NATIONAL ASSOCIATION OF
Community Health Centers

Telehealth Implementation Quick Guide

COVID-19 Resource Packet

May 13, 2020

During the COVID-19 pandemic, health centers have turned to telehealth and other virtual services in order to provide much needed care during this uncertain and rapidly changing time. This Resource Packet is intended to support health centers looking to create or advance telehealth or virtual services during this challenging time period.

Over the longer term, we recognize the immense opportunity to advance health centers' telehealth and telephonic services to patients. Some health centers have been providing telephone visits for years, often without payment. Other health centers are just starting because of new reimbursement structures, and telehealth is the only safe way to continue to provide care to patients who are sheltering at home or don't want the risk of a clinic exposure. While there are many components of a strong telehealth and virtual care program, the present goals are very clear: the continued provision of excellent and timely care to patients, the protection of staff and providers during the pandemic, and the maintenance of a strong financial footing.

This packet is best used in conjunction with other technical assistance resources more closely tailored to your local operating environment's payer policies, internet capabilities, and user comfort with technology. Health centers are responsible for determining appropriate and tailored operations suitable for their organization, staff, patients and community. Health centers should refer to applicable State, Local, and organizational regulations in consultation with the health center's general counsel.

Additional information and resources

Technical Assistance Resources

- **Center for Connected Health Policy's Telehealth Coverage Policies page**
  https://www.cchpca.org/resources/covid-19-telehealth-coverage-policies
- **National Consortium of Telehealth Resource Centers COVID-19 Telehealth Toolkit**
  https://www.telehealthresourcecenter.org/wp-content/uploads/2020/03/Telehealth-and-COVID-19-FINAL.pdf
- **HITEQ Telehealth Resource Page**
  https://hiteqcenter.org/Resources/Telehealth-Telemedicine
- **National Network for Oral Health Access Teledentistry Resources**
  http://www.nnoha.org/covid-19-coronavirus/teledentistry-resources/
- **NACHC's Coronavirus webpage**
  http://www.nachc.org/coronavirus/
- **Health Center Resource Clearinghouse Priority Page COVID-19**
  https://www.healthcenterinfo.org/priority-topics/covid-19/

Federal Information and Resources

- **HRSA Bureau of Primary Health Care Program Assistance Letter (PAL 2020-01): Telehealth and Health Center Scope of Project**
  https://bphc.hrsa.gov/sites/default/files/bphc/programrequirements/pdf/telehealth-pal.pdf
- **Health Resources and Services Administration (HRSA) Health Center Program COVID-19 Frequently Asked Questions (FAQ)** includes **Federal Torts Claim Act** (FTCA) updates
  https://bphc.hrsa.gov/emergency-response/coronavirus-frequently-asked-questions.html
- **Centers for Medicare and Medicaid Services (CMS) COVID-19 FAQs**
  https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page
- **CMS FQHC Page**
  https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center
- **Centers for Disease Control and Prevention (CDC) COVID-19 page**
  https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html

Inquiries about this document can be directed to telehealth@nachc.org

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1. Reimbursement and Legal Considerations for Telemedicine During the Pandemic

Purpose and Scope

With a focus on preparing for expanding screening, triage, and related treatment for COVID-19, the day-to-day care of many health center patients has been disrupted, which has led to significant patient access issues for health centers. In light of these realities, health centers are turning to virtual services, including telehealth, virtual communication services (a.k.a., virtual check ins), and E-visits. This document provides a high-level overview of the major issues and considers when implementing virtual services. Please refer to additional operational guides for more-specific implementation information.

Key Terms and Definitions

While the term "telehealth" is commonly used to describe a variety of services, its definition in federal law pertains to a more specific set of services and communications technologies. In this document, the term "telemedicine" includes all services that are delivered from a distance, including telehealth.

- **Telehealth** is defined as the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration.[1]
- **Virtual Check-In** services permit patients, without going to an office, to talk with a doctor, NP, or PA via a phone or integrated audio-visual system or evaluate a captured image or video.[2]
- **E-visits** allow a patient and a provider to interact via a patient portal instead of face-to-face at an office.[3]

There are two common terms that are used to describe how telehealth services are provided.[4]
- **Originating Site:** the location of an eligible beneficiary at the time the telehealth service is being provided
- **Distant Site:** the location of the eligible provider who is providing the telehealth service.

It is also important to note that within the context of the Health Center Program scope of project, "telehealth" is not a service or a service delivery method requiring specific HRSA approval; rather, telehealth is a mechanism or means for delivering a health service(s) to health center patients using telecommunications technology or equipment. As such, health centers are not required to seek prior approval from HRSA for a change in scope to use telehealth, nor separately record the use of telehealth as the means, to deliver a service.[5] During PHEs, temporary service sites are also permitted, and can be used to greatly enhance telemedicine capabilities.[6]

With an emphasis on health centers supporting social distancing and other proper protocols, this part of the Resource Packet focuses on the use of telehealth to manage health center patients seeking routine and/or acute care but who are not necessarily needing evaluation for COVID-19. This guide will provide an overview of how to document and capture services via ICD and HCPCS (e.g., CPT) codes and optimize reimbursement from Medicare, Medicaid, and commercial payers.

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[1] https://www.hrsa.gov/rural-health/telehealth
[2] https://www.medicare.gov/coverage/virtual-check-ins, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf
[3] https://www.medicare.gov/coverage/e-visits
[4] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsf ctsht.pdf
[5] Adapted from BPHC Program Assistance Letter 2020-01: Telehealth and Health Center Scope of Project.
https://bphc.hrsa.gov/sites/default/files/bphc/programrequirements/pdf/telehealth-pal.pdf
[6] See BPHC Program Assistance Letter 2020-05, https://bphc.hrsa.gov/sites/default/files/bphc/programrequirements/pdf/pal202005.pdf

Coverage of Telemedicine Services by Medicare, Medicaid, Uninsured, and Commercial Payers

Medicare

The Centers for Medicare and Medicaid Services (CMS) has made a number of changes to its telehealth and telemedicine provisions through regulation and guidance during the COVID Public Health Emergency (PHE). Below is an overview of the major provisions.

Elimination of geographic barriers: As of March 6, 2020, and for the duration of the COVID-19 Public Health Emergency (PHE), "Medicare will make payment for Medicare telehealth services furnished to beneficiaries in any healthcare facility and in their home."[7] One of the more important changes for FQHCs came from the CARES Act,[8] which made changes that allow FQHCs[9] to act as distant sites for telehealth applications for the duration of the emergency, meaning that providers at health centers may serve patients who are in other locations (the originating site).

Enhanced reimbursement for telehealth services: On April 17, 2020**,** CMS issued guidance allowing FQHCs and RHCs to receive enhanced Medicare reimbursement for telehealth services, per the provision in the CARES Act. Retroactive to January 27, 2020 and continuing for the duration of the COVID emergency, FQHCs are able to provide and be reimbursed for Medicare services as a distant site provider via telehealth. FQHCs will be reimbursed **$92.03** for these services. FQHC practitioners can provide these services from any location, including one's home, as long as they are working for the FQHC and can provide any telehealth service that is approved as a distant site service under the Medicare Physician Fee Schedule.[10]

On April 30, 2020, CMS released additional information on billing and coding for these distant site services. According to the updated MLN Matters article SE20016:

> ### *Claims Requirements for FQHCs*
> *For telehealth distant site services furnished between January 27, 2020, and June 30, 2020, that are also FQHC qualifying visits, FQHCs must report three HCPCS/CPT codes for distant site telehealth services: the FQHC Prospective Payment System (PPS) specific payment code (GO466, G0467, G0468, G0469, or G0470); the HCPCS/CPT code that describes the services furnished via telehealth with modifier 95; and G2025 with modifier 95.* ***These claims will be paid at the FQHC PPS rate until June 30, 2020, and automatically reprocessed beginning on July 1, 2020, at the $92.03 rate.*** *FQHCs do not need to resubmit these claims for the payment adjustment.*
>
> *When furnishing services via telehealth that are not FQHC qualifying visits,* ***FQHCs should hold these claims until July 1, 2020, and then bill them with HCPCS code G2025. Modifier 95 may be appended but it is not required****. (See https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/fqhc-ppsspecific-payment-codes.pdf for a list of FQHC PPS specific payment codes). Beginning July 1, 2020, FQHCs will only be required to submit G2025. Modifier 95 may be appended but it is not required.*

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[7] Adapted from CMS Telemedicine Health Care Provider Fact Sheet https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

[8] Coronavirus Aid, Relief, and Economic Security (CARES) Act. Signed into law on March 27, 2020. Accessible at: https://www.congress.gov/bill/116th-congress/house-bill/748/text

[9] Note: in this section, we will use the term "FQHC" as that is the term used to describe both federally funded health centers and lookalikes in the Medicare and Medicaid program.

[10] For more specifics on the "how to," including a list of the eligible codes and the appropriate way to code these services, please see the MLN Matters article: https://www.cms.gov/files/document/se20016.pdf

Sample Claims Forms

For January 27 to June 30, 2020

Revenue Code	HCPCS Code	Modifier
052X	G0467(or other appropriate FQHC Specific payment code	N/A
052X	99214 (Or other FQHC Qualifying visit code)	95
052X	G2025	95

For July 1 to the end of PHE

Revenue Code	HCPCS Code	Modifier
052X	G2025	95 Optional

Reimbursement for Audio Only Services: On April 30, 2020, CMS released a COVID related interim final rule, which included some important changes for health centers and additional detail on the billing and coding issues for the FQHC distant site provision. Retroactive to March 1, 2020 and through the duration of the PHE, FQHCs are able to provide audio only services to their Medicare patients. These services will be reimbursed at the same rate as distant site services, **$92.03**.

Virtual Check-ins: Since 2019, FQHCs have been able to provide "virtual check-ins" which are patient initiated calls into a provider. For the duration of the emergency, CMS has also added "evisits," communications that are initiated through an online patient portal. These services are "patient initiated" but CMS notes that providers may educate their patients about these options in advance of providing the services. Additionally, for virtual check-ins, CMS has waived the need to seek beneficiary consent prior to the service and has said that it can be obtained during the initial visit. The rate for virtual check-ins and e-visits is **$24.76** from March 1, 2020 through the duration of the emergency.[11]

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[11] More information on these and other expanded flexibilities for health centers can be found on the MLN resource here: https://www.cms.gov/files/document/se20016.pdf

	Summary of Medicare Telemedicine Services[12]		
Type of Service	**What is the Service**	**HCPCS/CPT Code**	**Patient Relationship with Provider**
Medicare Telehealth Visits	A visit with a provider that uses telecommunication systems between a provider and a patient	Common telehealth services include: • 99201-99215 (office or other outpatient visits) • G0425-G0427 (telehealth consultations, emergency department or initial inpatient) • G0406-G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new* or established patients. *To the extent the 1135 waiver requires and established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this PHE.
Virtual Check-in	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	• HCPCS code G2012 • HCPCS code G2010	For established patients.
E-Visits	A communication between a patient and their provider through an online patient portal	• 99421 • 99422 • 99423 • G2061 • G2062 • G2063	For established patients.

You can find the latest information on the CMS FQHC website, above linked under Additional Information and Resources.

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[12] Adapted from CMS Telemedicine Health Care Provider Fact Sheet https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Medicaid

Medicaid is jointly funded by states and the federal government. As such, states have significant flexibility in crafting their telemedicine policies, as long as they align with certain federal requirements. States have implemented a variety of telemedicine policies, by either adopting policies similar to Medicare or using state governmental authority to expand policies to allow for the use of telemedicine at FQHCs. Prior to the COVID pandemic, 38 states allow Medicaid reimbursement for health centers serving as distant sites.

CMS has encouraged states to use telemedicine, noting that it will work with states to expedite any needed policy changes[13]. The Center for Connected Health Policy maintains an [updated list](#)[14] of state actions related to telemedicine that should include any added audio-only components in addition to Medicaid telemedicine decisions.

The Uninsured

A portion of CARES Act funding has been designated to treat uninsured patients during the PHE. Any eligible provider may receive modified Medicare Physician Fee Schedule reimbursements, in addition to specific rates for testing and specimen collection.

Health care providers who have conducted COVID-19 testing or provided treatment for uninsured COVID-19 individuals on or after February 4, 2020 can request claims reimbursement through the program electronically. Steps will involve: enrolling as a provider participant, checking patient eligibility, submitting patient information, submitting claims, and receiving payment via direct deposit.[15]

To accommodate the added support for uninsured patients, sliding fee scale policies may need revision. This is due to funding requirements that no patient cost-sharing is permitted. Health center boards should authorize the management to establish an emergency policy and procedure and/or amend existing policies and procedures (as well as related forms), effective immediately through the length of the COVID-19 public health emergency, under which the health center may take the following actions in connection with COVID-19 testing and testing-related treatment services:

- Slide all charges to $0 for patients earning annual incomes at or below 100% of the Federal Poverty Level (FPL); and
- Waive/reduce fees to $0 for all patients earning annual incomes above 100% of the FPL.

Commercial Insurance

During the COVID-19 emergency, many commercial plans (e.g., Blue Cross Blue Shield, UnitedHealth Care, Aetna, etc.) are following Medicare's expanded policies expanding originating site definitions and permitting use of outpatient E&M code payment via telehealth.

NOTE: Each health center is encouraged to obtain written affirmation from state Medicaid and commercial payers.

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[13] http://www.nachc.org/coronavirus/covid-19-faqs/#telehealth
[14] https://www.cchpca.org/resources/covid-19-related-state-actions

[15] Uninsured claims reimbursement program information, including a link to the claims portal can be found at: https://www.hrsa.gov/coviduninsuredclaim.

HIPAA and Telemedicine

On March 17, 2020, HHS announced that "healthcare providers may use Skype, FaceTime, Zoom, Doxy.me, Updox, VSee, Google G Suite Hangouts Meet, and similar technologies for real-time audio/video communications with their patients, without fear that OCR [Office of Civil Rights] might levy a penalty," according to Jeffery P. Drummond, a partner with the Jackson Walker law firm. Normally, under HIPAA, the use of these platforms was restricted because they lack stringent security protections.[16] If a HIPAA-compliant telehealth product is currently being used by a health center, by all means continue using it. These other options exist in this time of extreme need under the current PHE. [17]

More information on HIPAA compliance with telework arrangements can be found in the NACHC policy memorandum, available here.

Notifying Patients of Telemedicine Service Availability

Below are some suggested processes for notifying patients regarding the availability of telemedicine:
- Triage incoming requests through call center.
- Contract with or expand internal staff around "nurse" line to answer questions and assist with triage.
- Send outbound messages via call center to "at risk" patients (e.g., patients with uncontrolled diabetes, hypertension, asthma, COPD, etc.).
- Mass/broad-based distribution to all patients via text, phone, patient portal, postcard, or CHC website regarding access to "virtual care."
- Update all social media and marketing platforms to promote access to "virtual care."
- Promote availability through local DOH or government health officials.

Necessary Equipment

Providers and support staff may require certain equipment to successfully manage practicalities of telemedicine:
- Providers: May need smart-phone, laptop, and Wi-Fi access. As able, securing communication via VPN or other HIPAA compliant process is strongly encouraged.
- Execute internal "letter of confidentiality" for employees discussing not only reminding them of typical protections around PHI but elevated scrutiny when working from home where non-employees may have access to PHI. Remind all staff that everyone is on a "need to know" basis following tenets of "minimum necessary info."

Evaluation & Management (E&M) Documentations of Services Rendered

Since new and established outpatient Evaluation and Management (E&M) services (i.e., 99201-99205 and 99212-99215) are reimbursed when rendered via telehealth,[18] remember that documentation must also follow current E&M guidelines.
- If providers use an electronic health/medical record (EHR/EMR) template, this should be sufficient.
- If handwritten or other "free form" E&M documentation is happening, providers are encouraged to follow the traditional **SOAP** (**S**ubjective, **O**bjective, **A**ssessment, and **P**lan) documentation protocols.

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[16] https://www.jw.com/news/jeff-drummond-hipaa-enforcement-patient-telehealth-services/

[17] This article provides more information: https://mhealthintelligence.com/news/ocr-gives-providers-more-leeway-to-use-mhealth-telehealth-tools

[18] https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet; Second "Key Take Away" after first section.

- Lastly, remember to document the modality of communication; i.e., EHR-recommended app, FaceTime, Skype, Zoom, etc.

Since many currently deployed EHR systems have an integrated application, it is recommended that health centers encourage patients to use those tools wherever possible. In this way, patients and providers will gain familiarity and comfort with a seamless platform that will continue to be useful long after the end of the PHE, and more common commercial applications are no longer permitted under HIPAA.

Telemedicine Requirements for health centers with Residency Programs & Operating Under the Residency Program's "Primary Care Exception"

Effective immediately, the American College of Graduate Medical Education (ACGME) will permit residents and fellows to participate in the use of telemedicine to care for patients affected by the pandemic.[19] The definition of Direct Supervision as part of these new telemedicine requirements includes the following: "the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology."[12] Billing for resident services for telemedicine is permissible, however the supervisory guidelines from the ACGME need to be followed. [13] In no situation will a program be penalized retroactively for appropriate engagement of residents and fellows with appropriate supervision in the use of telemedicine during this crisis. [13]

Temporary Sites Covered under the Federal Tort Claims Act

In emergency situations such as the COVID-19 pandemic, FTCA coverage extends to temporary locations.[20] HRSA approval is not required for the provision of in-scope health center services at locations already within the approved scope of project. Although not an exhaustive list, common temporary sites falling under the scope of this coverage include:

- "An approved health center service site (on Form 5B), including the addition of any modular units or trailers on the grounds of the 5B site;
- Mobile units (on Form 5B), including driving mobile units to additional locations in the health center's service area;
- Home visits (on Form 5C) to health center patients, including visiting health center patients in assisted living facilities and nursing homes;
- Portable clinical care (on Form 5C), where health center staff conduct clinical care outside of health center sites (for example, conducting screenings and consultations in a parking lot, on the street to individuals experiencing homelessness)."
- Other temporary sites not covered under this scope require approval from HRSA. For temporary sites operating within the health center's service area or adjacent to it, submissions must be made within 15 days from the onset of initiating emergency response activities. For temporary sites operating outside the health center's service area, prior approval is required.[21]
- To ensure coverage by the FTCA and meet HRSA requirements, health centers must submit a request for a change in the scope of project if they expect the temporary location to last more than 90 days.

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[19] https://acgme.org/Newsroom/Newsroom-Details/ArticleID/10111/ACGME-Response-to-the-Coronavirus-COVID-19
[20] https://bphc.hrsa.gov/emergency-response/coronavirus-frequently-asked-questions.html#sites
[21] https://www.nachc.org/wp-content/uploads/2020/03/NACHC-Coronavirus-FAQs-03.16.2020-1.pdf

State Law and Scope of Practice Limitations

Traditionally, telemedicine requirements limit providers to only treating patients who are physically located in the same state, but for the duration of the current PHE, CMS has temporarily waived this restriction under its 1135 authorities.[22] While federal restrictions are temporarily suspended, health centers are strongly encouraged to contact state licensing boards and/or insurance commissioner offices (in their state and surrounding/contiguous states where their patients may be) to assure this waiver applies to Medicaid and commercial payers under any applicable state's jurisdiction or rules of reciprocity.

In addition, it is important to be mindful that a provider's scope of practice requirements vary state to state. Issuing a prescription, physician oversight of NP/PA and other clinicians, facility admission decisions, and many other requirements may vary greatly from one state to the next. The American Association of Nurse Practitioners provides an interactive map for its members to learn more about these state variations in scope of practice.[23]

Taking care of patients in this time of need is essential, but ensuring that a health center continues to operate within legal parameters is also critical. Health centers should seek advice from retained legal counsel if there are any questions or doubts on their providers' allowable scopes of practice or other state licensure considerations.

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[22] https://www.ama-assn.org/delivering-care/public-health/key-changes-made-telehealth-guidelines-boost-covid-19-car
[23] https://www.aanp.org/advocacy/state/state-practice-environment

2. Operationalizing Telemedicine and Telephonic Visits

(Revision date: 30-April 2020)

Purpose and Scope

This part of the Resource Packet is a guide for healthcare providers and organizations who are starting or revising their telemedicine or telephonic visit protocols. This part contains tools, advice, workflows, and other best practices from health centers across the country as well as visit redesign concepts developed by Coleman Associates, a clinic operations consultation firm actively working with health centers around the country. Knowing that health centers continue to be important for patients seeking routine or acute care outside of COVID-19 evaluation, this part has a special focus on the operational components of telehealth and telephonic visits for those patients as well. This guide is NOT intended to be a billing guide for health centers. We have linked to additional resources to serve as examples as you make your telemedicine and virtual processes work for your patients and staff.

As we all know, these processes are changing rapidly. Please keep checking back to NACHC for updated information at www.nachc.org.

Starter Steps

1
- Know the laws and ethical practices for your state and health care specialty.
- Be sure to know what consents you need for treatment.
- Decide how you will obtain updated or new consent to treat. (Virtually or have the patient come by and fill out the information on a tablet in the parking lot).
- Be sure to comply with state guidelines regarding telemedicine and telephonic visits. State guidelines can be found here.

2
- Decide on a platform to deliver for your telemedicine services.
- Consider a web-based platform for telehealth services. See Software for Telemedicine below for illustrative options.
- Check with your state's PCA or with an HCCN to see if there are group discounts available when purchasing or leasing software as part of a bigger network.

3
- Decide how you will schedule your telemedicine patients.
- Most health centers are using their practice management system in their EHR. Be sure to pick the appropriate "schedule code" to identify the visit as telehealth versus in-person (often found under the encounter code).
- Make sure to educate staff and providers about how to schedule and read the schedule.

4
- Decide how you will register your patients, verify eligibility, correct co-pays or sliding scale payments, and bill for services.
- For patients paying out-of-pocket, investigate software that enables mobile fee collection or consider looking at telemedicine platforms that havew built-in payment.
- Each health center is encouraged to obtain confirmation of payers regarding requirements for billable, virtual services (e.g, date of last visit, originating site, established vs. new, etc.).
- Continue verifying eligibility and properly identify how to codew/bill for virtual visits. If you do this the day before or morning of a visit, you still have time to call patients who have insurance eligibility problems before their visits.

5
- Write and distribute scripting for scheduling medicine visits to Call Center and Front Desk staff.
- See the included scripting below for scheduling, confirming, and rescheduling telehealth visits.

6
- Set up providers and staff to deliver care virtually, wither from home or from the clinic.
- Regardless of where staff and providers are working (in the clinic or at home) confirm that they have: Adequate Internet speed, good phone service, a HIPAA-compliant work space, and access to the EHR for documentation.
- Execute internal "letter of confidentiality" for employees discussing not only typical protections around Protected Health Information (PHI), but elevated scrutiny when working from home where non-employees may have access to PHI. Remind all staff that everyone is on a "need to know" basis following tenets of "minimum necessary information."

Sometimes this decision has to do mainly with equipment costs, set-up and the financial ability to purchase or lease a telemedicine platform. Other times this decision is based on state reimbursement for telephone versus virtual visits. We are finding that virtual visits pay at a much higher rate than telephonic. Consider doing a cost/benefit analysis to see if the higher rate reimbursement for telehealth visits as opposed to telephonic would cover the monthly cost of purchasing a telehealth platform like Doxy or Updox.

Follow this link for coding advice for Medicare. State policies are updated regularly here.

Consider using backdoors for staff to enter who will only be conducting virtual or telephonic visits away from symptomatic COVID-19 patients. A separate entrance reduces exposure and saves Personal Protective Equipment.

Software for Telemedicine

Before choosing a platform for conducting telemedicine visits, see the current guidance from HHS patient privacy compliance and telemedicine.[24]

The following is a quote from HHS:

"Under this Notice, covered health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, or Skype, to provide telehealth without risk that the Office of Civil Rights (OCR) might seek to impose a penalty for noncompliance with the HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide PHE. Providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications."

The following table is a visual representation of current HHS guidance.[25]

🚫 Do Not Use for Telemedicine 🚫	⚠ Currently Permissible for Telemedicine ⚠	✔ More Secure Options ✔
• Facebook Live • Twitch • TikTok	• Apple FaceTime • Facebook Messenger Video Chat • Google Hangouts Video • Zoom • Skype	• EHR-related apps • Skype for Business / Microsoft Teams • Updox • VSee • Zoom for Healthcare • Doxy.me • Google G Suite Hangouts Meet • Cisco Webex Meetings / Webex Teams • Amazon Chime • GoToMeeting • Spruce Health Care Messenger

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[24] See https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

[25] Adapted from "Telehealth: Using Non-Traditional Technology for Telehealth during COVID 19 Pandemic" Accessible at: https://cdn1.digitellinc.com/uploads/nachc/articles/1cfd902037279f587602f5827416b4d9.pdf

Communication with Patients

This is a sample flyer to address patient FAQs. Feel free to adapt this for your organization's website, patient portal, waiting room, or bathroom signage. Yellow highlights indicate where you can tailor these for your health center.

FREQUENTLY ASKED QUESTIONS ABOUT TELEHEALTH AND TELEPHONE VISITS

1. What is telemedicine?

Telemedicine is the use of digital information and communication technologies, like computers, tablets, and smartphones to access and manage your health care away from your provider's office. These may be technologies that you use from home or that your provider uses to improve or support care services.

2. Why use telemedicine for a video visit with my healthcare provider?

Safe. Easy. Convenient. Confidential.

3. Who can be scheduled for a telemedicine visit?

Any [organization name] patient who has a smartphone, tablet, computer, or laptop with audio and video capabilities and stable internet connection. Not all of your healthcare visits are appropriate for telemedicine. Your clinic can help you schedule the best type of appointment for your healthcare needs. Call [phone number] for help with scheduling.

4. How much does telemedicine cost?

There is no additional fee for a telemedicine visit versus and in-person visit. We work with your insurance to get these visits covered. If you are self-pay you will be put on a sliding scale. [Insert organization specific information]

How to Schedule a Telemedicine Visit with Your Provider

STEP 1: Schedule a telemedicine appointment by calling your clinic to request a telehealth or telephonic visit from the comfort of your own home.

STEP 2: If you are using a laptop or computer with audio and video, you are good to go! If you are using a smartphone or tablet, download [insert software]. [No need to creat an account.]

STEP 3: Once you schedule your appointment, you will receive an [insert email, text, or call] from us. Click the link when it's time to start your telehealth cisit with your provider. [Update instructions as needed]

What to do if you're disconnected?
Simply click/tap the "REJOIN" button to connect with your health care provider. If you are having issues connecting, your provider will call you. Be sure to give the clinic the **best phone number** to reach you!

Other Methods to Notify Patients of Telemedicine Availability

- Via phone triage and requests made to the call center.
- Via outbound messages to "at risk" patients (e.g., asthma, COPD as well as other chronic diseases such as HIV, uncontrolled diabetes, hypertension, etc.).
- Via large-scale message distribution to all patients (e.g., text, phone, patient portal, postcard, letters, or health center website regarding access to "virtual care.")
- Via your Department of Health or other community partners.
- Update all social media and marketing platforms to promote access to "virtual care."

3. Clinical Workflow Toolkit

(Revision date: 30-April 2020)

Scripting for Scheduling Telemedicine /Telephonic Visits

"In response to the coronavirus epidemic, we are limiting our in-person visits. Your health is important to us, and we want to limit your exposure. A telephone/video appointment ensures the quality of care you will receive. We will be able to review any labs, diagnostic imaging, specialty reports, as well as send medications to the pharmacy."
We would love to schedule a [insert type of virtual visit] for all our patients.
Can we offer you a virtual/telephone visit on _____(day) between [give patients a window of 10-20 minutes]?
"Please be sure your phone is on and with you. When we call, you will see [xxx-xxx-xxxx. Insert number that will display]."

What will be the reason for the visit? _____ (Document the medical need).
Currently, we recommend screening to determine whether your patients are experiencing any respiratory or COVID-like symptoms. If they are experiencing symptoms, consider other options your organization may be offering the patient, such as drive-thru/walk-up testing at an alternate facility. Or - you may be able to start with this telehealth visit to screen whether or not an in-person visit is necessary.
We are excited to offer this new service. You will receive a second call by a member of our team to check you in for your visit on _____ (include day and time.) Be sure to have your insurance information handy then. Can you verify the best phone number where we can call/text you? Is there a particular app or video tool you would like to use for the visit?
During your call with your provider, be sure to have your medications available."

Script for Robust Confirmation Call for Telehealth/Telephonic Visits

"Hello, this is _____ (employee's name) from [insert organization name], calling to confirm your appointment for tomorrow at _____(time). Does that time still work for you?
Your provider, _____ (provider name) will be conducting a [telephone consultation/ virtual visit]. Your provider thinks it's safer to do a virtual visit than to have you come into the clinic.
I'd like to make sure we verify your insurance eligibility now. Is your insurance still _____ (insurance type)? There will be a $_____ copay for this visit. You will receive [a link to pay that through your cell phone].
On _____ (day), you will receive [insert if they should expect a call, texted link, etc.]. Can you please verify your cell phone number by reading it back to me? [Check to confirm phone # is the same as what is on record. If necessary, verify the email address in the same manner].

Script for Rescheduling Office Visit to Telehealth/Telephonic Visits

For health centers moving all their office visits to virtual visits, develop a script for support staff, so they have language around messaging. Here is a sample script:
- "Hello, this is _____ (Employee's Name), calling from [insert organization name]. I work with _____ (Provider's Name). We know you have an appointment on _____ at _____ and we also know patients are concerned about the spread of the Coronavirus. First, we want to assure you that we are doing everything we can to protect your health as well as the health of our community. With this consideration, we are changing all our office visits [or in-person visits] to telephone or video appointments. This change reduces your chances of exposure as well as the spread in the community. A telephone/video appointment ensures the quality of care you will receive. We will be able to review any labs, diagnostic imaging, specialty reports, as well as send medications to the pharmacy."
- **Pause for questions.**

- "What this means is that your appointment day and time will remain the same, but instead of coming into the office, we would reach out to you at home instead. Can I move forward with scheduling your telephone/video appointment?"
  - **If the patient says YES to the telephone/video appointment:**
    - "Thank you. We appreciate your understanding. Again, your appointment is on _____ at_____. _____ (Provider Name) will call you between ____ and _____ [insert organization's window from 10-20 minutes]. "Please be sure your phone is on and with you. When we call, you will see [insert number that will display]."
    - **Ask for any final questions before hanging up.**
  - **If the patient says NO to the telephone/video appointment and insists on coming in for the office visit:**
    - "I understand you would prefer to come in for your visit. I will need to speak with your provider. Before I do, do you have a specific concern that you want to address in person?" Take careful notes to share with the rest of the Patient Care Team.
    - "Once I speak with the provider, I will give you a call back. It should be in less than ___ hours. [insert your expected call back time]."

Follow your organization's policy for leaving voicemails for patients. Below is a sample script for leaving a voicemail.
- [Insert your organization's policy for rebooking the patient appointment into a telephone/ video appointment for the same date and time and notifying the patient via voicemail of the change].
- "Hello, this is _____ (name), calling from [insert organization name]. I work with _____ (provider's name). We know you have an appointment on _____ at _____. We are currently changing all appointments from in-person to telephone/video appointments. This change reduces your chances of exposure as well as the spread in the community. A telephone/video appointment does not interrupt the quality of care you will receive. We will still be able to review any labs, diagnostic imaging, specialty reports, as well as send medications to the pharmacy." Your new telephone/video appointment is scheduled for _____at _____ (make sure you emphasize if this is the same date and time or different). Please call us back at [insert organization phone number] to confirm you received this message, and I can give you more details."

Workflows

The following roles, terms and their definitions appear in the workflows below:

- **Patient Care Team**: The Patient Care Team is the consistent group of staff providing care to a given patient population. For example, provider, medical assistant (MA), front desk staff, etc.
- **Flow Coordinator:** In this case, the flow coordinator is managing the telehealth software to make sure that patients and staff are in the correct virtual "rooms."
- **Red Carpet**: Rather than yelling a patient's name from a partially opened doorway, in Red Carpeting, we go out to the patient, re-introduce ourselves and walk back with them. Generally, this implies walking side-by-side the patient, but during a pandemic like Coronavirus, there should be a six-foot distance between the patient and MA.
- **30-Second Report**: This is a brief but crucial verbal interaction between the MA/nurse and the provider that takes place right before the provider enters the exam room. It's the time to convey, in about 30 seconds, a rich summary of what the MA/nurse discovered during the patient intake conversation. This communication supports the clinician by decreasing the amount of time it takes to discern the patient's needs and concerns.

Health centers may wish to modify or adapt these roles to their particular needs, and depending on the particular applications of telemedicine.

Telemedicine Registration Workflow
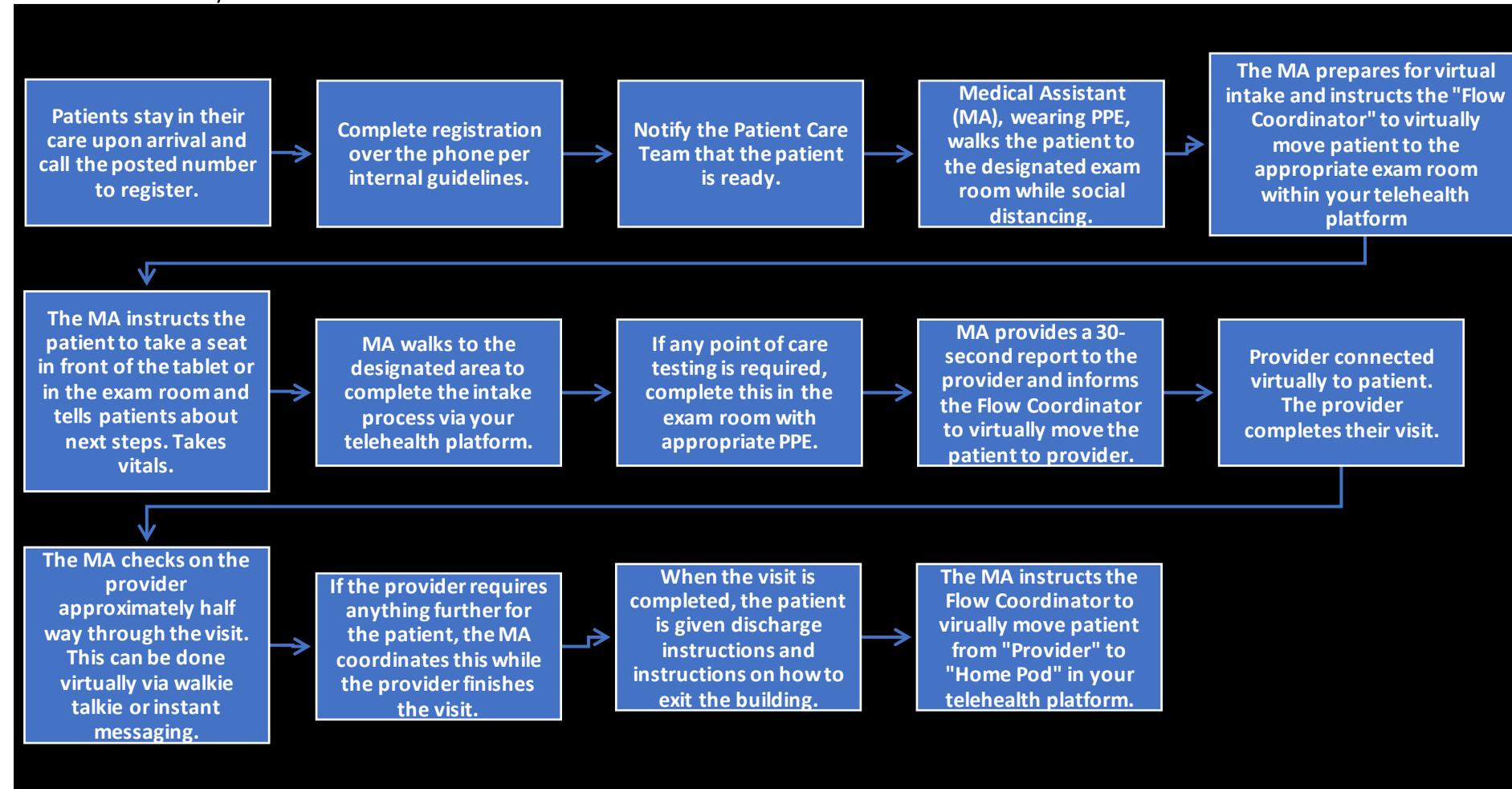

Please note that various payers, EHRs, and Payment Management Systems may differ compared to what is displayed in sample charts and tables in this document. These sample charts and tables are meant to be illustrative and are not exactly identical to what a health center might utilize based on their own systems.		
Visit Prep and Financial Prep	**Robust Confirmation Call**	**Pre-Registration**
- Complete Visit Prep before calling the patient to determine what paperwork and screenings they need. (Last Visit Date, Last Visit Reason, Quality Metrics Due, Outstanding Labs/Referrals) - Make a list of required screenings or questionnaires such as PHQ-9, GAD-7, etc. - For more information regarding the national PRAPARE process for gathering, responding and assessing social determinants of health, click here. - Verify insurance electronically before calling the patients. If the patient is on a sliding scale, determine if the patient is eligible to extend their sliding scale based on organizational policy. If the patient is not eligible for an extension, identify needed documents for the sliding scale application. - If available, send any documents the patient needs to sign electronically via your telehealth platform, the patient portal, DocuSign, etc.	- Call Patient. - Follow Script for Robust Confirmation Call for Telemedicine /Telephonic Visits with COVID-19 Screening Questions. **Ruthlessly Eliminate All Unnecessary Work** Bring all the necessary players together and get paperwork down to the bare minimum. For example, redundant screening questions, asking for the address multiple times, information you already capture verbally such as medical history.	- Get consent from the patient unless you sent the consent electronically. Many practices ask for consent verbally and document the results. Check your state regulations for what is allowed. - If you need documentation from the patient, such as income verification, ask the patient to send it virtually via secure email, patient portal, or video screen sharing as is compliant with your health center's policies and procedures. - Complete required screenings. - If a patient does not have access to any of the technology you are using, complete as much registration over the phone as possible and then set-up a "parking lot registration." Have the patient call when they arrive. Use a tablet or laptop to have them sign documents. Take pictures of any documents that you need for your records.

In-Clinic Telemedicine Work

Please note that various payers, EHRs, and Payment Management Systems may differ compared to what is displayed in sample charts and tables in this document. These sample charts and tables are meant to be illustrative and are not exactly identical to what a health center might utilize based on their own systems.
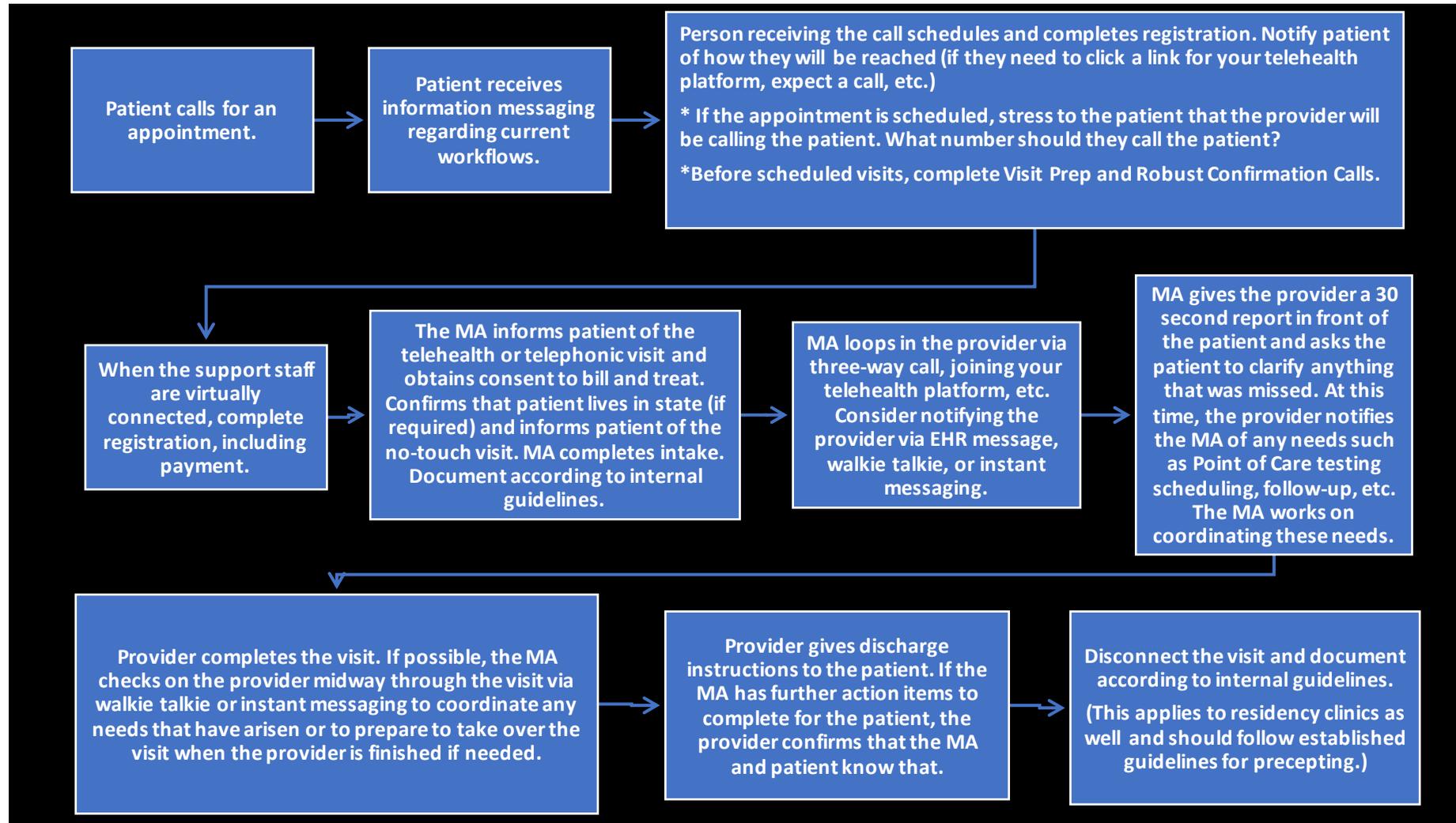
Remote Telemedicine

```
Patient calls for an
appointment.
```
→
```
Patient receives
information messaging
regarding current
workflows.
```
→
```
Person receiving the call schedules and completes registration. Notify patient
of how they will be reached (if they need to click a link for your telehealth
platform, expect a call, etc.)

* If the appointment is scheduled, stress to the patient that the provider will
be calling the patient. What number should they call the patient?

*Before scheduled visits, complete Visit Prep and Robust Confirmation Calls.
```

```
When the support staff
are virtually
connected, complete
registration, including
payment.
```
→
```
The MA informs patient of the
telehealth or telephonic visit and
obtains consent to bill and treat.
Confirms that patient lives in state (if
required) and informs patient of the
no-touch visit. MA completes intake.
Document according to internal
guidelines.
```
→
```
MA loops in the provider via
three-way call, joining your
telehealth platform, etc.
Consider notifying the
provider via EHR message,
walkie talkie, or instant
messaging.
```
→
```
MA gives the provider a 30
second report in front of
the patient and asks the
patient to clarify anything
that was missed. At this
time, the provider notifies
the MA of any needs such
as Point of Care testing
scheduling, follow-up, etc.
The MA works on
coordinating these needs.
```

```
Provider completes the visit. If possible, the MA
checks on the provider midway through the visit via
walkie talkie or instant messaging to coordinate any
needs that have arisen or to prepare to take over the
visit when the provider is finished if needed.
```
→
```
Provider gives discharge
instructions to the patient. If the
MA has further action items to
complete for the patient, the
provider confirms that the MA
and patient know that.
```
→
```
Disconnect the visit and document
according to internal guidelines.

(This applies to residency clinics as
well and should follow established
guidelines for precepting.)
```

Sample Policy and Procedure

Standard Telemedicine Policy

Policy Title: Telemedicine[26]

Purpose:
- To promote a quality telemedicine experience for the patient and provider
- To maintain the continuum of care

Policy:
- It is the policy of [insert organization name] to comply with all applicable federal, state, and local regulations governing telemedicine. These regulations and guidelines include, but may not be limited to:
- [Insert relevant regulations. A state by state guide to telemedicine regulations can be found here.]

Telemedicine services include the following:
- Established patients receiving telemedicine from a provider
- Consultation between healthcare providers
- Educational services[27]

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[26] Policies typically require Board approval. Keep it general.
[27] Adapted from the University of Nebraska Medical Center (UNMC, 2003).

(Generally, procedures do not require Board approval).

Summary
This document will review the process for documenting telemedicine visits and for providing billing and documentation guidance.

Call Center and Front Desk: Patient Call and Telemedicine Scheduling
- Call Center/Scheduler/Front Desk offers the patient a Telehealth visit if they are willing to be seen not face to face. [insert information about billing for visits]
- Create a patient appointment with details about signs and symptoms

Front Office: Telemedicine Registration from Scheduled Visits
- Complete standard registration to check-in patient appointments.
- [Insert information about Sliding Scale]
- Run eligibility as usual for patients

Provider: Telemedicine Visit Documentation
- [Insert relevant regulations. A state by state guide to telemedicine regulations can be found [here.]](link)]
- Provider to document like a routine medical visit, with the addition of the following components: [insert organization specific details]

Telemedicine Documentation Recommendations
- Documentation requirements for a telehealth service are the same as for a face-to-face encounter. Document the information of the visit, the history, review of systems, consultative notes, or any information used to make a medical decision about the patient.
- Documentation must include the services provided to the patient, to include participant consent, participant outcomes, and telehealth delivery of services.
- Document the patient's location, nature and modality of telehealth communication, and the time spent in discussion with the patient.

Sample Informed Consent for Telemedicine[28]

Patient Name:	Date of Birth:	Medical Record #:
Location of Patient:	Provider Name and Location:	Date Consent Discussed:

Introduction

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information to improve patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include, but is not limited to, any of the following:
- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data. They will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. Expected Benefits:
- Improved access to medical care by enabling a patient to remain in his/her provider's office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks

As with any medical procedure, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:
- 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 and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

By signing this form, I understand the following:
- I understand that the laws that protect the privacy and the confidentiality of medical information also apply to telehealth and that no information obtained in the use of telemedicine, which identifies me will be disclosed to researchers or other entities without my consent.
- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
- I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.

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[28] This is to only serve as an example of a possible Informed Consent for Telehealth. NACHC, its contractors and employees assume no liability, legal or otherwise, for the use of this document in professional practice.

- I understand that a variety of alternative methods of medical care may be available to me and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.
- I understand that telehealth may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
- I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.
- I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

Patient Consent to The Use of Telemedicine

I have read and understood the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize _____ (Provider Name) to use telemedicine in the course of my diagnosis and treatment.

Sample Cost-Benefit Analysis for Telemedicine Platforms

Complete the following table with the payers in your organization's mix and their fee scales.

Payer Name	Column A % of Payer Mix	Column B Telehealth (Video)	Column C Telephone-Only	Column D Telehealth (Video) (Multiply Column A x Column B)	Column E Telephone-Only (Multiply Column A x Column C)
		Reimbursement Rates		Weighted Reimbursement Rates	

Use the following worksheet to compare the costs and benefits of investing in a telemedicine platform. For guidance regarding state-specific telehealth guidelines and reimbursement, [click here.](#)

Average # of Telehealth/Telephonic visits per day_____ **(A)** Your Weighted Average Telehealth Reimbursement Rate (Add up Column D) _____ **(B)** Your Weighted Average Telephonic Reimbursement Rate (Add up Column E) _____ **(C)** *Cost per day to provide Telehealth Software _____ **(D)***
Multiply (A) _____x ((B) _____= **(E)** _____ This is your anticipated daily revenue from telehealth visits.
Multiply (A) _____x (C) _____= **(F)** _____ This is your anticipated daily revenue from telephonic visits.
(E) _____ - (D) _____= **(G)** _____ This is your anticipated revenue for telehealth visits minus the cost of software. If this number is negative, investing in telehealth software is likely too expensive, unless you are eligible for grant funds to offset some costs.

If (G) is a positive number,
(G) _____- (F) _____= **(H)** _____
If (H) is a positive number, telehealth software is likely a good investment. If (H) is a negative number, investing in telehealth software is likely too expensive.

(D)* - *Monthly cost of telehealth services / # of days in a month.*
For example: $1000 per month for software + $400 per month for High Speed Wifi + $150 per month for laptop leasing = $1550/ 20 days = $77.50 per day.
Disclaimer: This assumes monthly subscription commitments for costs versus an annual commitment.
During the COVID-19 emergency, states are looking at their policies and their flexibility to provide telehealth services.

For state specific questions on how your state can improve this policy, please contact your Primary Care Association or NACHC at state@nachc.org.

NOTE: Each health center is encouraged to obtain written affirmation from state Medicaid and commercial payers in this regard.

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Health centers are responsible for determining appropriate, tailored operations suitable for their organization, staff, patients and community. Health centers should refer to applicable State, Local and Organizational regulations in consultation with local general counsel.

Inquiries about this document can be directed to telehealth@nachc.org