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Introduction

Computers, smartphones and mobile devices increasingly offer new and potentially effective channels for delivering healthcare services. However, as telecommunications has revolutionized society, have healthcare organizations kept pace with the ability to offer telehealth services?

More than 40% of medical groups stated they are or are planning to offer telehealth services this year, while another 20% had not yet decided, according to a Jan. 9, 2018 MGMA Stat poll. Check out the results from the 2017 and 2018 MGMA Stat polls.

Healthcare organizations that have adopted telehealth services have touted the relative ease of getting their patients to understand and accept telehealth. For some patients, these services can be as easy to use as the video-call features, such as FaceTime or Skype, on their phones or home computers.

70% That has prompted many practices to rethink the care delivery process. In recent years, researchers have noted that approximately 70% of all patient visits do not require face-to-face interaction and could be done safely via virtual encounter.

The benefits of telehealth — boosting access to physicians, lowering costs for the practice and payers, and adding convenience for the patient — all make sense for medical practices shifting to value-based care only if the services can be implemented, maintained and reimbursed sustainably.

This report outlines numerous models that can help medical practices plan, implement and operate telehealth services. Understanding the drivers of telehealth services, as well as the operating requirements, and billing and reimbursement guidelines will help ensure successful adoption of the services.

Equally important, however, is understanding how healthcare consumers embrace telehealth services. According to a recent American Well/Harris Poll survey, nearly two-thirds of patients would like their primary care provider (PCP) to offer telehealth, and one out of five consumers said they would switch providers to one that offers video visits.

MGMA Data Solutions has conducted new surveys and qualitative interviews to identify why many practices add telehealth services. We also explored how the expectations of doing so were met or shifted once operationalized, and how leaders navigated the staffing, technological and financial realities.
Defining telehealth and telemedicine

The terms “telehealth” and “telemedicine” are often used interchangeably, yet they are distinct areas of focus.

| Telehealth, as defined by the U.S. Department of Health and Human Services (HHS), is the use of electronic information and telecommunications technologies to support and promote long-distance clinical healthcare, patient and professional health-related education, public health and health administration. | Telemedicine, as defined by the American Telemedicine Association (ATA), is the remote delivery of healthcare services and clinical information using telecommunications technology, that is, using internet, wireless, satellite and telephone media. |

Many organizations, including the ATA, treat these terms interchangeably. However, definitions can vary from state to state with some arguing that “telehealth” has a broader definition related to the medium, while “telemedicine” has a narrower definition of the actual delivery of care. A growing number of healthcare organizations make distinctions between the terms. Telehealth has a broader definition related to the medium, while telemedicine has a narrower definition of the actual delivery of care.
Within the realm of telehealth services, there are many ways to transmit information:

**Synchronous, live video** (also referred to as real-time) is a two-way audiovisual exchange between a provider and another person who may be a patient, a caregiver or another provider. Encounters may include a remote provider interacting directly with a patient being cared for by another provider in the room; a provider and a patient connecting with a remote specialist via live video during a patient visit; or a home caregiver and a patient connecting with a provider, either in the provider’s office or from a home telehealth office.

<table>
<thead>
<tr>
<th>EXAMPLES</th>
<th>PROVIDER AT HOME</th>
<th>PROVIDER IN OFFICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT IN OFFICE</td>
<td>Telepsychiatrist conducting medication management visits with a patient in a local office</td>
<td>Specialist conferencing with a patient and her PCP during an office visit</td>
</tr>
<tr>
<td>PATIENT AT HOME</td>
<td>Urgent care physician conferencing with a mother about her toddler’s pinkeye</td>
<td>PCP advising a patient about a chronic condition</td>
</tr>
</tbody>
</table>

Synchronous, live video typically falls under one of three pillars:

- Consumer telehealth: on-demand urgent care
- Patient telehealth: scheduled follow-up visits with existing patients
- Provider to provider: bedside specialty consults, typically using telemedicine carts

**Asynchronous/store-and-forward services** involves the secure, electronic communication of recorded health information for a provider to review outside of a real-time visit. This is commonly used for health history, such as x-rays or photos, that may be sent to a specialist for a patient in a rural area with limited access to specialty physicians.

**Remote patient monitoring (RPM)** uses technologies to collect medical and other health data from patients outside the care facility and then transmit that data to either a provider’s office or data processor for later use in care. Common types of health data collected via RPM include blood sugar results and various vital signs such as heart rate.

**Mobile health (mHealth)** typically involves healthcare and health education transmitted via cellphone, tablet or other mobile device, such as sending text reminders for a medication regimen, enhancing EMS care via GPS-enabled devices, or offering wayfinding to a nearby healthcare facility.
In the 2017 MGMA Telehealth Survey, which was conducted nationwide from Nov. 2 to 10, 2017 with a total of 131 respondents, 31% of practice leaders said their organizations currently offer telehealth services compared to 41% who said they do not. Another 24% said they plan offer services in the future.

When asked to identify the driving forces behind implementation, practice leaders said adding telehealth services was prompted by:

- Wider geographical coverage: 53%
- Patient satisfaction: 49%
- Access to specialists: 40%
- Additional revenue source: 39%
- Patient demand: 36%
- Value-based medicine: 36%
- Physician engagement: 18%
- Other: 10%

Offered multiple choices as to where payments for telehealth visits come from, practice leaders said:

- Commercial payers: 44%
- Self pay: 41%
- Medicare: 36%
- Medicaid: 33%
- Other*: 21%

* Respondents who indicated “other” largely noted that they receive no payment at the time of the survey. Not being reimbursed is an issue for many practice leaders, as 29% of those surveyed said that 25% or less of their organization’s telehealth consultations are reimbursed, while only 22% said that 76% or greater of their consultations are reimbursed. Another 32% were unsure as to how much of their consultations are reimbursed.
Patient satisfaction and new revenue source are the top return on investment (ROI) drivers for implementing telehealth services, according to respondents.

Practice leaders who said their organizations have not added telehealth services largely pointed to not knowing how to get paid for the services as the primary reason.

Reasons healthcare organizations do not offer telehealth services:

Patient satisfaction and new revenue source are the top return on investment (ROI) drivers for implementing telehealth services, according to respondents.

Anticipated ROI with telehealth services:
“It’s common for providers to feel some hesitancy before trying telehealth for the first time, but usually within a few sessions they love it. Telehealth can increase provider satisfaction through increased convenience, increased flexibility, reduced travel, more time in their day, better control over schedule, and more options for managing no-show time. It’s also usually much easier than they anticipated.”

— Rachel Dixon, Director of Telehealth, AccessCare, Denver, Colorado

After implementation, practices typically see a higher than expected ROI in the areas of patient retention and access to specialists than new revenue, including patient retention:

**ROI with telehealth services:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient satisfaction</td>
<td>74%</td>
</tr>
<tr>
<td>Patient retention</td>
<td>55%</td>
</tr>
<tr>
<td>Rural coverage</td>
<td>48%</td>
</tr>
<tr>
<td>Access to specialists</td>
<td>45%</td>
</tr>
<tr>
<td>Enhanced branding</td>
<td>40%</td>
</tr>
<tr>
<td>Supporting value-based initiative(s)</td>
<td>35%</td>
</tr>
<tr>
<td>New rev</td>
<td>30%</td>
</tr>
<tr>
<td>Provider satisfaction</td>
<td>25%</td>
</tr>
<tr>
<td>Other</td>
<td>10%</td>
</tr>
<tr>
<td>No ROI</td>
<td>8%</td>
</tr>
</tbody>
</table>

**Nick Hernandez from MGMA Member Community post:**

“Regardless of the setting (urgent care, pediatric, etc.), there are many steps to entertain before worrying about technology — from legal requirements to billing opportunities within your state and your patient catchment area, to what strategic goals you are trying to accomplish. One thing to keep in mind is that there is no such thing as a standard telemedicine model because implementation will vary significantly based on all the above (unlike a ‘normal’ EMR implementation).

There are ways to get paid even if getting reimbursed is not an option. Depending on what you are trying to accomplish, you may want to consider those. Lastly, you do NOT necessarily need to invest in technology. There are free options out there and some that are being integrated into EHRs.”
RESOURCES: TELEHEALTH BACKGROUND AND OVERVIEW

American Well Telehealth Index: 2017 Consumer Survey
Consumers want to see their own primary care physician (PCP) via video. Of those that have a PCP, 65% were very or somewhat interested in seeing their PCP over video. ... If their PCP does not offer video visits, 20% of consumers would switch to a PCP who offered video visits. Willingness to switch doctors to get video visits rises to 26% in 18- to 34-year-olds and 34% for parents of children under 18.

Reach Health 2017 U.S. Telemedicine Industry Benchmark Survey
Similar to 2016 findings, issues stemming from reimbursement and EMR systems pose the top impediments to telemedicine, accounting for six of the top seven challenges. Reimbursement, both government and private, poses the primary obstacle to success. Even when effective mitigation of challenges is taken into account, reimbursement continues to present the most formidable obstacles.

“How to get better value from telehealth” — HealthcareDIVE
“If you want to increase access and save money, then you need to think carefully about how to integrate a convenient alternative such as direct-to-consumer telehealth into your overall care delivery model.”

Study: Most healthcare execs consider telehealth a priority
Hospital executives are increasingly prioritizing telemedicine for delivering care services as the industry shifts from fee-for-service to value-based care. In fact, 51% of the executives and caregivers Reach Health surveyed, in fact, said telemedicine is a high priority and 36% ranked it as a medium priority. Only 13% responded that telehealth is a low priority today.

Survey shows major leap in telemedicine use over past 3 years
Three-fourths of healthcare organizations offer or plan to offer telehealth services this year, according to Foley & Lardner’s 2017 Telemedicine and Digital Health Survey.
Challenges and requirements in implementing telehealth services

HOW TELEHEALTH FITS WITHIN A PRACTICE’S MISSION

As the survey data show, adding access for patients is an important factor for practice leaders interested in telehealth services. In addition, maintaining access to quality providers is also a key consideration.

Chris Meyer, director of Marshfield Clinic Virtual Health, Marshfield, Wis., noted that a child psychologist working with Marshfield was moving out of state for family reasons. He said that this was “a huge blow” to the practice because it could take years to replace him while patients’ needs remained high. In addition, the remaining doctors already had large patient panels.

By incorporating telehealth, Marshfield was able to connect the child psychologist to the clinic’s patients from Utah, where the provider continued to deliver care.

While Marshfield initially targeted rural areas for these services, telehealth can also be utilized successfully in a city setting, though Meyer first recommends taking a step back to examine organizational missions.

“It’s not all about increasing revenues. In many cases, the work we are doing in telehealth is allowing our health system to save money by reducing risk.” — Chris Myer

“As health systems start assuming more and more risk and enter capitation models with payers, they will need to find lower-cost ways to care for patients and, more importantly, find ways to keep patients healthy to reduce unnecessary visits. Using telehealth to remotely manage a chronically ill patient may show an ROI without ever generating a single penny of reimbursement,” Myer said.

COLORADO ALLERGY & ASTHMA CENTERS, PC: BUILDING THE INFRASTRUCTURE

With 12 clinics in metro Denver, Colorado Allergy & Asthma Centers, PC, completed a merger of another Allergy practice in 2016 that was very engaged in mountain communities, the physician would travel to the mountain communities weekly. John Milewski, MHA, FACMPE, chief operating officer, saw an opportunity to expand to a patient population in the Rocky Mountains near Frisco, Colo.

A Rocky Mountain hospital system had started a telehealth program, which spurred Milewski’s organization to consider a similar program to boost patient outreach in the mountains without sacrificing providers’ time traveling to and from the hospital.

Information technology (IT) challenges: While the partner hospitals brought in computers and hardware as part of their shared expenses in the collaboration, bringing in new data lines to handle the secure transmission of the patient health data posed a serious challenge, Milewski said. That step took about six months as they also worked out scheduling and patient communication workflows.
Security and compliance: Before considering how to implement telehealth services, healthcare organizations should review state-specific regulations about the requirements of an established physician-patient relationship. While all states now allow for the physician-patient relationship to be established via a telehealth service (effectively allowing providers to see new patients remotely), many regulations must be adhered to based on varying standards of care, including verification of patient identity, performance of an appropriate exam before establishing a diagnosis, or other evidence-based standards of practice.

The Center for Connected Health Policy (CCHP) in Sacramento maintains an up-to-date, searchable database of current telehealth laws and policies, as well as pending legislation and regulations. Information is available for each state and the District of Columbia.

As with all protected health information (PHI), telehealth services must comply with the HIPAA Privacy and Security regulations. To address data security during telehealth encounters, many practices have adopted encryption to ensure that no unauthorized PHI disclosure will occur during transmission or when the information is stored. Reputable telehealth providers have technology that protects against unauthorized PHI sharing.

Though telehealth services are becoming more widely available, states do not have uniform laws and regulations that determine whether patients must provide informed consent about when they receive care via telehealth services. This is particularly concerning for telehealth services that operate across state lines, in which the practice, provider and patient could each be in a different state. Among states that require informed consent, written acknowledgment is required in some states while verbal consent is sufficient in others.

When evaluating telehealth technology solutions, practices should consider the following:

- **Proprietary software**
  Vendors may offer a telehealth-specific platform to ensure optimum interoperability with a practice’s existing practice management and EHR systems. This option would likely be more expensive than software from a third party, but the integration process could be less time-consuming.

- **Custom-branded/white label solutions**
  Vendors may utilize IT infrastructures to build virtual organizations that replicate existing practice branding while operating from a vendor-run platform to connect patients to providers.

- **Security and compliance**
  While some providers use videoconferencing software such as Skype to support their telehealth visits, this software does not address security and compliance concerns. More advanced telehealth software often addresses concerns such as HIPAA compliance, patient identify verification, provider state licensure and reimbursement eligibility.

- **Licensing and credentialing expertise**
  A telehealth company that has expertise in this area can help practices navigate state licensing needs and ensure that patients only see providers who are licensed in their state.
TEN TIPS FOR IMPLEMENTING TELEHEALTH SERVICES

1. Set clear goals and tie them to your strategic plan. Telehealth works best when it is part of your program. The fewer changes that you need to make, the easier adoption will be (read more on page 21).

2. Understand your patients’ wants and needs (read an effective strategy on page 26).

3. Determine how telehealth supports your value-based care initiatives.

4. Research reimbursement and licensure options and requirements in your area.

5. Engage and educate your staff.

6. Research telehealth vendors and platforms (read our tips on page 14).

7. Reach out to colleagues in your specialty who have already adopted telehealth so you can learn from their implementation experience.

8. Discuss liability issues with your medical malpractice carrier.

9. Be patient, mindful and realistic with the timeline. It may take more than a year between idea and implementation.*

10. Include the new services in your marketing plan.

* As noted by respondents in the Jan. 9, 2018, MGMA Stat poll, on average, telehealth program implementation took about one year, with the time frame ranging from as brief as a couple of months to as long as a couple of years.
Bradley Eshbaugh, MBA, FACMPE, FACHE, FHM, former chief administrative officer, iNDIGO Health Partners, Traverse City, Mich., primarily worked in outpatient care until joining iNDIGO about eight years ago. iNDIGO, a hospital medicine group offering inpatient services only, started looking at telehealth in late 2014 to offer cost-effective night coverage within its programs across Michigan. Currently, six of the eight programs offer telehealth night coverage for the hospitals.

“The biggest driver was the cost [on night coverage] for the hospitals ... For the majority of the hospitals, there might only be two to four admissions [each night] and maybe a dozen phone calls,” Eshbaugh said. “So to have a physician on-site is much too expensive because most nocturnists are pulling $300,000-plus [annually], and you have to have two of them to cover all 365 nights. You’re talking about a $600,000 bill to provide night coverage, and most of the time, the work isn’t there for them to do on-site.”

Development and staffing: Eshbaugh said iNDIGO purchases telehealth carts from a company in Texas, which also provides related IT services. The tricky part, he said, is helping partner hospitals incorporate the carts and service into their IT systems. In addition to relying on hospital Wi-Fi and IT infrastructure, iNDIGO uses its own cellular hotspots as another backup. With that structure, the group developed telehealth pods of one physician and one physician assistant (PA) who can cover two to three hospitals, depending on call volume and the number of nightly admissions. iNDIGO sometimes provides additional staff on weekends and holidays, and during Michigan’s hunting season, when hospitals traditionally see higher admissions.

Licensing, credentialing and hiring: With physicians working from California, Florida, Kentucky, Oregon and other states, Eshbaugh said licensing is a major challenge since there is no reciprocity on licensing among states. For example, to perform a telemedicine service on a patient in California, the provider must have a medical license in California. Additionally, since physicians are hired as employees, not independent contractors, iNDIGO must set up paperwork and accounts for payroll in a number of states. Eshbaugh also noted that credentialing telehealth providers as ICU-capable is becoming more of a challenge than credentialing on-site physicians. Since many of his telehealth providers are no longer performing procedures, which is the traditional way to credential for ICU privileges, it is difficult to quantify what makes a remote telehealth internist ICU-capable. iNDIGO must work with the hospitals on different privileging criteria so the physicians can be credentialed and renew their credentials.

Patient adoption: “Surprisingly, [rollout of services] was least disruptive for the patients,” Eshbaugh said. Most of the group’s business involves older patients on Medicare. While those demographics initially were a concern, Eshbaugh said those patients “were very used to Skyping and doing FaceTime with family,” and took to the technology quickly.

At one partner facility in a rural area of Michigan’s Upper Peninsula, a nurse dealing with reluctant patients asked them if they watched “Star Trek” back in the 1960s. Most were somewhat familiar while others were outright fans. When patients said they enjoyed the show’s futuristic stories, the nurse made the connection to telehealth and told them, “You’ve just entered that age.” That really resonated with the patients, making them active and enthusiastic participants.
TIPS TO GET YOUR STAFF ON BOARD:

Adoption of telehealth services requires buy-in from physicians and other clinical staff. Adding telehealth to practice operations may alter practice workflows and require physicians to adapt to a shift in how the patient-physician relationship is established. Here are seven tips to help get your staff on board with telehealth:

1. Start conversations early with clinical staff members to get their buy-in. Consider identifying a physician champion early adopter who can show the importance of the technology to the other clinical staff.
2. Identify the value for all stakeholders (what’s in it for them?) and for the entire organization.
3. Point to the flexibility of telehealth, which may allow physicians to work remotely from their home.
4. Educate physicians on “webside” manner. (Maintain eye contact, dress professionally, etc.)
5. Provide formal training on technology and protocols to all affected staff.
6. Explain how telehealth can help with patient recruitment, engagement and retention.
7. If your compensation model allows for it, incentivize!

SOME CONSIDERATIONS WHEN CHOOSING A TELEHEALTH VENDOR:

- Customer reviews (providers and patients)
- System compliance with HIPAA and medical boards
- Type of services provided (e.g., live video visits, mobile-friendly, phone, chat, secure messaging)
- 24/7 service and tech support
- Integration with current EHR
- Integration with current practice management system
- Implementation process
- Training provided
- Customizable solutions
- Custom program design
- Implementation as part of service
- Marketing support from vendor
- Provider eligibility requirements (using providers from the practice or using providers from the vendor network)
- Real-time eligibility
- Support for insurance claims
- Integrated telehealth kiosks/carts
- Cost
The rules surrounding telehealth are changing
Recently, physicians became eligible to apply for out-of-state licensure under the Medical License Compact (“Compact”). This Compact currently applies to 18 states and 23 medical boards that have voluntarily agreed to allow a physician, with a valid medical license in one of the Compact states, to also obtain an expedited license to practice medicine in another Compact state. This does not mean, however, that having a license in one Compact state will automatically license the physician in all the other states. However, the Compact does streamline the application process and will minimize the time frame for physicians to become licensed in other states.

50-State Survey of Telemental/Telebehavioral Health (2016)
Epstein Becker Green’s 50-State Legal Survey of Telemental Health (2016) (“Survey”) is an extensive compilation of research regarding the laws, regulations, and regulatory policies impacting the practice of telemental health in all 50 states and the District of Columbia.
Billing and reimbursement

Technology, coupled with the need for improved healthcare access, has moved reimbursement for telemedicine to the forefront of issues in many practices. Virtually all payers — governmental and commercial alike — pay for some type of telemedicine services. In a recent MGMA survey, however, almost 40% of respondents stated the leading reason their organization does not offer telemedicine services is because they do not know how to get paid for it. The coverage guidelines and billing rules often vary by payer and state, making understanding reimbursement policies particularly challenging.

TELEMEDICINE AND MEDICARE

In 1997, Medicare began paying for telemedicine services for its beneficiaries in rural health professional shortage areas (HPSAs). In 2000, the Benefits Improvement and Protection Act further expanded payment for telemedicine, as well as defined the term, noting that telemedicine visits had to occur between an originating site and distant site. The changes in 2000 also included expanding coverage to nonmetropolitan statistical areas (non-MSAs) and federal demonstration program areas.

As telemedicine services coverage continues to expand, Medicare coverage is still restrictive to services that are performed using real-time communications. Exceptions include Alaska and Hawaii where “store-and-forward” technology is allowed, with the provider at the distant site and the beneficiary at the originating site.

Originating site: The location of an eligible Medicare beneficiary at the time the service furnished via a telecommunications system occurs. Medicare beneficiaries are eligible for telemedicine services only if they are presented from an originating site located in a:

- County outside of an MSA
- HPSA located in a rural census tract

Distant site: The location where the practitioner provides the telemedicine services.

Distant site practitioners: Practitioners at the distant site who may furnish telemedicine services and receive payment for covered services (subject to state law):

- Physicians
- Nurse practitioners
- Physician assistants
- Nurse-midwives
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Clinical psychologists and clinical social workers
- Registered dietitians or nutrition professionals

Medicare covers telemedicine regardless of the patient’s location in some of its newer payment models such as Next Generation ACOs (accountable care organizations) and bundled payment programs.
MEDICARE BILLING AND REIMBURSEMENT

The Centers for Medicare & Medicaid Services (CMS) created a new Place of Service (POS) code in 2017 to identify services furnished via telehealth. **With the creation of POS code 02, the use of GT modifier was determined to be redundant and is no longer be required for Medicare telehealth services effective Jan. 1, 2018.**

*For services reported on UB-04 claim forms and ASC X12 837I paper forms that do not report a POS code, continue to use the GT modifier on these claim forms.*
The reimbursement rate for telehealth services is the same rate as face-to-face services.

Medicare reimburses the originating site $18 for HCPCS code Q3014.

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201-99215</td>
<td>Office or other outpatient visits</td>
</tr>
<tr>
<td>99231-99233</td>
<td>Subsequent hospital care services *limited to one telehealth visit every three days</td>
</tr>
<tr>
<td>99307-99310</td>
<td>Subsequent nursing facility care services *limited to one telehealth visit every 30 days</td>
</tr>
<tr>
<td>G0420-G0421</td>
<td>Individual and group kidney disease education services</td>
</tr>
<tr>
<td>G0425-G0427</td>
<td>Telehealth consultations, emergency department or initial inpatient</td>
</tr>
<tr>
<td>G0406-G0408</td>
<td>Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs</td>
</tr>
<tr>
<td>G0108-G0109</td>
<td>Individual and group diabetes self-management training services, with a minimum of one hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training</td>
</tr>
<tr>
<td>96150-96154</td>
<td>Individual and group health and behavior assessment and intervention</td>
</tr>
<tr>
<td>90832-90834, 90836-90838</td>
<td>Individual psychotherapy</td>
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<tr>
<td>90791-90792</td>
<td>Psychiatric diagnostic interview examination</td>
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<tr>
<td>90963</td>
<td>End-stage renal disease (ESRD)-related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents</td>
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<tr>
<td>90964</td>
<td>End-stage renal disease (ESRD)-related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents</td>
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<td>End-stage renal disease (ESRD)-related services for home dialysis per full month, for patients 20 years of age and older</td>
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<tr>
<td>90967</td>
<td>End-stage renal disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients, younger than 2 years of age</td>
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<tr>
<td>90968</td>
<td>End-stage renal disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 2-11 years of age</td>
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<td>End-stage renal disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 12-19 years of age</td>
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<td>97802-97804, G0270, G0436-G0437</td>
<td>Individual and group medical nutrition therapy</td>
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<td>96116</td>
<td>Neurobehavioral status examination</td>
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<td>99406-99407</td>
<td>Smoking cessation services</td>
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<tr>
<td>Procedure Code</td>
<td>Description</td>
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<td>----------------</td>
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</tr>
<tr>
<td>G0396-G0397</td>
<td>Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services</td>
</tr>
<tr>
<td>G0442</td>
<td>Annual alcohol misuse screening, 15 minutes</td>
</tr>
<tr>
<td>G0443</td>
<td>Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes</td>
</tr>
<tr>
<td>G0444</td>
<td>Annual depression screening, 15 minutes</td>
</tr>
<tr>
<td>G0445</td>
<td>High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes</td>
</tr>
<tr>
<td>G0446</td>
<td>Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes</td>
</tr>
<tr>
<td>G0447</td>
<td>Face-to-face behavioral counseling for obesity, 15 minutes</td>
</tr>
<tr>
<td>99495</td>
<td>Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)</td>
</tr>
<tr>
<td>99496</td>
<td>Transitional care management services with high medical decision complexity (face-to-face visit within seven days of discharge)</td>
</tr>
<tr>
<td>99497</td>
<td>Advance Care Planning, 30 minutes</td>
</tr>
<tr>
<td>99498</td>
<td>Advance Care Planning, additional 30 minutes</td>
</tr>
<tr>
<td>90845</td>
<td>Psychoanalysis</td>
</tr>
<tr>
<td>90846</td>
<td>Family psychotherapy (without the patient present)</td>
</tr>
<tr>
<td>90847</td>
<td>Family psychotherapy (conjoint psychotherapy) (with patient present)</td>
</tr>
<tr>
<td>99354</td>
<td>Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour</td>
</tr>
<tr>
<td>99355</td>
<td>Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes</td>
</tr>
<tr>
<td>99356</td>
<td>Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; first hour</td>
</tr>
<tr>
<td>99357</td>
<td>Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; each additional 30 minutes</td>
</tr>
<tr>
<td>G0438</td>
<td>Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) first visit</td>
</tr>
<tr>
<td>G0439</td>
<td>Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) subsequent visit</td>
</tr>
<tr>
<td>G0508</td>
<td>Telehealth Consultation, Critical Care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth</td>
</tr>
<tr>
<td>G0509</td>
<td>Telehealth Consultation, Critical Care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth</td>
</tr>
<tr>
<td>G0506</td>
<td>Care Planning for Chronic Care Management Services*</td>
</tr>
<tr>
<td>G0296</td>
<td>Visit to determine low dose computed tomography (LDCT) eligibility.*</td>
</tr>
<tr>
<td>90785</td>
<td>Interactive complexity*</td>
</tr>
<tr>
<td>96160-96161</td>
<td>Health risk assessment*</td>
</tr>
<tr>
<td>90839-90840</td>
<td>Psychotherapy for crisis*</td>
</tr>
<tr>
<td>Q3014</td>
<td>Telehealth originating site facility fee</td>
</tr>
</tbody>
</table>

*Effective for services on or after Jan. 1, 2018
Previously this service was always bundled into other services and not paid by Medicare. As of Jan. 1, 2018, CPT code 99091 — Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring, digitally stored and/or transmitted by the patient and/or caregiver to a physician or other qualified healthcare professional, qualified by education, training, licensure, regulation (when applicable), requiring a minimum of 30 minutes of time is covered.

### ADDENDUM B: RVUS AND RELATED INFORMATION USED IN CALENDAR YEAR 2018 FINAL RULE

<table>
<thead>
<tr>
<th>CPT/HCPCS</th>
<th>Status</th>
<th>Description</th>
<th>Work RVUs</th>
<th>Non-facility PE RVUs</th>
<th>Facility PE RVUs</th>
<th>Malpractice RVUs</th>
<th>Total Non-facility RVUs</th>
<th>Total Facility RVUs</th>
<th>Global</th>
</tr>
</thead>
<tbody>
<tr>
<td>99091</td>
<td>A</td>
<td>Collect/review data from patient</td>
<td>1.10</td>
<td>0.46</td>
<td>NA</td>
<td>0.07</td>
<td>1.63</td>
<td>NA</td>
<td>XXX</td>
</tr>
</tbody>
</table>

### TELEHEALTH AND MEDICAID

Medicaid’s definition of telemedicine is based on Medicare’s definition. State Medicaid programs, however, may select a different set of CPT/HCPCS codes and modifiers for reimbursing telehealth services. Medicaid may also have other flexibilities in coverage and reimbursement. Due to state-by-state Medicaid variances, it is important for each medical practice to review its state’s codes, rules and billing guidelines for telehealth.

*Every state Medicaid program, except in Hawaii and Kentucky, offers reimbursement for live video of some sort, yet some state programs limit the services reimbursed. For example, as of this writing, New Jersey only reimburses for telepsychiatry services.*

For Medicaid, originating sites can also be known as spoke sites, and distant sites can be known as hub sites, although their definitions remain the same. Moreover, most states do not carry the same geographical limits as Medicare. For example, Colorado Medicaid has no geographical barrier and, as of this report’s publication, still requests the use of the GT modifier, which adds $5 to the fee for the procedure code billed to hub or distant sites.

Regulations and laws outlining specifics for reimbursing RPM vary from state to state. Similarly, state-specific rules exist for site or facility transmission fee eligibility, which often vary depending on whether an originating site is a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC) or Critical Access Hospital (CAH), as well as considerations for school-based health centers, Indian Health Services clinics, public health clinics and other entities. Additionally, some states specifically note the types of providers eligible for an originating site facility fee.
Telehealth coverage and guidelines vary by commercial payer. While many of these payers have lifted the geographical limitations imposed by Medicare, practices must know their payers' policies, as well as any state-specific laws that may govern private payer reimbursement policies for telehealth services. According to CCHP, 37 states and the District of Columbia have such laws in effect as of Jan. 1, 2018.

Reimbursement rates for most payers are the same as an in-person encounter, and most still request the use of the GT modifier ahead of the Jan. 1, 2018, effective date of CMS' new POS code 02, which a handful of states — including Iowa, Kansas, Minnesota, Utah and Washington — adopted earlier in 2017.

Telehealth is a clearly rising trend in healthcare and increasingly reimbursable by commercial payers. As the requirements are constantly changing, practices should research the guidelines for their state and requirements from their contracted payers carefully as they explore telehealth opportunities.
How to create your telemedicine billing policy
How much will you charge your patients for a telemedicine visit? Will the fee vary based on the service? Will you go the reimbursement or cash-pay route for telemedicine? These are a few of the key questions you’ll need to answer to create your telehealth billing policy.

Medicare.gov: The official US Government site for Medicare
A federal government website managed and paid for by the Centers for Medicare & Medicaid Services.

Politico’s Morning eHealth: Telemedicine money jumping
Medicare’s telemedicine spending jumped 28% to a total of nearly $30 million in 2016, a big increase for the agency’s funding of the technology. The government program’s reimbursement for the modality has grown nearly two-thirds since 2014. Despite the big growth, telemedicine-devoted dollars are still an infinitesimal fraction of overall Medicare spending. (The program spent $588 billion in 2016.)

Telehealth: Use in Medicare and Medicaid
This testimony discusses (1) the extent to which telehealth is used by Medicare and Medicaid to provide healthcare services; (2) factors selected associations representing providers, patients, and payers reported as affecting the use of telehealth in Medicare; and (3) how emerging payment and delivery models could affect the potential use of telehealth in Medicare.

Telemedicine reimbursement: A guide to getting paid
This American Well blog post explains how payers make reimbursement decisions and what levels of reimbursement providers can expect in the future.
According to Bernard Tyson, chairman and chief executive officer, Kaiser Foundation Health Plan, Inc. and Hospitals, Oakland, Calif., more than half of the organization’s 110 million plus interactions between patients and medical group physicians were virtual visits in 2015, including secure email, scheduled telephone visits, video visits, smartphone interactions and other Kaiser technologies.

Kaiser facilities in California and the mid-Atlantic regions account for most of the video visits compared to Kaiser Permanente Colorado (KPCO). However, KPCO patients have over 25,000 online chats with physicians and more than 10,000 patient emails each month to go along with just under 1,000 video visits a year, according to Ted E. Palen, PhD, MD, MSPH, a practicing internist and manager of clinical reporting in the Resource Stewardship department at KPCO.

Palen, who practices in Denver, said the clinician-to-clinician e-consults during or after a patient's primary care visit helps address care issues in a timely manner. The program uses a secure messaging system within its EPIC EHR system and makes use of cameras at all workstations and exam rooms. The addition of taking and forwarding a picture as part of a clinician-to-clinician e-consult has been particularly useful for efficient advice and management of dermatology conditions. The e-consults between physicians have been shown to preclude the need for additional specialty care visits about 40% of the time.

Onboarding providers: KPCO first asked for physician volunteers to be trained on the new workflow for “doctor chats,” which involved a group of physicians who handled the patient-physician chats. They work in two- to four-hour blocks. Specialty physicians are on call for chats requiring additional clinical expertise. Short training sessions with physicians who already were adept at working in KPCO’s email outreach provided insights to improve efficiencies for other physicians.

Reimbursement: KPCO uses a capitation model with salary-based physicians, including those on call, as part of their scheduled clinic duties.

ROI: Virtual care options are a great convenience for patients. Palen noted that these options also enhance patient loyalty and retention. It also offers flexible schedules to some physicians, allowing them to work from home and in the clinic, was a boost for the clinicians. The Kaiser Permanente integrated care model provides for seamless communications between the care teams using virtual care modalities, which reduces unnecessary face-to-face visits.

Future focus: Questions remain regarding the long-term clinical outcomes of these consults, including issues related to chronic care management and acute care. The organization is also examining the effect virtual care has on the use of services, cost of care and clinical outcomes.
BLUE SKY NEUROLOGY
Adding community through consults

Christopher V. Fanale, MD, is a neurologist specializing in stroke and cerebrovascular disorders at Blue Sky Neurology, Denver. Fanale estimates that in 2006, approximately six consults were conducted each year for acute stroke evaluation and treatment. With grant money from the state of Colorado, he developed a large telemedicine stroke network in partnership with HealthONE.

The need for telemedicine around stroke is pronounced, Fanale said, because of a shortage of neurologists in many areas and the time-sensitive nature of the work. Strokes require evaluation in a matter of minutes, leaving little time for transferring patients who live in an area without a neurologist.

Blue Sky Telemedicine now covers over 132 hospitals, and Fanale is credentialed at all of them. As of October 2017, the program conducts approximately 900 consults per month.

Challenges: As with all care encounters, proper documentation of the televisit is crucial. Keeping pace with payers’ reimbursement policy changes is necessary, as is the state licensing requirements, which can take up to a full year.

ROI: Providing access to telemedicine services, especially in outlying, nonmetropolitan facilities, has a major impact, Fanale said, because patients then can access a specialist within their own community. Moreover, hospital-based providers at facilities without a full complement of specialty support feel more empowered to keep patients within their facilities, knowing they can quickly and easily call on specialists for consultations on the patients in-house.
UC DAVIS HEALTH
From early adoption to rapid expansion

At 1 week old, Avery Griffiths was alarmingly sick — in severe circulatory distress — and rushed to the emergency room at Sonora Regional Medical Center, Sonora, Calif. The transport team from UC Davis Children’s Hospital, where she could receive specialty care, was two hours away.

Sonora’s Donald P. Dudley, MD, emergency medicine, and Kelley W. George, MD, pediatrics, used a telehealth cart at their facility to connect with Francis Poulain, MD, pediatric neonatologist and associate professor, pediatrics, UC Davis Health, who was working via laptop at his home.

In the time it would have taken the transport team to arrive, Poulain worked with the providers at Sonora to evaluate Avery and begin treating her ailment, offering what all providers agreed was life-saving care.

Jim Marcin, MD, MPH, director of the pediatric telemedicine program and interim director of the Center for Health and Technology at UC Davis Health, has practiced pediatric critical care medicine since 1998 and has used telemedicine in his clinical work since 2000.

While the UC Davis telemedicine program first was intended to provide nonurgent, outpatient subspecialty consultations to rural and underserved clinics, the clinical programs developed out of the needs and opportunities determined by the different clinical departments. For example, the obstetrics and gynecology department started with remote fetal monitoring while the pediatrics department started with critical care tele-emergency consultations to sick children in rural emergency departments. The pediatric tele-emergency program network now includes more than 30 emergency departments throughout northern California.

Drivers: The key uses of the telehealth program were for outpatient specialty consultations and remote consultations to keep patients in their local communities. Marcin said that a pediatric endocrinology patient may travel five hours one way to see the specialist. The ability for the specialist to connect with those patients and check a glucometer remotely has positive outcomes for the patient in addition to decreasing emergency department utilization, decreasing patients’ reported A1C levels and improving care against national benchmarks.

“You’re doing it to keep patients in their own clinics and out of the hospital, as well as [offering] a service to referring practices, which provides marketing and a competitive edge. Working with other clinics and hospitals strengthens a relationship with that hospital,” Marcin said.

“The more competitive marketplace you’re in, the more likely you’ll be doing telemedicine.” — Jim Marcin
Providers: When it comes to the providers, “younger, more tech-savvy physicians are more amenable to integrating [telehealth] into their workflows,” Marcin said, adding that once providers started participating in these encounters, they generally liked the service.

The provider traits that make for a good face-to-face patient encounter are similarly important in a telehealth encounter. “If you have a doctor that patients like and [providers who] are engaged ... they go into telemedicine and do just as well,” Marcin said, noting that maintaining eye contact and being a good listener is vital regardless of whether the encounter is done in person or via videoconferencing.

Integrating telehealth into existing processes is another key method to increase provider buy-in: The less change to implement, the better. It also helps to understand which areas will be the easiest to add telehealth services. Mental health often is an easily achieved, one-on-one encounter, whereas multidisciplinary encounters such as diabetes management are more difficult to implement via telemedicine because of the number of providers, support staff and testing required.

Controlling the telehealth environment: A telemedicine consultation suite is preferred, with good acoustics and an appropriate microphone/directional headset for communication. Positioning a video camera (often mounted right over the video monitor) and the clinician should be done with an eye for proper lighting and angles. UC Davis conducts a monthly quality improvement meeting to review patient and physician feedback relating to the video consultations.

Reimbursement: The service models for telemedicine vary, according to Marcin. Fee-for-service is common depending upon state laws for Medicaid and federal restrictions for Medicare. Contracted rates are not uncommon, either in addition to or instead of fee-for-service, and depend upon the supply and demand as well as potential for downstream revenue and/or cost savings.

ACCESS PHYSICIANS
“Easy math” for adding telehealth

Access Physicians, Dallas, began as a traditional medical group without telehealth services, offering coverage in acute care hospitals and inpatient care. However, from a cost-efficiency standpoint, there wasn’t enough work to support the in-person, on-site model at night and on weekends. That led the group to launch its first virtual care program in 2013.

Drivers: The cost to maintain 24-hour coverage easily ranges between $1 million and $1.5 million each year. The model requires two doctors on 12-hour rotating shifts for seven days, who then swap with two other doctors. Annual compensation for each internist or community pulmonary physician is $250,000 to $300,000. That left the practice with three choices: Lose money on a staffing system that’s not cost-effective, go without coverage (which is not an option) or embrace telehealth.
Resources: Chris Gallagher, MD, FACC, president and co-founder, Access Physicians, said that finding an affordable vendor for the organization’s telehealth cart was difficult — the process took 12 months. For more than a year, the organization worked with software vendors to find and develop a proprietary system that was what they called “Fisher-Price easy.” “Simplistic so that, with minimal instruction or direction, a nurse or physician could participate in that telehealth encounter,” Gallagher said.

Ease of use: Gallagher stressed that ease of use for the system is a major part of ensuring program success. “The hard part is making it look easy ... making the technology look simplistic, feel simplistic, so programs really hit the ground running from day one,” Gallagher said. “If you misstep early, it can kill a program” if the users within your organization don’t have confidence in its abilities, which can turn them into “naysayers.”

Troubleshooting: Initial talks with vendors were challenging, Gallagher said, because they didn’t understand the importance of resolving IT issues quickly. “Technology fails. Time matters,” Gallagher said, noting that for some care settings, the time it takes to report a problem or wait for IT assistance at a hospital was unacceptable.

“We had to build our own IT system and IT infrastructure that was in-house so that we could quality-control the uptime and really understand how the downtime of the telemedicine cart was managed.”

Buy-in: “You have to figure out what value does [telemedicine] bring to each stakeholder,” Gallagher said, noting that nurses, physicians and executives within the organization need clarity about what telemedicine will bring to the practice. “If you don’t have them on your team ... it makes it much more difficult to survive those hiccups” that inevitably occur with the launch of a large program, Gallagher said.

Success story: Patients provided “overwhelmingly positive” feedback about the program, which, Gallagher said, is about good care and not necessarily the medium. Integrating a telehealth program as part of a care team’s daily routine leads to a better experience focused on care. “The patients really couldn’t care less whether ... their doctor is standing in the room,” Gallagher said. “All they need is ... someone who understands their problem and is there to listen and is there to develop a therapeutic plan. As long as you do all those things, patients love it.”

ROI: The flexibility telehealth provides for physicians is a key piece of ROI, in Gallagher’s opinion, especially those physicians who can provide telehealth from a home office: “Working nights is hard. Patient care is a 24/7 business. There are more nights and weekends than there are weekdays. ... [Working from home] makes the nights and weekends more tolerable. If you’re a physician and you’re doing telemedicine out of a bunker, your quality of life is not improved.”
American Well Consumer Telehealth Index 2017
American Well’s new consumer survey finds a growing vanguard of consumers who are willing to switch doctors in order to get video visits as part of their care. And the majority of consumers are increasingly open to video visits.

ATA issues guidance on telestroke, telemental health services for youths
The American Telemedicine Association (ATA) has released new practice guidelines on stroke assessments and mental health services for children and adolescents via telemedicine.

Improving children’s access to care through telehealth
In this webinar, Shayan Vyas, MD, medical director of telehealth, and Carey Officer, administrator of telehealth, discuss the clinical and operational requirements needed to create a successful telehealth program.

Philips and American Well form global partnership in telehealth for consumer health and professional healthcare
A partnership between American Well and Philips Avent will offer the uGrow parenting app to support parents monitoring their baby’s development.

Study: Telemental health use remains low, varies across states
Researchers looked at Medicare fee-for-service claims data on telemental health use between 2004 and 2014 in rural beneficiaries with a diagnosis of any mental illness and found that the number of virtual visits grew on average 45.1% annually.

Telehealth fills void when weather emergencies disrupt normal provider-patient experience
Teladoc, American Well and others delivered virtual care to thousands of storm victims in Texas and Florida after Hurricanes Harvey and Irma.

The efficacy of a telemedicine-based weight loss program with video conference health coaching support
The purpose of this study was to assess body weight change from a 12-week telehealth-based weight loss program that integrated health coaching via video conferencing.

VA Puts Telehealth to Work in ‘Anywhere to Anywhere’ Care Initiative
The VA has awarded a $260 million contract to launch a telehealth and telemedicine platform capable of connecting its doctors to patients no matter where they live, while enabling veterans to transmit mHealth data from devices in their homes.

VA Telehealth Services
The value VA derives from telehealth is not in implementing telehealth technologies alone, but how VA uses health informatics, disease management and telehealth technologies to target care/case management thereby facilitating access to care and improving the health of veterans.

Virtual visits for acute, nonurgent care: A claims analysis of episode-level utilization
Looking for evidence about telehealth cost savings? A new review of claims data by HealthCore presents savings from LiveHealth Online. John Jesser, president, LiveHealth Online and Wally Adamson, MD, vice president, Anthem, present the results of a peer-reviewed paper.

3-minute case study: The virtual MAT provider
Wells House [a residential treatment center] called Eric Weintraub, MD, associate professor in the Department of Psychiatry at the University of Maryland School of Medicine, to ask his help in finding a new MAT [medication-assisted therapy] provider. Instead, he offered an alternative: UMMC’s existing telemedicine platform. The MAT-certified providers on his team could manage buprenorphine treatment of patients at Wells House virtually from Baltimore.
Looking ahead

As both the healthcare and telecommunications industries are evolving, so will telehealth services. With each year bringing changes to telehealth codes and reimbursement, practices need to stay up-to-date in order to maximize revenue cycle opportunities. The technological side sees frequent changes too. Developments such as the Federal Communications Commission’s recent action on net neutrality could open the door to internet service providers transforming the current service structure to both medical groups and consumers. This could affect how and when RPM and other telehealth services are used or how cost-effective they are as pricing for internet service changes.

Practice leaders who want to remain on the front line of meeting patient demand regarding telehealth services should regularly revisit the topics covered in this report. |

Reviewing these issues with physician stakeholders and other key organization leaders to navigate to a telehealth solution will ensure the practice is not just sustainable yet also rewarding for both consumers and providers.

Want to learn more about topics like this?

- Check out more on Health Information Technology through MGMA's News and Insights webpage
- Learn more at upcoming events
- Data and insights from MGMA

MGMA thanks American Well for their generous support in helping us deliver this Research & Analysis report.

**About American Well:** American Well uses telehealth to improve people’s access to quality care. Through our partnerships with the nation’s largest health systems, insurers, employers, and retailers, our award-winning telehealth Exchange and our direct-to-consumer service, Amwell®, we connect millions of Americans to the doctors they trust for live video visits. Through the power of telehealth, we help patients get the care they need in a timely fashion, and help doctors be there for their patients. We build technologies to make healthcare go where people need it most. For more on how we are changing healthcare delivery through telehealth, visit AmericanWell.com. American Well and Amwell are registered trademarks or trademarks of American Well Corporation in the United States and other countries. All other trademarks used herein are the property of their respective owners.
MGMA Telehealth Survey

Methodology

Questions for the survey were developed by MGMA. The target population was the MGMA Stat panel, a group of medical practice leaders who participate in MGMA’s weekly polling initiative. The survey launched on Nov. 2, 2017 and closed on Nov. 10, 2017. The survey was completed by a total of 131 healthcare leaders in the United States. Of this total, 36 respondents indicated they would be willing to participate in a follow-up interview on this topic.

1. Does your organization offer telehealth services?
   ○ Yes, currently do
   ○ Yes, planning on it
   ○ No
   ○ Unsure
   ○ N/A

2. If answered “no” to Q1: Please select the reasons your organization doesn’t offer telehealth services. Check all that apply.
   ○ Insufficient resources
   ○ Don’t know how to get paid
   ○ Don’t know where to start
   ○ Don’t understand it fully
   ○ Not interested
   ○ Too small
   ○ Too big
   ○ Other reason (please explain)

3. If answered “no” to Q1: If you would like to receive resources from MGMA on telehealth, please provide your contact information:
   First name:
   Last name:
   Email address:
   Telephone number:
   Position / job function:

4. If answered “yes, currently do” or “yes, planning on it” to Q1: What are the driving forces behind implementing telehealth in your organization?
   ○ Wider geographical coverage
   ○ Additional revenue source
   ○ Patient demand
   ○ Patient satisfaction
   ○ Value-based medicine
   ○ Physician engagement
   ○ Access to specialists
   ○ Other (please explain)

5. If answered “yes, currently do” or “yes, planning on it” to Q1: Where do payments for telehealth visits primarily come from?
   ○ Commercial payers
   ○ Self pay
   ○ Medicare
   ○ Medicaid
   ○ Other (please explain)

6. If answered “yes, currently do” or “yes, planning on it” to Q1: What percentage of telehealth consultations are reimbursed?
   ○ 25% or less
   ○ 26-50%
   ○ 51-75%
   ○ 76% or greater
   ○ Unsure
7. If answered “yes, currently do” to Q1:
Where do you see return on investment (ROI) with telehealth in your practice? Check all that apply.
- New revenue source
- Patient retention
- Rural coverage
- Access to specialists
- Enhanced branding
- Supporting value-based initiative(s)
- Patient satisfaction
- Provider satisfaction
- No ROI
- Other (please explain)

8. If answered “yes, planning on it” to Q1:
Where do you hope to see return on investment (ROI) with telehealth in your practice?
Check all that apply.
- New revenue source
- Patient retention
- Rural coverage
- Access to specialists
- Enhanced branding
- Supporting value-based initiative(s)
- Patient satisfaction
- Provider satisfaction
- No ROI
- Other (please explain)

9. If answered “yes, currently do” or “yes, planning on it” to Q1: Would you be willing to participate in a follow-up phone interview on this topic?
- Yes
- No

10. If answered “yes” to Q7: Please provide your contact information:
First name:
Last name:
Email address:
Telephone number:
Position/job function:

11. If answered “yes, currently do” or “yes, planning on it” to Q1: If you have any insights to share about telehealth / virtual services, please feel free to comment.
Methodology

Questions for the qualitative interviews were developed by MGMA. The target population was experts in the field of healthcare who have either implemented telehealth into their organizational structure or those in the process of doing so. Some were selected from the aforementioned Telehealth Survey, some were recommendations from MGMA’s subject matter expert team, and the remainder were selected based on their presence in the media or on their successes in the industry.

The qualitative interviews were conducted between August and November 2017 by MGMA’s research and editorial teams over the phone, in person or via video conferencing. The qualitative research covered the following areas (see right).

1. Initial drivers behind offering telehealth / virtual services
2. Type of telemedicine services offered, and the impact of these
3. Any obstacles/barriers, including:
   - Information seeking
   - Reimbursement concerns
   - Technology
   - Infrastructure
   - Organizational support
   - Culture
   - Training staff
   - Enrolling patients
4. Biggest changes to implement
5. Reimbursement, billing
   - Medicare
   - Medicaid
   - Commercial payers
6. Best practices on how to provide telehealth services, focusing on:
   - Starting the program
   - Drivers
   - How did they know that offering this service was right for their practice?
   - Target population
   - Physician engagement
   - Education
   - Training staff
7. ROI
   - Direct and indirect ROI
   - New revenue stream
   - Enhanced branding
   - Cost effectiveness
   - Patient satisfaction
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