KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Telehealth Services				POLICY #: 4.53-P	
DEPARTMENT: Provider Network Management					
Effective Date: 9/19/2024	Review/Revised Date: 9/19/2024	DMHC	X	PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Chief Executive Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Compliance and Fraud Prevention Officer

_____ Date _____
Senior Director of Claims

_____ Date _____
Senior Director of Provider Network

POLICY:
Kern Health Systems (KHS) utilizes telehealth as an option for members to obtain access to necessary health care services. KHS, all delegates, and contracted network providers will comply with all applicable state and federal laws and regulations, and all contractual requirements when providing services via telehealth.

DEFINITIONS:

Telemedicine:	The practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

PROCEDURES:

1.0 PROVIDER REQUIREMENTS

Providers rendering services via a telehealth modality must be licensed in the State of California and be enrolled as a Medi-Cal Provide. If a provider is not located in California, they must be affiliated with a Medi-Cal enrolled provider group in California or a border community. Additional KHS provider qualification and enrollment information, including information for providers who do not have a Medi-Cal enrollment pathway, is outlined in KHS policy and procedure 4.01-P Credentialing and 4.43-P Medi-Cal Enrollment.

Providers rendering services via telehealth must meet all requirements of Business and Professions Code section 2290.5(a)(3), or otherwise be designated by the DHCS as able to render Medi-Cal services via telehealth.

2.0 SERVICES

Covered services, identified by CPT (Current Procedural Terminology) or HCPCS (Healthcare Common Procedure Coding System) codes, and subject to any existing treatment authorization requirements, may be provided via a telehealth modality only if all the following criteria are satisfied:

A. The treating Provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgement.
B. The member has provided verbal or written consent.
C. The medical record documentation substantiates that the services delivered via telehealth meet the procedural definition and components of the CPT or HCPCS code(s) associated with the service.
D. The 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
E. The services being rendered via Telehealth are appropriate for a Telehealth visit. Services requiring the presence of a Member should not be rendered or billed with a Telehealth modality. Provider must assess the appropriateness of the Telehealth modality to the Member's level of acuity at the time of the service.

Providers are not required to:

A. Document a barrier to an in-person visit for services provided via Telehealth (WIC section 14132.72(d))
B. Document the cost effectiveness of Telehealth

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.

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:

A. Offer those same services via in-person, face-to-face contact.
B. 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

3.0 MEMBER CONSENT

Providers must inform members prior to the initial delivery of 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. Consent must be documented in the Member's medical records and be made available to KHS and regulatory bodies upon request. Providers are required to explain the following to members:

A. The member's right to access covered services delivered via telehealth in-person.
B. 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.
C. The availability of non-medical transportation to in-person visits
D. The potential limitations or risks related to receiving covered services through Telehealth as compared to an in-person visit, if applicable

4.0 ESTABLISHING NEW PATIENTS VIA TELEHEALTH

Members may be established as new patients by providers via telehealth though the following methods:

A. Synchronous video Telehealth visits
B. Audio-only synchronous visits if one or more of the following criteria applies:
    1. The visit is related to sensitive services, as defined in Civil Code section 56.06(n) – 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
    2. The Member requests an audio-only appointment
    3. The Member attests they do not have access to video.

5.0 PAYMENT

Providers will bill KHS with appropriate CPT/HCPCS codes and modifiers as defined in the Medi-Cal Provider Manual for synchronous interactions and asynchronous store and forward telecommunications. Unless otherwise defined in the provider's service agreement with the Plan, KHS will reimburse network 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.

6.0 FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs), TRIBAL FQHCs AND RURAL HEALTH CLINICS (RHCs)

FQHCs, 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:

A. The member is physically present at a provider site, or at an intermittent site of the provider, at the time the covered service is performed.
B. 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.

C. The provider determines that the billing provider is able to meet the applicable standard of care.
D. A member who receives covered services via telehealth must otherwise be eligible to receive in-person services from that Provider.

FQHCs, RHCs, and Tribal Health Providers (THPs), are not allowed to be reimbursed for consultations provided via the e-consult telehealth modality.

REFERENCE:

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Revision 2023-07: Policy created by Provider Network Management to be in alignment with DHCS APL 23-007, DHCS approval received on 8/2/2023.