Preferred IPA of California

March 24, 2020

COVID-19 Guidance for Telehealth

Preferred IPA understands the immense pressure on our provider community to provide healthcare to patients in a manner that is safe for the patient, the provider and the office staff. Providers may choose to utilize telehealth services when medically appropriate for the patient's condition. Providers may also find that telehealth is an option for post discharge medication reconciliation or to ensure that patients are able to receive prescription medications in a timely manner.

Preferred IPA will follow the DHCS and CMS guidance regarding handling of claims for services. Claims for telehealth services will be processed following the same referral, payment and processing methodologies as those for in person services based upon the provider's contract with Preferred IPA.

Prior Referral Authorization for Telehealth Services

We understand that the decision to provide telehealth services is on a case by case basis. No special prior authorization is required to render telehealth services. Providers that have an existing referral for a patient may choose to provide those services utilizing telehealth as an alternative to an in-office visit when deemed medically appropriate for the patient's condition.

Payment for Telehealth Services

- Capitated agreements – Telehealth services are included in the capitation agreement; encounter data may be submitted on CMS1500 through Office Ally or via paper claim form
- Fee for service agreements – telehealth services will be reimbursed at the rate in your existing agreement with Preferred IPA.

Providers choosing telehealth as an alternative to an office visit may submit claims as follows:

Medi-Cal Members	
Place of Service	02 (telehealth)
Modifier	95 - Synchronous, interactive audio and telecommunications systems
Regular CPT or HCPCS codes that would correspond to the visit being done in-person	Examples: 99201-99205 99211-99215

Medicare and Commercial Members	
Place of Service	02 (telehealth)
Regular CPT or HCPCS codes that would correspond to the visit being done in-person	Examples: 99201-99205 99211-99215

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HIPAA Requirements

During the COVID-19 national emergency, which also constitutes a nationwide public health emergency, covered health care providers subject to the HIPAA Rules may seek to communicate with patients, and provide telehealth services, through remote communications technologies. Some of these technologies, and the manner in which they are used by HIPAA covered health care providers, may not fully comply with the requirements of the HIPAA Rules. Please visit the link for the requirements and temporary changes:

https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

Medical Records (DHCS Excerpt)

Medical record documentation must support the reason for the use of telehealth and the services provided.

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 covered service or benefit being provided are medically necessary.
- The 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 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 the 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.

For additional information please visit:

http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_30339_02.asp
https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet%
www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes