



A Toolkit for Building and Growing a Sustainable Telehealth Program in Your Practice

SEPTEMBER 2020

This toolkit was developed in partnership with Manatt Health.

manatt

About AAFP

The American Academy of Family Physicians (AAFP) is the national association of family physicians. It is one of the largest national medical organizations, with 136,700 members in 50 states, D.C., Puerto Rico, the Virgin Islands and Guam, as well as internationally.

We are a membership organization in the purest sense: an association of family physicians led by family physicians. With our colleagues throughout the country, we work to solidify family medicine as the cornerstone of a functioning health care system. We lobby government, negotiate with payers, partner with employers, educate patients, and champion family medicine on the national stage.

The AAFP exists to support family physicians so they can spend more time doing what they do best: providing quality, cost-effective patient care.

About Manatt Health

Manatt Health combines firsthand experience in shaping public policy, sophisticated strategy insight, deep analytic capabilities, and legal excellence to provide uniquely valuable professional services to the full range of health industry stakeholders. Manatt has deep expertise in advising providers, states, payers, and health tech companies on developing, providing, and paying for innovative virtual care solutions.

Our diverse team of more than 160 attorneys and consultants from Manatt, Phelps & Phillips, LLP, and its consulting subsidiary, Manatt Health Strategies, LLC, is passionate about helping our clients advance their business interests, fulfill their missions, and lead health care into the future.

For more information, visit <https://www.manatt.com/Health>.

A Toolkit for Building and Growing a Sustainable Telehealth Program in Your Practice



Table of Contents

I. Introduction	4
II. Telehealth Services and Payment	6
Types of Telehealth	6
III. Moving Your Telehealth Offerings to Sustainability	15
1. Establish Roles and Responsibilities	16
2. Check Licensing and Legal Requirements	18
3. Customize a “Telehealth Appropriateness” Approach	19
4. Assess the Technology	22
5. Design Your Patients’ “Digital Journey”	25
6. Redesign Your Workflow	31
7. Assess and Iterate	34
IV. Family Medicine Scenarios	35
Appendix	47
Billing and Coding Table	47
Commonly Used Modifiers and Place of Service	49
References	50

I. Introduction

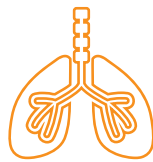
Prior to the COVID-19 pandemic, telehealth technology had been incrementally changing the practice of family medicine in the United States. In March 2020, only 13% of American Academy of Family Physicians members had provided video or telephone visits to their patients. By May 2020, 94% of members were regularly doing so,¹ aided by sweeping temporary policy changes that brought down many of the regulatory and reimbursement barriers that had inhibited the growth of telehealth for years. By spring 2020, physicians across the country achieved years of progress in a matter of weeks.

For family medicine practices, the COVID-19 pandemic laid bare the inadequacy of fee-for-service (FFS) payment to support family medicine practices' focus on health, wellness, and disease prevention. However, the COVID-19 pandemic has also allowed family medicine practices to innovate. AAFP members' swift adoption of telehealth has allowed practices to maintain continuity of care with patients and, in some cases, engage new patients. Many family medicine practices are finding that telehealth is a powerful tool to promote continuity of care and offer convenient, routine care across a broad range of cases in family medicine. Telehealth can also improve coordination with specialists outside the practice.

Family practices can use telehealth to care for:



Generally
Healthy
Patients



Patients With
Chronic
Conditions



Children



Pregnant
Women



Geriatric
Patients



Behavioral
Health

Infectious diseases to reduce transmission

Ad hoc, low-risk concerns

Pre- and post-operative checks

Quick check-ins between visits for continuity

Rapid follow-ups after tests and labs

Medication management

Remote patient monitoring

Self management groups and other supports

Common low-risk conditions that can easily be evaluated remotely (e.g., rashes, pinkeye)

Improve care environment for children with special needs

Limit time away from school

Routine checks for uncomplicated pregnancies

Remote patient monitoring for blood pressure and blood sugar

Avoid travel for frail patients

Improve care for patients with dementia

Routine monitoring of common medications for anxiety, depression, and ADHD

Conduct psychotherapy online

Improve integration between behavioral health and family practitioners

Perhaps most importantly, telehealth during the COVID-19 pandemic has been overwhelmingly popular with patients by enabling access to care without fear of infection.² Telehealth is convenient, especially when offered beyond typical office operating hours. More fundamentally, telehealth has the potential to transform the health care experience for elderly patients, patients with chronic conditions, patients with disabilities, and patients living in remote or underserved areas. It has become clear that patients will demand continued access to telehealth. In order to meet that demand, family medicine practices will need assurances that it will continue to be paid for at appropriate rates as has been the case on a temporary basis during the COVID-19 pandemic.³

This toolkit is designed to help family medicine practices plan for the medium term. When the COVID-19 pandemic recedes, the regulatory landscape for telehealth will shift to a “new normal.”

Although payment policy decisions have yet to be made at the time of publication of this toolkit, it is becoming increasingly clear that the payment environment will not look the same after the COVID-19 pandemic. Among the most likely flexibilities to remain in place are the availability of video visits from patients’ homes and the expansion of remote patient monitoring (RPM) options.

In this new environment, alternative models of virtual care outside primary care—such as direct-to-consumer virtual urgent care platforms—are also likely to expand rapidly, vying for the same patients served by your practice. Therefore, it is important for your practice to engage in medium-term planning now.

The AAFP recognizes that starting, maintaining, or expanding telehealth in your practice is not straightforward, especially at a time of significant disruption and financial uncertainty for many family medicine practices. Even though telehealth at your practice may well have started out of necessity in an unprecedented emergency, the path from here is more likely to be evolutionary.

Developing and implementing a telehealth strategy requires an understanding of the regulatory environment and skills to make it work in your practice. You may try a range of approaches, test ideas with your team, and get feedback from patients as you stay abreast of changes to payment policies across payers.

This toolkit is intended to cover all the major issues you will encounter as you move through this process, including:

- Reviewing telehealth services and payment (Section II);
- Providing key considerations for family medicine practices as they move their telehealth services to sustainability (Section III); and
- Laying out a series of family medicine scenarios for telehealth (Section IV).

Key Questions for Your Practice to Consider:

- What lessons has your practice learned during the COVID-19 pandemic?
- What telehealth services does your practice want to offer, and to which patients, a year from now? How about five years from now?
- What steps does your practice need to take to start building a permanent infrastructure for telehealth?

II. Telehealth Services and Payment

Types of Telehealth

The term telehealth refers to a broad collection of electronic and telecommunication technologies that support distant health care services. No single unified taxonomy of telehealth services exists, and definitions vary and overlap by state and payer. The AAFP defines telemedicine as “the practice of medicine using technology to deliver care at a distance, over a telecommunications infrastructure, between a patient at an originating (spoke) site and a physician or other practitioner licensed to practice medicine at a distance (hub) site. Telehealth refers to a broad collection of electronic and telecommunication technologies and services that support at-a-distance health care delivery and services.”³

The telehealth services that your practice may want to offer fall into two broad categories: clinician-to-patient and clinician-to-clinician.

Clinician-to-Patient



Video Visit (vVisit)

Clinician connects directly with the patient via video to conduct the equivalent of an in-person visit



Telephone Call (tVisit)

Clinician connects directly with the patient via telephone



Secure Messaging (eVisit)

Clinician connects with the patient via patient portal, secure email, or telehealth platform to provide clinical advice or support



Remote Patient Monitoring (RPM)

Clinician monitors patient vitals and other information via electronic communication technologies in near real time

Clinician-to-Clinician



eConsult

Clinician communicates via email or other software with a specialist to share information and discuss patient care



ECHO

Clinician links with an expert team in “virtual grand rounds”

The payment landscape for telehealth service is complex. Payment varies significantly by service, payer, and state. Additionally, most payers significantly expanded payment to support treatment during the COVID-19 pandemic, but the emergency flexibilities have varied and will revert to “normal” or a “new normal” on differing time frames. The AAFP has continuously updated coding information on its website, including information on coding for telehealth during the COVID-19 pandemic,⁴ telehealth coding scenarios,⁵ and an algorithm to help select the most appropriate codes for each modality.⁶

See Appendix for more information on coding by service.

Telehealth Coverage Summary by Payer

Payer	Coverage Landscape	Key Temporary Flexibilities during the COVID-19 Pandemic	Sources of Additional Information
<p>Medicare</p> <p>Note: Medicare Advantage plans must cover all telehealth services included in Medicare Part B FFS but may choose to expand coverage further.</p>	<p>By statute, Medicare tightly limits telehealth coverage of services that would normally happen in person, generally restricting payment to situations where the beneficiary is located in a rural area. In most cases, the originating site (where the patient is) cannot be the home. Medicare pays for telehealth visits at the facility rate that would apply to an in-person visit. Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are not permitted to furnish and bill Medicare for distant-site telehealth services.⁷</p> <p>Medicare has gradually expanded a separate stream of payment for “virtual check-ins,” which are typically telephone or secure messaging services that would not normally occur in person and are paid at lower rates. Medicare also pays for RPM and eConsults.</p>	<p>For the duration of the COVID-19 pandemic, Medicare is waiving geographic and originating site restrictions. Patients may receive telehealth services in any setting, including their homes.</p> <p>FQHCs and RHCs are permitted to furnish and bill Medicare for distant-site telehealth services.⁸</p> <p>Medicare is waiving and will cover cost sharing for COVID-19 diagnostic tests and visits related to COVID-19 testing. Physicians may voluntarily waive cost sharing for non-COVID-19-related telehealth and virtual/digital services. However, Medicare will not pay any cost sharing waived at a physician’s discretion.</p> <p>Medicare is temporarily paying for telephone evaluation and management (E/M) visits (as well as video visits) at the non-facility (higher) rate that would apply to the equivalent of in-person visits.</p> <p>See the AAFP’s website for more information about flexibilities associated with the COVID-19 pandemic.</p>	<p>U.S. Department of Health and Human Services (HHS) telehealth website</p> <p>Centers for Medicare & Medicaid Services (CMS)</p> <p>AAFP</p>
<p>Medicaid</p>	<p>Every state’s Medicaid program covers at least some telehealth services, but Medicaid programs vary greatly in their coverage.⁹ Coverage of RPM by states generally lags behind Medicare. Medicaid managed care plans usually cover all telehealth services included in the state plan but may also expand their coverage further.</p>	<p>All states introduced coverage of video and most introduced coverage of audio-only visits, to the extent that they had not done so before. Payment parity between in-person, video and audio-only services varies by state.</p>	<p>Center for Connected Health Policy</p> <p>National Consortium of Telehealth Resource Centers</p>
<p>Commercial Payers</p>	<p>There is no federal mandate requiring private payers to pay for telehealth services, and most commercial plans are regulated at the state level. Plans vary widely in their coverage and payment, and large payers’ policies vary by market.</p> <p>Ten states maintain payment parity statutes that require commercial plans to cover telehealth at the same rate as the equivalent in-person service.¹⁰</p>	<p>Most payers introduced coverage of video and audio-only visits on a broad basis, to the extent that they had not done so before. Payment parity between in-person, video and audio-only services varies.</p>	<p>America’s Health Insurance Plans</p>

The following sections describe each telehealth modality and how each is paid in FFS payment models.

Video Visit (vVisit)

A video visit is a real-time (synchronous) audio/visual interaction between the physician and the patient. A video visit can be used in place of an in-person visit for a variety of visit types.

Coverage and Payment Policies

Payer	Coverage Landscape	Key Temporary Flexibilities During the COVID19 Pandemic*
<p>Medicare Fee-For-Service</p> <p>Note: Medicare Advantage plans must cover all telehealth services included in Medicare Part B FFS but may choose to expand coverage further.</p>	<ul style="list-style-type: none"> • Medicare payment for video visits is restricted to patients in designated rural areas. Patients must attend specific originating sites (clinics, hospitals, or similar facilities) to receive services.¹¹ • Services available as video visits are limited to select services, including: <ul style="list-style-type: none"> – Inpatient and outpatient evaluation and management; – Follow-up hospital and nursing facility; – End-stage renal disease-related care; – Behavioral health; – Care management; – Preventive screening/assessment; and – Advance care planning services.¹² • Medicare pays for telehealth visits at the facility rate that would apply to an in-person visit. • Physicians, nurse practitioners, physician assistants, certified registered nurse assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians and nutrition professionals can bill for video visits. 	<ul style="list-style-type: none"> • Medicare is paying for video visits provided to any beneficiary at any originating site (including the patient's home).¹³ • Services available as video visits have been significantly expanded (85+ services).^{11,14} • Cost sharing is waived for visits that result in the order or administration of a COVID-19 test.
<p>Medicaid</p>	<ul style="list-style-type: none"> • Coverage varies widely by state.¹⁵ • Prior to the COVID-19 pandemic, all 50 states and Washington, D.C., paid for some kind of live video telehealth services, though some states limited coverage to rural areas and/or required a telepresenter, which in practice meant that the coverage was not utilized widely. • State Medicaid agencies and Medicaid managed care organizations do not always offer payment parity with in-person visits. 	<ul style="list-style-type: none"> • Almost all states and payers have expanded coverage to include video visits or broadened services available by video visit.¹⁶ • Changes have often mirrored the Medicare expansions, although details vary; it is very important to check coding requirements, including whether or not the payer is waiving cost sharing.
<p>Commercial Payers</p>	<ul style="list-style-type: none"> • Coverage varies widely by state and carrier. • Most states have a telehealth statute that applies to commercial payers regulated by the state, but details vary. Some states require full coverage parity between video and in-person visits. In states without coverage parity, coverage of video visits differs by carrier. • Coverage parity does not necessarily entail payment parity. Only around ten states require payment parity between video visits and in-person visits.¹⁵ 	<ul style="list-style-type: none"> • Payment parity with in-person visits are usually being offered.

* Use of modifiers, as well as appropriate COVID-19 ICD-10 diagnosis, is required to access flexibilities. See Appendix for more information on modifiers during COVID-19.

See Appendix for more information on coding.

Telephone Call (tVisit)

A telephone call is an audio-only interaction between the physician and the patient that can be conducted either using a traditional telephone or using the audio-only function of a telehealth platform.

Coverage and Payment Policies

A telephone call can be payable either as an online-only E/M encounter or as a brief check-in. Coverage policies and rates differ depending on payer. Telephone E/M and virtual check-ins must be patient-initiated, and there are restrictions on reimbursement for phone calls that are associated with other visits (see Appendix).¹⁷ Telephone calls are typically subject to cost sharing.

Payer	Coverage	Key Temporary Flexibilities During the COVID19 Pandemic*
<p>Medicare</p> <p>Note: Medicare Advantage plans must cover all telehealth services included in Medicare Part B FFS but may choose to expand coverage further.</p>	<ul style="list-style-type: none"> Medicare pays for telephone E/M and “virtual check-ins.” At the time of writing, CMS is proposing phasing out coverage of telephone E/M services at the end of the public health emergency and may replace them with new virtual check-in codes that would cover longer periods of time. A “virtual check-in” is a brief check-in with an established patient by telephone or online, typically to decide whether an office visit or other service is needed.¹⁸ Virtual check-ins do not have geographic or site restrictions attached, but the payment amount for these codes is low and they are meant to act only as quick contacts with patients that do not last more than a few minutes.¹⁶ Neither telephone E/M nor virtual check-ins are considered “telehealth” by Medicare since they do not replace in-person visits. 	<ul style="list-style-type: none"> Medicare is raising the rate for telephone E/M to the same rate as non-facility in-person visits and allowing it to be used for new and established patients. Medicare is covering audio-only delivery of a specified set of telehealth services during the public health emergency. Medicare is paying for virtual check-ins for both new and established patients.¹⁸ Physicians may waive cost sharing for visits. However, Medicare will not cover the beneficiary’s cost sharing.
<p>Medicaid/ Commercial</p>	<ul style="list-style-type: none"> Coverage varies widely by state. Separate payment for brief check-ins is less likely to be offered by Medicaid and commercial payers. 	<ul style="list-style-type: none"> Many Medicaid and commercial payers have expanded payment to telephone E/M services and/or allowed audio-only delivery of a service that would otherwise be delivered in person (e.g., audio-only delivery of 99212-99214).¹⁷ If the patient lacks audio/visual technology, some insurance carriers may reimburse for telephone encounters at parity with services delivered via video visit; check with the individual payer. It is very important to check all coding requirements, including whether or not the payer is waiving cost sharing.

* Use of modifiers, as well as appropriate COVID-19 ICD-10 diagnosis, is required to access flexibilities. See Appendix for more information on modifiers during COVID-19.

See Appendix for more information on coding.

Secure Messaging (eVisit)

Secure messaging is when the physician connects with a patient asynchronously via the patient portal, secure email, or telehealth platform to provide clinical advice or support. A patient’s message may include pictures or other attachments for review, sent securely (known as “store and forward”).

Coverage and Payment Policies

Secure messaging is never equivalent to an in-person visit. Secure messaging can be payable either as an online-only E/M encounter or as a brief check-in. There are restrictions on payment for secure messages that are associated with visits, as well as restrictions on payment in conjunction with the chronic care management (CCM) or transitional care management (TCM) codes.¹⁷ Secure messaging is typically subject to cost sharing.

Payer	Coverage	Key Temporary Flexibilities During the COVID-19 Pandemic*
<p>Medicare</p> <p>Note: Medicare Advantage plans must cover all telehealth services included in Medicare Part B FFS but may choose to expand coverage further.</p>	<ul style="list-style-type: none"> Medicare payment for online digital E/M codes is restricted to established patients.¹¹ A “virtual check-in” is a brief check-in with an established patient by telephone or online, typically to decide whether an office visit or other service is needed.¹⁸ Virtual check-ins do not have geographic or site restrictions attached, but the payment amount for these codes is low and they are only meant to act as quick contacts with patients that do not last more than a few minutes.¹⁶ Neither online digital E/M nor virtual check-ins are considered “telehealth” by Medicare since they do not replace in-person visits. 	<ul style="list-style-type: none"> Physicians can reduce or waive Medicare patient cost sharing for online digital E/M and virtual check-ins. However, Medicare will not cover the beneficiary’s cost sharing.¹¹
<p>Medicaid/ Commercial</p>	<ul style="list-style-type: none"> Coverage varies widely by state. Separate payment for brief check-ins is less likely to be offered by Medicaid and commercial payers. 	<ul style="list-style-type: none"> Some Medicaid and commercial payers have expanded payment to include online digital E/M,¹⁶ but less so than for telephone E/M. It is very important to check coding requirements, including whether or not the payer is waiving cost sharing.

* Use of modifiers, as well as appropriate COVID-19 ICD-10 diagnosis, is required to access flexibilities. See Appendix for more information on modifiers during COVID-19.

See Appendix for more information on coding.

Remote Patient Monitoring

Remote patient monitoring is the use of digital technologies to collect data from an individual, with secure transmission of that data to the physician's office and review of the data by the physician. "Remote physiologic monitoring" means more specifically RPM in which data is automatically transmitted to the physician, in contrast with forms of RPM where the patient must "push" the data to the physician.

RPM devices and technologies include wearables, Bluetooth devices that link via smartphone to be uploaded automatically to a provider's data storage platform, and continuous glucose monitors. RPM has the potential to speed up intervention when a patient's condition becomes concerning, improve continuity of care, and empower patients to engage in self-management. Use cases for RPM include monitoring of chronic conditions (e.g., congestive heart failure, diabetes, chronic obstructive pulmonary disease [COPD]), monitoring vital signs from home after surgery, pregnancy, and most recently COVID-19 symptoms.

RPM is still a relatively new practice. Reimbursement has been introduced relatively recently, and the technology itself and user experience are still evolving and improving. Nonetheless, RPM is swiftly gaining momentum, and Medicare is iterating and expanding its coverage each year. Even though the vast majority of RPM is currently being offered by larger practices and health systems, family medicine practices may also want to start learning about RPM and considering what use cases may make sense for your practice (see the Family Medicine Scenarios in Section IV for a possible example).

How Does RPM Work?



1
Patient is issued one or more devices (e.g., weight scale, blood pressure cuff, pulse oximeter, continuous glucose monitor) that track biometric data in real or near real time.

2
Device securely and wirelessly transmits physiologic data to care team electronically (or, for self-measured, patient calls or manually enters the data).

3
Care team receives data.

4
Care team reviews data and determines appropriate follow-up.

5
If needed, care team follows up with patient via telephone, video visit, or in-person visit.

Coverage and Payment Policies

Payer	Coverage	Key Temporary Flexibilities During the COVID-19 Pandemic*
<p>Medicare</p> <p>Note: Medicare Advantage plans must cover all telehealth services included in Medicare Part B FFS but may choose to expand coverage further.</p>	<ul style="list-style-type: none"> • Medicare rolled out expanded payment codes in 2019, which stimulated further growth of RPM that was already occurring. • Medicare covers remote physiologic monitoring. Coverage is limited to established patients with one or more chronic conditions, but at the time of writing, CMS is proposing permanent expansion to monitoring of acute, as well as chronic, conditions.¹⁹ • Medicare does not pay for the cost of the remote physiologic monitoring devices themselves but allows monthly billing for the “supply” of the device as a way to offset costs. • Medicare also covers assessment of self-measured (patient) blood pressure, which is called Self-measured Blood Pressure Monitoring and covered by its own codes. • None of the RPM CPT codes may be billed as FQHC or RHC services since these providers are paid an all-inclusive rate.¹⁹ 	<ul style="list-style-type: none"> • RPM is available for both acute and chronic conditions and can be provided for patients with only one disease, for new and established patients, and for fewer than 16 days in a month, with a minimum of two days. Consent for RPM can be obtained annually and at the same time that a service is furnished.^{20,21}
<p>Medicaid/ Commercial</p>	<ul style="list-style-type: none"> • Coverage varies widely by state. • Prior to COVID-19, about half of state Medicaid programs included some form of RPM.²² • Commercial coverage of RPM generally lags behind Medicare and Medicaid. 	<ul style="list-style-type: none"> • Some Medicaid and commercial payers extended coverage to RPM for the first time, or expanded coverage.²²

* Use of modifiers, as well as appropriate COVID-19 ICD-10 diagnosis, is required to access flexibilities. See Appendix for more information on modifiers during COVID-19.

See Appendix for more information on coding.

eConsult

An eConsult is when a “treating or requesting physician”—who could be a family physician—consults with a specialist via telephone, email, or other templated, secure communication to share information and discuss care of a specific patient. eConsults are a time-saving and cost-efficient way for primary care physicians to access specialist advice, and they are becoming increasingly popular.²³ There is also growing consensus that eConsults can act as continuing educational tools that strengthen a physician’s broader practice, not just the case at hand.²⁴ The most usual areas for eConsults have been cardiology, dermatology, endocrinology, gastroenterology, hematology, infectious diseases, nephrology, and neurology.²⁵ The patient is not directly involved in the eConsult but must verbally consent to the eConsult in advance. Cost sharing may apply.

Coverage and Payment Policies

Both the family physician and the specialist can be paid for this activity, using different codes.

Payer	Coverage	Key Temporary Flexibilities During the COVID19 Pandemic*
<p>Medicare</p> <p>Note: Medicare Advantage plans must cover all telehealth services included in Medicare Part B FFS but may choose to expand coverage further.</p>	<ul style="list-style-type: none"> Medicare pays for eConsults for new and established patients. Any condition may qualify for consultative services. 	<ul style="list-style-type: none"> No change.
<p>Medicaid/ Commercial</p>	<ul style="list-style-type: none"> Only a small number of states cover eConsults. Commercial carriers generally do not cover eConsults. 	<ul style="list-style-type: none"> A few state Medicaid programs extended coverage for eConsults for the first time.²⁶

* Use of modifiers, as well as appropriate COVID-19 ICD-10 diagnosis, is required to access flexibilities. See Appendix for more information on modifiers during COVID-19.

See Appendix for more information on coding.

ECHO

ECHO is a model in which primary care teams link with specialist teams, typically at academic “hubs.” The teams participate in “virtual grand rounds” supported by teleconferencing technology. During these grand rounds, primary care physicians from multiple sites present cases to the specialist teams and to each other in order to discuss new developments and determine treatment.²⁷ AAFP members have found ECHO to be a promising model for enhancing mental health and substance abuse treatment, especially in rural areas.²⁸ ECHO activities are not typically reimbursed by payers, but can be supported by the CCM codes and value-based payment models (below).

Virtual Care and the Medicare Fee Schedule Care Management Codes

Many family physicians regularly use Medicare’s CCM and/or TCM codes to improve payment for care management activities for patients with multiple chronic conditions that are typically not paid in the fee schedule. For 2020, Medicare added a new category called principal care management (PCM) for care of patients with a single, serious condition. The CPT codes are 99490, 99491, 99487, and add-on code 99489. These are not telehealth codes.

It will often make sense to integrate the workflows for these codes with your family medicine practice’s telehealth approach. The CCM and PCM approaches require 24/7 patient access to the practice, which can be accomplished via secure messaging and telephone. Similarly, the required follow-up after hospitalization under the TCM can be accomplished using telehealth. Non-visit activities that are considered part of the CCM, TCM, or PCM bundles cannot be separately billed as telehealth services during the duration of the care management episode for the same patient, and many of the telehealth codes cannot be combined with CCM, TCM, or PCM for the same patient at the same time. Nonetheless, revenue streams from both approaches can be combined to support a population health approach that integrates telehealth and fills gaps in payment for individual telehealth services.

Role of Telehealth in Value-based Arrangements

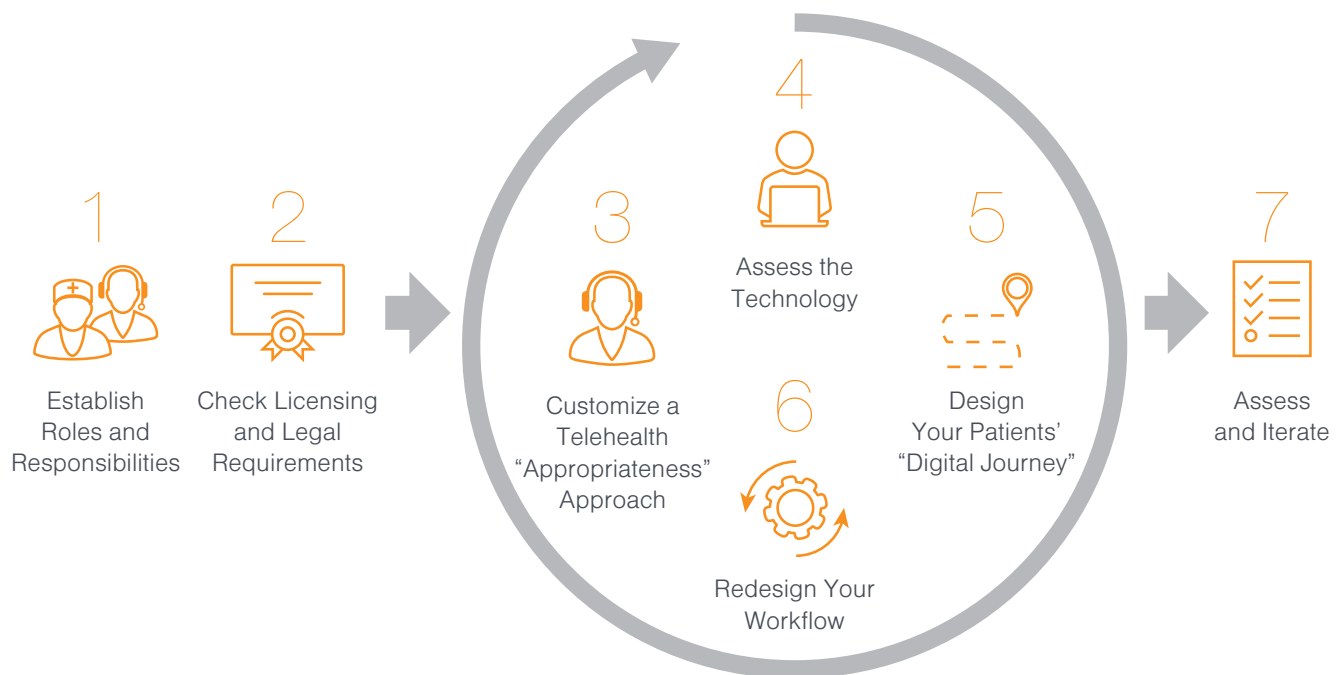
Telehealth can enhance success under alternative payment models (APMs) by enhancing care management and improving efficiency. To date, participants in certain APMs have more flexibility to use telehealth than payers allow other practices. For example, participants in CMS’ Next Generation Accountable Care Organization (ACO) and those in two-sided risk under the Medicare Shared Savings Program (MSSP) may be paid for video and audio visits conducted at home and without the usual geographic restrictions in Medicare. However, participants in MSSP with upside-only shared savings and participants in Comprehensive Primary Care Plus do not currently have these flexibilities.

The AAFP has long supported adoption of APMs that pay in advance (prospectively) for comprehensive primary care to a family medicine practice’s population. In response to the COVID-19 pandemic, public and private payers are altering benefit design and beginning to increase advance payments to primary care practices. Where payers are already offering comprehensive prospective payments, telehealth utilization assumptions will need to be factored into the valuation of those payments in the future alongside in-person visit assumptions. The higher the financial risk on the provider side, the more we can expect flexibilities for the use of telehealth.

III. Moving Your Telehealth Offerings to Sustainability

While most family medicine practices now deliver at least some services virtually, the process of sustainably integrating telehealth into your practice workflow on a permanent basis may just be beginning. Think of telehealth adoption as part of a broader project of practice transformation and as a catalyst for that transformation, rather than as a freestanding project. Just like other practice transformation work, it is iterative and will take time.

The following graphic summarizes the process of transforming your practice for implementing telehealth services. Each step is explained in detail below the graphic.



1. Establish Roles and Responsibilities

While telehealth affects everyone in your practice, a smaller group working together on the details will work best as your practice focuses on implementation. Assemble an implementation team that includes representative physicians, clinical support staff, information technology staff, and administration leads. For a smaller family medicine practice, the team might consist of a physician, front-desk staff person, and medical assistant (MA)/nurse. For a larger practice, the team could look more like a task force consisting of multiple clinical representatives, support staff, IT, specialists, and administration.

The administrative lead will be responsible for all aspects of day-to-day operations. This person is essential, since getting the basics right—such as scheduling and rooming—is critical to the early patient experience and effective functioning of the program. This person should be the sole “owner” of all administrative issues, be responsible and accountable for success of the process, and focus on troubleshooting in the early stages of the program.

Key Role	Team Member	
	Small Practice	Large Practice
Clinical lead	Physician	Medical director
Operational/administrative lead	Practice manager	Director of operations
IT lead	Practice manager or outsourced IT representative	IT director

In larger organizations, sponsorship and buy-in at the leadership level will be essential, particularly when budget and investment are required to improve the telehealth infrastructure. Establish early and frequent communication channels with senior leaders to discuss goals and progress, with specific understanding of what a successful implementation would look like for your practice.

It can often be helpful to seek out colleagues at practices similar to yours who have more experience with telehealth programs. If you are affiliated with another practice or health system, explore how they might support your implementation team. The AAFP also hosts an online [Telehealth Member Interest Group \(MIG\)](#) that you may want to consider joining.

Developing a Responsible, Accountable, Consulted, and Informed Model (RACI) and Matrix

Some organizations find it useful to run programs using the RACI model.²⁹ The RACI model is a tool used in project management to ensure that team members know their roles and responsibilities within the project. The acronym RACI stands for:

- **Responsible:** The person responsible for getting the work done or decision made. As a rule, this is one person. For example, in telehealth implementation, this could be the clinical lead who is responsible for creating the clinical quality metrics.
- **Accountable:** The person who is accountable for the correct and thorough completion of the task. This must be one person and is often the executive sponsor. For example, the clinical lead who is responsible for creating the clinical quality metrics is accountable to the quality improvement leader.
- **Consulted:** The people who provide information for the project and with whom there is two-way communication. This is usually several people and often subject matter experts. For example, the responsible IT lead may ask colleagues about electronic health record (EHR) or website questions.
- **Informed:** The people kept informed of progress and with whom there is one-way communication. These are people who are affected by the outcome of the tasks, so they need to be kept informed of progress. For example, this could be the chief executive officer or chief marketing officer.

A RACI matrix supports the model and is used to discuss, agree, and communicate roles and responsibilities. Creating a RACI matrix involves the following steps:²⁹

1. Identify all the tasks involved in delivering the project and list them on the left side of the chart in completion order.
2. Identify all the project roles and list them along the top of the chart.
3. Complete the cells of the chart, identifying who has responsibility and accountability and who will be consulted and informed for each task.
4. Ensure every task has a role responsible and a role accountable for it.
5. No tasks should have more than one role accountable. Resolve any conflicts where there is more than one for a particular task.
6. Share, discuss, and agree on the RACI matrix with your stakeholders before your project starts.

An example of a RACI matrix for a family medicine practice's telehealth activity includes:

	Responsible	Accountable	Consulted	Informed
Vendor selection	IT project manager	IT lead	Clinical lead	Administrative lead
Clinical workflows	Clinician	Clinical lead	IT lead	Administrative lead
Administrative workflows (pre- and post-visit)	Administrative project manager	Administrative lead	IT lead	Clinical lead
Billing and coding	Billing and coding specialist	Finance lead	Clinical lead	Administrative lead

2. Check Licensing and Legal Requirements

If your practice began offering virtual care during the COVID-19 pandemic when significant flexibilities applied, you will need to make a careful assessment of the permanent licensing and legal landscape that will apply again after the end of the pandemic. These requirements vary by state. Always seek individual legal advice if your practice is unsure about aspects of licensure or legal requirements.

Licensing and Legal Requirements:



Licensing



Prescribing
Limitations



Medical
Malpractice



Privacy and
Security

Licensing: Every state has its own rules and regulations on licensure set by the state medical board. Some reciprocities exist in regions where people commonly live and work over state lines. The Interstate Medical Licensure Compact can allow some efficiency in applications, but providers must still apply for licensure. Check the Interstate Medical Licensure Compact Commission website for the latest information.³⁰ During the COVID-19 pandemic, both the federal government and many states waived licensure requirements to permit telehealth encounters across state lines. Some states waived licensure requirements for telehealth only during the pandemic, or allowed specific flexibilities for college students who had returned home to a different state. **However, generally speaking, every provider must be licensed to practice in the state where the patient is located. The COVID-19 pandemic flexibilities are not expected to remain in place on a permanent basis.** Check with your state's medical board and the Federation of State Medical Boards for the most recent information.³¹

Insurance: If you have not done so already, discuss your telehealth plans with your malpractice insurer to check what additional coverage may be required.³² Most, but not all, malpractice insurers cover services provided by telehealth. Additionally, if you are engaging in telehealth encounters across state lines, check your coverage: insurers might not extend their coverage to other states. Finally, your practice may want to consider seeking cyber liability coverage to protect against data breaches and hacking.³³

Prescribing Limitations: State law about online prescribing varies, and there are special restrictions about controlled substances that vary by state. Practitioners intending to prescribe controlled substances as part of a telehealth encounter should consult state and federal law prior to doing so, particularly if the practitioner has not conducted at least one in-person medical evaluation of the patient. In most cases, there must be a patient-provider relationship, presumed to be established in an in-person encounter, before a prescription can be written. During the COVID-19 pandemic, there have been flexibilities around this rule.³⁴ The Drug Enforcement Agency (DEA) has a page dedicated to their flexibilities during the pandemic.³⁵

Privacy and Security: Physicians are responsible for all aspects of privacy and security of protected health information (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) when engaging in telehealth. While the federal government substantially waived enforcement during the COVID-19 pandemic by allowing the use of non-HIPAA-compliant platforms, this flexibility is temporary, and providers could still face legal liability from patients or others for any privacy breaches. If your practice is currently using a non-HIPAA-compliant platform, begin planning for compliance now by converting to a compliant telehealth platform. Always ensure that you and colleagues are in a private setting when communicating with patients virtually or by telephone.

Make sure you have a notice of privacy practices available on your website and email patients who visit your practice for the first time via telehealth with an electronic copy of such notice.

It is critical to anticipate and address cybersecurity issues when developing your practice's telehealth program. Cyberattacks can cause interruptions in practice operations, compromise EHR security, and be a direct threat to patients' well-being. While evaluating whether or not to implement telehealth technology in your practice, consider whether it would be appropriate to update your practice's HIPAA security risk assessment.³⁶

3. Customize a "Telehealth Appropriateness" Approach

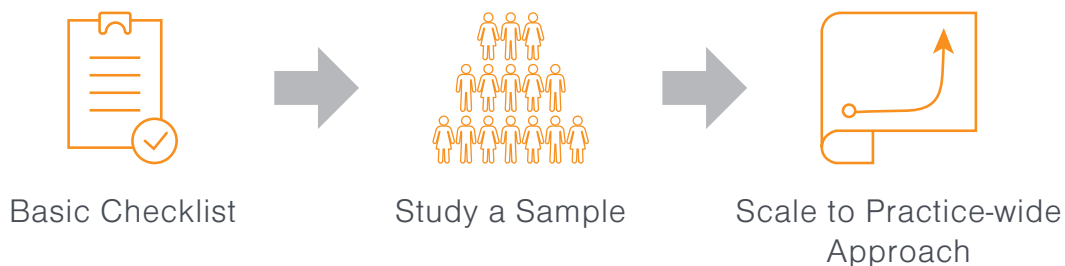
Now that telehealth is becoming more prevalent, practices are asking what the "right" or "appropriate" level of telehealth is for their practice. The answer is a moving target with patient preferences, practice capabilities, and reimbursement rapidly changing. The Robert Graham Center recently estimated that approximately 42% of primary care visits were amenable to telehealth.³⁷ However, this benchmark is based on a sample of visits conducted during the COVID-19 public health emergency. Even norms during this period are changing. For example, an in-person visit for a sore throat evaluation today might be a hybrid model in the future in which a video visit determines the need for a rapid strep and throat culture with an in-person visit to collect the sample.

Clinical appropriateness and effectiveness of telehealth for different clinical situations will help drive the development of decision-making tools for physicians. In the meantime, your practice will need to develop an approach that works for your team to determine when telehealth makes sense for a patient in a particular situation.

Many primary care physicians find the following conditions and patient encounter types work especially well virtually:

- Behavioral health follow-ups and medication adjustments;
- Conditions where treatment is heavily weighted toward a visual exam that easily can be conducted on camera (e.g., acne);
- Triage questions (e.g., assessing a laceration for suture need); and
- Chronic disease management that requires frequent check-ins (e.g., diabetes).

Many physicians find that their comfort with telehealth grows over time. Different physicians within a practice will also have different attitudes toward telehealth, both at the start of the process and with experience. You should expect a degree of controlled experimentation and iteration.



Basic checklist: Similar to the way you would assess whether a patient should be seen at the practice or go to the emergency room, start by asking these questions in an individual scenario:

1. Is this telehealth visit allowable under relevant laws and regulations?
2. Does this person need to be in the emergency room or admitted now or soon? (e.g., patient requires emergent imaging, lab testing, procedure or prolonged monitoring, or admission may be warranted)
3. Do I need to physically see and touch this patient? Many aspects of the physical exam can be completed through an audio or audio/video visit. See scenario one in the Family Medicine Scenarios in Section IV for an example.
4. Is the benefit/risk ratio of a telehealth visit acceptable to the patient?
5. Is this telehealth visit reimbursable?

Study a Sample: It will not always be practical for you to work through the checklist above for every patient individually. One way to start systematizing your practice's approach is to look back at all visits over a recent week or two as a sample cohort. If you switched a large proportion of your visits to video or audio to avoid contact during the COVID-19 pandemic, you already have a body of experience. For your sample, assess how well the encounters worked via video or audio-only modalities, or—if conducted in person—how well they would have worked if conducted via video or audio-only.

For your sample of patients, ask the same questions as in the basic checklist above and consider the details of questions three and four, in particular.

For question three (“Do I need to physically see and touch this patient?”), think about:

- Does this condition require diagnostic testing or other labs? If so, could these needs have been met before or after a telehealth encounter?
- Was there potential for a strong emotional reaction (e.g., diagnosis of cancer, sexually transmitted infection, or a poor/lower than expected prognosis) where speed to report was less important than being present in person?
- Was there a high-comorbidity complexity?

For question four (“Is the benefit/risk ratio of a telehealth visit acceptable to the patient?”), think about:

- Does this patient live far away?
- Does this patient have a disability impacting travel or ability to self-assess?
- Are there risks to this patient associated with travel or exposure to infectious disease at the clinic?
- Does this patient have the necessary technology to support a telehealth visit?
- Is the patient comfortable with the technology?
- Is there anything else you know about the patient that makes you think that the benefit of telehealth outweighs the risk, or vice versa?

Document the answer to each question above in a spreadsheet for your sample of patients. Then determine patterns for visit types, conditions, and patient demographics. Document these “appropriateness factors” to form the basis of a scaled approach.

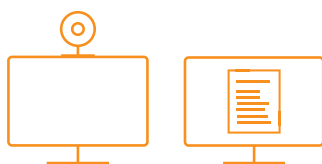
Scale to a Practice-wide Approach: Once you and your clinical team have a shared understanding of “appropriateness factors,” discuss them with your administrative lead and other schedulers. For example, if you have decided to try offering video visits to all patients with skin conditions easily visible on camera as a default option, develop a written definition of the conditions for which video visits should be offered, and share it with the entire care team (even those not currently engaged in telehealth). Develop a patient-facing explanation that can be shared on your website, in scheduling scripting, and for patient portal communications. As you add additional services, update your material and integrate the material across different clinicians—if approaches vary across the practice. If approaches do vary significantly among physicians, the physicians should discuss how cross-coverage of patients will be handled.

4. Assess the Technology

Once your practice has established the critical use cases for your telehealth approach, you can cross-walk those use cases with the technology you currently have and establish the gaps you need to fill.

Options to Support Telehealth

AAFP members intending to continue delivering services via telehealth once the COVID-19 pandemic recedes will need to set up HIPAA-compliant technology since many practices took advantage of the temporary flexibilities to use non-HIPAA-compliant platforms. Good technology solutions to support video visits, audio-only visits, and secure messaging are often inexpensive (i.e., averaging a few hundred dollars a month at the practice level). There are three basic options for the technology to support these functions.³⁸



Stand-alone
Product



EHR-Integrated
Application

Pros:

- Low cost
- Easy to implement
- Low commitment

Cons:

- Not connected to patient chart

Pros:

- Provider experience is seamless and integrated, enabling workflow efficiencies

Cons:

- May require patient to create an account and login, which may require support
- Can be costly and extend your EHR contract

Stand-alone Telehealth Platform: Stand-alone telehealth solutions facilitate communication with your patients without integrating with the EHR. If you use a stand-alone product, you will continue to use the EHR for scheduling, documentation, and billing. You can “double screen” (i.e., have one screen with the video call and one screen with the EHR) during appointments to communicate with the patient and simultaneously document the encounter.

EHR-Integrated Telehealth Platform: Your practice’s EHR may support the integration of one or more third-party applications. For example, your practice’s existing patient portal may have a telehealth option built into it. Using this functionality can allow you to leverage a tool your patients are already familiar with and that is integrated into your EHR workflow.

Check with your vendor about turning on or acquiring a telehealth module. If your EHR vendor does not have a telehealth module, they may have a recommendation on a telehealth vendor. Leveraging a third-party application allows for efficiencies in accessing patient demographics, launching a telehealth session from your appointments, and/or saving documents to the patient's chart.

For either of these options, consider the practice's workflow and technology requirements. The simpler the process and the more generic the technology requirement, the less technical assistance your practice will need to provide to your patients. Solutions that share a web link with the patient, allowing the patient simply to click on a link to begin, are recommended.

If you are considering RPM, your options will depend on the exact use cases your practice is considering. RPM is an extremely fast-moving area of technology, with new options being continuously added. At this time, interoperability varies widely among devices, platforms, and EHRs, and usability of clinician interfaces still has some way to go. Financial arrangements with RPM vendors vary. The most likely scenario is that you would sign a contract for a stand-alone RPM software platform—with or without the devices themselves. In this scenario, your practice team would be responsible for monitoring the data. More “full-service” RPM options are available, in which the vendor provides first-line data monitoring for the practice and may even offer a call center function for patients in the program.

For eConsults, the technology will look different depending on your affiliation. If your practice is affiliated with a larger health system or network, eConsult support may be built into the secure messaging function of the EHR. In the absence of that arrangement, you can purchase access to eConsults through a dedicated eConsult technology platform.

Approaching Your Vendor Selection

Before beginning conversations with potential vendors, work through your practice's requirements across the modalities you will offer. Customize the checklist below to articulate your practice's specific requirements and priorities for vendors.

Telehealth Vendor Selection Checklist and Question Guide

Area of Selection	Checklist	Key Questions to Ask
Vendor Experience and Existing Clients	<ul style="list-style-type: none"> ✓ Vendor has experience with our practice type and size ✓ Vendor can give examples of return on investment through impact on patient panel size, patient engagement, outcomes, and/or financial return 	<ul style="list-style-type: none"> • How long has the company been in business? Is it financially stable? • How long has the product been offered? • How many physicians use this product?

Area of Selection	Checklist	Key Questions to Ask
Product Functionality for the Practice	<ul style="list-style-type: none"> ✓ Product supports secure, high-definition video visits ✓ Product supports secure, audio-only encounters (if your practice wants to use platform for calls) ✓ Product supports secure messaging, including transmission of high-definition pictures 	<ul style="list-style-type: none"> • What are the equipment and software requirements? • What upload and download speeds are necessary to enable the software to run smoothly? • Can a third party (such as an interpreter) access the platform and participate in an encounter? • Does the product support pre- and post-visit questionnaires? If so, how are the data collected and stored? • Does the platform have data analytics capabilities?
Product Functionality for the Patient	<ul style="list-style-type: none"> ✓ Product is in use by patients of demographics similar to our practice's ✓ Product has high customer-satisfaction ratings ✓ Product supports patient self-scheduling of appointments 	<ul style="list-style-type: none"> • What are the equipment and software requirements for patients? • Does the platform require the patient to download an application onto a computer, phone, or tablet? • Does this product allow for pre-visit check-ins to make sure the appointment is properly set up and operating smoothly? • What are the login requirements? • What is the virtual waiting room experience like for the patient? • What accessibility features does the platform have to enable telehealth delivery to persons with disabilities?
Product Integration	<ul style="list-style-type: none"> ✓ Product is stand-alone and will be usable with "double screening" or similar, or ✓ Product is integrated with the patient portal, or ✓ Product is integrated with the EHR or information can be migrated to the EHR ✓ Product supports eConsult functionality within and outside my organization 	<ul style="list-style-type: none"> • Can the product be fully integrated into our EHR? At what cost? • Does the product capture patient history and records that can be transferred or exported to the EHR?
Cost	<ul style="list-style-type: none"> ✓ Vendor can provide a cost estimate based on a practice of similar size and baseline infrastructure, clearly breaking out one-time fees, initial-year costs, and expected ongoing costs 	<ul style="list-style-type: none"> • What is the cost structure and pricing algorithm across one-time fees and ongoing costs? • What are the costs for customization?
Software Licensing	<ul style="list-style-type: none"> ✓ User roles map to the roles and responsibilities for telehealth within our practice ✓ Software licensing is flexible when team members leave the practice and new members join 	<ul style="list-style-type: none"> • How are the software licenses organized, issued, and priced?
Security	<ul style="list-style-type: none"> ✓ Product complies with federal and state privacy and security requirements 	<ul style="list-style-type: none"> • Is any PHI stored on the platform?
Training, Support and Maintenance	<ul style="list-style-type: none"> ✓ Vendor provides a dedicated support person during early implementation ✓ Vendor provides telephonic user support at hours aligned with our practice's working hours 	<ul style="list-style-type: none"> • Will anyone be on-site for implementation? • What is the training model? • How are system failures addressed? • Does the system regularly require scheduled downtime?

Implementation and Adjustment

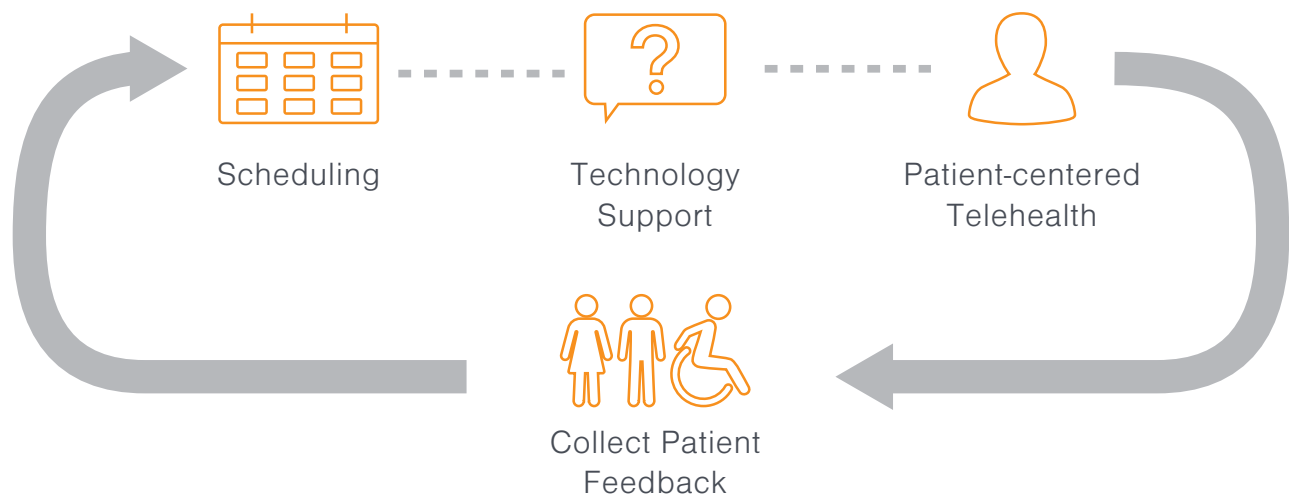
As with any new technology, be prepared for an early phase of rapid-cycle testing and improvement over the first few weeks as your team becomes accustomed to new workflows. During this period, set up frequent internal check-ins with the team for troubleshooting. Pay close attention to the early patient experience of the solution at this time, since all patients will be using it for the first time. Check in verbally with patients as part of the visit on their real-time experience of the technology.

If your telehealth technology is not integrated with the EHR, your practice may decide to set up a regular (e.g., quarterly) meeting with the telehealth vendor to work through any issues and plan adjustments to improve the platform over time.

5. Design Your Patients' "Digital Journey"

Telehealth has been overwhelmingly popular with patients during the COVID-19 pandemic, but it will take a concerted effort to keep listening to your patients and to iterate your telehealth offerings over the medium to long term. One way to think about patient-centered design is to consider the patient's entire "digital journey" through all their interactions with your practice, both administrative and clinical.

A smooth and integrated online experience is increasingly a deciding factor for patients and will become even more critical as more services move to telehealth. In fact, your online experience can be a powerful way to attract new patients if you can clearly communicate the benefits of the program in the community and continuously collect feedback from your patients. Think of communication to and from your patients using the graphic below.



Scheduling: Your scheduling process should smoothly integrate in-person and virtual options to minimize paperwork. If you offer self-service appointments via the patient portal, ensure the patient has the option to self-select telehealth. For patients calling the practice, develop a protocol or script for offering video- and audio-visit options. For patients who have made an in-person appointment that you think would be effectively

delivered virtually, develop a protocol or script for outreach to patients to offer them the option (see sample script). For patients attending in person, you can also have written material about telehealth by your practice's front desk so that patients know their options for the next appointment.

Once a telehealth appointment has been set up, follow up via email or the patient portal with clear information about the technology needed, what to expect on the day, and responsibility for cost sharing. Provide a step-by-step guide to the technology that patients will need in an easily downloadable and printable format.³⁸

Your practice may consider maintaining a list of patients who decline telehealth options. For patients at higher risk on that list, an MA, registered nurse, or front-desk staff could check in with them again in the future to discuss the potential benefits of telehealth. For other patients, the list can simply reflect patients' preferences when they have made them clear.

Sample Script for Administrative Staff:

Hello, Mr./Ms. _____. I am calling in regard to your appointment scheduled on [DATE] at [TIME] with Dr. _____. The doctor would like to see you for a telehealth appointment. A telehealth appointment allows you to consult with your doctor over audio or video from your home. Receiving your care via telehealth may be beneficial for you because your doctor can perform the same service as you would receive during an in-person visit and save you the time typically required to come in to our office. Telehealth is completely voluntary: you can decline a telehealth appointment at any time, and it will not affect your right to care or treatment, and you can be scheduled for an in-person visit instead.

Would you like to schedule a telehealth appointment now?

If Yes:

Let's see if you have the setup for participating in a telehealth visit:

- Do you have a device, such as a smartphone, tablet, or computer that has a camera and microphone that you can use for this visit?
- Where would you plan to have this appointment with the doctor? Do you have a space that is private and free of distractions? Is there internet access in the space?

If you would like, we can schedule a pre-visit consultation for a staff person to walk you through the technology and what to expect during the visit. Would you be interested in this service?

Payment for a telehealth visit is the same as for an in-person visit. A bill for this service will be generated and submitted for payment by your health insurance carrier. As with in-person health care visits, you will be responsible for any deductibles and/or copays required by your insurance plan.

We use HIPAA-compliant technology for the telehealth visit, and we will hold this appointment in a way that protects your privacy and confidentiality. Before the telehealth visit, we will ask for your consent to receive this service via telehealth.

Please be aware that we may need to schedule an additional appointment if clinically necessary, or if a technical problem occurs.

Thank you and have a great day! Please call us if you have questions or concerns.

Sample Telehealth Appointment Confirmation [Send to Patient via Secure Communication]

Thank you for scheduling a telehealth visit with Dr. _____. Your telehealth visit has been scheduled for [DAY], [DATE], from [HOUR RANGE].

NOTE: As the patient, you must be located in [STATE] at the time of the visit. Below are important details related to your upcoming telehealth visit:

- [Link/Attachment] Patient consent form, notice of privacy practices/HIPAA
- [Link/Attachment] Telehealth education materials and instructions
- [Link/Attachment] **If a new patient:** New patient forms and patient questionnaires: On the day of your appointment, please review and complete the enclosed forms and questionnaires and have them ready to review with your provider during your telehealth appointment.
- [Link] to the telehealth appointment: Please click on the link above/below and wait in the Zoom meeting until your health care provider joins the appointment.

If you encounter problems, please call the clinic at _____.

Technology Support: It is crucial to the success of your telehealth activities to provide the same level of support for video and audio visits that you would for in-person visits. The single most-effective way to prevent technology problems on the day of the appointment is to conduct a pre-visit technology check-in with the patient 24 hours before the visit for all new patients, and as an option for all patients. The pre-visit technology check is also an opportunity to assist the patient with filling out the pre-visit questionnaires, gather feedback on what they are hoping to get out of the visit, update their insurance, and complete other required tasks.

On the day of the telehealth visit, an MA can “room” the patient (and any caregivers) 15–30 minutes before the appointment begins by logging on, greeting the patient, describing what to expect, and confirming information in the same way as would occur in person. If the patient does not arrive during the 15-minute period, the MA can call the patient and assist with connection, if necessary.

Not all patients have equal access to the telehealth services your practice plans to offer. Patients may lack the necessary technology, digital literacy, and reliable internet coverage. Patients who disproportionately face barriers to telehealth services include older patients, patients of color and Tribal affiliation, patients whose first language is not English, patients who live in rural areas, and patients with low socioeconomic status.³⁹

Pre-visit technology checklist

- ✓ Device, browser, and other software supports the platform
- ✓ Internet connection is stable
- ✓ Participants can be heard and seen clearly
- ✓ Device, software, and internet are all the same as what the patient will use on the day of the visit
- ✓ Backup plan is established if connection fails

If possible, consider selecting a telehealth platform that does not require patients to download additional software, as they may have a limited data plan or insufficient storage on their devices. If the patient lacks audio/visual technology, determine whether the patient's insurance carrier will reimburse for telephone encounters at parity with services delivered via video visit. You may also want to develop a resource guide for patients to access federal, state, and local opportunities to purchase a smartphone, computer, and other technology, and deploy interactive video or written materials to teach patients the basic digital literacy skills they will need to participate in the telehealth encounter. The Lifeline Program for Low-Income Consumers is a key resource to connect your patients to help them acquire a discount on phone service.^{40,41} Around the country, some practices that specialize in serving high-needs populations have even begun to lend patients tablets and other technology to help them participate in telehealth.⁴² You may want to ask your Medicaid or Medicare Advantage payers if any support exists for such arrangements.

Patient-centered Telehealth: Studies show that most patients feel the quality of care provided by telehealth is as good as—if not better than—in-person visits,⁴³ but also that the gains can be quickly lost if the technology does not work smoothly. Therefore, think of your “webside manner” as your digital version of bedside manner (i.e., your way of building rapport with your patients that is especially mindful of the technology you and your patient are using).

Best Practices for an Excellent Webside Manner^{39,44}

• Preparation

- Ensure that you are in a private space that is appropriate for a HIPAA-compliant conversation.
- Test your internet connection to ensure that speeds are appropriate to support a well-working video feed.
- Set up your workspace so that you are front lit, the camera view covers approximately your head and shoulders, and the camera is at eye height. You should seem to be looking neither up at, nor down to, the patient.
- Make sure the patient can see your face. Having a window or light behind you can make the camera darken your face so the patient cannot see your facial features.
- Make sure the background is uncluttered and not distracting, and that you are dressed professionally.
- Review patient complaints and records before beginning the visit.

• During the visit

- Be sure to communicate instructions to the patient on what to do if the connection cuts out and you cannot reconnect (e.g., you might tell them that you will call the patient and continue the visit over the telephone).³⁹
- Demonstrate comfort with and confidence in the technology (regardless of how you are feeling about it) to help patients feel at ease and focus on their care instead of the virtual modality.
- Remember that the patient cannot see what you are doing offscreen, and may feel you are being inattentive if you look away from the camera. To help the patient feel comfortable, narrate actions or even ask permission if you are working offscreen (“Is it OK if I type while you are talking? I want to make sure that I am recording all of the important information you are saying.”)

- Speak clearly and deliberately.
 - Pause to allow for transmission delay.
 - Listen carefully to the patient. Let the patient know you are listening by providing cues such as nodding your head and saying things such as “I see.”
 - Express empathy by practicing the S.A.V.E. method (below):³⁹
 - Support or partnership statements
 - Acknowledge the situation
 - Validate the patient’s feelings or experience
 - Name their emotion
 - Verbalize and collaboratively determine next steps, such as follow-up appointments, care plans, or prescription orders.
 - Express gratitude for their engagement in the visit.
 - Invite the patient to end the encounter. Many patients appreciate the feeling of autonomy that gives, and it also allows the patient to determine whether they have any final questions or concerns.
- **After the visit**
- Share the post-visit summary and action plan.
 - Assist with scheduling referrals: If a patient needs to see a specialist, make sure your scheduling team provides a warm handoff by assisting with scheduling the visit or at least providing the specialist’s contact information and the referral. Your practice may check in on a weekly basis with the patient to make sure they saw the specialist.

Webside manner can be more challenging in audio-only visits when you lack access to the patient’s facial expressions and body language. Even if your patient can see you, here are some tips to make audio-only visits more productive and meaningful:⁴⁵

- Smile when you greet a patient on the telephone (research shows that people can tell by the tone of your voice if you are smiling).
- Reflect on something you admire about the patient.
- Elicit reactions overtly (e.g., “What do you think about that?”).
- Use empathic statements to make up for the lack of visual cues.

For patients whose first language is not English, telephonic interpreter services can be integrated into telehealth encounters as long as your practice ensures that the interpreter service has access to your telehealth platform or can call in through a conference line.

Collecting Feedback

To improve your patients' experience with your practice's telehealth offerings, collect feedback regularly on the entire telehealth experience, including the scheduling process, pre- and post-visit support, and any secure messaging or non-visit check-ins. Below is an adapted sample patient experience survey you can use. Some telehealth platforms allow integration of a post-visit survey so the patient can fill it out immediately after the conclusion of the visit before disconnecting.

Best Practice: Make sure to innovate and adapt the patient feedback collection process to ensure that it is inclusive of a diverse group of patients, including persons with disabilities and other marginalized populations.

Questions		Patient Satisfaction Survey ⁴⁶				
How did you hear about our telehealth offerings?	Drop-down choices: email, social media, office staff, office flyer					
How satisfied were you with:	Poor	Fair	Good	Excellent	Comments	
Scheduling Process						
Length of time required to get a telehealth appointment scheduled?						
Pre-visit Support						
Pre-visit setup process and technology check?						
How well your questions about the equipment were answered?						
Courtesy, respect, sensitivity, and friendliness of the practice staff person conducting the pre-visit check?						
Telehealth Visit						
Audio quality of the visit? (if applicable)						
Visual quality of the visit? (if applicable)						
Length of time spent with your doctor during the visit?						
Overall treatment experience using telehealth?						

If you want your survey to be even simpler, you could ask patients the Net Promoter Score question at the conclusion of each encounter: "How likely would you be to refer this service to a friend?"

6. Redesign Your Workflow

Your telehealth workflow will depend on the size of your organization and the extent to which different physicians within your practice are using telehealth. The most important tip is to have a dedicated staff person to oversee all aspects of administrative support for telehealth, especially in the early stages or when using a new technology platform.

Preparing an Optimal Environment for Delivering Virtual Care

Whether you are conducting visits from the office or home, you will need a private space with the ability to close the door. Make sure that others in the home or office know that you are engaged in a clinical encounter to avoid disruption.

A reliable internet connection is an imperative. While there is no specific minimum connection speed for telehealth visits, many telehealth programs require a minimum of 1.5 megabits per second (Mbps) for both upload and download speeds to successfully display audio and video data.⁴⁷ Remember, it is very likely you will be sharing bandwidth with others at the office or home. A basic business broadband connection of 50-100 Mbps should be more than sufficient. Run regular internet speed checks to make sure the connection is working properly. Many physicians choose to stay on the wired network. If you use Wi-Fi, check your speeds frequently, including in the exact location you plan to work to make sure that the speed is adequate to support high-quality video.

You will need a high-definition webcam and a headset or high-quality microphone. If your telehealth platform is not integrated with the EHR, having two screens is helpful. You may want to set them up with one screen over the other and the camera in between, which allows you to avoid looking away to make notes.

Preparing an Optimal Environment for Delivering Virtual Care:



Choose a well-lit area with a strong, secure internet connection.



Choose a private, confidential space.



Ensure there is no background noise and device notifications are silenced.



Use a high-definition webcam and microphone.

Managing Your Schedule

There is no single model of scheduling that works best for all physicians and all family medicine practices. Some physicians block certain days or portions of days for telehealth visits, as well as for attending to secure messaging or remote monitoring, perhaps on a day that is typically slower. Others offer visits outside working hours to serve patients less able to come to the office during the day. While it is possible to take video and telephone visits interspersed between in-person visits, this method is more logistically challenging.

Options for Scheduling



Telehealth
Time Block

- Best for reducing double scheduling with in-person care; may block out time daily or for certain periods throughout the week
- Not as flexible an option for patients; may limit their ability to self-schedule



Telehealth
Days

- Best for physicians who work remotely or see a large number of patients remotely
- Depending on overall workload, may be challenging to devote full day to telehealth appointments



On-Call
Scheduling

- Best for physicians who are looking to extend their hours into evenings or weekends
- May pose the most challenge to work-life balance



Open
Schedule

- Best for patients with urgent needs and for patient autonomy and flexibility
- May be challenging to manage overlaps and conflicts between in-person and virtual appointments

Documentation and Consent Requirements

Video Visits

The basic documentation requirements for a video or telephone call are the same as for an in-person visit. However, you may want to include in your documentation that the service was provided via telehealth, including the modality, the location of the person providing the service, and why the service was provided via telehealth. Note that documentation rules may vary by state and payer.

You may need to document that the patient gave informed consent for the use of telehealth for this visit.⁴⁸ Your practice may need to develop brief language that defines what to expect in a telehealth appointment and outlines expected benefits, as well as rare risks. For example, “In rare cases, information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision making by the physician.” The patient may sign the consent electronically, or you can read it as a script and receive verbal consent at the start of the visit.

Sample Patient Consent Form*

Permission for Telehealth Visits

What is telehealth?

- Telehealth is a way to visit with health care providers, such as your doctor or nurse practitioner.
- You can talk to your provider from any place, including your home. You don't go to a clinic or hospital.

How do I use telehealth?

- You talk to your provider by phone, computer, or tablet.
- Sometimes, you use video so you and your provider can see each other.

How does telehealth help me?

- You don't have to go to a clinic or hospital to see your provider.
- You won't risk getting sick from other people.

What are the drawbacks of telehealth?

- You and your provider won't be in the same room, so it may feel different from an office visit.
- Your provider may make a mistake because they cannot examine you as closely as at an office visit. (We don't know if mistakes are more common with telehealth visits.)
- Your provider may decide you still need an office visit.
- Technical problems may interrupt or stop your visit before you are done.

Will my telehealth visit be private?

- We will not record visits with your provider.
- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- Your provider will tell you if someone else from their office can hear or see you.
- We use telehealth technology that is designed to protect your privacy.
- If you use the internet for telehealth, use a network that is private and secure.
- There is a very small chance that someone could use technology to hear or see your telehealth visit.

What if I try telehealth and don't like it?

- You can stop using telehealth anytime, even during a telehealth visit.
- You can still get an office visit if you no longer want a telehealth visit.
- If you decide you do not want to use telehealth again:
 - Call XXX-XXX-XXXX and say you want to stop, **OR**
 - Sign into your patient portal and [add instructions here.]
 - It will be as if you never signed this form.

How much does a telehealth visit cost?

- What you pay depends on your insurance.
- A telehealth visit will not cost any more than an office visit.
- If your provider decides you need an office visit in addition to your telehealth visit, you may have to pay for both visits.

Do I have to sign this document?

No. Only sign this document if you want to use telehealth.

Do not sign this form until you start your first telehealth visit. Your provider will discuss it with you.

What does it mean if I sign this document?

If you sign this document, you agree that:

- We talked about the information in this document.
- We answered all your questions.
- You want a telehealth visit.

If you sign this document, we will give you a copy.

Your name (please print)

Date

Your signature

Date

Source: Adapted from the Agency for Healthcare Research and Quality (AHRQ).⁴⁹

Telephone E/M, Secure Messaging, Virtual Check-ins and “Store and Forward”

You may need to document all the time spent with each communication exchange that occurs over the seven-day period that the code(s) encompass to ensure that the time-based billing code billed is supported by the medical record. You may also need to save within the medical record any image files or files exchanged asynchronously. Make sure to check CMS and state rules related to consent.

7. Assess and Iterate

Adopting a continuous improvement framework for your practice’s telehealth activities will be key to its sustainability. There are numerous evaluation frameworks that your practice may use to implement processes to continuously evaluate and improve the program. The following are general guidelines and considerations.

Identify three to five goals that are most important for your practice or organization (e.g., continuity of care, financial sustainability, reimbursable interactions, reducing no-shows, patient satisfaction, physician satisfaction, access to care).⁵⁰ One framework you may use to guide goal setting is the SMART method, which states that goals should be Specific, Measurable, Attainable, Relevant, and Time-bounded.⁵¹

Identify which metrics are most appropriate for assessing progress and set up a process or system to collect data and track progress working toward your goals. Leverage your technology vendor’s platform analytics capabilities if available. Establish specific checkpoints to collect data, and set clear endpoint criteria to reevaluate as needed or to scale the program. Make sure to establish a baseline as a comparison point for your program’s success.⁵⁰

Some potential metrics to use might include:

- Virtual visit volume
- Number of providers trained and using virtual care services
- Number of additional appointments available as a result of virtual visits
- Percent of virtual encounters reimbursed (by modality)
- Patient satisfaction with virtual visits
- Provider satisfaction with virtual visits
- Reduced no-show rates for clinic visits
- As applicable, achievement of established standard of care recommendations (e.g., American Diabetes Association guidelines for visit frequency for diabetes patients)⁴⁴

Use the metrics you select to highlight impacts to patient outcomes, patient and clinician satisfaction, finances, and operational measures to determine:

- Whether to scale the program to expand benefits of telehealth to more patients, conditions, specialties, etc.
- How to rework the program to better perform against key metrics
- The most persuasive measures to justify continued or expanded funding⁴⁴

IV. Family Medicine Scenarios

The following scenarios may help you and your practice consider some concrete use cases for telehealth now or in the future. Each one considers:



1

A child covered by Medicaid with chronic asthma who has previously been evaluated in person and prescribed medication receives a series of follow-up check-ins via video visit with the parent present. The parent primarily speaks Spanish and could benefit from an interpreter. The practice uses a telehealth platform that allows the interpreter to join the visit as a video or audio-only participant.



Payer

Medicaid managed care



Telehealth Modality

Video visits



Roles and Responsibilities

- **Practice staff** manage the scheduling, appointment reminder, and technology check 24 hours prior to the visit. Practice staff “rooms” the family with a pre-visit technical check 15 minutes before the visit. In this case, practice staff are responsible for coordinating the interpreter services. The interpreter should be asked to join the technology and pre-visit session to ensure that the family understands how the visit will work.
- **Interpreter** joins the technical check and visit. The interpreter can either join the video call or call in to the video platform with just audio.
- **Physician** conducts the clinical visit.



Coding

Check with the Medicaid managed care plan for correct coding of video visits during and after the COVID-19 public health emergency, including appropriate modifier and point of service (POS).



Special Considerations

- **Telehealth physical exam:** (See box below.)
If necessary, the physician can also view the patient using the controller medication to ensure proper technique and proper use of spacer.
- **Medication reconciliation:** As necessary, the physician can do a medication reconciliation in which the family holds up the medications previously obtained and the doses of each medication used since prescription.
- **Engaging the family with the care plan:**
The physician can use part of the video visit to discuss the asthma action plan and ensure that the patient and the patient’s family understand it, including when to call the office and when and how to seek emergency care. During this part of the visit, the physician can ensure that the parent has all her questions answered and can teach back the asthma action plan.
- **Working with the interpreter:** This practice’s IT platform is set up to allow the interpreter to be a participant in the visit. Many practices that frequently need an interpreter are converting the service to use within video and audio-only visits.

Example Normal Video Physical Exam

Objective:

General: Confirm that the patient is awake, alert, and non-diaphoretic; has no psychomotor agitation; and is not in acute distress.

Head, Eye, Ear, Nose, and Throat Exam (HEENT):

- Head: Atraumatic, normocephalic, no rashes noted, no lesions noted; some temporal thinning of hair
- Eyes: No redness, discharge, swelling, or lesions
- Nose: No redness, swelling, discharge, deformity, or impetigo/crusting
- Skin: No lesions, wounds, erythema, or cyanosis noted on face or hands
- Cardiopulmonary: No increased respiratory effort, speaking in clear sentences, I:E ratio WNL
- Neuro: Cranial nerves grossly normal, speech normal rate and rhythm, orientation arrived at appointment on time with no prompting, moved both upper extremities equally

Psychological:

- Appearance, behavior, and attitude: Well groomed, pleasant, cooperative
- Attention and concentration: Focused, linear, appropriate, attends for longer periods of time
- Higher integrative function (executive function, intellectual function): Appropriate, good vocabulary
- Thought process (thought content, thought form, delusion, obsession, abstract thought): Appropriate
- Speech: Normal rate and rhythm
- Affect: Appropriate
- Insight and judgment: Appropriate

2

An established adolescent Medicaid patient calls the practice seeking help for anxiety and depression and is given a telephone appointment with the nurse practitioner (NP).



Payer

Medicaid managed care



Telehealth Modality

Telephone call



Roles and Responsibilities

- **Practice staff** manage scheduling, appointment reminder, any necessary technology setup, and rooming.
- **Nurse practitioner** conducts the clinical visit.



Coding

The Medicaid managed care plan is most likely to require use of telephone E/M (99441-99443, with selection of code depending on the length of the call). The practice should use the appropriate modifier and POS.



Special Considerations

- **Use of screeners:** The NP can consider sending a Patient Health Questionnaire (PHQ2 or PHQ9) screening tool via secure messaging for the patient to fill out before the visit.
- **Consent:** Consent without guardian approval for patients under 18 for a visit by phone or video follows the same state regulations as an in-person visit, and the same privacy concerns apply.
- **Choosing between telephone and video:** Staff could offer this patient options for either a telephone or a video visit, and choose whichever modality makes the patient most comfortable and builds rapport.
- **Patient's comfort:** The NP can ask the patient whether he is in a safe space to talk about his concerns, and support rescheduling if the patient feels like he is not in a space where he can speak openly and comfortably.

3

A rural family medicine practice sets up remote physiologic monitoring for a Medicare patient with chronic obstructive pulmonary disease and obesity to monitor oxygen saturation. The patient monitors his own oxygen levels daily, and the equipment automatically transmits the data passively to the practice. The practice checks in with the patient when the patient triggers an alarm for low oxygen saturation.



Payer

Medicare fee-for-service



Telehealth Modality

Remote physiologic monitoring



Roles and Responsibilities

- **Physician** conducts the setup visit with the patient.
- **Clinical staff** monitors incoming data daily and forwards information to the physician and contacts the patient when low saturations are observed.



Coding

99453 for setup and patient education; 99457 for first 20 minutes; 99458 for each additional 20 minutes. The physician cannot bill 99457 and 99458 on same day as an E/M telehealth or in-person service with the same provider. Codes 99457 and 99458 cover clinical staff, physician, or qualified health professional (QHP) time as long as the appropriate time threshold(s) is met.



Special Considerations

- **Length of monitoring:** Monitoring of this patient must be at least 16 days in duration, although flexibilities have been in place during the COVID-19 pandemic (see Appendix).
- **Availability of pulse oximeter:** The pulse oximeter may be acquired through the practice's preferred durable medical equipment (DME) provider.
- **Overlap with Medicare CCM or TCM:** RPM codes can be billed during the same month as CCM/TCM, but time cannot count toward CCM/TCM time.
- **Workflow:** Especially for this practice in a rural area, RPM may have a very strong value proposition if it can prevent the need for this patient to travel and help the patient efficiently pick up on oxygen concerns. However, RPM is likely to work best and most efficiently for the practice if offered to a cohort of similar patients, so that the practice can systematize the approach in the workflow (e.g., specific timing of staff checking the data and calling the patients). In this scenario, the patient would not need to be under continuous oxygen monitoring but would be doing daily spot checks. The patient should be counseled on signs and symptoms that require an emergency response, and to call 911 for a medical emergency.

4

A Medicare patient has an in-person visit with a resident with the family physician’s practice in which a routine blood draw is performed. The resident reviews the results from the lab and initiates an eConsult with a nephrologist about an abnormal blood urea nitrogen/creatinine (BUN/Cr) result. The resident schedules a telephone visit to discuss the abnormal result with the patient and to provide information gleaned from the eConsult.



Payer

Medicare fee-for-service



Telehealth Modality

eConsult; telephone visit



Roles and Responsibilities

- **Practice group** contracts with a group of specialists (in this case, nephrologists) providing eConsults.
- **Resident** writes up the eConsult case review and clinical question, and follows up with the patient.
- **Physician** reviews the resident work and countersigns.
- **Nephrologist** responds to the eConsult case review within a specified time.



Coding

The family physician bills 99452 for the eConsult. This service requires a minimum of 16 minutes to report. For the telephone visit, use 99441–99443 depending on the length of the phone call.



Special Considerations

Arrangement for eConsults: If this primary care practice is within a health system, it may have specialists available through secure messaging within the EHR to provide eConsults. If this practice is independent or within a health system that does not offer this service, it could contract with an eConsult vendor that uses proprietary secure technology to send consults to the vendor’s specialist physicians. Alternatively, the practice could work with its local referral network to establish a process for eConsults. This would likely not be as timely an option as a dedicated eConsult service but could provide better continuity if a traditional referral is then warranted.

5

An adult Medicaid managed care patient sends a smartphone picture of a skin lesion to the practice via secure email. The family physician initiates an eConsult with a dermatologist to review the picture and then follows up with the patient with a video visit.



Payer

Medicaid managed care



Telehealth Modality

Secure messaging; eConsult; video visit



Roles and Responsibilities

- **Practice group** contracts with a group of specialists (in this case, dermatologists) providing eConsults.
- **Family physician** reviews photo and history through secure messaging, writes up the eConsult case review and clinical question, and conducts the clinical visit by video visit.
- **Practice staff** conduct scheduling, appointment reminder, and technology setup 24 hours before the visit; room the family with a pre-visit check 15 minutes before the visit.
- **Dermatologist** responds to the eConsult case review within a specified time.



Coding

Check with the Medicaid managed care plan regarding payment and correct coding during and after the COVID-19 public health emergency. Transmission of the image to the specialist is included in the eConsult coding. The secure messaging and video visit may not be separately paid if within 14 days of each other. The practice should use appropriate modifier and POS, as needed.



Special Considerations

- **Images:** Both the family physician and the specialist will likely benefit from seeing high-resolution images. An assessment of the clarity of the image should form part of the family physician's review to ensure the success of the eConsult.
- **Documentation:** Images and files sent as part of an online eVisit must be saved in the patient's chart. It is best practice to save such files even if not billing for an eVisit.

6

A low-risk, pregnant, and commercially insured patient needs blood pressure monitoring. The patient monitors her own blood pressure at home and calls the practice once a week to report readings. Readings are not elevated, so management is discussed within the next routine appointment. The commercial payer is allowing prenatal visits to be conducted by video visit.



Payer
Commercial



Telehealth Modality
Remote patient monitoring; video visit



Roles and Responsibilities

- **Family physician** monitors readings and conducts the video visit.
- **Practice staff** collect readings telephonically once a week and record collected data in the EHR.



Coding

- **Prenatal video visit:** Many prenatal visits are paid by Medicaid payers as a bundle of visits.⁵² The video visit would replace one of the in-person visits in the bundle. The payer may require a modifier or other notation to document that the visit was conducted by video visit.
- **Blood pressure monitoring:** Check whether the payer will reimburse for the self-measured blood pressure monitoring codes (99473, 99474). Code 99473 is used for patient education/training and device calibration. Code 99474 is used for the blood pressure measurement and reporting to the practice and has certain parameters attached to it (e.g., minimum of 12 readings, 30-day period).



Special Considerations

- **Appropriateness:** Studies show that replacement of select prenatal visits with video visits, combined with remote monitoring, is as safe as standard care and has high acceptability with patients.⁵³ More studies are showing the efficacy of virtual care delivery. With the expansion of telehealth as a result of the COVID-19 public health emergency, we will likely see further growth in evidence around virtual care delivery.
- **Coverage of the blood pressure cuff:** The practice should check with the commercial payer about whether the cuff is covered.

7

An elderly established patient is discharged from the hospital to a skilled nursing facility (SNF) where the family physician has privileges. The family physician follows up with the patient with a video visit. The patient needs assistance using the technology.



Payer

Medicare fee-for-service



Telehealth Modality

Video visit



Roles and Responsibilities

- **Physician assistant** coordinates with SNF staff before the visit to do a technology check.
- **Physician** conducts the video visit.
- **SNF staff** help with vitals, hold the video equipment, and assist with the physical exam.



Coding

Assuming this video visit replaces the physician visiting the patient in the SNF, the physician would bill CPT 99307–99310 (Subsequent Nursing Facility Care), with the appropriate modifier and POS.⁵⁴



Special Considerations

- **Licensing and credentialing:** If a patient is in a facility setting, then the provider must have the licensing and credentialing that would be appropriate if they were seeing the patient in person.
- **Working with the facility staff:** Facility staff can also help patients with using or holding the video technology (usually a phone or tablet) or assist with the physical exam (e.g., with passive range of motion assessments). Working regularly with the same facility can build technology skills and confidence for the facility staff.

8

The parent of a commercially insured child who is an established patient requests a video visit (with the parent present) to review the child's attention-deficit/hyperactivity disorder medication and discuss adjustments. The family physician adjusts the prescription.



Payer
Commercial payer



Telehealth Modality
Video visit



Roles and Responsibilities

- **Practice staff** manage scheduling, appointment reminder, and technology setup with the parent 24 hours prior to the visit.
- **Physician** conducts the clinical visit.



Coding

The practice should check with the commercial payer. Many commercial payers use 99211–99215. The practice should use the appropriate modifier and POS.⁵⁴



Special Considerations

- **Controlled substances:** Electronic prescribing of controlled substances is subject to special requirements at both the federal (Ryan Haight Act) and state levels. The Ryan Haight Act requires that the patient has previously had an in-person visit with the provider, but it doesn't need to have been recent. State laws can be more restrictive. However, these requirements were relaxed during the COVID-19 pandemic and are subject to further change after the pandemic. Check with your state board and the [DEA website](#) for the latest information.
- **Cost sharing:** Depending on the payer, cost sharing may be waived.

9

A newly diagnosed patient with diabetes who is an established patient and Medicare Advantage member has a telephone check-in with the practice's diabetes nurse educator after an in-person visit. The patient then has a video visit after one week to review blood sugar readings, exercise, and diet.



Payer

Medicare Advantage



Telehealth Modality

Video visit. Note that the brief check-in would not be separately payable since it was a follow-up to the in-person visit.



Roles and Responsibilities

- **Diabetes nurse educator** conducts the telephone check-in and/or the video visit.
- **Physician** may also conduct the video visit.



Coding

99211–99215, depending on time spent, with the appropriate modifier. The practice should check with the Medicare Advantage plan for details.⁵⁴ The practice should use the appropriate modifier and POS.



Special Considerations

- **Practice and payer roles:** The Medicare Advantage plan may also initiate outreach to the patient to establish care management upon receiving claims data indicating the diabetes diagnosis. Work with your patient to discuss how your practice team will stay in continuous contact to help manage the diabetes and engage the patient on which support services will work best for them.
- **Cost sharing:** Depending on the payer, cost sharing may be waived.

10

A practice holds a 90-minute virtual diabetes self-management training for a group of established Medicare patients.



Payer
Medicare



Telehealth Modality
Multiparty video call



Roles and Responsibilities

- **Staff** schedules group visits, conducts a technology check 24 hours before the group session, and logs in 15 minutes early to help troubleshoot.
- **Diabetes educator** conducts the group visit and documents appropriately.



Coding

Diabetes self-management education is paid by Medicare.⁵⁵ For individuals, the practice should use code G0108 (Diabetes outpatient self-management training services, individual, per 30 minutes), and for groups of two or more, use code G0109 (Diabetes outpatient self-management training services, group session [two or more], per 30 minutes). Both codes are currently on the Medicare telehealth list and may be done audio-only. Another option could be to code the event as a shared medical appointment using an E/M code, but the practice should verify with its Medicare Administrative Contractor (MAC) that this is possible. In this scenario, all patients must sign a confidentiality agreement.⁵⁶ The practice should use the appropriate modifier and POS.



Special Considerations

Telehealth platform: Many telemedicine platforms that are optimized for one-to-one visits are not optimized for group visits. Practices may find that HIPAA-compliant consumer videoconferencing software may better fit their needs and be easier for patients to use in a group setting.

Appendix

Billing and Coding Table

Modality	Service Type	Commonly Used CPT Codes	Medicare Applicable Provider(s) ⁵⁷	Key Notes/Additional Guidance*
vVisit	Video visit	New patients: 99201-99205 Established patients: 99211-99215	Physicians and other eligible providers	CMS has enabled a wide range of services to be delivered via video. A list of these services can be found here .
		Virtual check-in: G2012	Physicians and other eligible providers	
		G2025/T1015	FQHCs, RHCs	
tVisit	Telephone visit – full visit	On a temporary basis, some payers are allowing certain services to be delivered via telephone. Check with your payer for a list of codes.	Physicians and other eligible providers	CMS has enabled select services to be delivered via audio-only. A list of these services can be found here .
	Telephone visit – brief check-in	G2012	Physicians and other eligible providers	If a telephone call is linked to a related E/M visit in the previous seven days or next 24 hours (or soonest available appointment), it is considered part of that E/M visit and is not separately payable under any of the above codes. 99421-99423 cannot be billed more than once per seven-day period.
		98966-98968	Qualified non-physicians	
		G0071	FQHCs, RHCs	

Modality	Service Type	Commonly Used CPT Codes	Medicare Applicable Provider(s) ⁵⁷	Key Notes/Additional Guidance*
eVisit	Online eVisit	99421-99423, G2010	Physicians and other eligible providers	<p>If an exchange by secure messaging is linked to a related E/M visit in the previous seven days or next 24 hours (or soonest available appointment), it is considered part of that E/M visit and is not separately payable under any of the above codes.</p> <p>Must be patient-initiated.</p> <p>99421-99423 cannot be billed more than once per seven-day period.</p> <p>Clinical staff time is not calculated as part of cumulative time.</p> <p>Cannot be billed with 99091, CCM, or TCM codes.</p>
		G2061, G2062, G2063	Qualified non-physician providers	
		G0071	FQHCs, RHCs	
Remote Patient Monitoring	Remote Physiologic Monitoring	99453, 99454, 99457, 99458, 99091	Physicians and other eligible providers	<p>Code 99453 should be billed only once for each episode of care. An episode of care is defined as beginning when the RPM is initiated and ending with attainment of targeted treatment goals.</p> <p>Codes 99453 and 99454 cannot be reported if monitoring is less than 16 days in duration. During the COVID-19 pandemic, the minimum number of days for which the codes can be billed has been lowered from 16 to 2.</p> <p>If the services described by code 99453 and 99454 are provided on the same day the patient presents for an E/M service to the same provider (whether by telehealth or in person), these services should be considered part of the E/M service and not billed under code 99453/99454.</p> <p>RPM must be conducted by a “qualified health professional,” but codes 99457 and 99458 can be conducted under general supervision of the QHP by other staff members of the care team (incident-to billing).</p> <p>Cannot be billed with CCM or TCM codes.</p>
	Self-measured Blood Pressure Monitoring	99473, 99474, 99091	Physicians and other eligible providers	<p>If 99474 services are provided on the same day the patient presents for an E/M service to the same provider, these services should be considered part of the E/M service and not reported separately.</p>

Modality	Service Type	Commonly Used CPT Codes	Medicare Applicable Provider(s) ⁵⁷	Key Notes/Additional Guidance*
Interprofessional Consult	eConsult	99452	Referring provider	The minimum amount of time spent on activities by the family physician is 16 minutes for 99452. 99452 cannot be reported more than once per 14 days per patient.
		99446, 99447, 99448, 99449, 99451	Consulting provider	The minimum amount of time spent on activities by the family physician is five minutes for code 99451. 99451 cannot be billed more than once in a seven-day period for the same patient and cannot be billed if the eConsult results in a recommendation to see a specialist within 14 days.

* Refer to the 2020 CPT Code Book for full information.

Commonly Used Modifiers and Place of Service

The following modifiers and place of service codes are commonly used for telehealth. Modifier and POS vary by payer, so always confirm with your payer to ensure appropriate coding and billing.

Modifier	Description
GT	Telehealth services via interactive audio and video telecommunication systems
GQ	Telehealth services via asynchronous telecommunications system
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system
Place of service (POS)	Description
02	Telehealth—The location where health services and health-related services are provided or received, through a telecommunication system*
11	Private office (if originating site for a telehealth visit)

* Check with payer for coding during the COVID-19 public health emergency. Medicare and some other payers will lower rates for claims with POS 02.

References

1. American Academy of Family Physicians (AAFP). Telemedicine study. Unpublished.
2. Adirondacks ACO, Advanced ICU Care, Inc., Advanced Medical Technology Association (AdvaMed), et al. Post-COVID telehealth priorities group letter. Accessed August 17, 2020. <http://connectwithcare.org/wp-content/uploads/2020/06/Post-COVID-Telehealth-Priorities-Group-Letter-FIN.pdf>
3. AAFP. Telehealth and telemedicine. Overview of telemedicine. Accessed August 17, 2020. www.aafp.org/advocacy/informed/hit/telehealth.html
4. AAFP. COVID-19: frequently asked telehealth questions. Accessed August 17, 2020. www.aafp.org/patient-care/emergency/2019-coronavirus/telehealth/faq.html
5. AAFP. COVID-19: Coding scenarios. Accessed August 17, 2020. www.aafp.org/patient-care/emergency/2019-coronavirus/telehealth/coding-scenarios.html
6. *FPM* Editors. A virtual visit algorithm: how to differentiate and code telehealth visits, e-visits, and virtual check-ins. Accessed August 17, 2020. www.aafp.org/journals/fpm/blogs/inpractice/entry/telehealth_algorithm.html
7. Cornell Law School. Telehealth services. Legal Information Institute. Accessed August 17, 2020. www.law.cornell.edu/cfr/text/42/410.78
8. United States Senate. 116th Cong., 2d Sess. Coronavirus Aid, Relief, and Economic Security Act. Accessed August 17, 2020. www.appropriations.senate.gov/imo/media/doc/FINAL%20FINAL%20CARES%20ACT.pdf
9. American Telehealth Association. Telehealth basics. Accessed August 17, 2020. www.americantelemed.org/resource/why-telemedicine/
10. Lacktman NM, Acosta JN, Levine SJ. 50-state survey of telehealth commercial payer statutes. Foley & Lardner LLP. Accessed August 17, 2020. www.foley.com/-/media/files/insights/health-care-law-today/19mc21486-50state-survey-of-telehealth-commercial.pdf
11. Centers for Medicare & Medicaid Services (CMS). Medicare telemedicine health care provider fact sheet. Accessed August 17, 2020. www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
12. CMS. Telehealth services. Accessed August 17, 2020. www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf
13. CMS. Physicians and other clinicians: CMS flexibilities to fight COVID-19. Accessed August 17, 2020. www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf
14. Becker's Hospital Review. CMS adds 85 more Medicare services covered under telehealth. Accessed August 17, 2020. www.beckershospitalreview.com/telehealth/cms-adds-85-more-medicare-services-covered-under-telehealth.html

15. Center for Connected Health Policy (CCHP). Current state laws & reimbursement policies. Accessed August 17, 2020. www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies
16. CCHP. Telehealth coverage policies in the time of COVID-19. Accessed August 17, 2020. www.cchpca.org/resources/covid-19-telehealth-coverage-policies
17. Moore, K. Coronavirus (COVID-19): new telehealth rules and procedure codes for testing. FPM.
18. CMS. Final policy, payment, and quality provisions changes to the Medicare Physician Fee Schedule for calendar year 2019. Accessed August 17, 2020. www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year
19. CMS. Federal Register. Medicare program; CY 2020 revisions to payment policies under the physician fee schedule and other changes to Part B payment policies. Accessed August 17, 2020. www.federalregister.gov/documents/2019/11/15/2019-24086/medicare-program-cy-2020-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other
20. CMS. Medicare and Medicaid programs, basic health program, and exchanges; additional policy and regulatory revisions in response to the COVID-19 public health emergency and delay of certain reporting requirements for the skilled nursing facility quality reporting program. Accessed August 17, 2020. www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf
21. CMS. Medicare and Medicaid programs, basic health program, and exchanges; additional policy and regulatory revisions in response to the COVID-19 public health emergency and delay of certain reporting requirements for the skilled nursing facility quality reporting program. Accessed August 17, 2020. www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf
22. CCHP. State telehealth laws & reimbursement policies. Accessed August 17, 2020. [www.cchpca.org/sites/default/files/2020-05/CCHP %2050 STATE REPORT SPRING 2020 FINAL.pdf](http://www.cchpca.org/sites/default/files/2020-05/CCHP%2050%20STATE%20REPORT%20SPRING%202020%20FINAL.pdf)
23. Vimalananda VG, Gupte G, Seraj SM, et al. Electronic consultations (e-Consults) to improve access to specialty care: a systematic review and narrative synthesis. *J Telemed Telecare*. 2015(21)6:323-330.
24. Liddy C, Abu-Hijleh T, Joschko J, et al. eConsults and learning between primary care providers and specialists. *Fam Med*. 2019;51(7):567-573.
25. Thielke A, King V. Electronic consultations (eConsults): a triple win for patients, clinicians, and payers. Milbank Memorial Fund. Accessed August 17, 2020. www.milbank.org/publications/electronic-consultations-a-triple-win-for-patients-clinicians-and-payers/
26. America's Health Insurance Plans. Health insurance providers respond to coronavirus (COVID-19). Accessed August 17, 2020. www.ahip.org/health-insurance-providers-respond-to-coronavirus-covid-19/
27. Project Extension for Community Health Outcomes (ECHO) Model. Accessed August 17, 2020. <https://echo.unm.edu/about-echo/model/>
28. AAFP. Mental health care services by family physicians (position paper). Accessed August 17, 2020. www.aafp.org/about/policies/all/mental-services.html

29. Haughey D. RACI matrix. Project Smart. Accessed August 17, 2020. <https://www.projectsmaart.co.uk/raci-matrix.php#:~:text=The%20RACI%20model%20is%20a,work%20to%20achieve%20the%20task>
30. Interstate Medical Licensure Compact. A faster pathway to physician licensure. Accessed August 17, 2020. www.imlcc.org/a-faster-pathway-to-physician-licensure/
31. Federation of State Medical Boards. Protecting the public. Accessed August 17, 2020. www.fsmb.org/
32. Pedrotty J. A guide to telemedicine for the physician practice. Physician Practice Resource Center. Accessed August 17, 2020. [www.massmed.org/Physicians/Practice-Management/Practice-Ownership-and-Operations/Guide-to-Telemedicine-for-Physician-Practice-\(pdf\)/](http://www.massmed.org/Physicians/Practice-Management/Practice-Ownership-and-Operations/Guide-to-Telemedicine-for-Physician-Practice-(pdf)/)
33. CCHP. National policy. Malpractice. Accessed August 17, 2020. www.cchpca.org/telehealth-policy/malpractice
34. CCHP. National policy. Online prescribing. Accessed August 17, 2020. www.cchpca.org/telehealth-policy/online-prescribing
35. Diversion Control Division. COVID-19 information page. U.S. Department of Justice. Drug Enforcement Administration. Accessed August 17, 2020. www.deadiversion.usdoj.gov/coronavirus.html
36. Shay DF. The HIPAA security rule: are you in compliance? *FPM*. 2017;24(2):5-9.
37. Jetty A, Jabbarpour Y, Westfall M, et al. Capacity of primary care to deliver telehealth in the United States. *J Am Board Fam Med*. 2021. Ahead-of-print article.
38. Aledade. Telehealth. Getting started with telehealth guide. Accessed August 17, 2020. www.aledade.com/telehealth-1
39. Cleveland Clinic. Cleveland Clinic COVID-19 response. Digital health playbook. Accessed August 17, 2020. <https://my.clevelandclinic.org/-/scassets/files/org/landing/preparing-for-coronavirus/covid-response-digital-health-playbook.ashx?la=en>
40. Nouri S, Khoong EC, Lyles CR, et al. Addressing equity in telemedicine for chronic disease management during the COVID-19 pandemic. *N Engl J Med Catalyst Innovations in Care Delivery*. Commentary. 2020. Accessed August 17, 2020. <https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0123>
41. Federal Communications Commission. Lifeline program for low-income consumers. Accessed August 17, 2020. www.fcc.gov/general/lifeline-program-low-income-consumers
42. Fernandopulle R. Imagining the world anew: Iora Health's COVID-19 response. Medium. Accessed August 17, 2020. <https://medium.com/@rushika/imagining-the-world-anew-iora-healths-covid-19-response-6fa106f19dd6>
43. Heath S. Patient satisfaction of telehealth hinges on convenience, quality. Patient Engagement HIT. Accessed August 17, 2020. <https://patientengagementhit.com/news/patient-satisfaction-of-telehealth-hinges-on-convenience-quality#:~:text=Overall%2C%20patient%20satisfaction%20with%20telehealth,before%20the%20visits%20was%20completed>
44. American Medical Association (AMA). Telehealth implementation playbook. Accessed August 17, 2020. www.ama-assn.org/system/files/2020-04/ama-telehealth-implementation-playbook.pdf

45. Martinez E, Sattler A, Sherman M, et al. 10 communication tips for physician phone visits during COVID-19. FPM. Accessed August 17, 2020. https://www.aafp.org/journals/fpm/blogs/inpractice/entry/telephone_visit_tips_2.html
46. Agency for Healthcare Research and Quality (AHRQ). Telehealth satisfaction survey. Accessed August 17, 2020. https://digital.ahrq.gov/sites/default/files/docs/survey/telehealthsatisfactionquestionnaire_comp.pdf
47. Kruger LG. Defining broadband: minimum threshold speeds and broadband policy. Congressional Research Service. Accessed August 17, 2020. <https://fas.org/sgp/crs/misc/R45039.pdf>
48. American College of Physicians. Telemedicine: a practical guide for incorporation into your practice. Accessed August 17, 2020. www.acponline.org/cme-moc/online-learning-center/telemedicine-a-practical-guide-for-incorporation-into-your-practice
49. AHRQ. AHRQ's easy-to-understand telehealth consent form. Accessed August 17, 2020. www.ahrq.gov/health-literacy/informed-consent-telehealth.html
50. AMA. Digital health implementation playbook. Accessed August 17, 2020. www.ama-assn.org/amaone/ama-digital-health-implementation-playbook
51. American Academy of Pediatrics. Quality improvement and evaluation in telemedicine. Accessed August 17, 2020. www.aap.org/en-us/professional-resources/practice-transformation/telehealth/Pages/Evaluation.aspx
52. Society for Maternal Fetal Medicine. SMFM white paper: interim coding guidance: coding for telemedicine and remote patient monitoring services during the COVID-19 pandemic. Accessed August 17, 2020. www.smfm.org/covid-19-white-paper
53. Butler Toba YS, LeBlanc A, Branda ME, et al. Randomized comparison of a reduced-visit prenatal care model enhanced with remote monitoring. *Am J Obstet Gynecol*. 2019;221(6):638.e1-638.e8.
54. AAFP. Coding scenario: telehealth. Accessed August 17, 2020. www.aafp.org/patient-care/emergency/2019-coronavirus/telehealth/coding-scenarios/telehealth.html
55. Theobald M, Masley S. A guide to group visits for chronic conditions affected by overweight and obesity. Americans in Motion – Healthy Interventions. AAFP National Research Network. Accessed August 17, 2020. www.aafp.org/dam/AAFP/documents/patient_care/fitness/GroupVisitAIM.pdf
56. Hodorowicz MA. Reimbursement for shared medical appointments incorporating diabetes self-management education/training or diabetes medical nutrition therapy. *Diabetes Spectr*. 2012;25(2):84-90.
57. CMS. Telehealth services. Accessed August 17, 2020. www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf

FOR MORE INFORMATION REGARDING THIS TOOLKIT, PLEASE CONTACT:

American Academy of Family Physicians
AAFP.ORG

