COVID-19 Telehealth Toolkit

2021

Version 6.0
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This guidance is intended to help healthcare providers accurately and completely code and/or bill services that, with proper documentation, may be reimbursable by a state or Federal healthcare program. This information is a tool for addressing common billing and coding issues, which are explained more fully in the CPT© Manual and the official, CMS-approved ICD-10 guidelines. You should review the CPT© Manual as well as the official, CMS-approved, ICD-10 guidelines and not rely exclusively on this informational material. Each healthcare provider bears full responsibility for its own billing and coding, as well as compliance with all applicable Federal and state laws and regulations.

This toolkit is not intended to answer every question you might have about COVID-19 telehealth guidance; however, it is the hope of Aledade that it will answer many. We will continue to update it as more information becomes available.

Please contact your Aledade Practice Transformation Specialist or email telehealth-support@aledade.com for related questions not addressed in this toolkit.

Table of Contents

Overview

What is telehealth? What is telemedicine?

Definitions

a. HealthIT.gov
"The Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services defines **telehealth** as the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications."

b. World Health Organization
"**Telemedicine**, a term coined in the 1970s, which literally means "healing at a distance" [1], signifies the use of Information and Communication Technologies [sic] (ICT) to improve patient outcomes by increasing access to care and medical information. Recognizing that there is no one definitive definition of telemedicine – a 2007 study found 104 peer-reviewed definitions of the word [2]. The World Health Organization has adopted the following broad description: The delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities"[3]."

c. Aledade uses the term **telehealth**.

How is telehealth different from telephone outreach?

Medicare telehealth traditionally requires an interactive audio and video telecommunications system for two-way communication between a health care professional and a patient. Some states permit telehealth encounters to be conducted only via audio if there is a previously established provider-patient relationship. Different payers will pay for audio only with the same codes as audio-visual while others will use different codes as Medicare does. Please note that just because a state permits audio-only telehealth, that does not mean that a payer will reimburse for it. CMS announced that a set of audio-only telehealth codes will be reimbursed, which are also temporarily included in the CMS list of telehealth codes. The slide for your state can be found in Appendix A and will inform you if your state's laws permit audio-only telehealth.

What types of telehealth applications are there?

Telemedicine and Telehealth

1. Live (synchronous) videoconferencing: a two-way audiovisual link between a patient and a care provider
2. Store-and-forward (asynchronous) videoconferencing: transmission of a recorded health history to a health practitioner, usually a specialist

3. Remote patient monitoring (RPM): the use of connected electronic tools to record personal health and medical data in one location for review by a provider in another location, usually at a different time
4. Mobile health (mHealth): health care and public health information provided through mobile devices. The information may include general educational information, targeted texts, and notifications about disease outbreaks

Requirements

What are the requirements to implement telehealth into my practice?

Licensing, scope of practice, and credentialing

1. State laws and regulations identify the providers who may perform telehealth encounters in that state. Appendix A provides that information for each state, specifying, for example, whether only physicians can practice via telehealth or if the state authorizes other qualified health professionals (e.g., nurse practitioner, physician assistant, clinical nurse specialist) or certain nurses (e.g., registered nurse) to provide telehealth services either under supervision or independently. These state authorizations may be the same as, or different from, payer reimbursement requirements. It is possible that, for example, a state may authorize Advanced Practice Registered Nurses (APRNs; including NP, CNS, CNM) to perform telehealth encounters but a payer will only reimburse if that encounter is provided by a physician.
2. As a general matter, any provider participating in telehealth must be licensed to practice in the state where the patient is located. Vice President Pence announced on March 18, 2020, that HHS will be issuing a regulation to permit doctors to practice across state lines. In addition, a large number of states have already lifted their own regulations to permit out-of-state doctors and it is likely that more will be doing so in the near future. In light of the fast-moving changes in this particular area, we are recommending that when a patient lives out of state and you are offering a telehealth encounter, you notify the patient if you are not licensed to practice in that state and obtain their consent to proceed with the telehealth encounter.

What do I need to know about patient consent?

Every state requires that a patient affirmatively consent to a telehealth encounter. In Appendix B you will find a consent form template that you can use for this purpose. When a patient lives out of state and you are offering a telehealth visit, you must notify the patient if you are not licensed to practice in that state and obtain their consent to proceed with the visit. This consent should be documented in the EHR.

Do I need a business associate agreement (BAA)? What do I need to know about HIPAA?

1. On March 17, 2020, the Office of Civil rights (OCR) within the Department of Health and Human Services (HHS) announced that it will not conduct enforcement action or impose penalties against providers who, in good faith, provide telehealth services during the COVID-19 nationwide public health emergency.

2. Therefore, if you want to use commercially available audio and/or video communication technology to provide telehealth encounters to patients during the emergency, you may do so. You may use Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Skype, and other commercial products without risk that you will incur OCR penalties. Some further cautions about these commercial applications are below:
    a. If your selected telehealth platform records the telehealth encounter, that recording must be treated as PHI.
    b. The platform that you choose, however, cannot be public facing. You **may not** use Facebook Live, Twitch, TikTok or any other public-facing video application.
    c. The state law considerations discussed previously still apply. This is limited relief from federal privacy regulations during this time of a national health emergency only. You should expect that, at some point, OCR will begin enforcement proceedings against providers using these commercially available platforms.

Can a provider conduct telehealth visits from their home?

There are no Medicare payment restrictions on distant site practitioners furnishing Medicare telehealth services from their home. Normally, physicians and other qualified healthcare professionals (e.g., NP, PA, CNS, CNM) are required to update their Medicare enrollment with their home location before consistently billing at home. However, CMS recently issued a waiver allowing physicians and other qualified healthcare professionals to conduct telehealth services from any location (e.g., their home) and bill through their normal practice location.

Can a patient receive a telehealth visit from the practice's parking lot?

Several practices have begun conducting "drive thru" visits, where the patient drives to the practice, receives a tablet with A/V capabilities from the practice's staff, and receives a virtual visit from their car in the parking lot. This visit is perfectly compliant and should be billed as a telehealth visit, assuming all relevant CPT requirements are met, since there is an audio and visual component to the visit, and the provider is not conducting the visit in-person. The practice should use the modifiers and Place of Service they would normally use had the patient been using their own tablet at home for the visit.

Telehealth Prescribing During COVID-19

Non-Controlled Substances

1. There is no change to normal prescribing guidelines for non-controlled substances when the preceding visit is conducted via telehealth.

Controlled Substances (CS)[1]

1. Due to the declaration of a public health emergency, the Federal Drug Enforcement Administration is permitting providers to prescribe controlled substance medications without an in-person visit first for controlled substance medications. But, you must also check the state-level regulation guide (linked in Appendix A) for the tele-prescribing laws in your state

[1] President Signs New Law Allowing Telemedicine Prescribing of Controlled Substances: DEA Special Registration to Go Live | Blogs | Health Care Law Today, Telemedicine and the Controlled Substances Act, COVID-19 Information Page

because they frequently are more strict than the Federal guidance with respect to controlled substances.

a. Must meet the following criteria under Federal law:
    i. Prescription is written for a legitimate medical purpose by a provider acting in the usual course of his / her practice
    ii. The telemedicine visit is conducted using an audio-visual, real-time, two-way interactive communication system
    iii. The provider is acting in accordance with federal and state laws
b. This applies to all CII-CV medications
c. The prescription can be issued using any methods currently available and in accordance with DEA regulations. The prescription can be sent electronically (schedules II-V), called into the pharmacy (schedules III-V), or called in as an emergency schedule II*.
d. "Provider" includes physicians, dentists, veterinarian, or other person licensed, registered, and permitted by the US or the jurisdiction in which they practice to prescribe controlled substances in the course of his/her professional practice
    i. Must be registered with the DEA

2. NOTE: If the provider has *previously* conducted an in-person medical evaluation of the patient, the following applies regardless of whether a public health emergency has been declared by the Secretary of Health and Human Services:
    a. The provider may issue a prescription for a controlled substance after having communicated with the patient via telemedicine, or any other means as long as the prescription is:
        i. Issued for a legitimate medical purpose
        ii. The provider is acting in the usual course of his/her professional practice
        iii. The provider complies with applicable Federal and State laws.

Payers & Billing

What are other payer coverage policies related to COVID-19 for Telehealth that I need to know about?

Commercial Insurers

Aledade is maintaining an ever-changing assessment of commercial insurers' approaches to telehealth during this emergency.

1. As of March 19th, **ALL commercial payers partnered with Aledade** in value-based contracts reimburse for telehealth (e.g., national payers such as Aetna, Humana, UnitedHealthcare in addition to each Blues plan).
2. Details vary e.g. some insurers pay providers at parity with E/M visits, some waive patient co-pays, and others allow telephonic in addition to audiovisual approach to telehealth.
3. Many commercial payers also offer third party platforms for insured patients to receive care from a virtual primary care provider (i.e., Teladoc, Doctor on Demand, etc).

4. For additional payer guidance, please see Appendix C.

CMS Federal Rules Changes

The Federal government has removed many barriers to the implementation of telehealth in response to the COVID-19 crisis.

1. Requirements
    a. Typically includes audio and video, two-way real time interactive communication. Providers cannot replace an office visit with just a phone call.
    b. Visits are still subject to **state specific laws and regulations** governing telehealth and privacy, which include how a patient may consent to telehealth, which providers may conduct telehealth, and the type of equipment.
2. This waiver applies to **all qualified professionals** regardless of where they work, so **RHCs and FQHCs can utilize this new authority.** On March 27th, additional legislation was passed to allow FQHC and RHCs to bill directly for telehealth.
3. Use of FaceTime and other consumer technology will not face HIPAA enforcement action for the duration of the national emergency, including apps like Apple FaceTime, Facebook Messenger, Google Hangouts, or Skype.
4. Billing
    a. Medicare will pay the **non-facility rates if billed properly**. These rates can be found in the physician fee schedule look up tool, and the list of services available through telehealth for Medicare patients is here.
    b. Requirements
        i. Traditional physician offices bill the CPT code **with the Place of Service code they would have used for an in-person visit, as well as the -95 modifier**.The documentation is the standard documentation needed to support the CPT code **plus patient consent to the telehealth**.
        ii. On March 27th, a third bill to address the effects of coronavirus was signed into law. This bill includes the ability of FQHCs and RHCs to bill directly for telehealth services their providers deliver. On April 17th, CMS released guidance further clarifying the process for FQHCs and RHCs to bill telehealth services, On April 30th, CMS released additional guidance for Rural Health Centers and Federally Qualified Health centers on how they should bill for telehealth services.
            - For telehealth distant services after July 1, 2020:
                a. RHCs must report HCPCS code **G2025 but should no longer put the CG modifier on claims with HCPCS code G2025**. Modifier 95 may be appended but it is not required.
                b. FQHCs no longer need to report the FQHC PPS specific payment code, the code that describes the services furnished via telehealth. They are **only required to submit G2025.** Modifier 95 may be appended but it is not required.
            - Effective March 1, 2020, FQHCs and RHCs can furnish audio-only telephone E/M codes 99441, 99442 and 99443 using G2025.
            - For services related to COVID-19 testing, including telehealth, FQHCs and RHCs waive the collection of co-insurance, and use the -CS modifier. These claims will be paid with the coinsurance applied, and the MAC will automatically reprocess these claims beginning on July 1.

HRSA is clear that telehealth is in-scope for both new and established patients.

iii. CMS recently issued guidance that FQHCs and RHCs can use the G0071 code to bill for services inclusive of those delivered with the two virtual check-in codes (G2012, G2010) as well as the three e-visit codes (99421-99423), reimbursement rate of $24.76, which is the average reimbursement rate of those five codes. Consult the Telehealth Health Center Medicare Billing Flowchart in Appendix P for additional guidance.

c. On March 30th, CMS announced a series of telephone-only codes. These can be billed by physicians and other qualified healthcare professionals. Note that similar to the virtual check-ins, telephone-only codes cannot be billed if it arises from an in-person or telehealth service within the past 7 days or results in an in-person or telehealth service in the next 24 hours or next available appointment and the patient must initiate and consent.
   i. 99441 (5-10 minutes)
   ii. 99442 (11-20 minutes)
   iii. 99443 (21+ minutes)
   iv. On April 30th, CMS announced that the reimbursement for these audio-only codes would be increased to match the value of office visit codes. As a result, the average Medicare reimbursement rates are the following, retroactive to March 1st:
      - 99441 - $56.88
      - 99442 - $92.82
      - 99443 - $131.55
   v. Similar to billing for telehealth, these telephone E/M codes should include the Place of Service (POS) code the practice would have normally used for an in-person office visit. Based on the April 30th announcement, practices should use the -95 modifier on these codes as well, similar to the other telehealth codes, retroactive to March 1st. Consult with your MAC to determine the steps needed to collect the updated reimbursement for claims that have previously been submitted.
   vi. Traditional telehealth (i.e., including both an audio and a visual component) remains the best tool for managing patients remotely. It is treated the same as an in person office visit with the same reimbursement for all codes, unlocks the ability to do transitional care management, includes risk adjustment and, importantly, is likely to continue to be available after the National Public Health Emergency. We do not expect that the reimbursement rates for audio-only codes will continue beyond the public health emergency.

d. Consult the Medicare Telehealth Billing Flowchart (Appendix P) for assistance in considering the different telehealth billing options.
e. Additional billing information can be found in the Coronavirus Billing Guidance (non-App users link here).

5. Other available options that will continue to be available post-coronavirus include the following
   a. **G2012:** 5-10 minute telephone check-in
   b. **G0071**: Communication technology-based services for RHCs and FQHCs only
   c. **99421-99423:** online E/M visits, based on time

CMS (Medicaid)
CMS **encourages states to consider telehealth options** during the COVID-19 pandemic and increasing patients' access to care. This document assists states to understand policy options for paying Medicaid providers for telehealth encounters. Also included is an overview and a sample state plan language.

Which health care providers are eligible to provide telehealth services under the Medicare Part B program?

CRS Reports

1. On April 30, 2020, CMS waived the requirements that specify the types of practitioners that may bill telehealth services. This expands the types of health care professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services, to include physical, occupational and speech therapists.
2. Each provider is subject to State laws and regulations.

Urgent Care, Nursing Homes and Skilled Nursing Facilities

1. **Urgent care** facilities are not subject to different requirements than private practices to bill telehealth. The guidance outlined for primary care clinics applies to urgent care clinics as well, including the need for the -95 modifier.
    a. The visit codes generally billed by urgent care providers can now be billed via telehealth using the -95 modifier.
2. Providers in **skilled nursing facilities and nursing homes** can bill telehealth services.
    a. The providers, not the facility, will be the billing entity.
    b. The visit codes generally billed by nursing home providers can now be billed via telehealth the -95 modifier.
    c. Previously, there were limits on how often Skilled Nursing Facilities could bill telehealth, but these have been waived during the COVID-19 emergency.

Additional information for these facilities can be found in the latest CMS guidance..

Do I need a telehealth consent?

Medicare & Coronavirus

Yes, a consent is generally required by state law. Signed (or otherwise agreed-to) consent is valid for 12 months, after which time the patient will need to consent to receiving telehealth services again. A sample consent template is found in Appendix B.

What do I need to know about Medicare's "virtual check-ins" or telephone calls?

Virtual Check-Ins

1. "Virtual" check-ins, telephone E/Ms, and chronic care management are the **only** codes that CMS pays for when only the telephone is used. While other modalities can be used, essentially these are the audio only codes.
2. Medicare covers "virtual check-ins" so patients can connect with their physician or other qualified health care professional by phone or video, or even an online patient portal, to see whether they need to come in for a visit. If they are concerned about illness and are

potentially contagious, this offers them an easy way to remain at home and avoid exposure to others. The practice should educate the patient about the option for a virtual check-in, but the patient must initiate the contact for the practice to bill these codes.

3. Virtual check-ins are brief, virtual services with their physician or other qualified healthcare professional, where the communication is not related to a medical visit within the previous seven (7) days and does not lead to a medical visit within the next 24 hours (or soonest appointment available).
4. The patient needs to verbally consent to using virtual check-ins and the physician or other qualified healthcare provider must document that consent in their medical record before they use this service. The patient will pay their usual Medicare coinsurance and deductible for these services.
5. Medicare also pays for patients to communicate with their physician or other qualified healthcare professional using online patient portals without going to an office. Like the virtual check-ins, the patient must initiate these individual communications.
6. Patient initiation is a very generous interpretation of the word initiation. The only type of call that would not qualify is a true cold call by the provider to their patient. For example, if the practice staff is calling the TCM worklist they can call the patient and arrange a time (same day is fine) for the physician to call the patient and if the patient agrees this is just like scheduling an appointment and the patient has "initiated" the call.
7. On March 30th, CMS waived the requirement that these virtual check-ins only be conducted with established patients.

Consult the Medicare Telehealth Billing Flowchart (Appendix P) for additional guidance.

How do I get paid for telehealth?

1. **MSSP/Medicare**
    a. Telehealth and Virtual Check-in Codes
        i. CMS Telehealth Services
        ii. CMS List of Telehealth Services
        iii. Coverage and Payment Related to COVID-19 - Medicare
        iv. Telehealth | Aledade
    b. Care Management Codes
        i. The Transitional care management (TCM) services face-to-face visit may be done using telehealth. The interactive contact can be done by telephone, face-to-face, or by email. Other care management services during the 30-day service period are non-face-to-face.
        ii. Chronic care management is the provision of non-face-to-face care management services and telehealth is not applicable. However, G0506 - Comprehensive assessment of and care planning for patients requiring chronic care management services, can be billed via telehealth since it requires a face-to-face component.
2. **Non-MSSP (Medicare Advantage, Commercial, Medicaid)**
    a. Service locations
    Beneficiaries will be able to receive telehealth services in any healthcare facility including a provider's office, hospital, nursing home or rural health clinic, as well as from their home.
    b. Private practice

Commercial plans will vary depending on the market. Information can be found in Appendix C.

3. **Patient eligibility**
   CMS has waived the requirement that the patient have a prior established relationship with a particular practitioner. The U.S. Department of Health & Human Services (HSS) will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.
4. **CPC+ practices can bill telehealth services the same way non-CPC+ practices would.**

What about doing an AWV, can I use telehealth?

CMS has cleared the use of HCPCS codes G0438 and G0439 when conducted via telehealth to a Medicare patient at home, but has not waived the components of the codes requiring the collection of body mass index (BMI) and blood pressure (BP). The IPPE (HCPCS G0402) cannot be billed when conducted via telehealth. Prior to May 15th, there was no communication from CMS directly on what to do if necessary vital signs were unable to be collected or if they were patient self-reported. On May 15th, we received communication from CMS that **patient self-reported vital signs are acceptable**. CMS specifically said they are still considering what to do when the patient is unable to self-report vital signs (e.g., blood pressure) for telehealth visits. The guidance from CMS (received via email) is below:

> *On our April monthly call there were several questions regarding billing for the Medicare Annual Wellness Visit (AWV) via telehealth. CMS has just updated information regarding this service. Please see below:*
>
> *Currently, Medicare policy allows for the billing of the AWV (G0438-G0439) when delivered via telehealth provided that all elements of the AWV are provided (Annual Wellness Visit - CMS).* ***For the duration of the public health emergency, the AWV may be administered using audio-only technology, if a video connection with the patient is not possible****. If the patient can self-report elements of the AWV (i.e., height. weight, blood pressure, other measurements deemed appropriate based on medical and family history), those measurements may be included and recorded in the medical record as reported by the patient. We encourage you to keep abreast of changes and updates by browsing our most up-to-date publications via the following CMS websites: Coronavirus Waivers; and MLN Connects®.*

A patient self-reported blood pressure and weight should be measured during the visit with an at-home blood pressure monitor and at-home scale. Like other telehealth codes, AWVs should be billed **with the Place of Service code they would have used for an in-person visit, as well as the -95 modifier.** CMS allows for AWVs to be billed when conducted via telephone without video (e.g., in the event that video is unavailable). HHS continues to permit the use of commercial (non-HIPAA compliant) video communication technologies provided they can be used privately.

Aledade recommends, for now, using the COVID-19 Outreach Worklist to prioritize patients for outreach and scheduling an AWV telehealth visit if they are due. Consult the *Telehealth AWV Workflow* document (non-app user link) for more information.

What about providing and billing for TCM services, can I use telehealth?
The face-to-face requirement for billing TCM services can be completed using telehealth. Telephone-only visits are not allowed in lieu of in-person or telehealth visits at this time.

What about risk coding and attribution, can I use telehealth?
CMS has confirmed that all diagnosis submitted through telehealth will contribute to a patient's risk score. CMS has stated that, for Medicare Advantage plans, a telehealth visit requires an interactive audio and video real-time communication to meet the risk adjustment requirement. All telehealth visits will count for risk adjustment for MSSP as well. CMS has **NOT** issued guidance for the use of the new telephone codes (99441-99443) for risk adjustment in MSSP, so we currently believe diagnosis codes included on these visits will NOT contribute to a patient's risk score. The existing telephone codes for G2012, G0071, and Chronic Care Management (CCM) do count for risk in MSSP. The pandemic may have effects on attribution so it is very important that every patient has the most accurate risk score possible.

On April 30, 2020, CMS issued guidance that, in addition to the primary care codes previously counted to determine attribution, CMS will also include the costs incurred through virtual check-in codes (G2010 and G2012), e-visit codes (99421-99423) and telephone E/M codes (99441-99443). The G0071 code used by FQHCs and RHCs should count as well, since this code includes the services provided for codes G2010, G2012, 99421, 99422 and 99423.

Technology

Is there a preferred technology platform I should try to use for these visits?
Please refer to Appendix D, where you will find Aledade's 'Getting Started with Telehealth' guide which includes an overview of solutions available for top-tier EHRs, along with Aledade's recommended standalone solution (Updox)

What about if I want to use FaceTime or something like it?
See Appendix E for guidance.

What are the training requirements?
Training options vary based on vendor and equipment selections. Training will be guided by the vendor, sometimes with Aledade's support. The preferred vendor vetted by Aledade (Updox) includes training and availability of troubleshooting support for patients, clinics, and providers. Aledade has some general resources to guide practices for select other vendors.

What does telehealth workflow look like?
Workflow is vendor dependent. Aledade will provide workflow guidance on our recommended solution by Updox. Otherwise, contact your vendor for best practices.

Is there a specific webcam Aledade recommends for telehealth?

If your practice doesn't already have an audio-visual setup to communicate with patients, we recommend using Logitech webcams. We have found that even their lower-end B525 Foldable Webcam ($64.99) is a good solution for mobile/stationary use-cases, and it is supported on both Mac and PC.

Scheduling & Implementation

Should the practice have an identified telehealth champion?

Designating and mentoring a practice telehealth champion can be a great first step in driving telehealth adoption. Review the Telehealth Checklist and Workflows for PTSs and Medical Directors document in Appendix E for more information.

When scheduling telehealth visits, do I need to designate a physical space?

1. During telehealth sessions, both locations (patient and provider) shall be considered a patient examination room regardless of a room's intended use. Providers should ensure privacy so clinical discussion cannot be overheard by others outside of the room where the service is provided. To the extent possible, the patient and provider cameras should be placed at the same elevation as the eyes with the face clearly visible to the other person. The features of the physical environment for both should be adjusted so the physical space, to the degree possible, maximizes lighting, comfort, and ambiance. (Best Practices in Videoconferencing-Based Telemental Health April 2018 - Telemedicine and e-Health)
2. Please consider privacy protection in cases where the patient believes he/she must speak very loudly in order to be heard or the individual participating in the telehealth visit must speak very loudly because the patient is hearing impaired.

Should we designate time specifically for telehealth visits or mix them in with in-person visit scheduling?

1. In most cases, the visit will be scheduled in place of a face-to-face visit. If the EHR has capability, it is suggested to add a telehealth visit type.
2. If desired, an unscheduled visit can also occur and documentation of visit should be done using your practice standards.
3. Scheduling preferences vary and flexibility is important. Examples include:
    a. Blocked time with at least one provider available for scheduling and participating in patient visits
    b. 'On the fly' scheduling with an available provider
    c. One provider dedicated to full-time telehealth visits

What do I need to do when I call the patient to schedule?

Key information must be delivered during the outreach call when scheduling the visit to assure that telehealth is the most-appropriate visit type for this patient at this time. This information includes the following. See Appendix F for a sample script. See Appendix G for a sample checklist.

1. Explain the technology, the risk/benefits/practical alternatives to a telehealth visit (such as a face-to-face visit) and invite/answer questions.

2. Inform them that if others from the practice will be present during the telehealth visit (e.g., MA), the provider will let them know at the beginning of the visit and ask if they agree to allow others to be present during the visit.
3. Each person interacting with a patient, either on the telephone or via telehealth visit, must ask who else is with the patient and may overhear or participate in the visit (e.g., daughter, neighbor).
4. After completing steps #1-2, inform the patient that you will be emailing (or sending through a portal) a telehealth consent for them to review before their telehealth visit. See Appendix B for sample consent.
    a. If they have an email on file, confirm that it is the one to use.
    b. If they do not have an email on file, ask for one to use, even if it is someone else's (e.g., a family member or caregiver's).
    c. If they chose to use someone else's email address, confirm that they will have access to review the consent before their telehealth visit. If they will be unable to read the consent before their telehealth visit, make a note in the telehealth visit encounter that the provider will need to read the document and obtain verbal consent at the beginning of the telehealth visit.
    d. **Exception to b. and c. when using vendor technology.** Refer to the patient portal/telehealth vendor workflow for assigning a proxy.
5. Document in the EHR
    a. You explained the technology, risks/benefits/practical alternatives, and invited/answered questions.
    b. You informed them that anyone from the practice who will be in the room during the telehealth visit will be disclosed to them and they have the right to ask them to leave or allow them to stay.
    c. You asked them who else was with them who may overhear or participate in the visit (e.g., daughter, neighbor).
    d. You sent the patient a copy of the telehealth consent form and that the same form was uploaded to the patient's record in the EHR.
6. Give the patient the visit date and time
    a. Be prepared to reschedule if the patient is unavailable or will not have access to a smartphone or tablet during that time.
    b. Explain to the patient that it is important that they be ready to accept the call for the visit right before or at the scheduled visit time. If they cannot participate in the visit right on time, it will be necessary to find another time now or call back and reschedule if they miss the scheduled visit time.
    c. Give the patient the phone number, email address or other pertinent information about where the telehealth visit will be coming from and ask them to turn off unknown number and text blocking as soon as this call ends.

After scheduling the telehealth visit with the patient, consider setting up a "test" visit to ensure that the patient is comfortable using the telehealth technology. In some Aledade practices, nurses and medical assistants use their telehealth platform to collect pre-visit information such as medication information, recent hospitalization history, etc. to confirm that the patient has the necessary technology to conduct the provider visit.

As the provider who will be conducting the telehealth visit, what do I need to do?

1. When a patient lives out of state and you are offering a telehealth visit, you must notify the patient if you are not licensed to practice in that state and obtain their consent to proceed with the visit. This consent should be documented in the EMR.
2. Confirm that the patient received and reviewed the telehealth consent. If they did not, you will need to read the consent to them.
3. Ask if they consent to the telehealth visit.
    a. If yes, document that the consent has been [reviewed by the patient or read by you] and that they gave verbal consent to continue.
    b. If no, document that after [reviewing the consent or being read the consent] the patient declines the telehealth visit and what the agreed-upon alternative was, including relevant information (e.g., in-person visit date)
    c. Either the signed consent form, or both the consent form and an indication that the patient consented (and by what method) should be documented in the patient's chart.

How can I do physical exams using telehealth?

Aledade has negotiated with Thomas Jefferson University to offer their **Telemedicine: Conducting an Effective Physical Exam** CME course at a group discount rate of $50 (regularly $100).

1. Please have your providers register online (registration link).
2. Create an account/login.
3. Select "Healthcare Provider" and add to cart.
4. Apply coupon code **LUQPUB**.

Appendix O includes links to a document titled **"Medicare Telehealth: Charting, Coding, Reimbursements"**. This document is a helpful resource with examples of completing physical exams over telehealth.

How should we socialize telehealth to patients?

Use all forms of patient contact to let patients know that you are offering telehealth visits and how to schedule one. Suggested contact includes phone messaging, Facebook pages, call center phone messaging, patient portals, etc. See Appendix M for marketing materials.

Should we prioritize any specific patient groups for virtual visits?

1. If patients are concerned or worried about COVID-19 or are either currently experiencing or are being actively treated for anxiety, telehealth could be useful to reduce concern, worry, or anxiety. In other words, video consultation may be more reassuring than a phone call (Acceptability, benefits, and challenges of video consulting: a qualitative study in primary care).
2. In patients with mild symptoms suggestive of COVID-19, visual examination may be helpful and is a use case for telehealth.
3. In patients with more severe symptoms, visual examination may reduce the need to perform a home or office visit in potentially contagious patients (Advantages and limitations of virtual online consultations in a NHS acute trust: the VOCAL mixed-methods study).

4. Rather than telehealth, patients who are well and seeking general advice should be directed to a website(s) or recorded phone message, when available (Advantages and limitations of virtual online consultations in a NHS acute trust: the VOCAL mixed-methods study).
5. Frail older patients or those who are immunocompromised / immunosuppressed, and in cases where there are trade-offs and the provider will need to use his/her best clinical judgement (Advantages and limitations of virtual online consultations in a NHS acute trust: the VOCAL mixed-methods study)
6. Patients who may have been identified as potentially non-adherent to their chronic medications (MED-C, MED-D, MED-H tags) are good candidates for a virtual visit. Providers and clinical staff will have more insight to a patient's medication organization and supply and may also be able to pick up on other barriers to adherence during these virtual conversations in the home (Medication Adherence & Access During COVID-19 Toolkit).

How many of my providers should be ready to perform telehealth?

Ideally, all physicians and other qualified healthcare professionals (e.g., NP, PA, CNS, etc.) should be ready to perform telehealth. Each practice will need to make the decision for implementation (all in or phased in) that makes best sense for the practice and providers.

What if demand exceeds our practice's supply? Are there any overflow options?

1. Telehealth technology has the capacity to manage multiple patients within their environments.
2. When the number of patients exceeds a provider's resource capabilities to provide telehealth, he/she can share responsibilities with other physicians and qualified healthcare professionals (e.g., NP, PA, CNS, etc.) as long as they meet state requirements for licensure and scope of practice for telehealth.

Do I need special equipment like monitors, cameras, headphones or special lighting?

During the Covid-19 national emergency, the U.S. Department of Health & Human Services (HHS) is suspending enforcement of privacy and security rules related to telehealth encounters. During this time period, you may rely on commercial two-way audio-visual communications platforms provided that they are not public facing. As a general matter, however, providers and organizations should select telehealth platforms that meet HIPAA's privacy and security rules. In the event of a technology breakdown, causing a disruption of the session, the professional shall have a backup plan in place (e.g., telephone access). Telehealth shall provide services at a bandwidth and with sufficient resolutions to ensure that the quality of the image and/or audio received is appropriate to the services being delivered. (Best Practices in Videoconferencing-Based Telemental Health April 2018)

Is my Internet speed fast enough to provide telehealth?

1. The technical requirements for internet speed is determined by the vendor selected.
2. Contact your Internet Service Provider (ISP) and ask them to conduct a speed test. If the speed test is insufficient to meet the vendor technical requirements or suggestions, work with your ISP to find possible solutions.

3. Oftentimes, it is recommended to consider using a Local Area Connection (LAN) rather than WiFi to achieve a more stable internet connection.
4. It is important to test and solve potential issues prior to telehealth implementation and work with your ISP, the telehealth vendor, and Aledade.

How can I make the most of the visit?

A telehealth visit is to be performed no differently than a face-to-face visit. The documentation requirements are the same and time spent is still a factor for many of the codes, with only face-to-face time spent with the patient or caregiver allowed.

What are the limitations of the visit? What can/can't I do during them (e.g., vital signs)?

1. Limitations are dependent on the equipment that patients do/do not have at home, the nature of the exam that you are performing, and coding requirements (e.g., AWV).
2. For example, if a patient has a scale, ask him/her to get it and weigh themselves while you watch them and record the value. Another example, if a patient has a blood pressure machine or a blood glucose machine, ask them to obtain a result while you watch them and record the value(s).
3. When an exam requires percussion, auscultation or obtaining a value that the patient is unable to provide, a telehealth visit is likely not the best option.
4. When performing medication reconciliation, ask to see the patient's pill bottles and take a thorough look at the labels. Check for things like the date it was filled to help to clue in for potential issues with non-adherence and if brand name medications are filled, bring up potential cost saving alternatives!

What will my patients need to have in terms of devices, WiFi, equipment, lighting etc.?

1. Patients will need access to either an internet connection or cellular service (phone or tablet) and a camera on their phone, tablet or desktop computer (internal or external) in order to participate in telehealth visits where audio and video are required.
2. During a telehealth visit, the patient and provider should participate in a well-lit, quiet, and private location.
3. It may be advisable to have patients gather and/or purchase a home scale, BP cuff and/or glucose monitor for use during the visit as appropriate.

Will my patients need to set up an account or remember a password?

Depending on the telehealth vendor, patients may need to download an app from the App store (iPhone) or from Google play (Androids) OR they may receive a link through text message or email to enter the PCP virtual visit. Follow the guidance and requirements of your selected vendor.

Will my patients be required to provide a credit card?

Depending on the application that your practice selects, a credit card may be required prior to starting the visit for co-pay or private pay collection. The practice has control over what is collected from the patient based on their billing processes and procedures.

What if they have trouble logging on or getting connected? What are our options for tech support?

1. Depending on the vendor, patients may access the support services like (Phone, Email, Live Chat, or Website) for troubleshooting issues.
2. During the surge in telehealth use, delays in support services may occur.

Should my patients try to have a family member or caregiver present? What about a 3-way (or more) video call?

1. Some telehealth technology allows for 3-way or group calling, but not all.
2. For the platforms that allow this:
    a. If the patient would normally have a family member or caregiver present, then yes.
    b. If there is concern about cognitive function, then yes.
    c. If the patient would like a family member or caregiver to be present, then yes.

Please use your best judgement when considering whether to ask a patient to come into contact with other individuals during the coronavirus emergency.

How should I interact with the patient while on the video call?

Please see Appendix H for suggestions on how to interact with patients during a video call.

Do I need a special template in my EHR for a telehealth visit?

No, you do not need a special template in your EHR. There is no difference between documenting a regular visit and documenting a telehealth visit.

If I cannot meet all the requirements of a CPT code during a visit, how should I document and bill for the visit?

It is important to remember, even for telehealth, that if you did not perform something you should not be billing for it. Document what you did and choose the code(s) that best represents your work and time, when applicable. Continue focusing on delivering the best quality care.

Are there any sample practice protocols?

See Appendix I for sample protocols.

Do you have scripts or FAQs we can use when patients are resistant to telehealth visits?

Please see Appendix J for guidance.

Appendices

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Appendix A: State Telehealth Laws and Regulations

Please review the State Telehealth Requirements document for additional information regarding telehealth in your patients' state.

- Link for App Users
- Link for non-App Users

Appendix B: Telehealth Consent Template

Every state requires that a patient affirmatively consent to a telehealth encounter. Here is a consent form template that you can use for this purpose. Be sure that this includes all necessary elements based on your specific state regulations and payer guidelines. (fillable internal PDF here)

We now have a Telehealth Consent form available in additional languages as well:

Spanish

- (App Users) Spanish Telehealth Consent
- (Non-App Users) Spanish Telehealth Consent

Chinese

- (App Users) Chinese Telehealth Consent
- (Non-App Users) Chinese Telehealth Consent

Vietnamese

- (App Users) Vietnamese Telehealth Consent
- (Non-App Users) Vietnamese Telehealth Consent

CONSENT FOR TELEHEALTH SERVICES

Practice Name, Address, and Telephone Number

_____

1. I understand that my health care provider wishes to engage in a telehealth visit or series of visits. I understand that these encounters will not be the same as a direct patient/health care provider visit because I will not be in the same room as my health care provider. Instead, we will communicate using two-way simultaneous audio-visual technology ("the technology").
2. I understand that I have the right to refuse to participate in any telehealth encounter at any time or to end it at any point during the encounter. I understand that if I do not wish to participate in a telehealth encounter I will need to either make an appointment for an in-person visit with my provider or seek care at the closest emergency department if I believe that my symptoms warrant that level of care. I further understand that my provider may not be able to accommodate an in-person visit and there may be a delay in my care if I choose an in-person visit.
3. I understand that my health care provider can discontinue the telehealth encounter if he or she believes that this technology does not meet the standard of care necessary to address my medical concerns. If that happens, I understand that I will need to either make an appointment for an in-person visit with my provider or seek care at the closest emergency department if I believe that my symptoms warrant that level of care.
4. I understand how the technology will be used to conduct any telehealth encounters with this practice. I also understand that, with this technology, there is a risk of interruption and technical difficulties.
5. I have had the opportunity to ask questions about telehealth encounters and the technology. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language that I understand.
6. I understand that I will be told the identity of everybody who will be in the room with my healthcare provider during any telehealth encounter and that those people will be present only because my health care provider has determined that their presence is necessary to assist in my medical treatment according to the applicable standard of medical care.
7. I have been told whether my provider is licensed to provide medical care in the state where I am located. If they are not licensed in the state where I am located, I consent to receive telehealth services anyway because the provider is fully licensed in the state where they are located.
8. I understand that I will be responsible for any copays and coinsurance that apply to my telehealth encounter(s).
9. This consent will remain valid for 12 months from the date of my first telehealth visit.

Appendix C: Commercial Payer Guidance

Note: Telehealth policies from commercial payers continue to change almost daily in response to COVID-19 and Aledade is doing its best to keep up with the latest information. Please refer back to the payer website (when available) linked here for the most updated guidance. In addition, please be aware that most payers offer third-party platforms to patients for accessing primary care on demand. Lastly, our scan of commercial payers revealed that patients are not subject to an originating site and can receive telehealth services in their residence home.

Note: guidance is currently limited to populations under Aledade value-based contract, please refer to the payer website for details on other insurance products.
Updated February 19, 2021

Market-specific Billing Flowcharts for DE, KS, LA, NC, NJ, UT and WV can be found in Appendix P.

PAYER *(alphabetical order)*	**POPULATIONS COVERED***	**ADJUSTMENT IN TELEHEALTH REIMBURSEMENT POLICIES AS RESULT OF COVID19**					
		Payer modified their telehealth policy?	**Reimburse-ment Parity to E&M visit**	**Waive Patient Co-Pay**	**Allowed Telehealth Approach**	**Modifier or Place of Service (POS) Code Needed**	**Credentialed Providers**
Aetna	-Commercial (Comm) -Medicare Advantage (MA)	YES: Coverage of expanded commercial telemedicine services will continue through March 31, 2021.	YES	Yes, for in-network telehealth visits for primary care and behavioral health through March 31, 2021.	Comm: Audio-visual **or** telephonic MA: Audio-visual **or** telephonic	Comm: GT or 95 Modifier + POS (02) MA: Follows CMS	MD, DO, NP, PA
Anthem Kentucky	Commercial	YES: Telephonic-only visits with in-network providers permitted through March 31, 2021.	N/A	YES, for telephonic-only in-network visits through March 31, 2021.	Telephonic	Modifier GQ,GT, or 95 (some CPTs do not require modifier)	Physician or other qualified professional
Blue Cross Blue Shield Kansas	Commercial	YES: Expanded telehealth and virtual services coverage until March 31,	YES	NO	Audio-visual **or** telephonic	Modifier GT + POS (02)	MD, DO, ARPN, person licensed, registered, certified, or otherwise authorized to

		2021.					practice by the behavioral sciences regulatory board
Blue Cross Blue Shield Louisiana	-Commercial -Medicare Advantage	YES: Effective 3/20/2020 health plan is adopting new policies.	N/A	YES	Audio-visual or Telephonic	Modifier GT or 95 Telephonic only: use CPT 99441-99443	ALL licensed providers except: Certified Nurse Assistants, Licensed Perfusionists, Licensed Radiology Technicians, Licensed Clinical Laboratory Scientists
Blue Cross Blue Shield North Carolina	-Commercial -Medicare Advantage	YES: Effective through 6/30/2021.	YES	YES	Audio-visual **or** Telephonic	Audio-visual: POS (02) Telephonic only: Modifier CR + POS (02)	All providers credentialed with BCNC
Florida Blue	Commercial	YES: Effective 3/18/2020	YES	YES	Audio-visual **or** Telephonic dependent on patient coverage please see billing guidelines	POS with 95 or GT modifier.	Credentialed Providers
Highmark (Blue Cross Blue Shield DE)	-Commercial -Medicaid -Medicare Advantage	YES: Effective through at least March 31, 2021.	YES	YES [Comm. + Medicaid]	Audio-visual **or** Telephonic	Modifier GT or 95 + POS (02) [Comm. + Medicaid]	Providers performing and billing telehealth services must be eligible to independently perform and bill the equivalent face to face service. May include: MD, DO, PA, Nurse Midwife, Clinical Nurse Specialists, CRNA, Registered Dieticians, Clinical

							Psychologists Clinical Social Worker, NPs
Horizon (Blue Cross Blue Shield NJ)	-Commercial -Medicare Advantage	YES: effective 3/13/2020 health plan is adopting new policies	YES	YES	Audio-visual **or** telephonic	Modifiers GT and 95	Provider of telemedicine services shall be: validly licensed, certified, or registered to provide such services in the State of New Jersey, or licensed in the state where the patient is physically located at the time of the telemedicine encounter.
Humana	Medicare Advantage	YES: through 2021. Additional info available on the telehealth provider page.	YES	YES	Audio-visual **or** telephonic	POS 11	Credentialed by Humana
Magnolia (Centene Mississippi)	Medicaid	YES through April 2021 (through the end of the PHE). Temporary telehealth guidelines linked here.	YES	N/A	Audio-visual **or** telephonic (limited to 99441-3)	Audio-visual: Modifier GT and POS 02 Audio-only: POS 02	MD, DO, PA, NP, Psychologist, LCSW, LPCs, BCBAs
UnitedHealth - Care Mississippi	Medicaid	YES through April 2021 (through the end of the PHE). Temporary telehealth guidelines linked here.	YES	N/A	Audio-visualFor audio-only, reach out to your UHC rep to confirm reimbursement	Audio-visual: Modifier GT, GQ, G0 or 95	MD, DO, PA, NP, Psychologist, LCSW, LPCs, BCBAs
Public Employees Insurance	Commercial	YES: effective 3/16/2020 health plan is	YES		Audio-visual **or** telephonic	Modifier GT or 95	Licensed provider

Agency (WV)		adopting new policies				(telehealth limited to 99211-99213)	
Regence (BCBS UT, OR, WA)	Commercial	YES: effective through 2021	YES	N/A	Audio-visual **or** telephonic	POS and Modifier 95	MD, DO, or other qualified professional
Regence (BCBS UT, OR, WA)	Medicare Advantage	Yes; effective through 2021	YES	N/A	Audio- and video	POS and Modifier 95	MD, DO, or other qualified professional
Sunflower (Centene Kansas)	Medicaid	YES	YES	N/A	Audio-visual **or** telephonic	POS 02 (only available for 99221-4)	MD, DO, PA, APRN, person licensed, registered, certified or otherwise authorized to practice by the behavioral sciences regulatory board
UnitedHealth-Care	Medicare Advantage	YES: effective through 4/20/2021.	YES	YES	Audio-visual **or** tele-phonic	Modifier -95 POS 11	Physician, Nurse practitioner, Physician assistant, Nurse-midwife, Clinical nurse specialist, Registered dietitian or nutrition professional, Clinical psychologist, Clinical social worker

Appendix D: Getting Started with Telehealth

Please refer to the Getting Started with Telehealth guide for information on telehealth offerings for specific top-tier EHR products, along with general system selection and workflow guidance.

- Link for App Users
- Link for Non-App Users

Telehealth Best Practices

Getting Started with Telehealth

- ❑ Consult the Getting Started with Telehealth (non-app users) guide.
- ❑ Review the telehealth resources on the Aledade Learning Center, including the Telehealth Toolkit (non-app users).
- ❑ Review State Telehealth Laws and Regulations (non-app users) and the specific policies of payers to ensure your practice is delivering and billing telehealth appropriately.
- ❑ Conduct 'test visits' with your Aledade Practice Transformation Specialist to help the providers and staff become comfortable with the telehealth technology, and so that the PTS can explain the experience and any expected questions from the patient side.
- ❑ Conduct 'test visits' with patients prior to the first scheduled visit.
- ❑ Establish workflows for the pre-visit and post-visit steps, and consider how the patient will interact with the practice during this process. Consider incorporating the collection of insurance information and images of the insurance card during the pre-visit workflow.

Communicating Telehealth Visits to Patients

- ❑ Consider creating a video or hosting a Facebook Live to explain telehealth to your patients and demonstrate the process and platform.
- ❑ Use "assumed yes" language when communicating that in-person visits will be changed to telehealth visits.
- ❑ Review the scripting resource called "Sample Scheduling a Telehealth Visit Script" in the appendix of the Telehealth Toolkit (non-app users) on the Aledade Learning Center.

Scheduling Telehealth Appointments

Problem: Doctors are sitting and "waiting" for patients to join the visit.

- ❑ Consider having designated blocks of time for televisits so the provider could be doing other notes or chart prep at the same computer while they wait for the patient to join.
    - Some practices are moving sick visits to one time of day and telehealth to others (e.g., sick visits in AM and telehealth PM)
- ❑ Consider a team-based approach where clinical support staff such as MAs are involved earlier in the process (see the next section for more details on the workflow).

Problem: Patients have been cancelling appointments.

- ❑ Look in the EHR and contact all patients that have cancelled appointments in the past few weeks and reschedule them for a telehealth visit.
- ❑ Convert your cancellations! When a patient calls to cancel, offer them a telehealth visit with an 'assumed yes' approach rather than giving options or asking if they want to change.

Other scheduling best practices to consider:

- ❑ Create a Telehealth visit type in the EHR.
- ❑ Put the method of contact (text or email link) with the correct cell number or email address at top of each visit note or in the chief complaint. This allows it to be right in front of the provider when starting the visit.

Familiarizing Patients with the Technology

Problem: Patients may not be comfortable with the telehealth technology and valuable time is spent helping patients get set-up instead of on the actual telehealth visit.

- ❏ Consider this team-based approach:
  - Determine who will perform a 'test' visit with the patient 1-2 days before the actual visit.
  - On the day of the visit, the front desk staff starts the process about 10 minutes before the appointment time with a phone call to get the patient 'checked in', (if needed) get a consent form signed, then hand the call off to a clinician.
  - A clinician verifies the reason for visit, updates the visit notes, reviews medications and explains the next steps to the patient. Consider verbiage like *"Dr. _____ is seeing a patient right before you, she will send a text with the video link as soon as she wraps up, probably in about 5 minutes."* At the end of that call, the clinician 'rooms' the patient and marks them 'ready' in the system for the provider.
- ❏ When applicable, schedule telehealth visits (e.g., TCM), at the same time that a home health visit is occurring. A home health nurse or other clinician (e.g., PT) can help the patient address technical difficulties, obtain vital signs, and perform additional hands-on assessments.
- ❏ When the clinician prepares charts the day before the visit, and it is the first time a patient will participate in telehealth, complete a test visit to troubleshoot and resolve issues ahead of the scheduled time with the provider.

Post Appointment Care/Follow-up

- ❏ Call back AFTER the telehealth visit to schedule any follow-up care, collect copay, review the after-visit instructions, and debrief with the patient on the telehealth experience. Consider incorporating patient feedback into telehealth workflows.
- ❏ Add the telehealth visit summary and any photos or other documents to the patient's chart.
- ❏ Billing/coding staff should verify that all telehealth visits include the correct modifier and place of service prior to sending the claim.

Appendix E: Telehealth Visit Workflow

Practice Setup

1. Select which available audio and/or video communication technology that you will use to provide telehealth encounters for patients. Options include:
    - Vendor Applications (e.g., Updox or other vendor)
    - Commercial Applications (e.g., Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, WhatsApp, Skype or Signal)
    - Consider having more than one (1) option available.
2. Verify that the technology is available and functional on all devices that will be used for telehealth visits. The provider may need to download relevant applications.
3. Verify that the technology has been set up for use on all provider's devices and that cellular phone numbers and email addresses are individualized for each provider. When using commercial applications (e.g., Apple FaceTime), consider giving providers new numbers or email addresses for telehealth use if they are concerned about privacy and want to avoid using personal ones.
4. Review state and federal requirements governing telehealth devices to ensure compliance (ie consent to telemedicine and HIPAA waivers as applicable).

Patient Setup & Scheduling

1. Outreach to patients and let them know which audio and/or video communication technology will be used for telehealth visits (Outreach via Facebook, Website, Newsletters, patient portal, etc..).
2. If a patient does not have the application on their device, does not have a computer, or does not have internet access:
    a. Ask them if they want you to assist them with downloading an application (as needed)
    b. If they would prefer to have someone else (e.g., family member, caregiver, friend) download an application for them or use their computer and help them with the video visit, have them write down the name of the application, and they can ask their 'someone else' to call you for help.
3. Scheduling a visit
    a. Key information must be delivered during the outreach call when scheduling the visit to assure that telehealth is the most-appropriate visit type for this patient at this time. Details can be found earlier in the Scheduling and Implementation section of this toolkit.
        - Explain the technology
        - Explain risk, benefits, and alternatives
        - Invite questions
4. Schedule a 'test' visit so that the patient has an opportunity to use the technology before their actual visit.

Completing the Televisit: Provider

1. Verify that compatible application(s) are downloaded to all devices that the you will be using for telehealth visits
2. Test all applications and troubleshoot until there no issues with initiating and using the applications(s) on each device
3. Open the the televisit encounter and prep, as usual
4. Initiate the telehealth visit at the scheduled visit time

5. Complete the telehealth visit and close the call
6. Follow vendor-enabled and normal encounter closure processes (e.g., necessary documentation, coding)

After Care

Send the patient's after-visit instructions/summary/plan of care via appropriate channels (e.g., patient portal, secure text, etc.)

Commercial Applications

	Apple FaceTime	Facebook Messenger	Google Hangouts	Skype	Google Duo	WhatsApp	Signal
App Icon							
Operating System Compatibility	iOS Mac	iOS Android Mac Windows	iOS Android Mac Windows	iOS Android Mac Windows	iOS Android Mac Windows	iOS Android Mac Windows	iOS Android Mac Windows
Browser Compatibility	No	Yes - Go to messenger.com	Yes	Yes	Yes	Yes - Must scan a QR code inside the app and phone needs to stay connected to the Internet	No
Download Needed?	iOS/Mac - No, already installed Android - NA	iOS - Yes Android - Yes	iOS - Yes Android - Yes	iOS - Yes Android - Yes	iOS - Yes Android - No, already installed	iOS - Yes Android - Yes	iOS - Yes Android - Yes Desktop - Yes

Telehealth Checklist and Workflows for PTSs and Medical Directors

Goal: The outline of actions and responsibilities below provide the PTS and Medical Directors with key points to coach and mentor their practices who are implementing telehealth.

Office Staff

Designate and mentor a **Practice Telehealth Champion**. Responsibilities of the champion include but are not limited to: addressing the patient's telehealth technology and connectivity issues, calling patients the day before their visit and conducting a test visit, and addressing questions, comments, and concerns from patients about telehealth visits (e.g., quality, safety, privacy, etc.)

Telehealth Workflow

A Week Before the Visit

Practice Telehealth Champion - Telehealth Emphasis and Education

1. Explain the telehealth visit focusing on the value and addressing any questions about the visit type, technology, quality, etc.
2. Ensure that patients have access to necessary technology or a caregiver to support setting up the technology for the telehealth visit.
3. Ensure that the patient is comfortable using the telehealth technology and that all equipment works as expected, troubleshooting as needed
4. When applicable, acknowledge patient reluctance and concerns regarding the use of telehealth. Answer questions and provide reassurances to overcome reluctance and address concerns.

Convert/Schedule Telehealth Appointments

- ❏ Prioritize outreach to TCM, then ED, then the highest vulnerability patients and convert currently scheduled visits to telehealth or if there are no scheduled visits, schedule 'Stay Well at Home' visits
- ❏ **Practice Telehealth Champion:** Set up and conduct a 'test' visit ahead of the visit with the provider to work through any possible technical issues/barriers
- ❏ If the patient is unable or unwilling to participate in a telehealth visit, offer alternative methods of having appointments with their provider (e.g., telephone) and consult with the provider regarding enrollment of eligible, appropriate patients into CCM or PCM

Day Before the Visit

Make Reminder Calls

- ❏ Set up a reminder call to the patient one (1) day before the scheduled appointment.
- ❏ If the patient has not filled out the consent form, during the reminder call/voicemail remind the patient to fill out the form or be ready to give verbal consent to the provider.
- ❏ Offer the patient another opportunity to do a 'test' visit ahead of the provider visit.

Day of Visit

Daily Huddle Review

- ❏ Review the Daily Huddle daily for the highest vulnerability patients scheduled for visits that day. Ideally, this has already been done and if not, complete 1.a-d above.
- ❏ Execute internal workflow for smooth handover of patients prior to, during, and after a telehealth visit.

Key:
A number represents information; A box (☐) represents an action/ checklist item

Appendix F: Sample Scheduling a Telehealth Visit Script

Sample Scheduling Call Script

Good morning, **[Mr., Mrs. Ms. Miss. name]**. This is **[insert caller's name]** calling from **[insert provider's name]** office. **[Insert provider's name]** is concerned about keeping you safe during the coronavirus outbreak and wants you to stay home instead of coming to the office for your appointment. **[insert appropriate pronoun]** will be using a telehealth (video) visit to see you while you stay at home instead of coming to the office. This is just like a normal office visit, but a telehealth visit uses a camera and a microphone on either your phone, tablet, or computer so that you can hear and see us just like if you were in person.

To prepare for your telehealth (video) visit, I need to ask you a few questions.
Do you have access to a smartphone (like iPhone), tablet (like iPad), or a computer with a camera? [If a caregiver would normally accompany the patient to the office visit or if a caregiver is still in physical contact with the patient, they can also bring a smartphone or computer with video capabilities, or support the patient in-person. However, please use your best judgement when considering whether to ask the patient to come into contact with other individuals during the coronavirus emergency.]

No: Thanks. Let me talk with **[insert provider's name]** to see what suggestions **[insert appropriate pronoun]** has for you to see **[insert appropriate pronoun]**. I will call you back **[give date and time window]**.
Yes: Great! Let me tell you about the technology we will be using so that you understand it better and how to set it up. [explain technology, its risks/benefits, alternatives, and that if anyone else will be with the provider during the visit they have the right to ask them to leave].

Do you have any questions?

- **Yes:** [Answer them as best you can until the patient is satisfied.] Let me know if any other questions come to mind or call me if you think of any after we hang up.
- **After there are no further questions or their answer is no:** I will be sending you a telehealth (video) visit consent form for you to read before your visit with **[insert provider's name]** and **[insert appropriate pronoun]** will ask you if you have any questions about it at the beginning of your visit.
- **Portal user:** Send like you send other documents or messages to patients.
- **Not a portal user:** What email address should I use? [if they do not have an email address, be sure to ask if they have family or friends or neighbors who might be able to help them over the phone]

Let's get your telehealth (video) visit scheduled. I have **[insert date and time]** available. Does this time work for your schedule? [Follow the normal process used to schedule visits where the patient is available during open provider time slots.]

It is very important that you are **ready for your visit at your scheduled time**. If you are unable to keep your appointment, please call us and we can reschedule. You will be **[give them the appropriate technology log in or call information]**.

Please let us know if you have questions or need to reschedule and stay safe!

Appendix G: Telehealth Scheduling Checklist

- ❏ Explain the technology, the risk/benefits/practical alternatives to a telehealth visit and invite questions.
- ❏ Inform the patient that if others from the practice will be present during the telehealth visit (e.g., MA), the provider will let them know at the beginning of the visit and ask if they agree to allow others to be present during the visit.
- ❏ Inform the patient that you will be emailing (or sending through a portal) a telehealth consent for them to review before their telehealth visit.
    a. If they **have an email on file**, confirm that it is the one to use.
    b. If they **do not have an email on file**, ask for one to use, even if it is someone else's (e.g., a family member or caregiver's).
    c. If they chose to use **someone else's email address**, confirm that they will have access to review the consent before their telehealth visit.
    d. If they will be **unable to read the consent before their telehealth visit**, make a note in the telehealth visit encounter that the provider will need to read the document and obtain verbal consent at the beginning of the telehealth visit.
- ❏ Give the patient the visit date and time
    a. Be prepared to reschedule if the patient is unavailable or will not have access to a smartphone or tablet during that time.
    b. Explain to the patient that it is important that they be ready to accept the call for the visit right before or at the scheduled visit time. If they cannot participate in the visit **right on time**, it will be necessary to find another time now or call back and reschedule if they miss the scheduled visit time.
    c. Give the patient the phone number, email address or other pertinent information about where the telehealth visit will be coming from and ask them to turn off unknown number and text blocking as soon as this call ends.
- ❏ Set up a "test" visit to ensure that the patient is comfortable using the telehealth technology prior to the scheduled visit.
- ❏ Document in the EMR
    a. Technology was explained and questions answered.
    b. Risk, benefits, and practical alternatives to a telehealth visit were discussed and questions were answered.
    c. You informed them that anyone from the practice who will be in the room during the telehealth visit will be disclosed to them and they have the right to ask them to leave or allow them to stay.
    d. You sent the patient a copy of the telehealth consent form and that the same form was uploaded to the patient's record in the EMR.

Appendix H: Interacting with Patients during a Telehealth Visit

1. Patients **can see you best** if you have a light shining in front of you from the direction of the screen, rather than behind you pointing at the screen. The same is true of windows: to avoid being "backlit" you should be speaking to a patient facing a window rather than having the window at your back.
2. **Pauses in conversation can feel more awkward and less natural** on video calls than in-person but you should still allow pauses in conversation to allow the patient to gather their thoughts and speak, especially if an emotional topic is being discussed.
3. Since video calls **can have issues with sound quality**, it is even more important than usual to do "teach-backs" where you ask the patient to tell you their understanding of what you said to them, such as their understanding of diagnosis, prognosis and treatment plan.
4. **Never say anything that could be perceived as derogatory about a patient**; it's a good rule in all cases, but especially before or after a telehealth call as there may be times you didn't realize the audio was on.
5. It is important to **have a plan for what you would do if the patient decompensates** during the telehealth appointment.

Appendix I: Sample Office Telehealth Protocol

Green Spring Internal Medicine - Dr. Dahlman

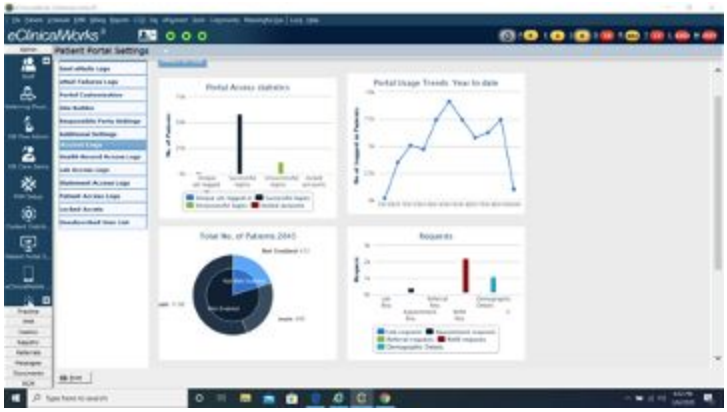
TELEVISITS!

Rationale for Televisits at this time: to spare time for younger patients who need a brief, on time visit, to improve efficiency for all by providing care in the appropriate setting, to help triage patients under investigation for COVID19 and other infectious diseases without having them come to our setting, to assure our other patients with chronic conditions who simply need to continue their care that we can continue to provide for them

What can NOT be a Tele Visit: medical emergencies for which 911 should be called, visits requiring examination with a tool (for example, ear pain), visits for which physical examination or other procedures will be needed (for example, chest pain), visits for which a rapid test will be needed (_Strep_ , pregnancy test).

Cost: $2 per TeleVisit

What makes this extra possible at our practice? Approx 80% of our patients have Portal/Healow Access. This was the result of years of team effort! Televisits can easily be scheduled within eCW. We have 11e which allows for Televisits without added set-up.



What are challenges as of 3/16/2020?

Patients have been having trouble with Healow due to delay in 2 Factor authentication. Please see patient process instructions below. Patients need their userid and password. Please ask patients to write down all of our instructions.

What are patient laptop requirements?

- Webcam or laptop computer video OR a smart phone with the Healow app setup
- Audio
- At least 3 mbp internet speed, good internet connection

What are the patient phone requirements?

- Android or iPhone
- Internet connection 3 mbps
- Patient Portal login
- Healow app installed on the phone
- Healow login set up on the phone
- Healow app must be up and running before the appointment
- The patient should go to the appointment section in the app
- On today's appt, there will be a video camera that says (join televisit)
- They will then see at the top of the Healow wheel where then can enter the TeleVisit (Appointments)

What is the process for the patient from a laptop or desktop?

- Laptop with a camera and microphone
- Internet access (with at least 3 mbps)
- Active Patient Portal / Healow login
- Click the orange button from the reminder email or access the TeleVisit via Portal

1. Do compatibility check
2. Enter vitals if available
3. Click on the orange button on the laptop or desktop and proceed.
4. Click "Start Televisit" which will put them in a virtual waiting room

What is the process for the provider?

1. Receive notice through a chime that the Televisit is pending (see TV jellybean on far right of screen within eCW)
2. Enter the progress note
3. Click on the Televisit icon (orange)
4. Conduct and document the visit
5. You can move the video where you want on the screen and freeze or mute your own video, if you like
6. Complete documentation of the progress note during the video visit
7. At the end of the visit, hit CHECKOUT only once. This will END the visit. Do not choose other options
8. Enter billing codes

Billing

1. Every TeleVisit is billed as usual and needs a 95 modifier (note: this is only true for some commercial payers).
2. Place of service

Remaining questions:

1. Co-pays, we believe are waived
2. Most insurance allows TeleVisits, paid the same as office visits. Are there any who don't?
3. Would we be able to screen self-scheduled patients for COVID-19 exposure, respiratory symptoms or febrile illness?
4. What does it look like using the Healow app? Please use a Test patient
5. Visit duration (via Admin can be customized to provider
6. Avoidance of stacking visits > wait times for patient or provider lasting more than 15 minutes late will get knocked off the schedule
7. How do we get the word out about Televisits?

The front desk team will call the patient about 10-15 minutes before their scheduled appointment to do a phone registration/check in and collect any copay. The patient will be moved to the "waiting room" in eMDs at that time.

The nursing team will "room" the patient (we have created "Telehealth" rooms for each practice) and mark them ready for the provider.

The provider will login to the Updox webpage (NOT using remote desktop) and initiate the visit with the patient. Alternatively: you can have your nurse connect with the patient first, using a device that they can pass to you when her work is complete.

The provider/nurse/scribe team start the visit and document the note AS USUAL in eMDs, just like the patient was in your exam room. There are only two differences: first, hit the "Telehealth Visit" in the CC section of the note; and second, change the Place of Service code and affix a modifier to the billing code for some payers before signing the note.

When you are finished with the visit, you end the Telehealth session and send the summary to yourself, then check the patient out of eMDs.

The front desk will watch for that check out to happen, then call the patient back to schedule any needed follow up (be sure to put that info in your note) and/or collect any deductible not known before the visit. Voila!

Appendix J: FAQs for Patients about Telehealth Visits

Included here talking points and scripts when talking to patients about telehealth options.

- **Why is this so important RIGHT NOW?**
    - In this Coronavirus (COVID-19) situation, we are worried that patients might risk catching the virus from another sick patient if they come into the office in person.
    - Telehealth visits offer us a way to talk to you about your health concerns without putting you at risk for catching other viruses or infections going around.
    - We are confident that we can address many health problems you're worried about without you having to leave home. You can still see your doctor without leaving your house!
    - If for any reason we think that we do need to see you in person, or that you need to go to a specialist or to a hospital, we can let you know that over the video chat and make a plan.
- **What is it?**
    - Video and phone calls to assess and treat our patients without them needing to come into the office for a visit.
    - We can do most of what we normally do in the office over a video call.
- **How does it work?**
    - We will talk to you ahead of time to make sure that you know how to get in touch with us when it's time for your visit.
    - You will talk to your provider over a video using either your phone, a tablet device such as an iPad, or a computer with a web camera.
    - You won't need to leave your house, or buy any special equipment.
    - You can expect to have a conversation just like you would in-person at our office.
- **How do I know whether I should come into the office or try a telehealth visit?**
    - Call us! Chances are, it would be best if we tried a telehealth visit. Please call us about getting set-up for a telehealth, or video visit.
- **Will I be charged for this visit?**
    - **If practice is <u>not</u> waiving copays**: Yes, telehealth visits have a copay, just like a normal office visit. You can expect to pay for a telehealth visit as you would for any visit that brings you to our office.
    - **If practice is waiving copays**: We are happy to do this telehealth (video) visit for you at no cost and will waive the copay.
- **What do I do if I don't have a way to do a video call?** We recommend talking to a caregiver or family member before your visit to see if someone you know has a way to help you make video calls. However, please use your best judgement before coming into contact with other individuals during the coronavirus emergency.
    - Did you know the iPad your grandchildren use or got you has a camera?

    - Do you have access to a smartphone (like an iPhone), a tablet (like an iPad) or a computer with a web camera (laptop or desktop)? Those all work great for a video call!
    - If you can't access video, call your practice to check-in and also make a plan as more limited services may be available over the phone.
- **[For practice toolkit only] More help supporting resistant patients:**
    - If the patient does not feel comfortable using technology or may not have access to make a video call:
        - Ask the patient to talk to a caregiver/friend/family member to see if there is someone who could help them over the phone to get set up for the virtual visit
        - If a caregiver would normally accompany the patient to the office visit or if a caregiver is still in physical contact with the patient, ask them if they'd consent to the caregiver/friend/family member to sit with them during their visit to help them with any technical issues they might have. Use your best judgement when considering whether to come into contact with other individuals during the coronavirus emergency.
    - Consider having a provider directly reach out to patients to explain the importance of telehealth.

Script for a Provider Recorded Voicemail: Hi, this is **[Provider Name]** from **[Practice Name]**. To ensure the health and safety of our patients, we have started using Telehealth as a way to assess and provide treatment during the coronavirus (or COVID-19) outbreak. Telehealth is a way for us to provide the "in-office experience" in the privacy of your own home using video and phone calls.

This is so important right now, given the coronavirus scare. The safest place for you is in your own home and we now have the technology to take care of you there.

These telehealth visits are not just for people worried they might have the coronavirus. We can see you for all kinds of visits, refill your medications and check in on your health conditions. It is better for you right now to stay home, but your normal healthcare needs are more important right now than ever. These telehealth visits will help us keep you safe.

If you think you have been exposed to coronavirus or have symptoms such as cough, fever or shortness of breath or are not feeling well but are worried about coming into the office to see us in person at this time, call us first at **[xxx-xxx-xxxx]**. We will talk to you about next steps on how to schedule a telehealth (video) visit with us. Thank you and we look forward to supporting you through this difficult time.

Appendix K: Billing Alternatives for Telehealth AWVs

Alternative E/M Billing for Medicare Annual Wellness Visits conducted via Telehealth

All providers must use their clinical judgment to determine whether an AWV can be performed using telehealth consistent with the applicable standard of care. If you cannot meet the standard of care due to vital sign collection, this is an alternative billing approach.

Description	CPT/HCPCS Time	Average Fee (Non-Facility Rate)	Notes
Document and bill for E/M	99212 - 10-19 min 99213 - 20-29 min 99214 - 30-39 min 99215 - 40-54 min	$56.88 $92.47 $131.20 $183.19	Same documentation requirements for face to face encounters.
Document and bill for: Annual depression screening	G0444 -15 minutes	$18.84	Document results and follow up plan
Document and Bill for: Prolonged services	99354 -First additional 60 minutes (minimum 16 min) 99355- each additional 30 minutes	$129.10 $96.30	Use only when prolonged service is greater than 31 minutes beyond E&M Not recommended to use with 99215
Document and bill for: Advance Care Planning	99497 -30 minutes (minimum 16 min) 99498 -Additional 30 minutes	$85.48 $74.32	Document time spent, voluntary nature, an account of the conversation, and those present

Appendix L: Scheduling & Consent Workflow Checklist

Workflow Step	Fulfilling Requirements
1. Pre-work and Scheduling:	
Notifying Patient	❏ Explain the technology, the risk/benefits/practical alternatives to a telehealth visit and invite questions. ❏ Inform the patient that if others from the practice will be present during the telehealth visit (e.g., MA), the provider will let them know at the beginning of the visit and ask if they agree to allow others to be present during the visit.
Scheduling the Telehealth Appointment	❏ Give the patient the visit date and time A. Be prepared to reschedule if the patient is unavailable or will not have access to a smartphone or tablet during that time. B. Explain to the patient that it is important that they be ready to accept the call for the visit right before or at the scheduled visit time. If they cannot participate in the visit right on time, it will be necessary to find another time now or call back and reschedule if they miss the scheduled visit time. C. Give the patient the phone number, email address or other pertinent information about where the telehealth visit will be coming from and ask them to turn off unknown number and text blocking as soon as this call ends. D. Set up a "test" visit to ensure that the patient is comfortable using the telehealth technology prior to the scheduled visit.
Obtaining Consent for Telehealth	❏ Inform the patient that you will be emailing (or sending through a portal) a telehealth consent for them to review before their telehealth visit. A. If they have an email on file, confirm that it is the one to use. B. If they do not have an email on file, ask for one to use, even if it is someone else's (e.g., a family member or caregiver's). C. If they chose to use someone else's email address, confirm that they will have access to review the consent before their telehealth visit. D. If they will be unable to read the consent before their telehealth visit, make a note in the telehealth visit encounter that the provider will need to read the document and obtain verbal consent at the beginning of the telehealth visit.

2. Document in the EMR:	
Record Necessary Information in the EMR	❑ Document in the EMR A. Technology was explained and questions answered. B. Risk, benefits, and practical alternatives to a telehealth visit were discussed and questions were answered. C. You informed them that anyone from the practice who will be in the room during the telehealth visit will be disclosed to them and they have the right to ask them to leave or allow them to stay. D. You sent the patient a copy of the telehealth consent form and that the same form was uploaded to the patient's record in the EMR. E. If the signed consent form isn't uploaded, document that the patient consented and indicate by what method (verbally, replied to email, etc.)

Appendix M: Marketing Materials

Telehealth Marketing Posters

- App Users Longer Version
- Non-App Users Longer Version

- App Users Shorter Version
- App Users Shorter Version (Spanish)

- Non-App Users Shorter Version
- Non-App Users Shorter Version (Spanish)

Phone Tree Script
- App Users Version
- Non-App Users Version

Testing FAQs
- App Users Version
- Non-App Users Version

Telehealth Made Easy Poster
- App Users Version
- Non-App Users Version

Telehealth Made Easy Postcard
- App Users Version
- Non-App Users Version

Appendix N: Additional Telehealth Resources

Regional Telehealth Resource Centers (RTRCs)

- California Telehealth Resource Center (CA) - www.caltrc.org
- Great Plains Telehealth Resource and Assistance Center (ND, SD, MN, IA, WI, NE) - www.gptrac.org
- Heartland Telehealth Resource Center (KS, MO, OK) - www.heartlandtrc.org
- Mid-Atlantic Telehealth Resource Center (VA, WV, KY, MD, DE, NC, PA, DC) - www.matrc.org
- NorthEast Telehealth Resource Center (CT, MA, ME, NH, NY, RI, VT) - www.netrc.org
- Northwest Regional Telehealth Resource Center (MT, WA, AK, OR, ID, UT, WY) - www.nrtrc.org
- Pacific Basin Telehealth Resource Center (HI, Pacific Basin) - www.pbtrc.org
- South Central Telehealth Resource Center (AR, MS, TN) - www.learntelehealth.org
- Southeast Telehealth Resource Center (GA, SC, FL, AL) - www.setrc.us
- Southwest Telehealth Resource Center (AZ, CO, NM, NV, UT) - www.southwesttrc.org
- TexLa Telehealth Resource Center (TX, LA) - www.texlatrc.org
- Upper Midwest Telehealth Resource Center (IN, IL, MI, OH) - www.umtrc.org

Other External Resources

- Medicare Coverage and Payment of Virtual Services - CMS
- Incorporating Telemedicine as Part of COVID-19 Outbreak Response Systems - AJMC
- Why the Telemedicine Physical is Better Than You Think - Telemedicine Magazine
- 10 communication tips for physician phone visits during COVID-19 - AAFP
- American College of Physicians (ACP) Telehealth Resources
- Special coding advice during COVID-19 public health emergency - AMA
- HHS Telehealth

Appendix O: Performing a Physical Exam over Telehealth

Telehealth Physical Exam Tips

John Scheitler, MD

Thomas Jefferson University, 'Telemedicine: Conducting an Effective Physical Exam' (CME.jefferson.edu)

- Verbalize your observations with the patient in order to confirm your observations
- Instruct the patient through self-exam or recruit a third party (family/friend/roommate). Recognize that it will take extra time to talk them through the techniques.
- GU exam: conduct in privacy, provide reassurance; office visit if patient/provider uncomfortable
- If unable or difficult to examine core component of physical, recommend an in-person exam

VITALS: temp, RR, pulse (machine or verbalize self-palpation), BP, pulse ox, weight

Unable: if the patient doesn't have the equipment to measure

GENERAL: appearance, distress

HEENT

HEAD: swelling, appearance, external lesions (lips/cold sores/impetigo), sinus tenderness (self-palpated)

EARS: external appearance (swelling/redness/lesions)

Unable: ear canal, tympanic membrane

EYES: visual acuity, extraocular movements, pupil reactivity/appearance, eyelid swelling, nystagmus

Unable: fluorescein uptake, slit lamp, intraocular pressures

NOSE: appearance, swelling, discharge

Unable: nasal speculum exam

THROAT: erythema, exudate, swelling, uvula, tongue, sores/lesions, muffled voice quality

SKIN: lesions (quality/type/size), wounds (length, type, depth), pain, itching, erythema, cyanosis, blanching, extension, rashes (character, distribution, color, appearance)

CARD: heart rate and rhythm (patient verbalizes palpated radial pulse), precordium (self-palpated), skin tone, signs of cyanosis, cap refill, LE edema, pain to calf palpation

Unable: auscultation, peripheral pulse symmetry

PULM: respiratory effort/distress, tachypnea, nasal flaring, intercostal retractions, audible wheezing/stridor

Unable: auscultation

ABD: appearance, distension, tenderness to self-palpation (or per family member palpation), CVA tenderness, guarding/rebound, scars, pain with jumping (peritoneal signs)

Unable: rectal

GU

Male: external appearance, lesion/rash, penile discharge, testicular/scrotal swelling, cremasteric reflex

Unable: prostate exam, full scrotal/testicle exam

Female: external appearance, vaginal discharge

Unable: internal female exam

Musc/Skel: swelling, bruising, edema, laceration, range of motion, stability, point tenderness, gait

Neuro: cranial nerves, balance, mental status, coordination, gait, muscle strength (squat), follows commands

Unable/difficult: reflexes

Lymph: self-palpated, external appearance

Psych: mood, affect, speech, orientation, insight

Additional resources:

Aledade has negotiated with Thomas Jefferson University to offer their **Telemedicine: Conducting an Effective Physical Exam** CME course at a group discount rate of $50 (regularly $100).

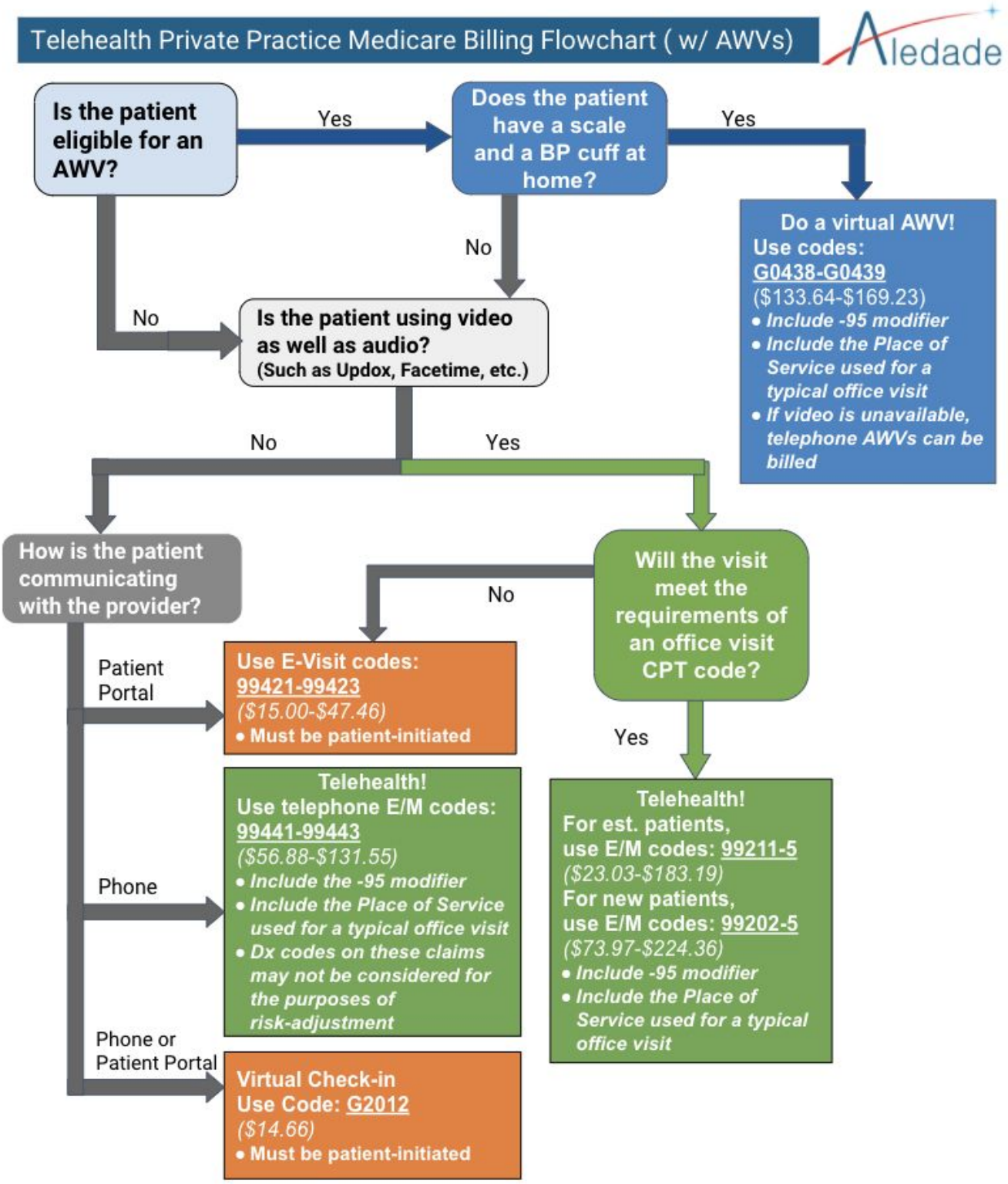
- Please have your providers register online (registration link).
- Create an account/login.
- Select "Healthcare Provider" and add to cart.
- Apply coupon code **LUQPUB**.

This document is a helpful resource with examples of completing physical exams over telehealth.

- Medicare Telehealth: Charting, Coding, Reimbursements (App Users)
- Medicare Telehealth: Charting, Coding, Reimbursements (Non-App Users)

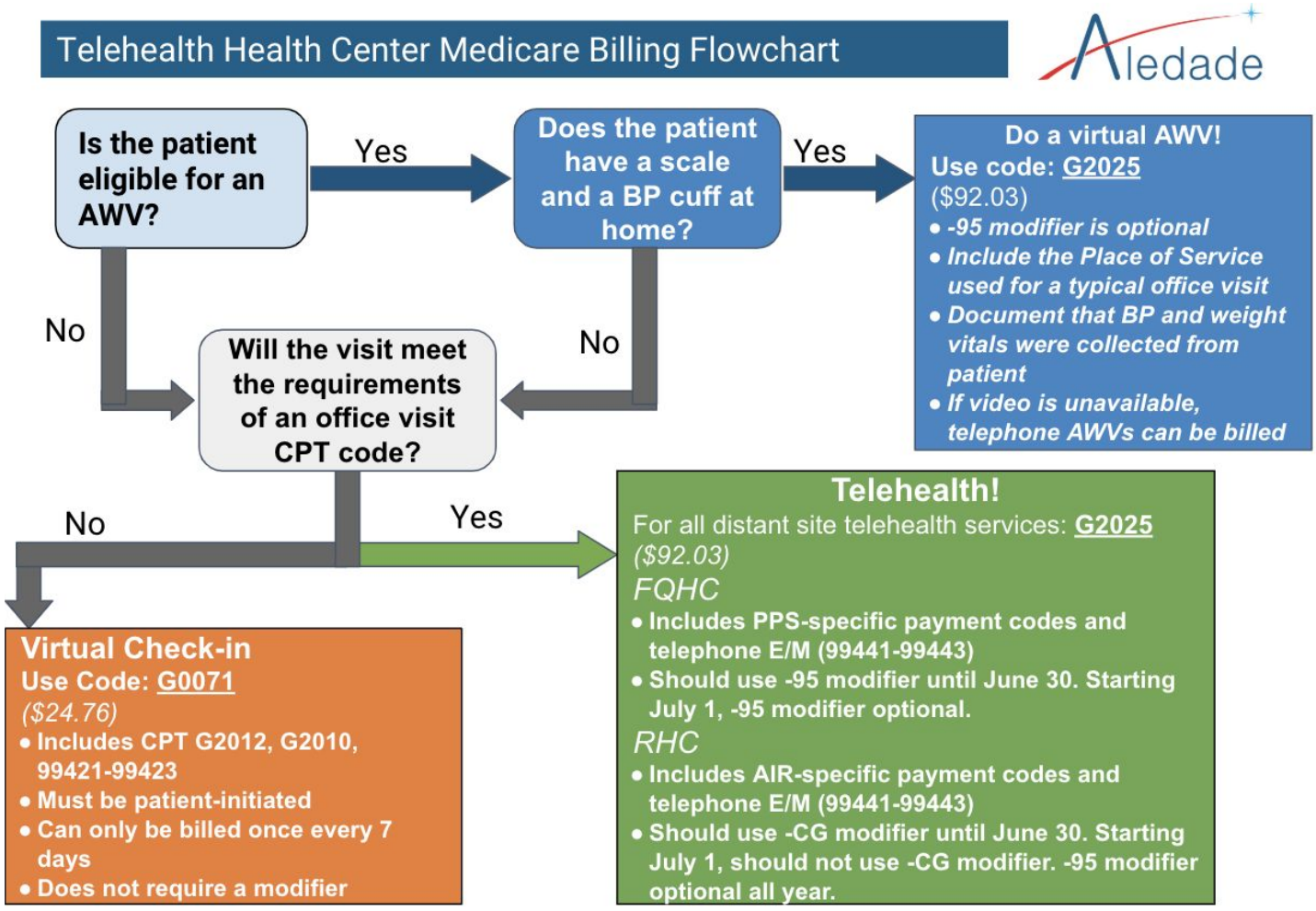
Appendix P: Telehealth Billing Flowcharts

MSSP - Private Practices



NOTE: These are national reimbursement rates for CMS, there is some variation by geography. Modifiers and reimbursement rates also vary depending on payer. Refer to payer specific guidance for more information about this.

Code	Description		Average CMS Reimbursement
Eval + Mgmt of a NEW patient	**Requires a problem-focused history and examination and _____.**	**If using time: _____**	**Average non-facility rates**
99201	**Note: This cannot be billed in 2021.**	n/a	n/a
99202	**Straightforward** medical decision making	15-29 min	$74
99203	**Low level** of medical decision making	30-44 min	$114
99204	**Moderate level** of medical decision making	45-59 min	$170
99205	**High level** of medical decision making	60-74 min	$224
Eval + Mgmt of an ESTABLISHED patient	**Requires a problem-focused history or examination and _____.**	**If using time: _____**	**Average non-facility rates**
99211	• Does not require presence of qualified health professional • Presenting problems are minimal	n/a	$23
99212	**Straightforward level** of medical decision making	10-19 min	$57
99213	**Low level** of medical decision making	20-29 min	$92
99214	**Moderate level** of medical decision making	30-39 min	$131
99215	**High level** of medical decision making	40-54 min	$170
Telephone E/Ms (EFFECTIVE 3/1/2020)	***Telephone E/M* cannot be billed if it arises from a service within the past 7 days or results in a service in the next 24 hours or next available appointment; 5-10 minutes of medical discussion; requires consent (verbal, written or electronic); patient initiated; use modifier -95; *4/30/20 rule adds these to the telehealth list and increased payment***		**Average CMS Reimbursement**
99441	5-10 minutes of medical discussion		$57
99442	11-20 minutes of medical discussion		$93
99443	21 or more minutes of medical discussion		$132
Virtual Check-in	***Virtual check-in cannot be billed if it arises from a service within the past 7 days or results in a service in the next 24 hours or next available appointment; 5-10 minutes of medical discussion; requires consent (verbal, written or electronic); patient initiated***		**Average CMS Reimbursement**
G2012	Brief communication technology-based service (e.g., virtual check- in) by a physician or other qualified healthcare professional (QHP) who can report E/M services (excludes clinical staff)		$15
G2010	Remote (asynchronous) evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward)		$12
E-Visit	**Online digital evaluation and management service, for an established patient, for up to 7 days. Cumulative time over 7 days:**		**Average CMS Reimbursement**
99421	5–10 minutes		$15
99422	11-20 minutes		$30
99423	21 or more minutes		$47



CHC Telehealth Guidance	
FQHC Billing	FQHCs should bill only G2025 and the -95 modifier is optional.
RHC Billing Codes	RHCs must bill G2025 **without** the -CG modifier and the -95 modifier is optional
Place of Service	For telehealth E/M codes and virtual check-ins, use the typical Place of Service for a face-to-face office visit
Additional Guidance	FQHCs and RHCs will be paid at the PPS and AIR rates, respectively, for telehealth services through June 30, 2020, but that reimbursement is retroactively set to a national average of $92 effective Jan. 27th. For services related to COVID-19 testing, including telehealth, FQHCs and RHCs must waive the collection of co-insurance, and use the -CS modifier. These claims will be paid with the coinsurance applied, and the MAC will automatically reprocess these claims beginning on July 1.

NOTE: These are national reimbursement rates for CMS, there is some variation by geography. Modifiers and reimbursement rates also vary depending on payer. Refer to payer specific guidance for more information about this.

Effective January 27, 2020

Code	Description	Average Reimbursement

G2025	G2025 should be billed for all distant site telehealth services rendered by FQHCs and RHCs. G2025 covers the E/M codes below.		CMS Reimbursement
Eval + Mgmt of a NEW patient - G0466	**Requires a problem-focused history and examination and _____.**	**If using time, typically:**	
99201	**Note: This cannot be billed in 2021.**	n/a	
99202	**Straightforward** medical decision making	20 min	
99203	**Low level** of medical decision making	30 min	
99204	**Moderate level** of medical decision making	45 min	
99205	**High level** of medical decision making	60 min	
Eval + Mgmt of an EST. patient - G0467	**Requires a problem-focused history or examination and _____.**	**If using time, typically:**	
99211	• Does not require presence of QHP • Presenting problems are minimal	5 min	$92
99212	**Straightforward level** of medical decision making	10 min	
99213	**Low level** of medical decision making	15 min	
99214	**Moderate level** of medical decision making	25 min	
99215	**High level** of medical decision making	40 min	
Telephone E/Ms	***Cannot be billed if it arises from a service within the past 7 days or results in a service in the next 24 hours or next available appointment; 5-10 minutes of medical discussion; requires consent (verbal, written or electronic); pt initiated***		
99441	5-10 minutes of medical discussion		
99442	11-20 minutes of medical discussion		
99443	21 or more minutes of medical discussion		
G0071	**HCPCS G0071 can be billed for any of the CPT codes listed below, all with the same rate of reimbursement by Medicare.**		**CMS Reimbursement**
Virtual Check-Ins	***Cannot be billed if it arises from a service within the past 7 days or results in a service in the next 24 hr or next available appointment; 5-10 minutes of medical discussion; requires consent (verbal, written, electronic); pt initiated***		
G2012	Brief communication technology-based service (e.g., virtual check- in) by a physician or other qualified healthcare professional (QHP) who can report E/M services (excludes clinical staff)		$25
G2010	Remote (asynchronous) evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward)		
E-Visits	***Online digital evaluation and management service, for an established patient, for up to 7 days. Cumulative time over 7 days:***		
99421	5–10 minutes		
99422	11-20 minutes		
99423	21 or more minutes		

Non-MSSP

Additional Non-MSSP Telehealth Billing Resources available upon request.
Please contact hposner@aledade.com if you are interested.

Appendix Q: Community Health Center Telehealth Billing Reporting One-Pager

On July 1, 2020, the Center for Medicare and Medicaid Services (CMS) issued that **telehealth services for both FQHCs and RHCs** **are to be billed with code G2025, regardless of service rendered**. FQHC and RHCs are to use the revenue code 052X, and the "95" modifier is optional. The current reimbursement that health centers receive when using the G2025 telehealth code is $92.03, which is at a much lower rate than other services rendered, such as an Annual Wellness Visit (AWV) → AWV (PPS + 34.16%).

In order to track higher value visits, such as AWV or TCM, there was guidance from Medicare Administrative Contractor (MACs) to bill the service rendered as a line item (i.e., for AWVs - G0468, G0438, or G0439) on the claim, thus allowing the ability to track which telehealth visits were an AWV, TCM, or other services. Following that advice from MACs, some health centers have submitted a claim with the G2025 + the service type and have received payment for **BOTH** the G2025 and the additional service billed, which may create an administrative burden on your health center. Due to this double reimbursement, moving forward, we recommend health centers to **only use the code G2025 for any services rendered via telehealth and do not include the service type.**

What does this mean for you? Given the coding mechanism now recommended by CMS, Aledade will lose visibility into which visits are billed via telehealth. AWVs and in some cases TCMs are two of the types of visits commonly included in the calculations that determine the percentage of earned shared savings a practice receives.

What is the solution? To ensure you receive credit for these important services in value-based care, we are requesting that health centers upload a patient list report from your EHR system to FileShare (on the Aledade App) on a monthly basis *only for telehealth visits*. **This is a list of patients who have had a telehealth AWV, if your ACO has included TCMs in the distribution formula, a separate list of TCMs provided via telehealth**.

**Aledade is currently looking into other work-around reporting mechanisms to eliminate the need for this process as soon as possible.*

This report is to include the following information:

- Name
- Sex
- Date of Birth
- Date of Service
- MRN

We are requesting that this report include telehealth health visits rendered beginning July 1, 2020, as this was when the G2025 rule began.

If you have any questions or concerns on how to pull this information, please contact your health center's ACO coordinator or Practice Transformation Specialist.

Appendix R: Toolkit Update History

1. Version 6.0 - 2/19/2021
    a. Updated the MSSP telehealth billing flowchart.
    b. Updated the non-MSSP telehealth guidance.
    c. Removed the links to the non-MSSP telehealth billing flowcharts.
    d. Updated the code descriptions and reimbursement rates.
    e. Added pharmacy guidance to the "Scheduling and Implementation" section.

2. Version 5.0 - 10/1/2020
    a. Updated risk adjustment guidance for telephone E/Ms.

3. Version 4.3 - 9/18/20
    a. Added the Community Health Center Billing Reporting One-Pager in Appendix Q.

4. Version 4.2 - 9/16/20
    a. Updated AWV guidance in the telehealth CHC billing flowchart.

5. Version 4.1 - 9/2/20
    a. Updated telehealth billing guidance for CHCs.

6. Version 4.0 - 9/1/20
    a. Updated guidance on telephone visits and risk-adjustment.
    b. Updated Telehealth Medicare Billing Flowcharts to reflect accurate telephone visit risk-adjustment information in Appendix P.

7. Version 3.0 - 8/12/20
    a. Updated the Telehealth Consent Template in Appendix B.
    b. Updated Telehealth Medicare Billing Flowcharts with AWV guidance in Appendix P.

8. Version 2.2 - 5/18/20
    a. Updated AWV guidance on pages 12-13.

9. Version 2.1 - 5/11/20
    a. Updated FQHC guidance on pages 8-9 and Appendix P.
    b. Updated guidance on audio-only telehealth billing, including updated reimbursement rates for telephone E/M codes on pages 9-10 and Appendix P.
    c. Updated guidance on which providers can deliver telehealth services on page 10.
    d. Added guidance on codes that are considered when determining ACO attribution on page 13.
    e. Added the Telehealth Made Easy poster and postcard to Appendix M.
    f. Added an AMA resource on COVID-19 billing/coding and the HHS telehealth website to Appendix N.

2. Version 2.0 - 4/24/20
    a. Updated typical times for E/M visits in Appendix P.
    b. Added a note to consider collecting insurance information during a telehealth "pre-visit" in the Best Practices guide in Appendix D.

3. Version 1.9 - 4/21/20
    a. Updated FQHC/RHC billing guidance on page 8.
    b. Updated Telehealth FQHC/RHC Medicare Billing Flowchart in Appendix P.
    c. Updated Commercial Payer Guidance in Appendix C for Aetna.
    d. Added new guidance on patients receiving telehealth visits from the practice's parking lot on page 6.
    e. Added a new Telehealth Checklist and Workflows for PTSs and Medical Directors to page 13 and Appendix E. We encourage practices to establish a **Practice Telehealth Champion** to help patients navigate telehealth technology and troubleshoot/solve issues prior to the provider visit.

4. Version 1.8 - 4/14/20
    a. Added the Telehealth Best Practices guide to Appendix D.
    b. Added Telehealth FQHC/RHC Medicare Billing Flowchart to Appendix P.
    c. Updated guidance on Risk Coding via telehealth visits on page 11.
    d. Updated guidance on FQHC/RHC billing for virtual check-ins (G0071) on page 8.
    e. Added links to additional state-specific billing flowcharts for NJ and UT in Appendix P.
    f. Updated Commercial Payer Guidance in Appendix C for Magnolia (Centene MS).
    g. Added links to an AAFP resource on phone visits and a telehealth resource from the American College of Physicians to Appendix N.
    h. Moved ongoing Toolkit Update History to Appendix Q.

5. Version 1.7 - 4/6/2020
    a. Included guidance on the appropriate Place of Service (POS) for Telephone E/M codes on page 10.
    b. Added links to telehealth consent forms in Spanish, Chinese and Vietnamese to Appendix B.
    c. Corrected typo regarding previous limits on urgent care telehealth billing on page 11. These limits were applicable previously to Skilled Nursing Facilities, not Urgent Care centers.
    d. Added additional guidance on performing a physical exam via telehealth to Appendix O.
    e. Updated Medicare Billing Flowchart in Appendix P to include guidance on appropriate Place of Service (POS) for telehealth and telephone E/M codes.
    f. Updated Commercial Payer Guidance in Appendix C for Highmark, Humana and UHC.
    g. Added a link to the Medicare Learning Network telehealth video to Appendix N.
    h. Added guidance to consider a "test" telehealth visit to ensure that the patient has the necessary technology and is comfortable using the platform on page 16 and in Appendices E, G and L..

6. Version 1.6 - 4/2/2020
    a. Updates to audio-only telehealth billing options on pages 10 and 11.
    b. Update to CMS reimbursing telehealth services at non-facility rates, the -95 modifier, and changes to billing requirements on pages 10, 11 and 13, and in Appendix K.
    c. Updated guidance for providers conducting telehealth from their home on page 8.

d. Added note on CMS waiving the requirement for Virtual Check-Ins to be conducted on established patients on page 11.
e. Updated Commercial Payer Guidance in Appendix C for Aetna, BCBS KS, Highmark, Humana, Magnolia (Centene MS), Sunflower (Centene KS) and UHC.
f. Updated language that referenced the third bill to address the effects of coronavirus to which Congress agreed in principle on March 25. The Bill was signed into law on March 27. The changes were made on pages 10 and 13.
g. Added brief guidance on tele-prescribing non-controlled substances on page 8.
h. Added guidance on billing telehealth for patients in urgent care, nursing homes and skilled nursing facilities on page 11.
i. Added the Medicare Telehealth Billing Flowchart and links for additional state-specific flowcharts for Delaware, Kansas, Louisiana, North Carolina and West Virginia in Appendix P.
j. Added additional language around asking if there are other individuals in the room with the patient during the telehealth or telephone visit on page 15.

7. Version 1.5 - 3/27/20
    a. "How can I do physical exams using telehealth?" section has been added to page 17 and to Appendix O.
    b. An additional note on the requirement for Medicare virtual check-ins to be patient-initiated has been added to page 12.

8. Version 1.4 - 3/26/20
    a. Significant update to telehealth billing guidance for FQHCs and RHCs has been made on pages 10 and 12.
    b. Added tele-prescribing guidance on page 7. The State-Level Regulations guide (linked in Appendix A) has also been updated to reflect state-level tele-prescribing regulations as well as new guidance from state agencies governors' offices.
    c. State-specific payer guides for Delaware, North Carolina and West Virginia have been added to Appendix C.
    d. Added a link to a Spanish telehealth consent form in Appendix B. Please note the disclaimer embedded in Appendix B that practices must review before using this consent form.
    e. Added note on Logitech webcam recommendation for practices that are not equipped for audio-visual visits on page 14.
    f. Added links to new patient-facing materials and a Spanish version of the patient-facing telehealth poster in Appendix M.

9. Version 1.3 - 3/24/20
    a. Update AWV guidance to clarify current position on waiting until later in the year to bill AWVs on page 12
    b. Indicate that a signed telehealth consent is valid for 6 months on page 10
    c. Update Commercial Payer Guidance in Appendix C for BCBS LA, Horizon (BCBS NJ), Highmark (BCBS DE) and Humana
    d. Updated guidance on telehealth Chronic Care Management billing, specifically for G0506 on page 11

10. Version 1.2 - 3/23/20
    a. Updated FQHC/RHC guidance on page 11
    b. Updated Commercial Payer Guidance in Appendix C for Anthem, BCBS KS, BCBS LA, UHC and Mississippi Medicaid
    c. Added a link to an editable PDF Consent Form in Appendix B
    d. Added clarification on how providers can bill telehealth when they're not physically in their practice on page 7
    e. Update language throughout to avoid encouraging patients to come into contact with friends/family they would not have seen in-person otherwise
    f. Clarified that telehealth E/M visits will be subject to more significant billing constraints post-COVID on page 9
    g. Fixed the internal link in Appendix A
    h. Added Appendix M with patient-facing marketing materials
    i. Added an additional workflow to Appendix I
    j. Moved additional external resources to Appendix N
    k. Added a "Return to Table of Contents" link to footer