service.
 - ii. A Provider is not required to be present with the Member at the originating site unless determined Medically Necessary by the Provider at the distant site.
- c. All Providers, except for Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Tribal Health Providers (THPs), are allowed to be reimbursed for consultations provided via a Telehealth modality.
- i. These electronic consultations (e-consults) are permissible using the appropriate CPT-4 code, modifier(s), and Medical Record documentation defined in the Medi-Cal Provider Manual.
 - ii. Members cannot initiate e-consults as they are interprofessional interactions, and therefore only permissible between Providers. Providers, including FQHCs, RHCs, and THPs are permitted to be reimbursed for brief virtual communications that consist of a brief communication with a Member who is not physically present (face-to-face) at the FFS rate.
- d. Effective no sooner than January 1, 2024, all Providers furnishing applicable Covered Services via audio-only synchronous interactions must also offer those same services via video synchronous interactions as to preserve Member choice. Also, effective no sooner than January 1, 2024, to preserve a Member's right to access Covered Services in-person, a Provider furnishing services through video synchronous interaction or audio-only synchronous interaction must do one of the following:
- i. Offer those same services via in-person, face-to-face contact.
 - ii. Arrange for a referral to, and a facilitation of, in-person care that does not require a Member to independently contact a different Provider to arrange for that care.

3. Member Consent

- a. Providers must inform Members prior to the initial delivery of Covered Services via Telehealth about the use of Telehealth and obtain verbal or written consent from Members for the use of Telehealth as an acceptable mode of delivering services.
- b. If a Provider, whether at the originating site or distant site, retains a general consent agreement that specifically mentions the use of Telehealth as an acceptable modality for the delivery of Covered Services and includes the required information below, this is sufficient for documentation of consent.
 - i. Providers also need to document when a Member consents to receive Covered Services via Telehealth prior to the initial delivery of the services. Consent must be documented in the Member's Medical Record and made available to DHCS upon request.
- c. In addition to documenting consent prior to initial delivery of covered services via telehealth, Providers are also required to explain the following to Members:
 - i. Right to In-Person services
 - ii. That use of Telehealth is voluntary and that consent for the use of Telehealth can be withdrawn at any time by the Member without affecting their ability to access Medi-Cal Covered Services in the future.
 - iii. The availability of Non-Medical Transportation to in-person visits when other available resources have reasonably been exhausted
 - iv. The potential limitations or risks related to receiving Covered Services through Telehealth as compared to an in-person visit, if applicable.
 - v. Availability of Translation Services. See Member Services Policy and Procedure PHC-CA Language Access Service.
- d. DHCS has created model Member consent language for the Health Plan and Providers to use, which can be found on the [DHCS website](#).

4. Establishing New Patients via Telehealth

- a. Members may be established as new patients by Providers via Telehealth through the following ways:
 - i. All Providers may establish new patient relationships via synchronous video Telehealth visits.
- b. All Providers may establish new patient relationships via audio-only synchronous interaction only if one or more of the following criteria applies:
 - i. The visit is related to sensitive services, which is defined in Civil Code section 56.06(n) as all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender-affirming care, and intimate partner violence, and includes services described in Family Code sections 6924 - 6930, and

HSC sections 121020 and 124260, obtained by a Member at or above the minimum age specified for consenting to the service specified in the section.

- ii. The Member requests an audio-only modality.
- iii. The Member attests they do not have access to video.
- c. FQHCs, including Tribal FQHCs, and RHCs may establish new patient relationships through an asynchronous store and forward modality, as defined in BPC section 2290.5(a), if the visit meets all of the following conditions:
 - i. The Member is physically present at a Provider's site, or at an intermittent site of the Provider, at the time the Covered Service is performed.
 - ii. The individual who creates the patient's Medical Records at the originating site is an employee or Subcontractor of the Provider, or other person lawfully authorized by the Provider to create a patient Medical Record.
 - iii. The Provider determines that the billing Provider is able to meet the applicable standard of care.
 - iv. A Member who receives Covered Services via Telehealth must otherwise be eligible to receive in-person services from that Provider.

5. Payment

- a. To ensure proper payment and record of Covered Services provided via Telehealth, all Providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered through both synchronous interactions and asynchronous store and forward telecommunications.
- b. Regarding the rate of reimbursement, unless otherwise agreed to by the MCP and Provider, the Plan must reimburse Network Providers at the same rate, whether a Covered Service is provided in-person or through Telehealth, if the service is the same regardless of the modality of delivery, as determined by the Provider's description of the service on the claim.
 - i. For example, if the Plan reimburses a Provider \$100 for an in person visit, the MCP must reimburse the Provider \$100 for an equivalent visit done via Telehealth unless otherwise agreed to by the Plan and Provider. Likewise, MCPs must reimburse Providers for a Covered Service rendered via telephone or video at the same rate for in-person visits, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the Member.
- c. Billing Requirements for Specific Telehealth Services
 - i. Synchronous, Telephone or Other Interactive Audio-only Telecommunications Systems: Modifier 93
 - 1. Modifier 93 must be used for Medi-Cal covered benefits or services delivered via synchronous, telephone or other interactive audio-only telecommunications systems. Only the portion(s) of the telehealth service rendered at the distant site are billed with

modifier 93. The use of modifier 93 does not alter reimbursement for the CPT or HCPCS code.

2. Health care providers must use an interactive audio-only telecommunications system that permits real-time communication between the provider at the distant site and the patient at the originating site. The audio 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. The totality of the communication of information exchanged between the provider and the patient during the audio-only service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction. Providers must document in the patient's medical file that the patient has given a written or verbal consent to the audio-only telehealth encounter.

ii. Synchronous, Interactive Audio and Telecommunications Systems: Modifier 95

1. 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.
2. 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.
3. Under federal regulations (Code of Federal Regulations, Title 42, Section 410.78), the presence of a health care provider at the originating site is not required as a condition of payment for the telehealth service unless the health care provider at the distant site determines it is medically necessary. 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) to qualify as an interactive two-way transfer of medical data and information between the patient and health care provider.

iii. Asynchronous Store and Forward Telecommunications Systems: Modifier GQ

1. Modifier GQ must be used for Medi-Cal covered benefits or services, including, but not limited to, teleophthalmology, teledermatology and teleradiology, delivered via asynchronous store and forward telecommunications systems, including e-consults. 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 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.

iv. E-consults

1. 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. A health care provider at the originating site must create and maintain the following:
 - i. 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
 - ii. A record of a request for an e-consult by the health care provider at the originating site.
 - b. In order to bill for e-consults, the health care provider at the distant site must create and maintain the following:
 - i. A record of the review and analysis of the transmitted medical information with written documentation of date of service and time spent; and
 - ii. A written report of case findings and recommendations with conveyance to the originating site.
 - c. 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

- d. In accordance with the AMA requirements, CPT code 99451 is not separately reportable or reimbursable if any of the following are true:
 - i. The distant site provider (consultant) saw the patient within the last fourteen (14) days.
 - ii. The e-consult results in a transfer of care or other face-to-face service with the distant site provider (consultant) within the next fourteen (14) days or next available appointment date of the consultant.



- iii. The distant site provider did not spend at least five (5) minutes of medical consultative time, and it did not result in a written report.
 - e. If more than one (1) 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.
 - f. CPT code 99451 is not reimbursable more than once in a seven (7) day period for the same patient and health care practitioner.
 - g. 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).
 - h. 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.
- v. Brief Virtual Communications and Check-Ins
- 1. Virtual or telephonic communication includes a brief communication with an established patient not physically present (face-to-face). Medi-Cal providers may be reimbursed using HCPCS codes G2010 and G2012 for brief virtual communications.
 - a. 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 twenty-four (24) hours, not originating from a related evaluation and management (E/M) service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment.
 - b. 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 seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment; five (5) to ten (10) minutes of medical discussion. G2012 can be billed when the virtual communication via a telephone call.
- vi. Originating Site and Transmission Fees
- 1. 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 fees and transmission fees are not available for audio-only synchronous services.
 - 2. Originating Site and Transmission Fee Restrictions

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

HCPCS Codes with Restrictions for Billing		
HCPCS Code	Transmission Site	Frequency Limit
Q3014	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

- b. 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.
- c. 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.

6. Subcontractors and Network Providers

- a. The Plan responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all Subcontractors and Network Providers.

Procedure:

1. The National Director of Contracting and Provider Relations is responsible to include telehealth language in Health Plan contracts or amend existing contracts to add in telehealth language that includes:
- a. As deemed necessary and appropriate by the Health Plan, provider shall provide telehealth covered services in accordance with professionally recognized medical practice standard in effect at the time of services.
- b. Provider shall provide clinical services to enrollees utilizing telehealth in the same manner in which services are provided to all other patients.
- c. The quality of telehealth covered services provided to enrollees shall be no less than the quality of services provided to providers' other patients and shall meet or exceed professionally recognized standard of practice in effect at the time of services.
- d. Providers must obtain enrollee consent to provide appropriate covered services via telehealth pursuant to this policy and procedure.



2. The National Director of Contracting and Provider Relations ensures that telehealth services must be rendered by a licensed provider in the State of California and all providers must have an established contract with the Health Plan prior to rendering services to enrollees. Providers serving Health Plan’s Medi-Cal members must be enrolled as a Medi-Cal rendering provider or non-physician medical provider (NMP).
3. The National Director of Managed Care Operations or is or her designee is responsible to compensate providers for telehealth covered services per standard claims turnaround time and processes. Compensation is based upon the reimbursement outlined and in accordance with reimbursement schedule outlined in the provider contractual agreement with Plan. Provider must use the CPT codes, Modifier and Place of Service (POS) terms for all Telehealth claims submission to the Plan as outlined in the table below:

Modifier	Place of Service (POS)
93	02-TELEHEALTH

Definitions:

1. 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.
2. 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.
3. 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.
4. E-Visits: communications between a patient and their provider through an online patient portal.
5. Synchronous Interaction: means a real-time interaction between a patient and a health care provider located at a distant site.
6. 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.



7. **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.
 - a. 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.
8. **Sensitive Services:** All health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender-affirming care, and intimate partner violence, and includes services described in Sections 6924 through 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.

Monitoring:

This policy is updated, as necessary, reviewed and approved annually by the Member Provider Committee.

References:

1. "Medicine: Telehealth" section of the Medi-Cal Provider Manual at <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele.pdf>
2. Business and Professions Code (BPC) section 2290.5(a)(3)
3. Health and Safety Code (HSC) section 1374.13
4. Welfare and Institutions Code (WIC) sections 14132.72, 14132.100, and 14132.725
5. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-007 [Telehealth Services Policy \(Supersedes APL 19-009\)](#), dated April 10, 2023.
6. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013, [Provider Credentialing/Recredentialing and Screening/Enrollment](#), dated July 19, 2022.
7. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-001, [Network Certification Requirements \(Supersedes APL 21-006\)](#), dated January 6, 2023.
8. Member Services Policy and Procedure PHC-CA Language Access Service.
9. Provider Relations Policy and Procedure PHC- CA Network Development and Management
10. Credentialing Policy and Procedure PHC-CA Provider Screening and Enrollment

11. Claims Policy and Procedure PHC-CA Provider Reimbursement

