Telehealth Program Assessment

Introduction

While many organizations, clinicians and care teams have been delivering telehealth and other remote services for many years, others are new to the telehealth table and are in the early stages of fully implementing and adopting a robust telehealth program. The following assessment provides the opportunity to assess gaps or areas to improve while also recognizing the investment of time and effort that has brought the organization to its current state of remote health care service delivery. Celebrate the items for which the organization has a high score!

The assessment is specific to outpatient health care clinic organizations that primarily deliver telehealth services, acting as a distant site, but may also act as an originating site when specialists or other clinicians deliver telehealth services to a patient that is at the organization/location.

This assessment can be completed by one individual who knows the organization and the state of telehealth well. However, consider completing the assessment together with individuals representing several roles in the organization – leadership, clinicians, medical assistants, nurses, reception staff, etc. Choose the response that best fits the current state even if a response does not perfectly match how things are at the organization; make notes to reflect what the actual current state is.

Intake (only if administering to a group of organizations)

Name and role:
Email address and phone number:
Organization:
Type of organization:
Using an electronic health record (EHR)?
  Yes – please enter the EHR(s) used:
  No

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Organization is located in a/an…

Urban area (≥ 50,000 or more people)

Rural area (< 50,000 people

Both

Assessment was completed by:

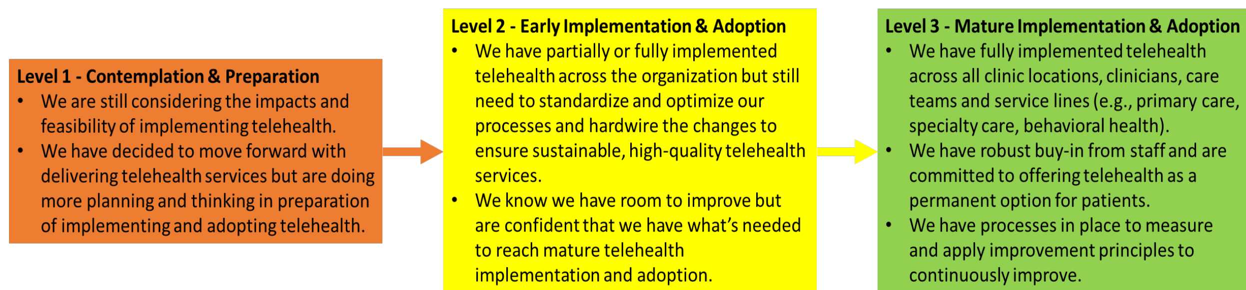
One individual

Team with responses derived by consensus

If completed as a team, list team names and roles:

Telehealth Maturity Model

This assessment is based on this very simple progression or maturity model; prior to taking the assessment, most organizations, teams and individuals will know where they fall along the continuum. Use the assessment to identify the current state and then retake the assessment in three to six months to highlight progress and perhaps to clarify remaining work to reach mature implementation and adoption to sustain telehealth service delivery.



Scoring

Level of Telehealth Implementation & Adoption	Score
Level 1 – Contemplation & Preparation	0 – 15
Level 2 – Early Implementation & Adoption	16 – 50
Level 3 – Mature Implementation & Adoption	51 – 78

*Note that scores have not been validated to ensure high fidelity with the levels in the maturity model.

Terminology

While telehealth is an all-encompassing term, when it comes to health care service delivery, the ability to bill and collect reimbursement using a billing code constrains the options for remote service delivery to sets of codes and services. Those fall into two categories: 1) the discrete set of Medicare telehealth services and 2) other virtual services. This Telehealth Program Assessment uses the term telehealth to refer to the discrete set of Medicare telehealth services[1].

Telehealth Services:

- Are defined by a discrete set of services and codes for which Medicare, Medicaid and other health plans make payment.
- Can also be furnished in person.
- Have a distant site (where the provider is) and an originating site (where the patient is)
- Must include both audio and video components (not required during the public health emergency)

Other virtual services include but are not limited to:

- Telephone Evaluation and Management (E/M) (only during PHE)
- Virtual Communication Services: virtual check-in and remote evaluation of pre-recorded patient information
- E-visits – Online Digital Evaluation Services
- Chronic and Principal Care Management
- Behavioral health integration and Psychiatric Collaborative Care Services
- Interprofessional consultation
- Remote physiologic monitoring

Note that there are typically three types of telehealth that are described:

1. Real-time or synchronous interactive communication using audio and video
2. Store and forward, using electronic transmission of images, data, sound, or video (e.g., radiology images, electrocardiograms (ECGs), pictures of skin problems or injuries) for review or evaluation
3. Remote physiologic (or patient) monitoring (RPM) through collection and transfer of health data collected at a patient's home or other location for surveillance and response or management as needed

[1] List of Telehealth Services. *Centers for Medicare & Medicaid Services*. https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Organizational Readiness

Systemwide awareness, commitment, and planning signals readiness to implement telehealth and is key to its sustainability. If leadership is not fully engaged and supportive, the success of the telehealth program is at stake.

Our organizational perspective on telehealth is:

	We will provide telehealth as needed but only during the COVID-19 pandemic. (1)
	We will support telehealth permanently for clinicians, care teams and patients who are interested in it but have not or will not implemented it across the entire organization. (2)
	We are committed to permanently offering telehealth as a modality to deliver our health care services for all patients, clinicians, care teams, and locations and have or will implement it across the entire organization. We are all in! (3)

Leadership is engaged and has demonstrated engagement by actions such as identifying an implementation or dedicated telehealth team, supporting learning activities, including telehealth in strategic planning, considering budgetary and other impacts and more.

	There is little or no leadership engagement. (0)
	Leadership generally supports telehealth but has not taken specific actions to demonstrate engagement. (1)
	Leadership has indicated robust support of telehealth and has taken specific actions to demonstrate engagement. (2)

Our degree of overall degree of buy-in and endorsement of telehealth by our staff – inclusive of clinicians and care teams - is:

	Low – most are not onboard with implementing telehealth for the long term. (0)
	Medium – we have a mix of those who support it and are excited about the possibilities but also have several who either refuse to deliver telehealth or do it only reluctantly. (1)
	High – we have broad and almost complete buy-in and support by everyone. (2)

Training and Expertise

Training is important and purposeful practice through repeated telehealth visits builds expertise for clinicians, the care team, and others. Focusing on the needed skills and working to improve them over time is key but people need to learn the correct fundamental skills first.

Our telehealth training is:

	Nonexistent. (0)
	Ad hoc – we only provide training when we think it is needed. (1)
	In progress (internal) – we are working on developing an internal program. (2)
	In progress (external) – we are searching for a comprehensive, affordable/external free training program. (2)

Our method of assessing expertise, including comfort with navigation, workflows and the technology is:

	Nonexistent. (0)
	Provided when we hear there is a problem. (1)
	Provided when requested. (1)
	Assessed prior to implementation of any telehealth offering. (2)
	Provided until individuals are comfortable with their telehealth expertise and proficiency. (2)

Resource: The Northwest Regional Telehealth Resource Center has several high-quality and free online trainings.

Policy and Procedure

Creating policies and procedures (P&P) around telehealth ensures that those services are high-quality, safe, and equitable. Strong and well-done policies and procedures can also serve as training materials when onboarding new staff.

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We have a telehealth policy and procedure in place.

	No. (0)
	No – but we are working on one. (1)
	Yes – but it is not broadly available to everyone. (2)
	Yes – and it is broadly available to everyone with review and updates on an annual basis. (3)

Each organization has a process for drafting, reviewing and approving P&Ps. Existing P&Ps (and possibly job descriptions) need to be reviewed to include telehealth, and new P&Ps need to be generated as the telehealth program begins. Know how this will unfold and how to share any changes or new P&Ps as it can be a matter of quality and patient and staff safety.

We have reviewed and updated existing P&Ps to ensure telehealth and virtual services considerations are included. We have developed the new and relevant P&Ps to ensure quality and safety.

	No. (0)
	No – but we are in the process of doing so. (1)
	Yes. (2)

Telehealth Triage

Not all visits are appropriate for telehealth visits. To keep patients safe, each organization needs a written triage protocol for which diagnoses, symptoms and other issues a telehealth visit is appropriate vs. those for which an in-person visit is required.

We have a telehealth visit triage protocol in place.

	No. (0)
	No – but we are working on one. (1)
Yes – and it is (choose all that apply):	
	Readily available to all staff (1)
	Made available to patients (e.g., handout, on website, shared by social media) (1)
	Approved by medical staff (1)

Patients

A poorly designed, inefficient telehealth program results in lack of use and high no show rates. It is important to know how your patients' telehealth experience and to continually improve with the important Lean principle top of mind: define value from our customers' perspective.

We have support in place to help patients easily engage in telehealth visits, including offering test telehealth visits to reduce apprehension and build proficiency.

	No. (0)
	No – but we are working on one. (1)
	Yes – but we do not have a system of feedback from our patients, families, and caregivers on how we need to improve. (2)
	Yes – and we have an easy way for people in our telehealth program – those receiving (and delivering) telehealth – to provide feedback that we act upon to continually improve the telehealth experience. (3)

To engage in telehealth, patients need the following:

- Private, quiet, safe space
- Device with camera and microphone
- Stable internet with adequate bandwidth
- Help for limited digital proficiency

With creativity, innovation and community-based solutions, organizations can help overcome patients' barriers to telehealth.

	We are not currently working to find solutions to patients' barriers to engage in telehealth visits. (0)
We have or are working to find solutions for patients for the following barriers (choose all that apply):	
	Private, quiet, safe place to engage in a telehealth visit (e.g., library, place of worship, employer) (1)
	Device with camera and phone (e.g., telehealth kiosk within the community, staff bring device to patient) (1)
	Stable internet with adequate bandwidth (e.g., free, or reduced fee options for internet, community-based solution, mobile hot spot) (1)
	Help with limited digital proficiency (e.g., staff or community health workers go to where patient is) (1)
	Back-up plan or protocol if telehealth visit is scheduled, and patient, provider or care team is unable to engage in telehealth visit (1)

We keep track of which patients are or are not able to engage in telehealth, including what their specific barrier(s) is/are, in similar fashion to how we track social determinants of health. Best practice is to capture this information as structured data. Ideally an organization will run data on their telehealth-enabled patients and work to improve the percent that are able to engage in telehealth (provided that is the preference of the patient).

	No. (0)
	No – but we are working on finding a solution to do this. (1)
	Yes. (2)

Resource: See Northwest Regional Telehealth Resource Center Patient Resources for a Patient Telehealth Checklist and more.

Suite of Telehealth Services

The organization or team needs to outline the telehealth service delivery "package" or list of specific services that will be delivered to patients. An additional consideration is for scenarios when the organization or clinic sites will act as originating sites (where the patient is) for receiving telehealth services.

As a distant site (where the provider is). We have carefully reviewed the current and full set of telehealth services and codes listed on the Centers for Medicare & Medicaid (CMS) List of Services and have a selected from that list the set of services that align with the same or similar in-person visits/services that we offer.

	No. (0)
	N/A because we cannot act as a distant site. (0)
	No – we *can* act as a distant site but don't currently offer telehealth; we are in the process of implementing telehealth and assessing the full set of telehealth services that we can offer. (1)
	Mostly – we offer telehealth services but have not assessed if there are additional codes/services that we can deliver by telehealth. (2)
	Yes. (3)

As an originating site (where the patient is). We have identified the full range of possible telehealth visit options that our patients could receive – either at one of our clinic sites, in their homes or if the patient is located elsewhere. (See list below for guidance or inspiration.)

	No. (0)
	No – but we are in the process of doing so. (1)
	Yes. (2)

We have assessed which, if any, insurers will reimburse an originating site fee (~ $27) when our organization is the originating site for a telehealth visit (e.g., visit with a specialist).

	No. (0)
	N/A because we cannot act as an originating site. (0)
	No – but we are in the process of doing so. (1)
	Yes. (2)

The current health care services that we offer by telehealth are (check all that apply) – note that a comprehensive list is included to accommodate as many options as possible but also to demonstrate the range of possibilities for telehealth.

- Addiction medicine (substance use disorders)
- Allergy and/or Immunology
- Audiology
- Autism
- Bariatric medicine
- Burn/Wound care
- Behavioral/mental health
- Cardiology
- Chronic disease management
- Dementia
- Dentistry
- Dermatology
- Emergency medicine
- Endocrinology/Diabetes
- Gastroenterology
- Genetics/genetic counseling
- Geriatrics
- Gynecology/Women's Health
- Hematology
- Hepatology
- Home health/care
- Hospice/palliative care
- Hospitalist
- Infectious disease
- Integrative medicine
- ICU (intensive care unit)
- Internal medicine
- Long-term care
- Medication-assisted treatment
- Microbiology
- Mobile health (mHealth)
- Neonatology
- Nephrology
- Neurology
- Neuro-psychological testing
- Nursing
- Nutrition/obesity
- Obstetrics
- Occupational medicine
- Oncology
- Ophthalmology
- Orthopedic surgery
- Otorhinolaryngology (ENT)
- Pain management
- Pathology
- Remote patient monitoring
- Pediatrics
- Pharmacy
- Physical/occupational therapy
- Podiatry
- Primary care
- Psychiatry
- Psychology
- Pulmonology
- Radiology
- Rehabilitation
- Rheumatology
- School-based services
- Speech-Language pathology
- Sleep medicine
- Stroke
- Surgery
- Toxicology
- Trauma
- Urgent care
- Urology
- Other

Billing and Reimbursement

We have identified the places of service, modifiers and other telehealth billing requirements for the telehealth codes we are using for each of our patients' insurers (e.g., Medicare - CMS List of Services , state Medicaid agency – refer to Center for Connected Health Policy state pages for state-specific billing information, private/commercial insurer).

	No. (0)
	No – but we are in the process of doing so. (1)
	Yes. (2)

Workflow

Efficient, person-centered workflows are one of the most important aspects of a successful telehealth program and it is also the aspect that most organizations and teams struggle to streamline, standardize, and continually improve.

We have standard workflows in place for

- **Before the visit** (e.g., scheduling, ensuring patients have what's need for a telehealth visit),
- **During the visit** (e.g., completing intake by MA/nurse, documenting in the medical record, ensuring technology is working and back-up plan if not), and
- **After the visit** (e.g., sending written plan to patient/caregiver, coordinating follow-ups, sending referral information). We have identified and put in writing (e.g., Word, Visio, PowerPoint) our key workflows for all individuals involved from scheduling to billing and for every person/role, including reception staff, clinicians, care team, patient and family.

	No. (0)
	No – but we are working on workflows. (1)
	Yes – but not everyone can easily access them to ensure the workflow is consistently and sustainably implemented across all care teams. (2)
	Yes – and we have made sure we review the workflows; they are easily accessible to everyone, and; we monitor to ensure staff adhere to workflows and adjust based on feedback from those whom the workflows impact (including patients). (3)

Documentation

While documentation for a telehealth visit should include all of the same components of the equivalent in-person visit, there a few additional key components, including but not limited to:

- **Start and end times.** Because physical exams are difficult (but not impossible for certain anatomy), most telehealth office visits – evaluation and management visits – will likely be billed by time rather than medical decision-making complexity. Note the new time-based determinations for office or other outpatient services (including when they are delivered by telehealth visits), starting Jan 1, 2021.
- **Patient exact location/address.** Important in case patient suffers an adverse event and emergency services need to be called.
- **Consent.** Medicare, most state Medicaid agencies and other insurers require patients' informed consent for telehealth.
- **Participants.** All participants on the telehealth visit should be documented in the medical record, including patients, family, care givers, clinician(s), care team members, and more. (This will be increasingly important for risk management in the future.)

We have identified standard processes for documentation during a telehealth visit with assigned roles and responsibilities for the above at a minimum.

	No. (0)
	No – but we are in the process of doing so. (1)
	Yes. (2)

Hardware

We have all the devices with camera and microphones (with headsets, if needed) for our clinicians, care teams and others who will participate in telehealth visits.

	No. (0)
	No – but we are in the process of doing so. (1)
	Yes. (2)

Peripherals. Peripherals are devices that are used to collect patient biometrics and physical exam information between and/or during a telehealth visit. Examples include stethoscopes, fetal dopplers for babies' heart rate, otoscopes, lighted tongue depressors to visualize the oropharynx and more.

We have assessed the need for peripherals and budget needed to purchase what our clinical staff would like to have, or we already have in place what is needed.

	No. (0)
	No – but we are in the process of doing so. (1)
	Yes. (2)

Software

Selection of a telehealth "platform" does not need to be complicated or expensive, nor does it need to be a platform per se or be integrated into the EHR as long as clinicians have easy access to patients' medical records and can document easily (i.e., they may need a second screen).

We have selected a HIPAA-compliant telehealth solution that works well for all parties involved in our telehealth visits. Note – the assumption is that the organization has signed a Business Associates Agreement (BAA) if the solution is HIPAA-compliant. (For information on BAAs and definitions please see Business Associates Contracts – Sample Business Associate Agreement Provisions from the U.S. Department of Health & Human Services – Office for Civil Rights)

	No. (0)
	No – but we are in the process of doing so. (1)
	Yes. (2)

Broadband and Connectivity

We have ensured that our broadband speed and reliability is sufficient to support both audio and video for a glitch-free telehealth visit, regardless of whether we are the distant or originating site, throughout all locations, including for clinicians and care teams not onsite that will engage in telehealth.

	No. (0)
	No – but we are in the process of doing so. (1)
	Yes. (2)

We have a process to assess whether each patient has (or has access to) broadband or a data plan to support both audio and video for a glitch-free telehealth visit (ideally captured in the patient chart for future reference).

	No. (0)
	No – but we are in the process of doing so. (A good rule of thumb is that connectivity is adequate if the patient can watch live-streaming videos.) (1)
	Yes. (2)

Resource: The Federal Communications Commission identifies a speed of ≥ 25 Mbps download/3 Mbps upload for fixed broadband as a minimum performance benchmark. There are many resources for checking broadband speed, including the speed test option from the Utah Education and Telehealth Network.

Communication about Telehealth

We have multiple ways for patients to learn about telehealth (e.g., messaging when they call to schedule a visit, website, social media)

	No. (0)
	No – but we are in the process of getting the word out in multiple ways. (1)
	Yes. (2)

We have a strong system of communication within our organization to ensure effective communication about the telehealth program to providers and other staff.

	No. (0)
	No – but we are in the process of developing communication methods that work for our staff. (1)
	Yes. (2)

Quality Assurance

Each person should have the same high-quality telehealth experience, regardless of several variables (e.g., workflows, devices, clinicians, support staff). Monitoring the quality of telehealth visits (e.g., patient/staff satisfaction surveys, peer-review of the telehealth session to provide constructive feedback) and acting on improvement opportunities is one of the keys to ensuring quality assurance.

We have a process in place to ensure that everyone has a high-quality telehealth experience within the confines of what we can control

	No. (0)
	No – but we are in the process of doing so. (1)
	Yes. (2)

Quality Improvement

We have a set of process and outcome measures in place to monitor the safety, quality and effectiveness of telehealth.

	No. (0)
	No – but we are in the process of doing so. (1)
	Yes. (2)

HIPAA Privacy and Security

There are several unique and new privacy and security concerns when implementing telehealth services. However, HIPAA also requires that health care organizations have a dedicated Privacy Officer and Security Officer (sometimes the same individual), who should be diligent about identifying and mitigating any risks. Note that this is not legal advice nor is this checklist comprehensive by any means.

HIPAA Privacy

Telehealth and audio-only interactions can occur in areas that risk others overhearing either one or both sides of a conversation, especially if there is not a dedicated, private space like an exam room for these encounters. Note that a best practice is to post a sign to ensure patient privacy (e.g., "Telehealth Session in Progress").

Clinicians and other staff have headset or earbuds to ensure conversation cannot be heard by others.

	No. (0)
	No – but we are in the process of purchasing what is needed to ensure clinicians and all other staff engaged in virtual care have headsets/earbuds. (1)
	Yes. (2)

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Privacy screens are provided to clinicians and other staff working from home or other offsite locations.

	No. (0)
	No – but we are in the process of assessing who needs the screens and/or are in the process of providing them. (1)
	Yes. (2)

HIPAA Security

Implementing telehealth opens new vulnerabilities that need to be identified and addressed. Security is further complicated when clinicians, care teams and others work from home or other locations. Below is somewhat of a check to ensure that necessary provisions and analyses are in place, but ultimately it is the responsibility of the designated Security Official at the health care organization.

Check all that apply (1 point each).

	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.
	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 Rights[2]
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.

[2] 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

	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.

Score =

As a reminder, here are the levels of telehealth implementation and adoption that are associated with your score.

Level of Telehealth Implementation & Adoption	Score
Level 1 – Contemplation & Preparation	0 – 15
Level 2 – Early Implementation & Adoption	16 – 50
Level 3 – Mature Implementation & Adoption	51 – 78

Additional Virtual Services

While the sections above are very specific to telehealth – the discrete set of codes and services defined within the CMS List of Services, there are additional opportunities to expand the suite of virtual services to enhance access, meet patients' needs, optimize care, and capture revenue. This bonus section includes some but not all of those opportunities. The scores from this section of the assessment are not included in the calculations because they do not technically fall into what we traditionally call telehealth.

Virtual Communication Services

There are three opportunities that fall under virtual communication services. The information below is specific to RHCs and FQHCs. For all of the 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 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.

	We are unfamiliar with these services.
	We know what these services are but have not explored the details or requirements to implement and capture reimbursement.
	We have explored the details of these services but have decided not to implement them because (insert reason):
	We are in the process of implementing or have partially implemented these services.
	We have fully implemented these services.

Resources:

1. Virtual Communication Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions. CMS. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf
2. CMS Virtual Check-In Patient Page. CMS. https://www.medicare.gov/coverage/virtual-check-ins
3. New & Expanded Flexibilities for RHCs & FQHCs during the COVID-19 PHE. CMS. See "Expansion of Virtual Communication Services". Information current through Dec 31, 2021. https://www.cms.gov/files/document/se20016.pdf

Chronic and Principal Care Management Services

Chronic and principal care management services are an excellent way for health care organizations to provide and be reimbursed for care management and care coordination for certain patients. Medicare reimburses for these services for beneficiaries that fulfill the requirements. Some state Medicaid agencies and private insurers also provide reimbursement for these services. These services are provided on a monthly basis and can be billed once the required time is reached for the respective billing code.

	We are unfamiliar with these services.
	We know what these services are but have not explored the details or requirements to implement and capture reimbursement.
	We have explored the details of these services but have decided not to implement them because (insert reason):
	We are in the process of implementing or have partially implemented these services.
	We have fully implemented these services.

Resources:

1. Chronic Care Management (CCM). CMS. https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/chronic-care-management
2. Principal Care Management (PCM) Services in RHCs and FQHCs. CMS. https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center
3. Care Management (also Advance Care Planning, Behavioral Health Integration and Transitional Care Management). CMS. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment PhysicianFeeSched/Care-Management
4. Chronic & Principal Care Management: Implementation Guidance https://nrtrc.org/resources/resources.shtml#cah
5. CCM Services CMS. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf
6. Care Coordination Services and Payment for RHCs and FQHCs. CMS. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10175.pdf
7. Care Management Services in RHCs and FQHCs – FAQs. CMS. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

Behavioral Health Integration & Psychiatric Collaborative Care Services

These two services are very similar to the CCM and PCM services above but are focused on providing mental health services.

	We are unfamiliar with these services.
	We know what these services are but have not explored the details or requirements to implement and capture reimbursement.
	We have explored the details of these services but have decided not to implement them because (insert reason):
	We are in the process of implementing or have partially implemented these services.
	We have fully implemented these services.

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. https://aims.uw.edu/sites/default/files/CMS_FinalRule_FQHCs-RHCs_CheatSheet.pdf
2. Behavioral Health Integration Services – MLN Booklet. CMS. Updated March 2021. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

Interprofessional Consultation

This patient-centered option for referrals for consults is underutilized and is a great option for clinicians and their patients, living in rural areas, as long as the patient does not need to be seen in person. Medicare does not reimburse RHCs or FQHCs for any of the interprofessional consultation codes, but it is a great option to expand access and serve patients. For each specialist, consider whether an IC is most appropriate and ascertain if the specialist is willing to engage in an IC.

	We are unfamiliar with these services.
	We know what these services are but have not explored the details or requirements to implement and capture reimbursement.
	We have explored the details of these services but have decided not to implement them because (insert reason):
	We are in the process of implementing or have partially implemented these services.
	We have fully implemented these services.

Resource:

Interprofessional Consultation – A Patient-Centered Referral Option. NRTRC and Comagine Health. https://nrtrc.org/resources/resources.shtml#cah

Remote Physiologic (or Patient Monitoring) (RPM)

RPM is the one virtual service that has the greatest potential to reduce emergency department visits, admissions and readmissions. Monitoring appetite, mental changes, biometrics, etc. through software platforms or apps with virtual daily check-ins to monitor for potential issues can be helpful, especially if specific care

instructions and/or reminders regarding hygiene and/or medications are included[3]. RPM is a great addition to self-management support for patients. While Medicare does not currently reimburse RHCs and FQHCs, these organizations can often include and bill for these services as part of Chronic Care Management. Check the fee schedules of your state Medicaid agency to see if RPM codes are listed as covered services.

There are at least three versions of RPM to keep distinct.

1. RPM as defined by Medicare, includes five billing codes and have 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/or self-reported)"[4], 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 a great 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.

	We are unfamiliar with these services.
	We know what these services are but have not explored the details or requirements to implement and capture reimbursement.
	We have explored the details of these services but have decided not to implement them because (insert reason):
	We are in the process of implementing or have partially implemented these services.
	We have fully implemented these services.

Resources:

1. Remote Physiologic Monitoring. NRTRC and Comagine Health. https://nrtrc.org/resources/resources.shtml#cah
2. American Medical Association Digital Health Implementation Playbook (aka Remote Patient Monitoring Implementation Playbook) https://www.ama-assn.org/system/files/2018-12/digital-health-implementation-playbook.pdf

[3] Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency – Interim Final Rule. CMS. April 2020. p. 19249.
[4] Calendar Year 2021 Physician Fee Schedule Final Rule (CY 2021 PFS FR) p. 84543