

Telehealth and Virtual Services: A Guide for FQHCs and RHCs

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Introduction

During the COVID-19 pandemic, there was an urgent need to provide remote services to continue uninterrupted health care services to expand access and keep people safe. This resulted in a rapid increase in the delivery of telehealth services in the primary care setting. This guide provides helpful advice, checklists, resources, and best practices to optimize and support telehealth for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).

One may ask “What makes this different from other telehealth guides?” The authors have endeavored to keep the content practical and simple, with a focus on providing value to FQHCs/RHCs and those they serve. Nothing in this document should be treated as legal or billing advice. Confer as needed with the appropriately credentialed and trained individuals to confirm information in this document.

Keep it Simple — but Effective

Feedback from the frontlines suggests a perception that implementing, fully adopting, and sustaining telehealth is a complex and costly endeavor. The truth is that it does not have to be. Here are a few tips to keep in mind:

- Telehealth has been around for decades. It is not a new strategy; it is simply an additional option for health care service delivery.
- The leadership and organization-wide leadership telehealth perspective(s) set the tone and direction. At your organization, is telehealth perceived as a stopgap to use during the pandemic only, or as a permanent way to expand access and options for patients to engage in their health care? The latter is a harbinger of success with telehealth sustainability.
- If an organization has strong and reliable bandwidth in addition to devices with cameras, speakers and microphones, a HIPAA-compliant telehealth platform may be the biggest budget item.
- Selection of a telehealth “platform” does not need to be complicated or expensive, nor does it need to be a platform per se. Any HIPAA-compliant solution that offers interactive audio and video using real-time telecommunication technology will suffice (e.g., Zoom, doxy.me). Many states have free or reduced cost options.
- Once you sort out telehealth billing details and workflows for Medicare, Medicaid and other health insurers, this work is essentially done and will only need to be updated on an annual or as-needed basis.
- The greatest complexity is facilitating patient engagement, identifying their challenges, and finding solutions, such as lack of a device, no connectivity, limited digital proficiency or other. Successful, motivated organizations, teams and individuals just find a way, approaching the problems with “We can do this *if*...” rather than “We can’t do this *because*...”

Top 10 Practical Telehealth Implementation Steps

Below are 10 practical steps that can be taken once the decision has been made to implement telehealth. Note that most of this document is focused on optimizing telehealth services after these steps have been taken.

1. **Assign a telehealth/virtual service champion.** Identify an internal “motivator for change” who can lead a small team of clinicians, care team members and IT staff
2. **Know and correct any telecommunication weaknesses.** Assess bandwidth and Wi-Fi strength throughout the clinic sites. Pilot-test capabilities to ensure glitch-free remote sessions
3. **Select a telehealth platform or solution.** While the public health emergency (PHE) allows for immediate adoption of telehealth using options that are not HIPAA-compliant (e.g., FaceTime), plan for a permanent solution that is HIPAA-compliant and provides interactive audio and video telecommunications that permit real-time communication among the clinician, the care team, and patients

4. **Ensure an adequate number of devices with camera and microphone.** Some organizations use this as an opportunity to review their inventory and to purchase new devices that are telehealth-capable
5. **Educate/train staff.** Use a combination of in-person and/or remote training sessions, telehealth how-to videos and tip sheets to get existing and new staff up to speed quickly. The [California Telehealth Resource Center Telehealth Course Finder](#) is a great place to start and includes the host of the training, information on credits, and cost (if any)
6. **Develop standard workflows.** Key workflows include scheduling the appointment and processes for day of visit at both the distant (where the provider is) and the originating site (where the patient is)
7. **Establish expectations.** All involved should know the expectations. For example, telehealth visits should start on time, otherwise patients are stuck waiting and may not be able to be on a call or otherwise use their device or step away as they wait. Patients sometimes do not consider a telehealth visit as important as in-person visits and will multitask during the telehealth call, taking the call while driving or shopping or doing something else. Consider sending a short email or letter with expectations
8. **Develop a communication and marketing strategy.** All staff need to be kept apprised of telehealth progress and activities. Patients and families need to be aware that telehealth is an option, too, in multiple ways (e.g., reception staff, clinician, care team, website, on-hold message, social media)
9. **Find solutions to patient barriers.** Lack of access to telehealth is a social determinant of health that we can address with [creativity and resources](#), and the will to do something about it
10. **Monitor our performance.** Work with the quality improvement (QI) team to identify and track relevant metrics, especially those related to quality, safety, efficiency, and patient and staff experience

BONUS: Make a list of all distant site telehealth services you can deliver to patients, mostly depending on the insurer. Consider making another list of all originating site telehealth services your patients can (or should) receive at your facility (e.g., specialty services).

Telehealth Services Basics

The Centers for Medicare & Medicaid Services (CMS) acknowledges that “The health care community uses the term ‘telehealth’ broadly to refer to medical services furnished via communications technology.” CMS further clarifies that while all kinds of services may fall into this broad use of the term telehealth, they use “Medicare telehealth services” to refer to the discrete set of services and codes for which Medicare makes payment, all of which can also be furnished in person rather than by interactive, real-time telecommunication technology¹.

In this context, primary care telehealth services:

- Are defined by a discrete set of services and codes found in the [Medicare List of Telehealth Services](#)² for which Medicare, Medicaid and other health plans make payment.
- Can also be furnished in person. For non-FQHCs/RHCs the same code and service description is used for telehealth or in-person visit and specific coding (e.g., Place of Service (POS) code 02-Telehealth Provided Other than in Patient’s Home). At least until the end of 2021, FQHCs/RHCs will use G2025³ for telehealth services.
- Are reimbursed at \$99.45 for FQHCs/RHCs through 2021.
- Have a distant site (where the provider is) and an originating site (where the patient is).

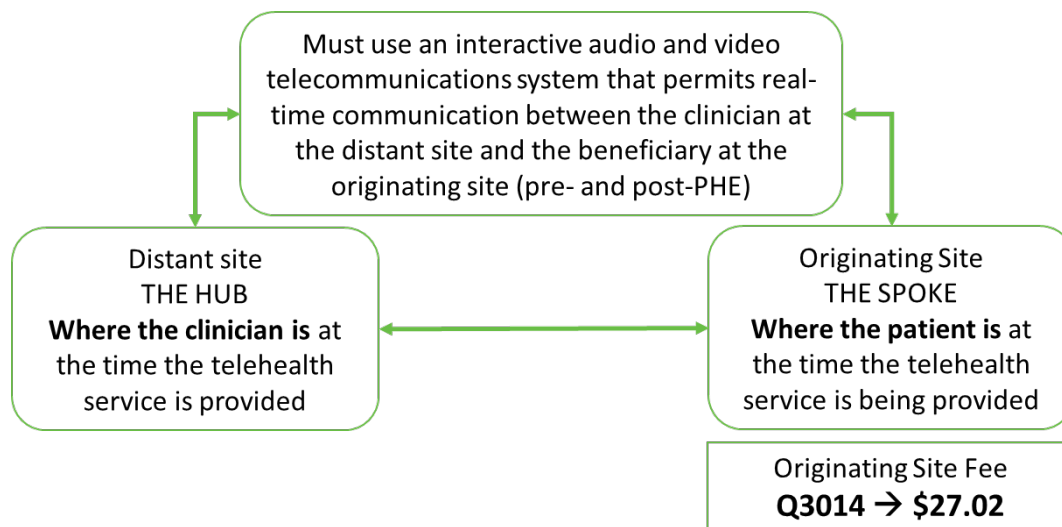
¹ [Calendar Year 2021 Physician Fee Schedule Final Rule](#). CMS. December 28, 2020.

² [List of Telehealth Services](#). CMS.

³ [New & Expanded Flexibilities for RHCs & FQHCs during the COVID-19 PHE](#). CMS. February 23, 2021.

- Must be delivered using an interactive audio and video telecommunications system that permits real-time communication between the provider at the distant site and the patient at the originating site (video is not required for select telehealth services during the PHE).
- Require [consent](#) for Medicare beneficiaries, most state Medicaid agencies, and many other insurers.

Figure 1. Medicare Telehealth Basics

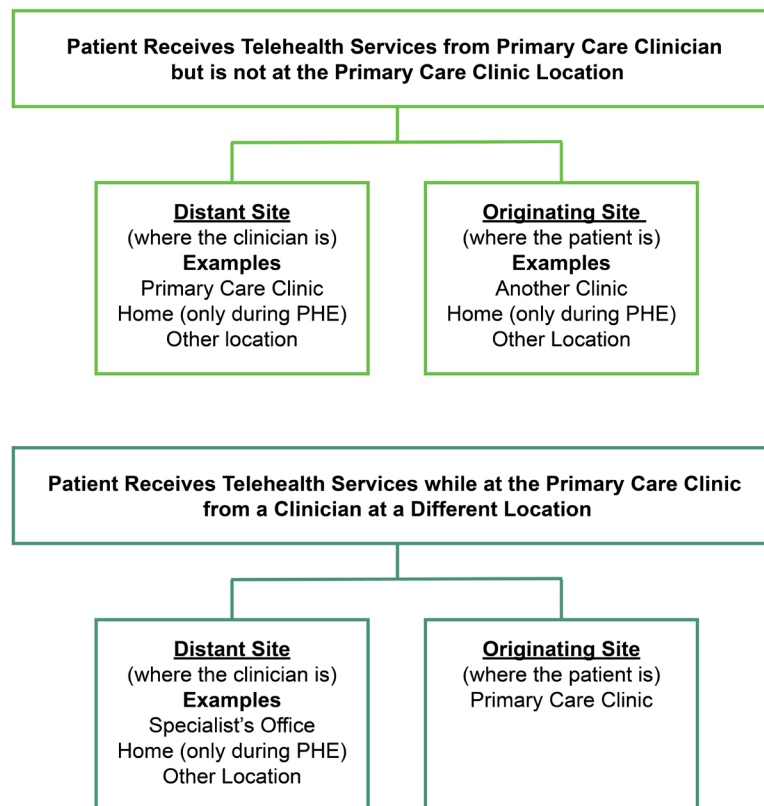


Originating site fees

- The Medicare payment amount for the originating site fee is adjusted every year. For calendar year 2021, the payment amount for Healthcare Common Procedure Coding System (HCPCS) code Q3014 (telehealth originating site facility fee) is 80% of the lesser of the actual charge, or \$27.02 (the beneficiary is responsible for any unmet deductible amount and Medicare coinsurance)⁴
- There is a short list of authorized originating sites, including “physician and practitioner offices,” FQHCs and RHCs that can be reimbursed for originating site fees for Medicare beneficiaries. Refer to the [CMS Telehealth Services Booklet](#) for the full list
- Each state Medicaid determines whether they will reimburse for an originating site fee. The best place to identify state-specific requirements is at the Center for Connected Health Policy (CCHP) site [Current State Laws & Reimbursement Policies](#). It may require consulting the state statute links on the CCHP site or directly contacting your state Medicaid.

⁴ [CMS Manual System Pub 100-04 Medicare Claims Processing](#). CMS. Updated December 4, 2020.

Figure 2. Distant site (where the provider is) and originating site (where the patient is).
FQHC/RHCs have essentially two scenarios to consider for distant and originating sites.



Resources

1. [CMS Telehealth Services Booklet](#). CMS. Excellent resource with the details of telehealth service delivery for Medicare beneficiaries.
2. [CMS List of Telehealth Services](#). CMS. Full list of telehealth services and codes updated frequently during the COVID-19 pandemic but usually just updated annually.
3. [Telehealth Services and Codes](#). Northwest Regional Telehealth Resource Center (NRTRC). This is a resource with the CMS List of Telehealth Services, including Category 1, 2, and 3 (available until Dec 31, 2023) and the interim codes (available through the PHE) grouped by discipline with codes, descriptions and helpful resources.
4. [Physician Fee Schedule Look-Up Tool](#). CMS. Use this tool to search pricing amounts for billing codes.
5. [Current State Laws & Reimbursement Policies](#). CCHP. Telehealth policy changes, including comprehensive, state-specific look-up tool with state Medicaid statutes and other information related to telehealth policy and allowances.
6. [Billing for Telehealth Encounters – An Introductory Guide on Fee for Service](#). CCHP. March 2021. Excellent information about telehealth billing and reimbursement.
7. [American Medical Association Telehealth Implementation Playbook](#). American Medical Association (AMA). This is a long document at 128 pages, but it is comprehensive and done well. Not all sections are relevant, however, it is worth scrolling through the document for the parts that apply, such as Designing the Workflow and references to documentation.

8. [National Consortium of Telehealth Resource Centers](#) – Provides trusted consultation, resources, and news at no cost to help you plan your experience. Start here to find the HRSA-funded Telehealth Resource Center representing your state.
9. [Telehealth Services for Medicare Fee-for-Service Providers](#) CMS telehealth fact sheet; also applies to FQHCs and RHCs.
10. [Health and Human Services Telehealth Homepage](#). Excellent telehealth resources.

State-Specific Telehealth Elements to Know

With few exceptions, the specifics for delivering telehealth to Medicare beneficiaries are the same across the nation. However, there is a fair degree of variability among the states in their approach to telehealth for Medicaid beneficiaries. Know the status of the telehealth elements below in your state. The [Current State Laws & Reimbursement Policies](#) is a good place to start. It includes links to state statutes and manuals, but you must check your state regulations for confirmation and full details. For example, the CCHP site may indicate that remote physiologic monitoring is covered, but the state may limit it to just one condition or place other limits that are important to know. Below are the elements, using Nevada as an example.

Telehealth definition. While knowing your state Medicaid agency's definition of telehealth may not impact your delivery of telehealth, it may be helpful to know.

Nevada: "Telehealth is the use of a telecommunications system instead of an in-person recipient encounter for professional consultations, office visits, office psychiatry services and a limited number of other medical services. [Telehealth Billing Instructions](#).

Billing specifics. Check for the details for billing telehealth encounters. For example, many states require using 02 as a Place of Service code and may require additional modifiers.

Nevada: "The provider at the distant site must use Place of Service (POS) Code 02 when billing for services provided via telehealth." [Telehealth Billing Instructions](#). [POS 02 Telehealth Provided Other than in Patient's Home](#) (updated by CMS in October 2021).

Consent requirements. Each state seems to have their own set of requirements. Find out what those are, and then create a template in the EHR or cheat sheet to make it easy to obtain from the patient and to document in the patient's chart.

Nevada: We did not find regulations, statutes or other guidance regarding consent in Nevada, but did find [this consent form](#) from the [Nevada Legislature](#) website

Originating sites. Check who Medicaid defines an eligible originating site (where the patient is) and whether FQHCs, RHCs and/or the patient's home are included. Identify if Medicaid reimburses an originating site fee, including how much the reimbursement is and what the requirements are for billing (e.g., using HCPCs code Q3014). Even if FQHCs/RHCs cannot receive reimbursement, they can still be originating sites to expand service delivery for their patients, saving time and the inconvenience of traveling for patients and families.

Geographic limits. While Medicare imposes geographic limits on originating site locations, most (if not all) state Medicaid agencies do not have the same limits. For Medicare, the originating site must be located in either a county outside a Metropolitan Statistical Area (MSA) or a Rural [Health Professional Shortage Area](#) (HPSA) in a rural census tract.

Nevada: “The originating site must be located within the State of Nevada and is the location where the recipient is.”, including the patient’s home. [Telehealth Resource Guide](#).

Nevada: “If the originating site is enrolled as a Nevada Medicaid provider, they may bill Healthcare Common Procedure Coding System (HCPCS) code Q3014 (Telehealth originating site facility fee).” [Telehealth Billing Instructions](#) ~ check the document for full details but NV considers FQHCs and RHCs as eligible sites.

Nevada: “Facilities that are eligible for encounter reimbursement (e.g., Indian Health (IH) programs, Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs)) may bill for an encounter in lieu of an originating site facility fee, if the distant site is for ancillary services (i.e., consult with specialist). If, for example, the originating site and distant site are two different encounter sites, the originating encounter site must bill the telehealth originating HCFA Common Procedural Coding System (HCPCS) code and the distant encounter site may bill the encounter code.” [Medicaid Services Manual Changes Chapter 3400-Telehealth Services](#)

Distant sites. Check which providers/sites can provide services as a distant site (where the provider is) and whether FQHCs and RHCs are included because this is a major factor in being able to deliver services by telehealth. For example, CMS does not include FQHCs/RHCs as distant sites and does not currently consider speech language pathologists or physical and occupational therapists as distant site providers. However, several states do.

Nevada: “Effective December 1, 2015, telehealth may be used by any Nevada Medicaid and Nevada Check Up provider working within their scope of practice to provide services that can be appropriately provided via telehealth.” [Telehealth Billing Instructions](#).

Payment parity. CMS reimburses telehealth encounters at the same rate as when the services are provided in-person. However, not all insurers do. Doublecheck to make sure the payment rates are the same as for in-person visits.

Nevada: “Services provided via telehealth have parity with in-person health care services.” [Medicaid Services Manual Changes Chapter 3400-Telehealth Services](#)

Coverage parity. CMS reimburses for ~ 110 Category 1 and 2 codes, which has been expanded to ~ 270 with the addition of Category 3 and interim codes during the PHE. (Note that Category 3 codes will likely be extended until Dec 31, 2023⁵.) Know which codes are covered by your state Medicaid agency, and it is quite likely there will be codes covered that Medicare doesn’t have on their list (e.g., well child visits).

Nevada: “Services provided via telehealth have parity with in-person health care services.” [Medicaid Services Manual Changes Chapter 3400-Telehealth Services](#)

Audio-only. Each state can be very specific if or in which situations they allow audio-only. This is one of the most important elements to know. There is at least one state that only allows audio and video for telehealth and disallows billing for the visit if it must be converted to audio-only due to poor connectivity or glitches.

⁵ [Calendar Year 2022 Physician Fee Schedule Proposed Rule](#) (CY2022 PFS Proposed Rule). CMS.

Nevada: Based on available information, Nevada does not allow audio-only telehealth.

In-person visit requirements. Know whether there are any in-person visit requirements. Some state Medicaid agencies require an in-person visit prior to seeing new patients using telehealth.

Nevada: The only information we found pertains to the requirement for an in-person visit when providing telehealth ESRD services. [Medicaid Services Manual Changes Chapter 3400-Telehealth Services](#)

Cross state licensure. This is important to know for your clinicians who may deliver telehealth across state lines and for your patients who may receive services from clinicians in another state. If this element impacts your FQHC/RHC and your patient population, it may require some investigation and/or communication with your state licensing/credentialing boards, medical associations and more. You may need to check if the rules are different depending on the discipline (e.g., behavioral health, SUD, inpatient, specialists, outpatient)

Nevada: Providers must be licensed in the state of Nevada to provide telehealth but do not need to live in the state [RS 629.515](#). Additionally, Nevada is a member of the [Interstate Medical Licensure Compact](#) and the [Psychology Interjurisdictional Compact \(PSYPACT\)](#) Psychosocial Rehabilitation (PSR) services.

School-based telehealth. Many FQHCs/RHCs provide school-based telehealth. Check your state statutes and regulations for this telehealth option.

Nevada: While we did not find information from Nevada Medicaid regarding school-based telehealth, please see this [Nevada School-Based Health Center Toolkit](#).

Teledentistry. Many states recognize the benefits of teledentistry to expand access and address health inequity. Some states are very sophisticated in their definitions, rules and regulations around teledentistry, but that is not the case in all states.

Nevada: The [Nevada State Board of Dental Examiners](#) notes that their Board “...passed a motion finding that telehealth is within the scope of NRS 631.215, which defines the practice of dentistry in the State of Nevada. The Board also voted to create a regulation to address and define telehealth as it relates to the practice of dentistry in the State of Nevada. While such a regulation has yet to be created and adopted, the Board has already concluded that practitioners may practice in teledentistry.”

Asynchronous telehealth services.

Nevada: “Asynchronous telehealth services, also known as Store-and-Forward, are defined as the transmission of a patient’s medical information from an originating site to the health care provider distant site without the presence of the recipient. The DHCFP reimburses for services delivered via asynchronous telehealth, however, these services are not eligible for originating site facility fees.” [Medicaid Services Manual Changes Chapter 3400-Telehealth Services](#). It is not clear for which asynchronous telehealth services Nevada Medicaid reimburses.

Manuals and clear guidance. Some states have resources that are dedicated to telehealth. For other states finding telehealth specifics can be an arduous search with conflicting information from document to document. It can be helpful to identify and keep a handy reference with hyperlinks to the relevant documents. Linking to the documents is preferred over printing (sometimes necessary) because the information is often updated on the website.

Nevada: We found three resources - [Telehealth Billing Instructions](#), [Telehealth Resource Guide](#), and [Medicaid Services Manual Changes Chapter 3400-Telehealth Services](#).

The Texas [Telecommunication Services Handbook](#) is also very nicely done.

Telehealth platforms. Even if it is not explicitly stated (it usually is), best practice dictates having a HIPAA-compliant platform.

Nevada: We did not find mention of using a HIPAA-compliant platform outside of documents specific to the PHE.

Documentation requirements. Some but not all Medicaid agencies state explicitly that both telehealth and in-person visits and accompanying documentation must comply with all components and procedural definitions for the CPT or HCPCS code that is billed.

Nevada: We did not find details on documentation for telehealth visits.

Telehealth and FQHC/RHC Opportunities

During the PHE, the list of possible telehealth services expanded dramatically from about 109 codes and services to about 271 codes as of the writing of this guide (October 2021). FQHCs and RHCs were excluded from acting as a distant site for Medicare beneficiaries, which has temporarily changed during the PHE, opening new possibilities for FQHCs/RHCs to expand access, keep patients safe and capture revenue.

BEST PRACTICE: Review the full list of telehealth codes and services to identify the primary care services that your clinic can provide by telehealth.

At least through 2021, FQHC/RHCs are not paid by Medicare for telehealth under the prospective payment system (PPS) or the all-inclusive rate (AIR) but are reimbursed at a rate of \$99.45 – regardless of telehealth service. There is pending legislation that will allow FQHCs/RHCs to continue acting as distant sites, and the reimbursement will likely follow the PPS and AIR models after the PHE ends.

However, it is important to note that most state Medicaid agencies were reimbursing FQHCs/RHCs for telehealth services prior to the pandemic. Below is a starter list of primary care services that are commonly delivered in person but can also be delivered by telehealth. Because it is unclear whether FQHCs/RHCs will continue using a generic code (e.g., G2025) for telehealth or will need to use the CPT code, we have included the CPT codes in the tables below.

For each service, consider a team-based approach that aligns with the clinic’s processes for team-based care for in-person visits, ensuring that everyone is working to the top of licensure, scope, training, and comfort level.

New and established (est) evaluation and management (E/M) visits. These telehealth codes and services are the same as “office visits,” only they are delivered remotely using telehealth (audio and video). Starting in 2021, E/M visits can be based either on encounter time or medical decision-making (MDM). As per the [CY 2021 Physician Fee Schedule Final Rule](#), 99201 is deleted. Even though FQHCs/RHCs bill G2025 for any telehealth service, consider documenting start and end times as well as the accompanying CPT code. Some EHRs will recode the appropriate CPT code to the G2025 code automatically for FQHCs/RHCs. Activities that count toward the encounter time expand opportunities for reimbursement for care team activities and include:

- Preparing to see the patient (e.g., review of test results, pre-visit planning)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluations

- Counseling and educating the patient/family/caregiver
- Documenting clinical information in the medical record
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (provided it is not reported separately)

Code: G2025 for FQHCs/RHCs	Encounter Time (Min)*	MDM
99202-New Level 2	15-29	Straightforward
99203-New Level 3	30-44	Low
99204-New Level 4	45-59	Moderate
99205-New Level 5	60-74	High
99211-Est Level 1	0-9	N/A
99212-Est Level 2	10-19	Straightforward
99213-Est Level 3	20-29	Low
99214-Est Level 4	30-39	Moderate
99215-Est Level 5	40-54	High
Reimbursement for FQHC/RHC for telehealth for 2021 is \$99.45. *Time component includes total non-face-to-face and face-to-face time per patient per 24-hour day; documentation should include the total number of minutes spent and how that time was accrued.		

Resources

1. [Physician Fee Schedule \(PFS\) Payment for Office/Outpatient Evaluation and Management \(E/M\) Visits](#). CMS. Dated January 11, 2021.
2. [Evaluation and Management \(E/M\) Office or Other Outpatient and Prolonged Services Code and Guideline Changes](#). AMA. Updated March 9, 2021.

Additional telehealth services for FQHCs and RHCs to consider. As noted above, while most state Medicaid agencies have reimbursed FQHCs/RHCs for telehealth, outside of the PHE, Medicare does not currently recognize these organizations as distant sites, and many organizations are not aware of all possible services that can be delivered by telehealth. Below are several telehealth services to consider delivering to Medicare beneficiaries and possibly to those with other insurers. Most states have a select set of codes for which they reimburse when the services are delivered by telehealth. Again, note that due to current uncertainty with how Medicare reimbursement will evolve, following several pending pieces of legislation, keep in mind that at least until Dec 31, 2021, FQHCs/RHCs use G2025 for telehealth services delivered to Medicare beneficiaries. The table below includes the CPT or HCPCS code primarily as a reference to ensure compliance with the published rules and guidelines for the services that correspond with each code. Several states clearly indicate that when a service is delivered by telehealth, clinicians are required to comply with all requirements and details of each CPT code, making it important to double check with your billers, coders and/or CPT codebook.

For each of the following consider:

- ☐ Identifying an individual (or small team) to be the champion/manager, who will also know/learn the rules and guidelines for each CPT code/service.
- ☐ Outlining each component/task of the process with an assigned owner.
- ☐ Including in pre-visit planning.
- ☐ Running a report to identify all patients in each target population and conducting outreach calls to schedule telehealth or in-person visits.

Description	Code
Advance care planning (ACP). Now more than ever, advance care planning is a critical component of health care service delivery. FQHCs should offer ACP to all patients; completing advance directives is not a required component, and this is a great opportunity to apply team-based care. <ol style="list-style-type: none"> 1. Advance Care Planning Fact Sheet. CMS. Updated October 2020. 2. Frequently Asked Questions about Billing the Physician Fee Schedule for Advance Care Planning Services. CMS. Updated July 2016 (but still relevant). Check question No. 4 “Who can perform ACP services?” 	
ACP, including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate	99497
Each additional 30 min of ACP. List separately in addition to code for primary procedure.	99498
Transitional Care Management (TCM). CMS has responded to findings on the benefits and low usage of transitional care management services by increasing reimbursement (not applicable for FQHCs/RHCs that are paid by PPS/AIR) and removing several co-billing restrictions, including allowing TCM services to be billed concurrently with chronic care management codes. TCM is a critical tool for ensuring that patients are supported during the transition to home after a hospital or skilled nursing facility stay. Note that face-to-face does not mean in person; a telehealth visit is face-to-face when using audio and video. <ol style="list-style-type: none"> 1. Transitional Care Management Services (updated July 2021 and the accompanying FAQ sheet (updated March 2016 and does not reflect that TCM and chronic and principal care management can now be billed during the same calendar month). CMS. 2. Transitional Care Management. American Academy of Family Physicians. 	
Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge; medical decision-making of at least moderate complexity during the service period; face-to-face visit within 14 calendar days of discharge	99495
Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge; medical decision-making of at least high complexity during the service period; face-to-face visit within 7 calendar days of discharge	99496
Initial and subsequent annual wellness visits (AWV): Many primary care practices already provide in-person initial preventive physical examinations (IPPE) and AWVs for their Medicare patients, but these can also be conducted through telehealth. <ol style="list-style-type: none"> 1. Medicare Wellness Visits. CMS. Updated October 2020. 	
Annual wellness visit, includes a personalized prevention plan of service, initial visit	G0438
Annual wellness visit, includes a personalized prevention plan of service, subsequent visit	G0439
Additional telehealth opportunities. While this guide includes several common primary care services, there are many more that may be relevant to your practice. Additional options are in the truncated table below, but check the Medicare List of Telehealth Services to ensure you are using all of the telehealth options available to clinicians and care teams in a primary care practice.	
Medical nutrition therapy (MNT) – individual and group	97802-97804
Diabetes self-management training (DSMT) – individual and group	G0108,G0109
Chronic kidney disease patient education – individual and group	G0420,G0421
Counseling visit to discuss need for lung cancer screening using low-dose CT scan (CMS’ Medicare Coverage of Screening for Lung Cancer with Low Dose Computed Tomography) – see also CMS’ Patient Page on Lung Cancer Screening	G0296
Treatment for opioid use disorder – several codes and services – a few are listed here. Barriers & Challenges to FQHC use of Telehealth for Substance Use Disorder	G2086-G2088

Resources

1. [Rural Crosswalk: CMS Flexibilities to Fight COVID-19](#). CMS. Telehealth and Other Virtual Services – crosswalks among FQHCs, RHCs, CAHs, hospitals and SNFs. It appears that CMS created this resource to capture the information more efficiently, but it does make it a bit more challenging to pull out exactly what is specific to FQHCs/RHCs from this 46-page document
2. [COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers](#). CMS.
3. [COVID-19 Frequently Asked Questions \(FAQs\) on Medicare Fee-for-Service \(FFS\) Billing](#). CMS. Note section M “Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)”
4. [New & Expanded Flexibilities for RHCs & FQHCs during the PHE](#). CMS. Excellent resource for billing telehealth for Medicare beneficiaries. CMS updated in Feb 2021 to include the 2021 reimbursement rate of \$99.45 for telehealth services and \$23.73 for G0071.
5. [Resources for Telehealth at Safety Net Settings](#). University of California San Francisco – Center for Vulnerable Populations. Some nice resources to peruse.

School-Based Telehealth. This is an amazing opportunity to expand the reach of primary care, telehealth, and the care team. Telehealth can also be an excellent option for schools that do not have a school nurse, or to support an existing school nurse. Telehealth services can be delivered to patients at a school, which serves as the originating site (where the patient is).

There is some pre-work that needs to happen before fully implementing school-based telehealth, including, but not limited to:

- ☐ Confer with the school about feasibility and need for school-based telehealth – either to provide or support a school nurse and/or to deliver health care services by telehealth
- ☐ Ensure that the community, parents, and culture are supportive of this approach
- ☐ Check the state Medicaid telehealth requirements to identify which services/billing codes can be used along with all other requirements (e.g., consent). Some state statutes are supportive, detailed and very clear about delivering school-based telehealth.
- ☐ Allocate a quiet, private space at or near the school
- ☐ Ensure there is a computer or other device with audio and video capability with adequate connectivity
- ☐ Work with/train school staff to provide the necessary support to facilitate telehealth visits, even if it’s just to get the visit started
- ☐ Draft a written form letter for parents or legal guardians to sign, giving their expressed written consent for school-based telehealth visits and in which situations the parent or legal guardian indicates they must also be part of the telehealth visit (ensure that written consent from a parent or legal guardian is valid for the entire school year). Make sure the consent complies with all state requirements.
- ☐ Test on a small scale to identify and implement any needed improvements to the processes

Teledentistry. This is an option for FQHCs/RHCs with oral health integration that are interested in expanding access to oral health. Dental hygienists can assess the mouths of patients, chart areas of concern, decay, or periodontal disease, take high-resolution photographs and X-rays, and transmit that information to a dentist who can review the materials, and develop a treatment plan for a patient. Additionally, in rural areas with shortages of dentists, the care team can “bring” a dentist or other oral health specialist into the exam room by synchronous (live video) communication to assess and discuss a dental issue and subsequent treatment plan for a patient.

While there are several teledentistry modalities available, the following are the high-leverage applications:

- Using store and forward technology for dental hygienists and others on dental and medical care teams
- Including dentists and other oral health and dental specialists (e.g., orthodontist) to join office visits

- Using synchronous and asynchronous (e.g., secure messaging/email) options for clinician-to-dental professional consults
- Providing synchronous and broad oral health education

Checklist

- ☐ If the FQHC/RHC has oral health/dental services onsite, know the teledentistry options that are or can be offered to patients located at a variety of originating sites
- ☐ List teledentistry options offered by dental professionals that are at a distant site other than the primary care clinic, especially if in a rural area with a shortage of dentists
- ☐ Ensure that the clinic and staff have the equipment needed (e.g., high-quality camera)
- ☐ Ensure that all patients have a dental home and are receiving preventive and curative dental services – by teledentistry if necessary and available
- ☐ Consider an oral health education program that is delivered virtually or remotely and/or includes mHealth or app-based options

Resources

1. [Virtual Dental Home Example](#) – Provides a “Roaming Dental Home” example for primary care clinics.
2. [Fast-Track to Teledentistry – Removing Barriers to Care while Maximizing Overall Health](#). DentaQuest.
3. [Teledentistry – Lights. Camera. Open Wide](#). Southwest Telehealth Resource Center (SWTRC). This is a short blog that includes additional resources.

Peripherals. Peripherals are devices that are used to collect patient biometrics and physical exam information between and/or during a telehealth visit. Devices used for remote physiologic monitoring include scales, blood pressure monitors, basic electrocardiogram (ECG), digital thermometers that transmit data, blood glucose monitors, pulse oximeters, peak flow meters and more. Devices used to facilitate physical exams include exam cameras, thermometers, otoscopes, stethoscopes, tongue depressors and more that are used by individuals, including patients, caregivers, clinicians, care team members and others at the originating site (where the patient is). FQHCs/RHCs offering obstetric (OB) services often provide fetal heart monitors to their pregnant patients for use during OB telehealth visits.

Other Virtual Services

While telehealth has tremendous opportunities to enhance access, keep people safe and capture reimbursement, there are additional virtual services for FQHCs/RHCs to consider adding to the suite of options for health care service delivery. Check with your state Medicaid Physician Fee Schedule to know if these services are reimbursed.

Mental Health Services

In the [Calendar Year 2022 Physician Fee Schedule Proposed Rule](#) (CY2022 PFS Proposed Rule), CMS proposed amending the regulation at § 410.78(a)(3) to define interactive telecommunications system to include audio-only communications technology when used for **telehealth services** for the diagnosis, evaluation, or treatment of **mental health disorders** furnished to established patients when the originating site is the patient’s home. Physicians or practitioners must **have** the capacity to furnish two-way, audio/video telehealth services but are providing the mental health services via audio-only communication technology in an instance where the beneficiary is unable to use, does not wish to use, or does not have access to two-way, audio/video technology.” (p. 39148). As of the writing of this guide, we await the full details in the Final Rule.

Telephone-Only Evaluation and Management – Office Visits (during PHE only!)

FQHC/RHC providers may use G2025 (\$99.45 for 2021) to provide and bill for CPT codes 99441 (5-10 min), 99442 (11-20 min) and 99443 (21-30 min), which are audio-only telephone evaluation and management (E/M) services.

- A physician or Medicare provider who may report E/M services must provide at least 5 minutes of telephone E/M service to an established patient, parent, or guardian to bill for these services.
- 7/24 rules: these services cannot be billed if they originate from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the next 24 hours or soonest available appointment.

Nevada: These codes are not listed on the [Provider Type 20 Physician, MD., Osteopath](#) fee schedule (as of Oct 24, 2021)

Virtual Communication Services – G0071 (\$23.73 through Dec 31, 2021)

For all three Virtual Communication Services below:

- Use G0071
 - Obtain consent, which must be documented in the medical record, which can be obtained at the time of services and by staff under the general supervision of the FQHC/RHC provider (only during the PHE for the latter two)
 - Adhere to “7/24” rules noted above in Telephone-Only E/M services
 - Must be patient-initiated
1. **Virtual Check-Ins – Phone Call.** Five to ten minutes of medical discussion described as a brief communication technology-based service (audio-only real-time telephone interactions) by a physician or other qualified health care professional who can report evaluation and management services. This is a great option to determine if a patient needs a virtual or in-person office visit
 2. **Store and Forward - Remote Evaluation of Recorded Video and/or Images.** Includes interpretation with follow-up with the patient within 24 business hours.
 3. **E-Visits** are online digital evaluation and management services that are provided over a 7-day period and are non-face-to-face, digital communications using a secure patient portal

Nevada: These codes are not listed on the [Provider Type 20 Physician, MD., Osteopath](#) fee schedule (as of Oct 24, 2021)

Resources

1. [Virtual Communication Services in Rural Health Clinics \(RHCs\) and Federally Qualified Health Centers \(FQHCs\) Frequently Asked Questions](#)
2. [CMS Virtual Check-In Patient Page](#)

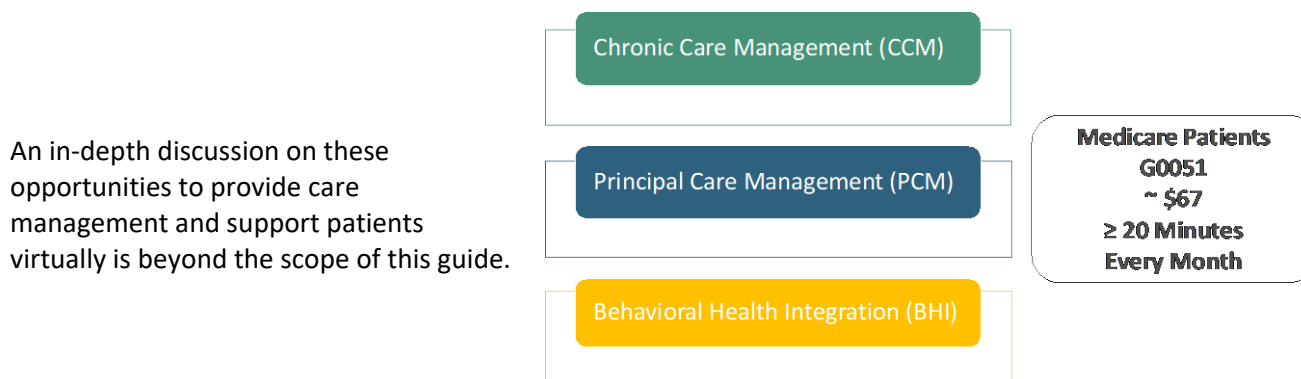
Interprofessional consultations (e-consults). While e-consults are not traditionally considered telehealth, there is a full set of codes to facilitate delivery of these services, which can be efficient for referring clinicians, specialists and the patients/families that we serve. You may need to go to your state Medicaid physician fee schedule, check to see if the e-consult codes are listed, then contact Medicaid to know if your FQHC/RHC can be reimbursed for these codes and what the rate is (PPS, AIR, something else); CMS does not reimburse FQHCs/RHCs for e-consults using the interprofessional codes. However, only one of the five codes is for the referring physician; the rest of the codes are for the specialist. This is an opportunity to enhance access to specialists and to improve convenience for patients.

Resources

1. [Interprofessional Consultations: A Person-Centered Referral Option](#). SWTRC. This is a blog that helps make the case for e-consults and includes additional resources.
2. [Interprofessional Consultations: A Person-Centered Referral Option](#). NRTRC. This is a three-page document with a deeper dive into the billing codes and details.
3. Louisiana – see [this document pp. 10-12](#). LA is one of the few states that addresses their coverage of e-consults. However, a case can be made that e-consults enhance access, taking less time for specialists and cut health care costs, suggesting that now may be the time to encourage more states to cover this health care service.

Chronic and Principal Care management (CCM/PCM), Behavioral Health Integration (BHI) and the Collaborative Care Model (CoCM)

Like the information above for e-consults, check your state Medicaid physician fee schedule for the codes.



Resources

1. [Cheat Sheet on CMS Medicare Payments for Behavioral Health Integration Services - Federally Qualified Health Centers and Rural Health Clinics](#). University of Washington AIMS Center. 2019.
2. [Behavioral Health Integration Services – MLN Booklet](#). CMS. Updated March 2021.
3. [Chronic & Principal Care Management Services: Implementation Guidance](#). Comagine Health and NRTRC.

Remote Physiologic (or Patient) Monitoring (RPM)

Remote physiologic monitoring is the virtual service with the strongest evidence for keeping patients out of the emergency department and preventing hospital admissions. It is also a great tool for patients' self-management support. Unfortunately, Medicare does not reimburse FQHCs/RHCs for RPM, stating that this work and service is included in the PPS or AIR. However, several state Medicaid agencies *do* reimburse for RPM, and the best way to know is to find your state's fee schedule online and search for the RPM codes. Recognizing the importance of RPM, many FQHCs/RHCs are creatively integrating RPM into Chronic and Principal Care Management. Below are the codes and descriptions as a starting place to research whether your state Medicaid reimburses for these codes.

Nevada – no mention of covering RPM. Examples of RPM in other states include:

- [RPM in Louisiana](#) – Limited to heart failure, diabetes or pulmonary disease and limited to the [Community Choices Waiver](#) (i.e., seniors and persons with adult-onset disabilities)
- [RPM – In Texas](#) – Called “Telemonitoring Services” and requires prior authorization. [Home Telemonitoring Services Prior Authorization Request](#)
- RPM in Colorado – See the [strict conditions for Colorado Medicaid](#)

There are at least three distinct versions of RPM:

1. As defined by Medicare, RPM includes five billing codes and has several conditions and requirements. These RPM services require that “the medical device should digitally (that is, automatically) upload patient physiologic data (that is, data are not patient self-recorded and self-reported),”⁶ which is not the case for the 2 and 3 below.
2. Medicare reimburses for other RPM services (e.g., self-measured blood pressure monitoring and continuous glucose monitoring (CGM) and [ambulatory blood pressure monitoring](#)) that don’t technically fall under their RPM definition from 1 above.
3. Remote patient monitoring that may or may not be “physiologic” can be an excellent adjunct for chronic disease and other self-management and may include regular check-ins, reminders, diet logs, and so much more. With the explosion of patient health apps, the possibilities continue to expand.

Resource

[Remote Physiologic Monitoring \(RPM\)](#). Comagine Health.

Telehealth Policy and Procedure

To ensure that telehealth is safe, high-quality, and equitable, add telehealth specifics to existing policies and procedures. However, it is strongly recommended to also have in place a telehealth policy and procedure. See [Appendix – Telehealth Policy and Procedure Starter](#) for a place to start your own customized telehealth policy and procedure.

Equity

While telehealth can expand access, it also exacerbates health inequity.

To engage in telehealth, patients need the following:

- Private, quiet, safe space
- Device with camera and microphone
- Stable internet with adequate bandwidth
- Someone to help those with limited digital proficiency

BEST PRACTICE: Ensure that all individuals have the same access and support to engage in virtual care and telehealth.

Unfortunately, too many people do not have some or all the above. Lack of access to telehealth should be considered a social determinant of health, documented as structured data, and addressed in innovative and creative ways. Envision and execute community-based solutions; likely partners include libraries, senior centers, places of worship, employers, community centers, homeless shelters and more. Below is a starter set of barriers and potential solutions. Add/modify barriers and potential solution specific to your organization, location, and patient population. The potential solutions below have all been used by others.

Telehealth Barriers and Potential Solutions for Patients

Connectivity – lack of internet connection or data plan

- Identify federal or state programs to help pay for internet (e.g., [FCC Lifeline Support for Affordable Communications](#), [EveryoneOn](#), [National Digital Inclusion Alliance](#))
- Provide prepaid phones
- Dispense prepaid data or internet/wireless service cards
- Provide mobile hot spots
- Work with the local partners to find community-based solutions that can provide connectivity and more (e.g., library, senior center, places of worship, employers)

Connectivity – lack of broadband in patient's location

- While this may be a difficult barrier to overcome until reliable, high-speed broadband is available in the patient's location, consider lack of broadband as social determinant of health and document as structured data for future reference (e.g., we do not keep offering telehealth visits if in the same location) and for possible reports
- Develop a broadband availability map using available sources for majority of the geographic area served by the FQHC/RHC

Lack of phone/data plan to talk on phone

- Provide prepaid phones and/or data plan cards
- Call patients at the beginning of the month/cycle when they are likely to still have minutes – with their permission to use those minutes for the call we are making
- Use a mobile or landline phone at a community-based option

We already have many audio-only options to support patients, including chronic and principal care management, behavioral health integration, the collaborative care model, virtual check-ins and more. Most people have phones, but not everyone does, nor does everyone have a data plan that allows them to engage in virtual care services.

Lack of device with camera and microphone

- Have staff deliver device to patients' homes (and help with navigating technology). [Off-Site Video Collaboration](#) (a three-minute video on how this can work)
- Consider a mail-to-patient option that provides easy option for the patient to return the device
- Direct the patient to community-based locations that have agreed to help/host with telehealth visits

Low digital proficiency

- Offer practice virtual visits
- Make allowances (e.g., more time) and reassure patient that it will get easier with time
- Send clear easy-to-read/understand instructions in advance by mail
- Provide training if patient is interested
- Send staff (e.g., community health worker, promotor(a)) to patient's location to help navigate technology
- Direct the patient to nearby community-based locations that have agreed to help/host telehealth visits
- Ask if family/caregivers can help

Cognitive impairment and those with intellectual/developmental disabilities

- Request having family/caregiver join
- Consider whether virtual service is the best option if patient can make it to the FQHC/RHC
- Speak slowly and clearly – send post-visit notes and treatment plan by mail

Language/translation needs

- Know and connect with translation services; have arranged and ready to go at time of call (e.g., [Process to Add Interpreter to Zoom](#))
- Arrange American Sign Language (ASL) translation services for individuals who are deaf, when appropriate and available
- Note that this can be a significant barrier. Depending on a clinic's patient population, arranging, and coordinating translation services can be complex and time-consuming

Hearing-impaired

- Speak clearly and help patient turn up volume; ask patient if speaking louder is helpful
- Ensure patient has headset with noise-cancelling feature to block out ambient noise; send patient a headset if they do not have one
- Check with patient beforehand if telehealth is the best option and/or what other accommodations can be made

Private quiet place that is safe

- Talk to the patient about safe options and if there are none, the team may need to accommodate the best the patient can do
- If possible, direct the patient to nearby community-based locations that have agreed to help/host telehealth visits

Unhoused individuals

- Bring device to people who are unhoused to engage in telehealth visits. Recognize that some patients may distrust technology or have concerns about privacy. Make sure patients can clearly see your credentials and check in frequently on the patient's comfort level.

Person-Centered Telehealth

If telehealth is not person-centered for all involved - patients, clinicians, and the care team - they will not engage in telehealth, and it will not be sustained beyond the COVID-19 pandemic. In addition to "walking in the shoes of our patients," the best way to streamline and ensure person-centeredness is to measure what matters and ask people for feedback on what's working and what we can do better.

When one health center switched from audio-only to telehealth, requiring both audio and video, their no-show rate went from 5% to 50%, indicating that the process was not "working" for patients.

Several best practices include:

- Making telehealth the default. Patients will be scheduled for telehealth visits unless they want or need to be seen in person.
- Assessing and improving digital proficiency by supporting patients and staff until they are comfortable with the technology and new processes.
- Scheduling when it is convenient for patients, even if that means evenings and weekends
- Calling at patients' preferred times.
- Choosing a telehealth solution based on patient rather than clinician/care team preference — otherwise patients may not use it.
- Sending links for telehealth visits in ways that work for patients (e.g., texting the link can be challenging for some patients as they do not know how to navigate to the link while they are talking on the phone).
- Providing simple instructions and tip sheets (e.g., [My Telehealth Checklist](#), [20 Things to Know about Telehealth](#)).

- Trying at least two more times during the day if the care team cannot reach a patient at their scheduled appointment time.
- Providing cheat sheets to clinicians for non-clinical questions patients may ask during a telehealth visit (e.g., “How do I pay my copay?”).
- Allocating a tech-savvy individual to be on the conference or video-conference call to help troubleshoot problems (at least until the virtual care team is comfortable with the technology). Having the opportunity to text or instant message with tech support staff can be very helpful.

Telehealth Etiquette. Below are several of the standard recommendations for telehealth etiquette:

- Check your lighting and screen presence to make sure you are mostly in the middle of the screen without your chin or top of head cut off
- Introduce yourself and anyone else with you or “on the line” (e.g., scribe, MA, student)
- Include your credentials or title: “Hi I’m Alice. I’m the medical assistant, and I’ll be gathering some information and asking questions before you see your provider.”
- If possible, have easy-to-read signs behind with your name and title or role: Alice – Medical Assistant
- Let the patient know how long the telehealth visit is
- Acknowledge when people speak to convey that you have heard and understand
- Look directly into the camera; it is the only way for the patient to feel as though you are looking right at them and have eye contact (if not typing)
- Lean in closer to the camera when seeking to convey empathy
- Let the patient know you are typing in the medical record if you must look away to do so
- Do not comment on their background or environment
 - This is contrary to what you may hear from others. Patients can be self-conscious, uncomfortable, or untrusting. It is best to just not comment on their background
- If you are wearing a mask, let them know when you smile: “You can’t see my mouth right now, but I am smiling a big smile. I’m so happy that you are now able to see your grandchildren.”

Resources

1. Telehealth Etiquette Resource: [Video Sessions Tips for Clinicians & Other Helping Professionals](#)
2. [Video Sessions Tips for Clinicians & Other Helping Professionals](#). EM Consulting. Well-done eight-page guidance document.
3. If you are using Zoom, there are great resources under “[For Clinicians](#)”
4. [Conducting Sensitive Screenings Using Telehealth](#). EM Consulting. Includes nice example phrases and verbiage.

Virtual Care Team – Essential Tools of the Trade

FQHCs/RHCs may continue allowing clinicians and care teams to work virtually after the PHE. High-performing virtual care teams need a short list of essentials to successfully engage in telehealth. Consider how best your organization can provide the following.

Laptop/mobile device. If the virtual care team is working from home or another offsite location, they need a mobile device provided and maintained by the primary care organization. This does create a security risk if devices are lost or stolen, but there are safeguards to put in place, and this is an essential tool.

Access to the electronic health record. For the virtual care team to be effective, they need access to patient information (especially for clinicians), recognizing the inherent technical, security and privacy issues. Providing secure

access through a virtual private network (VPN) may be a solution, but IT staff will know the best way to accomplish this.

Privacy screen. When virtual care teams work from home, there is always the risk that friends or family can see a patient's information. Providing a privacy screen for the monitor/screen prevents purposeful or inadvertent viewing of patient information.

Teleconference and videoconference capability. If audio-only is either allowed or is the only option for a patient, the team may need both tele- and videoconferencing. It is possible that one solution will cover both requirements (e.g., Zoom).

Reliable, high-speed broadband. For interacting with patients as well as the rest of the virtual care team, a reliable connection is a must.

Strong phone connectivity. This is a perennial problem in rural areas, and while 5G holds promises, it is not here yet. Solutions include boosters, using an internet-based phone solution (e.g., WhatsApp) if internet is adequate, or having the team member work in a place with better phone service, if home is not an option.

Readily available technical support. Some organizations have strong IT teams that can provide tech support while others may have that one individual who just seems to have the knack for finding solutions. Either way, the team needs to have support for when the technology is not working.

Workflow

Telehealth visits are the same health care services that are delivered in-person but are conducted using video and/or audio. For the most part, the team should continue with the same roles and responsibilities as with an in-person visit. As with in-person visits, standard, efficient workflows are the key to having telehealth visits run smoothly and ensuring patient safety. As telehealth is being implemented, consider forming a small team of two to three individuals who are responsible for establishing, mapping, fine-tuning and continuously improving workflows.

Find a solution for huddles and pre-visit planning. Many teams have found asynchronous ways to huddle at the beginning of clinic due to the challenges of getting everyone in one place at one time regardless of working virtually. If huddles are used to convey information that is specific to a certain group and does not include patient information, email works well as do other bulk messaging options. One health center has a team of two individuals with high energy and creativity who record "huddle" information first thing in the morning and send the recording link to staff. Each organization needs to find a solution that works for them and their staff given available resources.

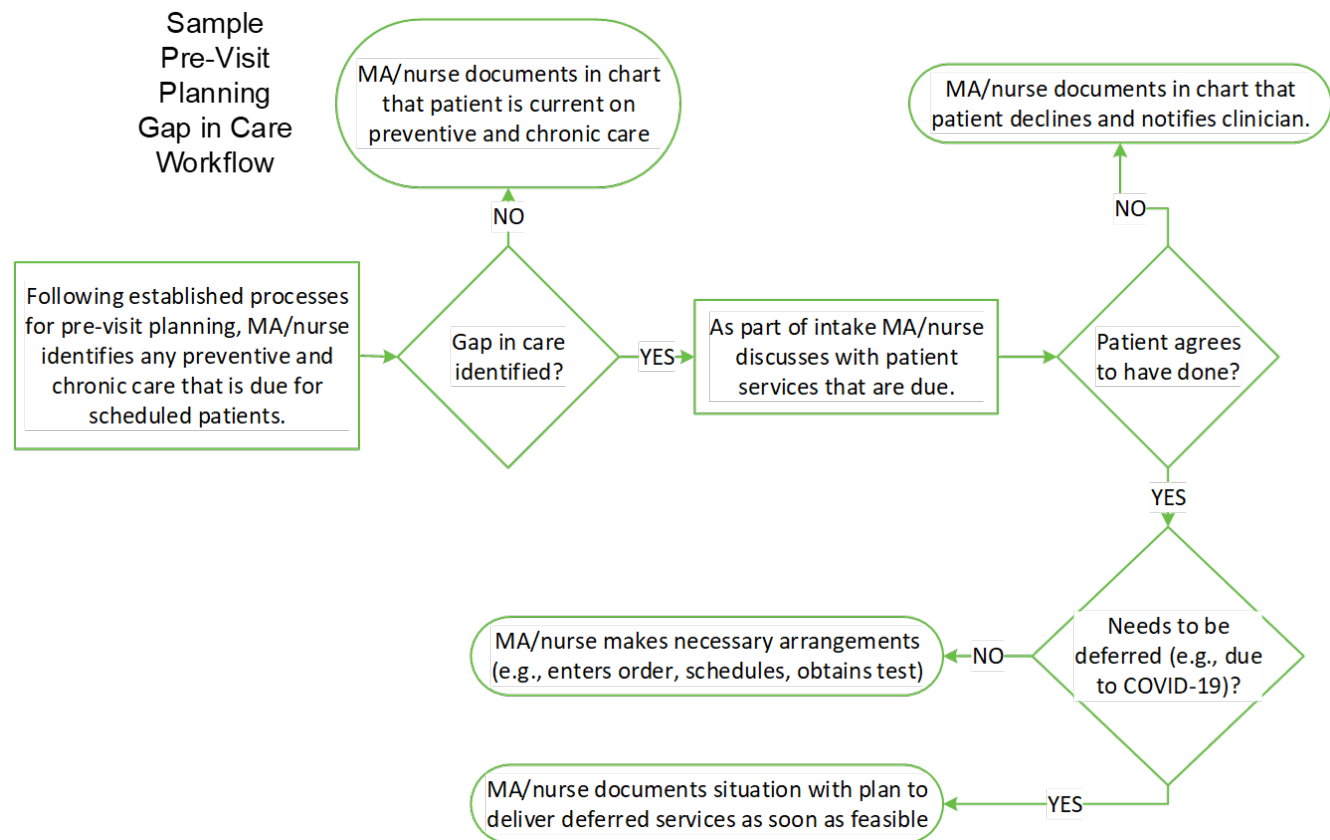
Identify and address gaps in preventive and chronic care. Unfortunately, this important piece of primary care service delivery is often skipped with telehealth, placing the patient at risk for missed and delayed diagnoses and services. *See Figure 3. Sample Pre-Visit Planning Workflow* below.

Clarify who will document what in the patient chart and how, while optimizing team-based care. The clinician needs to complete the history of present illness (HPI) (or confirm what another team member has entered for the HPI), document physical exam findings, develop the assessment and treatment plan, and prescribe medications. Recognizing that the clinician has complete responsibility, any other aspect of the visit may be delegated to someone else on the team if it complies with federal, state, local and organizational regulations, requirements, protocols, etc. The individual must also have the requisite skills, licensure, training, and comfort level.

Streamline all patient-facing workflows. Test and test again to ensure everything is easy as possible for patients to schedule and participate in a telehealth visit.

Identify situations where handoffs are likely to occur and outline the step-by-step process. Make sure that the process does not leave a clinician or care team member without an option to keep working. For example, handing off a device during a telehealth visit from a clinician to a behavioral health specialist without another option for the clinician to keep working or see the next patient is not ideal.

Figure 3. Sample Pre-Visit Planning Workflow



Before the Visit – Telehealth Scheduling Best Practices & Workflow Considerations

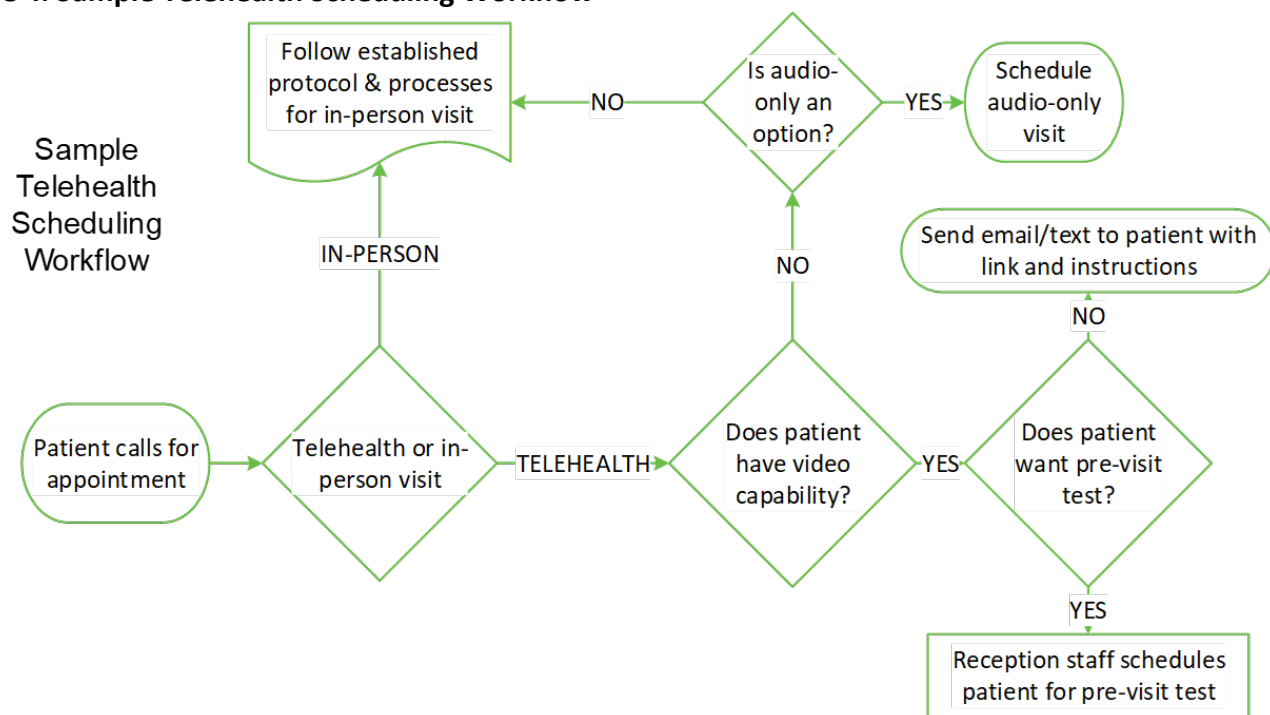
- Offer telehealth as an alternate option to in-person visits when patients call for an appointment
- Create script for reception staff to talk about telehealth as an option
- Provide written clinical protocol for visits that are appropriate for telehealth vs. visits that must occur in person
- Dedicate blocks of time on the schedule for telehealth visits rather than mixing in with in-person visits

PROMISING PRACTICE: Offer telehealth a few times to patients who initially decline. They often decide to give it a try after a few offers.

BEST PRACTICE: Provide clear, written guidance for reception staff for which conditions and symptoms require an in-person visit rather than a telehealth visit.

- Ask all patients that are interested in telehealth, “Do you have a smartphone, tablet or desktop computer with camera and internet?” If patients have one of the three or have engaged in at least two visits with video, they can be considered “video-capable”
- Document and track which patients have audio and video vs. audio-only; consider this a social determinant of health linked to equity and access to health care that may be addressable
- Offer a pre-visit technology test for those new to telehealth and/or provide patients with educational materials (e.g., website, online videos, mail, email, text)
- Consider discussing telehealth expectations with patients who are new to the experience. Advise them to treat their visit the same as they would an in-person visit. Remind them that they would not multitask during an in-person visit, and that they should avoid doing other activities during their upcoming telehealth visit (e.g., shopping, driving or walking down the street). They should prioritize finding a quiet place for the telehealth visit.
- Have telehealth materials on-hand to send to the patient (e.g., [20 Things to Know about Telehealth](#), [My Telehealth Checklist](#))
- Send appointment time and date to patient with instructions on how to join the telehealth visit
- Send appointment reminder per patient’s preferred method (e.g., phone call, text, email)

Figure 4. Sample Telehealth Scheduling Workflow



Day of the Visit – Telehealth Team-Based Care & Workflow Considerations

- Start the patient visit on time! If patients must wait for the visit to start or wait for the clinician, they often cannot use their device during the wait, which can be very inconvenient if that device is their smartphone
- Be prepared to end the telehealth visit and have appropriate options available if a telehealth visit is deemed not appropriate or the patient states they would prefer to have an in-person visit
- Have MA/nurse perform the intake that occurs for in-person visits as closely as possible and add telehealth-specific intake tasks
- Obtain and document consent in the medical record (may differ depending on patient's insurance)
- Verify patient identification (e.g., match to patient picture in EHR, Social Security number, date of birth, address, phone number)*
- Review backup plan if audio or video fails (e.g., number for team to call patient)
- Confirm address where patient is — important in case patient suffers adverse event and emergency medical services need to be called
- Advise patient about how to pay copay/deductibles
- Confirm chief complaint, collect information for history of present illness, possibly confirm patients' list of questions
- Confirm any updates to social, family, or surgical history
- Reconcile medications (for review and confirmation by clinician)
- Administer any screening tests (e.g., PHQ9)
- Begin review of systems questions
- Address preventive and chronic gaps in care (if COVID-19 prevents obtaining care that is due, document the plan to obtain that care once restrictions are lifted)
- Depending on the telehealth platform (e.g., Zoom), help patients with adding a background if they are self-conscious or do not want the clinician/care team to see their surroundings
- Consider acting as scribe during the visit

PROMISING PRACTICE: To avoid multiple patient handoffs, cross-train MA/nurses to perform the intake that reception staff usually do for telehealth visits.

BEST PRACTICE: Many health centers struggle with when and how to collect copays. Feedback from the field suggests that collecting copays before the visit works well.

BEST PRACTICE: Signal to others that you are on a telehealth visit. For example – put a sign on your door.

*Note that there are growing concerns about fraud and abuse with telehealth. Do the best you can to confirm the identity of the patient and make sure to document how the patient was identified in the medical record.

PROMISING PRACTICE: While frequently overlooked, telehealth visits provide an amazing new opportunity to include family members and/or other caregivers for select patients, especially those that have cognitive impairment, intellectual disabilities and/or are a minor (e.g., if delivering school-based telehealth). There are two important caveats:

1. The patient or health proxy must provide permission.
2. The visit must still be focused on the patient without disruption from other participants.

Resources

1. [Remote Visit Workflow](#). Nicely done example
2. [Telehealth and Telephone Visits in the Time of COVID-19: FQHC Workflows and Guides](#)
3. [Nice example of a step-by-step workflow including screenshots of the EHR](#)
4. Basic information on workflows can be found at the Agency for Healthcare Research and Quality website [What is workflow?](#).
5. The National Telehealth Research Center provides a 47-minute instructional video on [Mapping and Designing Telehealth Clinic Workflows](#) that covers the basics of workflow mapping.
6. The California Telehealth Resource Center provides additional telehealth [sample workflows](#)
7. [Rapid Implementation of Telepsychiatry in a Safety-Net Health System During Covid-19 Using Lean](#) – excellent example with nice cause-and-effect diagram and workflow

Consent

The care team can obtain and document consent to receive telehealth. Medicare, most state Medicaid agencies, and other insurers require patients' informed consent for telehealth. While consent for Medicare beneficiaries is straightforward, other insurers, including state Medicaid agencies, have informed consent requirements that can be complex. Below are the consent requirements for Medicare. Check directly with other insurers for their specific requirements and guidance for informed consent.

Medicare Consent for Telehealth

Medicare requires beneficiary consent — verbal or written — for telehealth and other virtual services as well as notification of any applicable cost-sharing, including potential deductible and coinsurance amounts. Consent must be documented in the patient's medical record.

State Medicaid Agencies Consent for Telehealth

Each state has its own requirements for consent for telehealth. The best place to know what is required in your state is to go to the Center for Connected Health Policy (CCHP) site [Current State Laws & Reimbursement Policies](#). Click on your state and scroll to consent.

Patient Safety Tips

There are several potential patient safety issues with telehealth or calls, which can be mitigated with care.

Emotional and mood cues may be missed. Because the communication is different with telehealth or calls and may not include a video component, facial cues are blunted, and clinicians may not see distress or tears if not using video.

BEST PRACTICE: Have available each clinician's telehealth clinical pathway to determine when a virtual visit acceptable and when an in-person visit is required.

Diagnoses may be missed or delayed. Telehealth is not always the right choice. Robust physical exams that could reveal a serious condition cannot be conducted. Some workflows for remote services have shifted from established workflows away from the way things are done for in-person visits, which may lead to patient safety issues. For example, it is more challenging to deploy team-based care virtually to conduct pre-visit planning and huddles to identify and address preventive and chronic gaps in care.

Clinicians and the care team do not have the benefit of all their senses with telehealth. Keen diagnosticians use all their senses, including their sense of smell, to evaluate, diagnose and otherwise better understand what the status of their patient is. With telehealth, clinicians are limited to vision and hearing, which may not be sufficient to best evaluate the health and well-being of patients.

There is a potential increased risk for domestic abuse. While one hopes that this never happens, some patients are at risk for domestic abuse due to potential abusers hearing part or all the virtual visit. Additionally, patients, including children, may not have the privacy to let a clinician or other staff know if they are being neglected or abused.

Know the physical location/address where the patient is. If emergency medical services need to be called for the patient, it is a key aspect of patient safety to know and document the specific location of the patient.

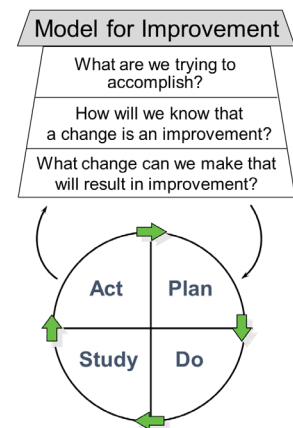
Plan for emergencies. In addition to having the patient's phone number if connectivity fails, it is important to have this information in case of an emergency. Additionally, just planning to call 911 may not suffice. Always have on hand the emergency phone numbers *in that patient's location/county* (e.g., staff may need to call the Sheriff's Department directly) as well as *local (to the patient) mental health crisis lines*.

Quality Improvement and Quality Assurance

Quality improvement. From a performance improvement standpoint, consider a set of process and outcome measures that are aligned with the organization and virtual care team's goals. In addition to satisfaction surveys, clinical quality measures and UDS measures, consider tracking the following suggested measures:

- Percent of encounters that are telehealth visit vs. in-person visits
- Percent of visits that start and end on time – including reasons why visits did not start or end on time (e.g., clinician running late, patient ready on time, appointment time too short to cover issues, questions, concerns)
- ED visits, admissions, and readmissions rates over time
- Clinical quality measures (e.g., vaccine and cancer screening rates, A1Cs, blood pressure control)
- Percent patient who are telehealth-capable

Quality assurance. Each person should have the same high-quality telehealth experience, regardless of several variables (e.g., workflows, devices, clinicians, support staff). Create a process to collect, collate and respond to questions/items related to telehealth. Below is a starter set of questions to assess the patient, clinician, and virtual care team experience.



BEST PRACTICE: Keep surveys short, focused, and easy to complete. Sometimes just asking two simple questions is all that is needed.
"How was your visit?"
"What could have gone better?"

Patient Telehealth Satisfaction Questions	Possible Responses
Overall, I am satisfied with my telehealth visit.	Strongly disagree (1) Disagree (2) Agree (3) Strongly agree (4)
The process to sign on and begin the telehealth visit was easy.	
The visit started on time.	
The clinician's credentials were clearly displayed.	
The clinician and other team members introduced themselves.	
I could see the clinician clearly.	
The clinician listened carefully.	
The clinician explained things in a way that was easy to understand.	
What could have gone better?	Free text box
Clinician Satisfaction Questions	Possible Responses
The telehealth visit went smoothly; I had the support I needed for any glitches.	Strongly disagree (1) Disagree (2) Agree (3) Strongly agree (4)
The visit started on time.	
The virtual care team performed well and completed all pre-visit tasks.	
What could have gone better?	
	Free text box

Technology – Hardware and Software

While telehealth has been around for decades, its recent resurgence has increased awareness. Along with this awareness are concerns for the additional cost of delivering and/or receiving telehealth. The following are some hardware and software considerations related to telehealth. The costs of implementing and adopting telehealth are often not as high as expected. All that is needed is a computer or other device with a camera and a microphone, connectivity (e.g., internet) and a telehealth solution. There are inexpensive/free, HIPAA-compliant options available.

Hardware

Computers, laptops, tablets, etc. – Having a mobile option provides flexibility and efficiency. Mobile devices can be used as part of workflows when a patient is handed off virtually to other staff (e.g., mental health professional, MA). Some organizations bring mobile devices to patients' homes to engage in telehealth.

Headsets or earbuds – There are many inexpensive options abound.

Telemedicine peripherals – These include digital options for conducting portions of the physical exam or providing remote physiologic monitoring (e.g., digital stethoscope, otoscope, or scale; Bluetooth®-enabled glucometer or O² monitor, etc.).

Software

There are several types of telemedicine-related software, but the most common consideration is the telehealth platform/solution that is used by the clinicians, care team, patients, and other staff. Telehealth platforms are sometimes integrated with the EHR, but that is not required. The most important consideration is the ease of access from the patient perspective. If the workflow to engage in a telehealth visit is challenging, patients will not use it and no-show rates for these visits will be high.

HIPAA Privacy and Security: Telehealth Considerations

HIPAA Privacy and Security are always at risk, but it is easier to control and mitigate that risk in the more controlled clinic environment. Below are several privacy and security considerations for the virtual care team.

HIPAA Privacy

There are at least three aspects of patient privacy that need reinforcement when using telehealth and other virtual services:

Use a headset or earbuds. This is a recommendation for the virtual care team *and* patients. An exam room provides a space for private conversations among patients, family, caregivers, clinicians, the care team and more. It is important to maintain a similar level of privacy during virtual communication. On both ends of the virtual communication, it is essential that 1) patients and clinicians can speak freely without risk of being overheard by someone who should not or does not need to hear the conversation and 2) the computer mic is not used when there are others near who can hear either or both sides of the conversation. Using a headset or earbuds can help alleviate this privacy issue.

Protect patient's protected patient information.

- Use a privacy screen so others cannot read patients' information
- Do not let family or friends use your work device

Prevent two patients from joining the same visit. Use the waiting room or other feature to make sure two patients do not join the same session by mistake or other individuals do not join the session for nefarious reasons (e.g., spying or "Zoom bombing").

HIPAA Security

The HIPAA Security Rule requires adherence to the standards and implementation specifications components of the security risk analysis (SRA) is required by the HIPAA Security Rule. The checklist below provides some relevant guidance based on some of the required SRA components. Note that this is not legal advice or a comprehensive checklist.

- ☐ Our designated Security Officer (required by HIPAA) has updated all relevant HIPAA standards and implementation specifications in our security risk analysis to include changes we have made with telehealth and other virtual services.
- ☐ The Security Officer has provided security training to all staff, with additional training for individuals delivering or supporting telehealth offsite.
- ☐ All devices (e.g., laptops, tablets, etc.) used for telehealth:
 - Are protected, using unique passwords for each user
 - Have current and functioning antivirus software
 - Are secured physically to prevent unauthorized access or removal
 - Terminate an electronic session after a predetermined time of inactivity
 - Include ability to encrypt/decrypt electronic PHI (ePHI) when deemed appropriate
 - Are included in the inventory of all devices that create, receive, maintain, or transmit ePHI
 - Can be remotely wiped and/or disabled (in the event of theft or loss of device(s))
 - Are protected by a firewall whenever possible
 - Have updated security software
- ☐ We have a security awareness and training program that includes telehealth-related security concerns for all employees (including management)

- Any telehealth platforms that we use are HIPAA-compliant, and we have signed business associate agreements (BAAs) for relevant persons or entities as described by the Office for Civil Rights⁷

[Mobile Device Privacy and Security from HealthIT.gov](#) Provides specific guidance on how to protect and secure health information when using a mobile device – important for clinicians and other staff working from home or other remote locations.

⁷ Business Associates. U.S. Department of Health & Human Services – Office for Civil Rights. Accessed Jan 4, 2021. <https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/business-associates/index.html>

Appendix - Telehealth Policy and Procedure Starter

Use this policy and procedure template as a starting place as you build your organization's written policies and procedures when offering telehealth visits. Customize and expand as needed.

Policy

Our policy at [ABC Clinic] is to provide telehealth as an option for health care service delivery to enhance access in ways that are convenient, safe, and equitable for our patients.

Terminology

Telehealth. For purposes of this policy and procedure, by telehealth we mean the discrete set of codes⁸ promulgated by the Centers of Medicare & Medicaid Services (CMS) that can either be provided in person or by using an interactive audio and video telecommunications system that permits real-time communication between the clinician at the distant site and the beneficiary at the originating site.

Distant site. We are the distant site when we deliver telehealth services to patients at a different location, including their home.

Originating site. This is the site where the patient is and may be when:

- We deliver telehealth services to a patient at a different location, including their home – either of which would be the originating site, or;
- A clinician/specialist at a different location delivers telehealth services to a patient at our clinic, making our clinic the originating site.

Procedures

Scheduling as Originating Site: When a patient is scheduled at our location to receive telehealth services from a clinician/specialist at a distant, we will provide a private space with camera, microphone, and headset for the patient to engage in the telehealth visit. The patient will be advised to arrive 30 minutes prior to the appointment to set up and test the equipment. The patient will be offered a knowledgeable staff member to accompany the visit to ensure a smooth telehealth experience. Prior to the visit, we will ensure that:

- The clinician/specialist has been e-faxed or otherwise provided with the medical records needed for the visit while adhering to the HIPAA Privacy rule governing “minimum necessary” when providing records/information.
- Both our staff and the clinician/specialist are clear on their roles and responsibilities, especially around consent, documentation, and payment.
- A referral order has been entered so we can close the loop and ensure that our ordering clinician has signed the referral notes/results.

[Insert process for billing as an originating site, if appropriate – Q3014 – who will do it and how]

Scheduling as Distant Site: When a patient calls to schedule an appointment, they will be offered an in-person or telehealth visit. If the patient chooses telehealth, reception staff will administer the questionnaire to establish whether the reason for the visit and/or chief complaint is appropriate and will

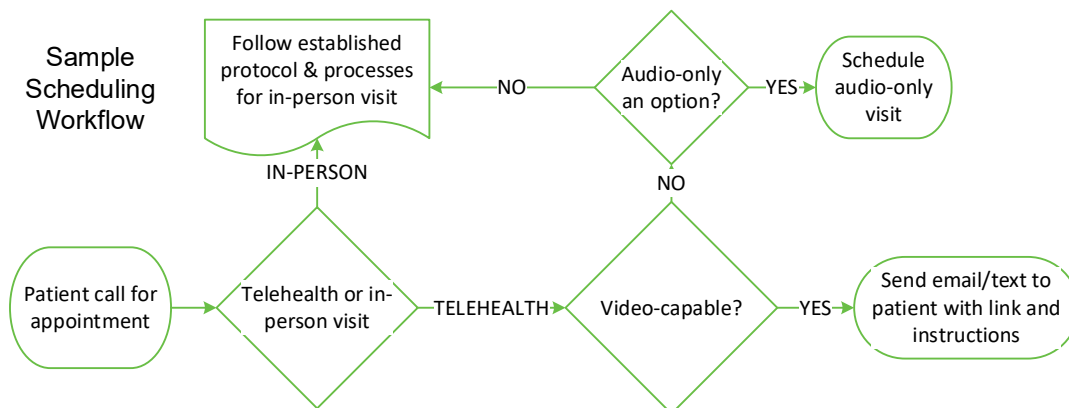
⁸ List of Telehealth Services. Centers for Medicare & Medicaid Services. <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>

deliver the standard script indicating that the telehealth appointment is made based on information provided in the questionnaire and that if conditions change, the patient may need to be seen in person or seek urgent/emergent care. Reception staff will also provide additional scripting to ensure patients are clear on the expectations (i.e., must have a quiet place to take the telehealth visit, no multitasking) and the cost requirements as patients are often surprised that the cost/reimbursement for a telehealth visit is the same as an in-person visit. If patient is a minor, follow guidance in our P&P governing when minors seek health care services.

Reception staff will ask ““Do you have a smartphone, tablet or desktop computer with camera and internet?” If patients have one of the three, they are considered “video-capable.” Reception staff will note video capability *[insert how this will be documented, ideally as structured data – consider as a social determinant of health]*

Patient will be sent appointment confirmation by email or text, depending on patient preference, with date/time of appointment with link for telehealth visit and instructions for connecting and an offer for a “test” telehealth visit.

[Insert specific process for appointment type, time, etc. for telehealth appointments]



Before Visit

- Within three business days of the telehealth visit, the patient will receive an appointment reminder per their preferences – call, email, text, or portal message
- The medical assistant (MA)/nurse on the patient’s care team will identify all current preventive and chronic gaps in care to discuss with patient prior to meeting with the clinician. The MA/nurse will also identify any outstanding orders or referrals to discuss with the patient and/or clinician to determine the status – pending, need to cancel, waiting for referral notes/results, etc.

Day of Visit

All clinic participants on the call will clearly introduce themselves to the patient and wear or otherwise display their first and last names and credentials.

MA/nurse will:

- Confirm the patient's identity – picture on file, name, date of birth, etc.
- Conduct intake, including the portions usually performed by reception staff for in-person visits.
- Advise the patient how to pay their copay.
- Discuss backup plan for if the audio or video fails, or the technology otherwise is not working for the patient or the care team, including a number to call the patient or for the patient to call the clinic.
- Confirm and document the patient's physical location in case emergency or other services need to be called to assist the patient in the event of serious signs or symptoms. In some cases, this may include the make and model of a car, if a patient is in their car for the telehealth visit.
- Obtain consent for the telehealth visit, depending on patient's primary insurance:
 - Medicare requires beneficiary consent — verbal or written — for telehealth and other virtual services as well as notification of any applicable cost-sharing, including potential deductible and coinsurance amounts. Consent must be documented in the patient's medical record.
 - Medicaid Consent for each state Medicaid is different. Check for and insert the consent requirements for your state by accessing the Center for Connected Health Policy [[Current State Laws & Reimbursement Policies](#)]
 - Commercial and other insurers [Check their website. If no consent is noted, consider obtaining the state-required telehealth consent]
- Act as scribe for clinician [if this is something your clinic supports].
- Perform checkout for the patient at the conclusion of the visit as per our procedure for in-person visits, including asking the patient if they have any additional questions about their treatment plan and scheduling any follow-up or other visits.

Clinician/care team will:

- Document as per requirements for the given type of visit (e.g., evaluation and management/office visit).
- Enter the appropriate billing code with modifiers, and other relevant information, depending on insurer (this may be the responsibility of billers/coders).

After Visit

MA/nurse will:

- Provide visit notes/summary to patient per patient's preference (mail, email, portal, etc.)
- Communicate with patient's preferred pharmacy for any prescriptions not transmitted electronically.
- Follow up on all orders/referrals, etc.
- Ensure patient understands co-payment/deductible amounts and how to pay.
- Send telehealth follow-up survey to patient per their preferences
- Administer the follow-up survey to clinic staff that participated during the telehealth visit, during our designated survey periods (e.g., first week of each calendar quarter for all telehealth visits)

HIPAA Privacy

- Patients will be advised to use headset/earbuds and must identify for the clinician and care team any other individuals that are present

- Clinical team must be in a private space (e.g., exam room or office) or wear headset/earbuds to ensure conversations are private
- Clinician and staff will use waiting room or other feature to make sure two patients do not join the same session

HIPAA Security

All efforts have been made to ensure the patient's protected health information (PHI) is secure through use of HIPAA-compliant devices and telehealth platforms for both the patient and clinical staff. We have signed business associate agreements with all telehealth platform vendors or others that may create, receive, maintain, or transmit electronic protected health information (ePHI) as part of our telehealth processes to ensure HIPAA compliance. All other contingencies have been made; the Security Officer has reviewed our policies and procedures to ensure that we are HIPAA-compliant and have mitigated any risks, including updating the security risk analysis with any changes resulting from the use of telehealth.

[OCR FAQs on Telehealth and HIPAA During the COVID-19 Public Health Emergency](#)

Excellent source for pressing questions about HIPAA and telehealth during COVID-19.

In addition to the Office of Civil Rights (OCR) FAQs in the resource above, consider the following related HIPAA considerations and best practices. Note that these are linked to the HIPAA standards and implementation specifications that are elements of the HIPAA security risk analysis (required of all health care organizations).

- Ensure the telehealth platform(s) are HIPAA-compliant, recognizing there is currently some leeway on this requirement during the public health emergency
- Require business associate agreements from any vendors providing telehealth services or platforms
- Ensure unique identifiers (user ID and password) when accessing hardware and software required to deliver telehealth
- Implement automatic logoffs if not already in place
- Document or update relevant policies and procedures to include remote health care service delivery
- Adopt a process to validate the identity of the recipient of telehealth (e.g., date of birth and address/phone number)
- Check to make sure there is an audit process in place to verify that ePHI is protected against unauthorized access during telehealth sessions
- If new devices were purchased to deliver telehealth, make sure all required security measures have been taken, especially for those that are used in the homes (and other locations) of clinicians and other staff
- Retrain staff on relevant HIPAA Security Rule requirements, taking into consideration that the Administrative, Physical and Technical safeguards need to be addressed with staff working from outside the organization to deliver telehealth and virtual services
- Clarify responsibilities with the designated Security Official
- Reassess your termination protocols if staff have devices at home or are accessing patient information from home or other locations
- Ensure that staff only use approved devices with adequate security features (e.g., firewalls, passwords, anti-malware protection, limits on app downloads, etc.)
- Reassess the HIPAA standards and implementation specifications related to telehealth by going through your entire security risk analysis