[Please stand by for realtime captions.] >> This is Shannon with Trenton Medicaid amounted to welcome everyone to the WebEx and thank you so much for taking the time out of your schedule to join us. We are grateful you took the time and to have you on the line. We have attendance almost 1400 people signed up as a earlier this afternoon and I'm sure we have more than that no. We appreciate so many people from around the state taking a break from their hard work to listen into updates you have. I've been impressed with the enthusiasm around the state as well as providers of all types reached out to me with input and suggestions in positive feedback as well and the enthusiasm around the state is really remarkable and clear to me how much hard work everyone is doing. I've been impressed with the medicine in North Carolina together this presentation and it's heartwarming and also inspiring. Because we haven't incredibly bright clinicians taking care of the state. For we take off with the program I want to introduce special guest that were able to join us. For opening remarks.

Secretary [Inaudible]. >>

Hello everyone, this is Mandy Cohen and I want to jump on quickly to thank you and echo Dr. Dollar saying what's going on and I'm incredibly proud of how the medical team across the state are pulling together. We are in unprecedented times and I don't need to tell you all that. This is unbelievably challenging day-to-day circumstances that are changing two-minute. I appreciate you all pulling together as one team here because that's what we need to be, coordinated one team. And as we work to respond and with that it means that things will change over time. For example Dr. Tilson will get on and with a particular phase where we are with the response effort and that advice is going to be changing. And it will likely change again as we move through different phases of this work. I think you know today, we announced the first confirmed lab documented case of community spread which it means it's our first official time where we know the virus is out in the community and we were obviously acting as if we had community spread which is a Ackley why the governor took the aggressive action that he did in terms of limiting large drinks and closing the bars and restaurants and closing schools. Those were incredibly hard decisions and the reason he made those hard decisions was to slow the spread of the virus so that fewer people get sick at the same time. He is aware that what is of concern and coming his string to all of you in a stream to the medical resources. We are working very hard to make sure we can be as efficient and needed to maximize all the medical resources that we have and that's why I'm happier join the call so thank you for all your doing and please bear with us and know that things are going to change. The advice you get, this week is different than death not advice but guidance. It will be different than guidance that we may give next week and the week after as we move through this. Please stay in close contact with us as we move through. I want to thank Dr. Tilson for her leadership that she is thinking about you all and how hard it is to respond on the frontline of this at every moment and no that I'm pleased she is able to leave us through these hard times. So I am appreciative and I will turn it over to you.

Shannon, you are up next.

Thank you secretary:. Thank you Shannon and thank all of you for joining. We will definitely dive deep into the Medicaid pieces of this but I will give you an overview on public health and where we are. And also let you know we are now pivoting [Inaudible] as Sec. Cohen said where we think we are going. So you have a little bit of that forward thinking because as the guidance changes rapidly, we went to be communicating as proactively as possible and what you to think about getting towards possibilities and not where it is right now. So I give you a heads up the direction we're going. So you so you are prepared. Ex. A little bit more about the public health peace and making sure that you know where you can get updated information, and we did have 97 cases as a this morning and we already see that we are in the acceleration phase and expect to get more cases now day by day. We are in the acceleration phase and although we were acting in expecting that we had community spread, this was today in the first day that we documented that and expect to see that more and more and if you're interested in following the accounts on the DHS website, if you go to DHS.gov and\coronavirus, that does the website and we are posting daily dashboards and numbers if you want to follow. We have that readily available on the website. If you think how one approaches an outbreak there are two main phases. One what we call containment. Beginning of the spread you do rigorous identification cases and contract tracings and monitoring 14 and very intensive containment to slow the spread as much as you can so we can get ready. We are still doing containment strategies but we also have already been [No Audio]

Betsy we lost your audio. >>
[No Audio]

It looks like the connection dropped. Shannon, what we jump into the ground rules and agenda for Max. -- Ground rules and agenda.

Most of thousand following an exciting that you are interested in we want to run through a quick test a couple logistics and agenda. The agenda is packed and we don't have much time so I will not talk to lock except to tell you a couple quick things about the logistics. This is a webinar and you can access it using the webinar function. If you dialed in you cannot ask questions and we cannot recognize you. If use the webinar function, then we will be happy to recognize you by clicking on the Q&A function. This is huge Tilson from [Inaudible] sorry I forgot to introduce myself. Think you all for again being on. And again you can respond through Q&A and if you respond or try to communicate through the chat function we will respond to medical -- technical issues but only to respond to questions through Q&A. So we can better manage and control the inflow as they commit. We also will record this and post it so slides will be available publicly. We'll talk more about that later. Let me quickly run through, this is intended to be a weekly series so we will do this every Thursday from 530 to 630. I know we had originally said 530 to 6 routine but there's enough information that we will air staying on longer. And we will hold that time till 630. We will work in partnership with [Inaudible] and Medicaid to identify the agenda and what information is out there and try to make this as useful as possible for you and is good use of your time. I want to quickly tell you we are standing at the website you can

see the site and again we will make these slides available on the site. And where we put information about both Medicaid as well as general [Inaudible] information as that continues to adjust so there is a place and try to make it as convenient as possible. I will pause and get it back to ANSI. Who is on the line. Dr. Tilson.

Yes. It's lovely when your husband can fill in for you when you drop off.

So I'm not sure when I dropped off. I think it was talking briefly about the phases with the aggressive containment and more towards [Inaudible] mitigation. Now as we see the escalation you will see ramping up again more litigation strategies a lot think of things we put in place. But also it will be different especially when it comes to primary care providers around thinking about testing the role of testing at this phase. So we are there in the middle of still doing containment strategies but forward thinking of what more escalated community ignition strategies and so forward thinking and what might come in the next couple days and you can start digging through that. When we think through about specifically testing strategies, we think through that we have a lot of I think you know we have a lot of concerns around personal protective equipment and supplies not only in the outpatient setting but also getting ready or MedSurg and what are the resources or when the emergency care comes. We also have to start thinking about the other measures we need to do to decrease acceleration of spread. That also think through windows testing help us and went doesn't it. Testing has helped us in the beginning to understanding when we see acceleration and where but as we go through forward testing will not need that for the epidemiology activities. Then thinking through the utility of testing for individuals and mild disease is probably not as helpful anymore. So the things that we think through in terms of recommendations for testing.. As we move forward, to signal where we think we will be, we're working on thinking through other ways of doing surveillance to understand the spread of disease across the airline and is many of you are aware we do a lot of food surveillance and we have a food surveillance network so we are looking to think about using the network to family food surveillance but do COVID-19 through that surveillance network . That is one thing we worked to put up. Second thinking through again, what is the benefit of testing someone with mild illness who can stay at home and start thinking through that in the prioritize people who are the symptoms that they can stay at home and do all monitoring without folks having to get a test. Thinking through Dewey went to prioritize the tests that are coming into the state lab and thinking about reserving them for more of a public health priority outbreak and again no changes right now but forward thinking when do we want to think through state lab testing and surveillance an outbreak and higher settings like long-term care facilities and health care workers. Then thinking through from a primary care standpoint, working with you all and understanding that making sure you are having triage call lines and telehealth and what can you do that patients are calling in and triaging and understanding if you have mild illness and stay-at-home. But also making sure if someone has symptoms that need medical care, how is it that we can be sure that if they need to be seen, more [Inaudible] or affection or

asthma and how can we be sure that they come into you and have be seen safely to you the patient and some guidance on that earlier this week that can [Inaudible] him Mr. demand engineering and things you can do in the practice and whatever the PPP Econ is a reason to condemn the practice and can you have a dedicated respiratory care team where you have [Inaudible] and different strategies to reduce the demand and need for PPE because we know it is in shortage. We heard you loud and clear that you don't have sufficient PPE. We know that and were working hard and thinking through identifying more PPE and being able to rock it out. And be able to get it out to primary care and outpatient things. It's not in your hands right yet but we are working hard and planning to route it through the local management and changing restrictions that can get rotted out. They are all in place and hopeful that we can start getting PPE out to you mid week next week. Working hard on then have to wait for deliveries and make sure that think about what we got ordered and that is high on the list to make sure that we have PPE out to you and not only to get patients out for testing but have patience that need to be seen and received medical care so that is coming and were trying to figure out easy ways for you to identify who [Inaudible] coming through the local emergency management to identify who is the emerging management accounting and make sure you know [Inaudible] healthcare preparedness coalition and also explore that this could be a way that 211 can identify who [Inaudible] is if you don't know who that is. All that is in planning and not, I don't want to tell you it's in place of a cousin stop but the plan for midweek next week to respond to that need that we know. And also start thinking through those of you who have been thinking through the state lab in different creatures but also those of you who are tapping into commercial testing and taking through prioritizing the commercial testing for the people who have more moderate symptoms. Then also tapping into the community alternative testing sites that are up and identify to throughout the preparedness website or signal that there is a ramp up and trying to get community alternative testing sites and that they will start thinking about wrapping those down because we don't want is people with symptoms going on in testing because of the way to accelerate sprints he went to see changes in recommendations of broad-based community testing and instead of having more illness encouraged to go to [Inaudible] and stay home and not spread it or get affected themselves. Those are where we're going and were not there yet. But that is where we are headed and I want to give you a heads-up of changes you start seeing and get out more guidance in context out to you or the next several days and I already have a ping from people today this is with the commencement it will make changes in testing so I want you to know are making that pivot and get the information out to you as we go forward. So with that I will turn it back over to Dave or Shannon.. --

Thank you. We appreciate you jumping on the call and giving up that so I will handed over to Dr. Tom Wroth .

Accomack -- Accomack -- [Indiscernible - echoing]

[Indiscernible - echoing]

Hopefully build your confidence and implement encodes this weekend then excited to pass it back to Dr. Dollar who will talk about the next phases. Keep the brief coming of the slides, there are several links that are useful so we will try to be efficient. Really with the slide, when we went through the. Will talk a lot about with the telephonic codes and document changes, the standard of care. And how to provide care and go to the next slide.. In the webinar last week we have the state North Carolina Medicaid policy changes that are in the Medicaid bulletin and quickly from the provider community kudos to the state and department for being able to do this and usually policy changes take six 6 to 12 or 18 months to make it happen. Great work and high-level overview of the changes. There are reminders that the home was a codes are still active and around the co-pay and co-pays are not required to be paid at the time of her so we don't want to delay care for anyone. There's guidance about the current ICT test ICD 10 code for coronavirus and right now the city released 10 codes that could be used for coronavirus and we will have that up on the website for you all as well and will focus around telephonic visit codes in a key reminder is to remember the modifiers and are modifiers we will go through that and again the bulletin there is reminders about the level codes for testing and important pharmacy policy changes in trying to ensure patients can get 90 day supply and we move some of the requirements for having a previous dirty days script. And also medical equipment, releasing the prior authorization for respiratory climate and oxygen supplies. Allowing patients to get mask easily for those that are transported back-and-forth to infusion therapy or dialysis also allowing gloves and supplies without some of the quantity of limits. We put together to page or trying to condenses information so if you click it will take you over to that and onto the website that we mentioned before. I will focus on the telephonic visit codes in the first phase of rolling out telehealth. From a clinical perspective what we are trying to do is we went [Inaudible] was talking about is keep people out of acute care settings and those that have routine visits and those that need screening to figure out what level of care they need if they have respiratory illness so some and the clinical intention and high-level pieces were using which allows us to bypass the seven day 24 rural that are usually part of telephonic codes and this also gives the trigger to the system and also from an audit perspective, tells everyone that this is related to the current emergency. And a couple questions we had from the provider community if you do have telehealth equipment that has video and audio, it's okay to go ahead and use those during this phase. So there is the telephonic [Inaudible] can be done using multiple modalities. Writer Rosalie providers and clinicians in quarantine and or isolation at home. If they are well they can do visits telephonically and no co-pays and these are for established patients only. On the bottom there's a link to the rates that came out a couple days ago so you can see from [Inaudible] perspective where we are and go to the next slide. For non-[Inaudible] and rural health centers were splitting the codes into two groups and you code for GTO 12 Hicks pics codes and those are for physicians and advance care providers. For routine uncomplicated care, you will be coding the 994 441 the 994 4412 and three and there were time-based codes and those are for physicians in advance care providers and the CR modifier will be key. For behavioral health codes, these are for established patients

and the provider care would be licensed nonphysician health professional and you see the credentials. And 98966 and eight are again time-based codes and the CR modifier.

Very important part of the healthcare system in North Carolina. The state has done a great job in filling out how to allow this group to be able to use the telephonic and telehealth code. You will use [Inaudible] 7714 both COBIT like symptoms or other routine care. Hyper more minutes and these are by physicians or other health professionals but does include PhD psychologist and technical piece on the HQ seaside and those in those since purchases will understand that what you do is to modifiers for core medical care and submitting the T 1015 with the GT modifier which tells us telehealth and CR [Inaudible] the coronavirus attrition and on the behavioral health you have the health modifier with HR -- HI and [Inaudible]. Let's move had to run things. We did research on documentation and guidelines and best practices and a lot of this is around what you all are doing and using other platforms. Inconsiderate documenting patient identifiers and consents with a telehealth visit and present during the discussion. The link we have is what I have today and it is HHS broadening the HIPAA requirements for telehealth. And discretion in what we do during the COVID situation . We are reviewing that a lot of folks are but giving you click on that to review that so we can move ahead efficiently. The documentation is straightforward and something that you do with the electronic medical record and we will jump over to some cases. Get down to people. And the practices from first cases 60-year-old woman with fever and cough. She calls into the practices morning and in Wayne County entrained the front dust out to ask every patient whether they have fever cough or shortness of breath or they have been in contact with anyone who has been diagnosed with coronavirus and travel history. The front dust transfers that call to one of the clinicians and family nurse practitioners who is doing telephonic visits today and if you go to the next slide, the condition -- the clinician takes history and documentation that is done, and very much like your routine note the person is not sure breath and clearly has the flulike illness and the plan here is to bring the person to be tested for the flu. Then probably negative to move forward to coronavirus. You can see that the practice has figured out a way to bring the patients in through the side door and keeping them away from the side door and into a healthy [Inaudible]. This case we went through the schedules yesterday and called our patients that have nonessential care. 35-year-old with history of seasonal allergic rhinitis and hypertension. The visit was rescheduled for telephonic visit. We have again one of the conditions in the next slide. It has interviewed the patient over the phone and evaluated the allergies and symptoms and insured us that we talk about respiratory illness and other preventive care issues and has a strong [Inaudible] plan so we fill the meds and keeping her out of the acute care setting and it looks like the hypertension is recently one controlled at home and refill medication and bring her back when we are able to see her face to face. In this visit with took 14 minutes in code 99492 and add the CR modifier.. So the next case, a little bit different. And similar situation and reminding us in the healthcare setting we have the G G0771 that's were you do the 1015 with the GT ANSI modifier and sorry we don't have that on the slide. With the next

slide we have a patient calling in and appeared desperate calling in who was to follow up for ADHD follow-up and medication refills is on stimulant medication. The clinician here interviews my mom and theoretically could interview the kid to the child to some degree. And as did good history how is doing at school they completed the Vanderbilt earlier and the assessment plan is straightforward. And refilling medication and setting a plan for the summer. Here the blue box we didn't update that an we've learned some of the information today but the backside G0071 and on the front side the code that goes to state would be T 1015 GT CR modifier on top of that.. We are down to the last case. In the practice your fortune up to heaven OCS to view seeing folks with behavioral health needs and all those visits have been converted to telephonic visit to reduce the risk of bringing patients in and exposing healthcare workers. We have the behavioral health code, based on time and in the acute HC doing HI GT CR modifier and private practice you are adding a CR modifier. Again the next slide, examples of documentation very similar to what would be happening and documentation that you see face-to-face. We have a patient who has a history of depression which is stable but now had increase stressors and difficulty sleeping at night and the clinician and the patient, they did a pH Q9 over the phone and show that things are stable and no high risk situation. The clinician patient set a plan to reduce stresses and triggers for stress. It's link to the prescriber to get medication refilled in such a future date for follow-up office visit. Again here is my nine [Inaudible] CR modifier to do the billing. And with that we move through that quickly but the intention is to get it out and you have the slides and we are here to help. I would like to pass it to Dr. dollar to get a pH update then we will all address questions.

The next wave of exciting changes. Telephonic seems like a lot of work 10 days ago and now turn when compared to what we are turning on next week. Tell you about things that will be live on the 23rd. We giving your education advance because practices to have days notice to start planning for some of these things as much as possible. And also just so you have an awareness of things that we are working on. There's anxiety over the weekend. I can take a number of emails and phone calls I got provider types control that we were talking about them so we want to get you information in advance of turning on codes so that you know that were thinking about you and getting systems ready. First initiatives are a variety of items and things that apply notifications for personal care due to duty nursing office visit were remove any limits that we may have had and in a pre-covered world and removing the Weber health edit to the pharmacy and so a lot of the times there is a dosing that seems outside the norm, it has to go through and edit process and sometimes the pharmacist will manage and not call the practice but sometimes they call the practice and returning those off and the pharmacist will do the normal due diligence like with any prescription. Additionally we had significant new codes with virtual and telehealth and to be clear we talk about these two things, virtual and telehealth and want to make sure everyone understands were talking about. It will help me talk about the telephonic codes and the nonvisual communication. That includes the [Inaudible] codes which involved provider to physician consultation and patient portal

communication and those are in the virtual health definition. When we had broad telehealth and telehealth psychiatric codes and we will do this for care that is audio and visual. Two-way real-time audio communication. There are so many different people we need to include in this work that there's no way we can do it altogether or if we did it would take a month to roll anything out and we didn't feel that was the right call. Wave number one which will go live on Monday. It will be the medical and behavioral focus telehealth expansion. We've number two will start working on tomorrow and the specialist therapy. PPO T [Inaudible] and looking at what modifications need to happen. We've number three is actually diabetes in educators and additional clinical pharmacist. Right now we have clinical pharmacist and medical behavior that will look at additional and EDA [Inaudible] in way. Three. We talked today about what wave number four will look like. There will be lots of ways but just because these are such huge policy changes, to do them at once it would be very time-consuming and delay is getting these things out to you so that's why we do them in these waves. And as we think about the emergency COVID response we think about triaging.

The first one I will tell you about is the new virtual code which is provider to physician consultation. You see the name, inner [Inaudible] assessment and management and it's an ENS coat and I went and put the rates and general on these two because of some of the questions around the telephonic coat and a little bit of leg getting those onto practices and it varies taste on a number of factors. So that is the range. The billing provider has to document the verbal and written encounter. And there are restrictions for these codes if the patient has been seen in the prior 14 days. And afterwards if you use the CR modifier get you around that 14 day pre-and post restriction. How might you use this? We think of this in terms of infectious disease, it's totally overwhelmed the hospital and not able to take care of the amatory practice that they normally went. Permission a lot of follow-up for some of the specialty colleagues in the hospital and they might want to pick up the phone and consult with that infectious disease doctor about the patient they have in common. Or between an immense practitioner in a roll area that might need to do a consultation with the provider with a physician and in the urban site. We want to be able to bill for that work is mended because it has a value next -- and access care for the patient. Bulletin will be out tomorrow morning to me even hit the website tonight but I will don't want to overpromise. It will be out tomorrow in the bulletin will have more information on these codes. This is a high-level overview tonight. Next is around portal communication. I certainly when I was in more clinical practice than I am now, I would come home after a full day of clinic and feed my kids and maybe jump in the hot tub to find out about the teachers -- teenagers days and they go to bed and I start doing my charts and responding to labs and abnormal CT scans. It was frustrating that there was not a way to get paid on a real basis for that work. We are turning on a portal communication where when you are doing that work in responding to a patient with a abnormal starter falling up for the initiate the message, you're going to be a will to bill for the work you can do through the secure portal. A code like other virtual codes are established patients only. This is not for new patients. This is based on coding for a seven-day window of time. Cluster

correspondence based on the time in a week and you can see the three different codes are based on different numbers. This can occur in the same patient with multiple specialists of the cardiologist and pulmonologist and family.can bill for this portal communication if they need to. And again more will be out in the bulletin in the morning but I think this is a real went as we look at care moving more remotely for patients and for the next month or if you must or whatever the future is that you can be paid for the work that you are doing on this portal.

That sends us to the big telehealth changes. I will acknowledge that North Carolina's Medicaid was a little bit behind. Some other states on the provisions of telehealth and we actually driven back in December to say how can we modernize telehealth coverage? We didn't have budgets authorities when that is a barrier that we were working against but we were still moving the work forward and COVID has allowed us to move this work forward at a more rapid rate than we anticipated so we are making Rod changes during the time of this emergency and here's the bad news, true for all the virtual codes and telehealth codes and also true for the prior off changes in [Inaudible] changes that we are doing everything we can to reduce administrative burden and increase access to care and help folks [Inaudible] and we do live in a world that has limitations outside [Inaudible]. So as much as we hope to keep these things turned on that is promises in a given that caveat. The new telehealth are pretty broad and originating site will now provided essentially wherever the patient is and the nontraditional side of service and previously it was a narrow Indo. Distant sites are also now very broad. Previously we had a consultative only model and now [Inaudible] might be the provider home and if we have a provider quarantine they cannot go into the office, we want them to keep seeing patients if at all possible so we want to maintain access. Prior authorization is removed and no prior authorization required. As I talk to the other side, we talk about how to roll these things out. Phase 1 and waypoint changes and our focus is on the primary care specialty health and different likes and license types and it does include some of the clinical pharmacist and actually a happy surprise. They were in wave number three but I found yesterday we were doing policy work that they were getting coverage and able to keep them [Inaudible].

And the service in what we're covering will be a broad utilization and allow cell phone technology to be acceptable for telehealth in have appeared in payments. The same payment for telehealth as it would be for face-to-face. From a HIPAA compliant standpoint, we did write into this to allow temporary flux ability on certified adrenaline technology because of the emergency we are in. And the office and OS are put out guidance yesterday around really relaxing HIPAA compliance and allowing medical visits to happen virtually and through telehealth on platforms that historically were not okay. You have a link to the on the webpage so everyone can see with the guidance was. I think that will make people feel comfortable. We are also allowing a few HC and RHC [Inaudible] to bill distance sites. This is not something that Medicare allows. Historically Medicaid falls along within misguided. Just like on some of these other telephonic codes, I don't say we are breaking the rules but bending the rules to meet the needs and we are going to allow a

few HC's to build both virtual health codes and portal medication and consultation code as well as telehealth code system. These are big wins if you are living in that world. The phase 3 initiative are underway and these are the next things that we will work on in addition to brining the telehealth in the prototype we have not got to get. 1135 emergency waiver we sent to CMS and waiting to get a crew around eligibility consideration and sending coverage daily for verbal and high risk populations and eliminating co-pay of all kinds. Brought illumination of PA that left ministry burn with the team and thinking about what if it's like this for three or four months? We need to make sure that parental health [Inaudible] patients in a totally different when maybe we start meeting to take back Tran went to the home and rely on as partners with new nominal springs and we think about ulcers of ways what the future will look like. I tell you that to let you know that we are not stopping with the work that we have done so far and continue to be open to your feedback and want to hear your feedback because we think about what is next depending on how long we are in this new world. We are updating the PDL in real time and if we run into any drug shortages to preferred styles without you knowing it and we're talking about MAT if we need to extend the days that a patient can get MET for opioid use disorder. I have a war you can learn more, have a website you can learn a bunch of new information. One is around residents. Residents who are in training, we are okay with the resident and the virtual health codes and we think that they shouldn't part of the workforce in a tele-patients in North Carolina so the guidance to you like you normally would with face-to-face [Inaudible] resident program and attending or supervising physicians immediately available and cosigning the note and bill for them like you would in the practice so we are okay with them being involved in using telephonic and portal colds -- portal codes. The virtual codes are not okay with new patients, establish patients only put tele-can use with new patients. In encoding book is specific what is to be provided for patients at the time of a visit. They have strict requirements. I think one of the things we ask [Inaudible] for the next one passes to talk about how you might do a new patient visit with telehealth and one of the things you need to document to meet those criteria. The rates that or a little leg on posting and I apologize for that I think we have the system a little bit more streamlined. On the website where you have the questions and answers in the bulletin, we also have a bucket of information on telehealth. We know some have not been able to do it and you can do it fast and some of you have been doing it and they will tell you we are going to make the telehealth retroactive to March 10. If you been doing telehealth out of the goodness of your health and we are going to make those bills retroactively went to submit claims later after we go live with these coats. And to remind you, this is 323 turn on and all I would say that we need [Inaudible] and we turn a huge amount of work over a very short timeframe which means we have not worked out the glitches in the billing system and you have claims rejected and we need to hear from you that we want to hear from you and Telus as soon as something is not working well for you. I would say please don't email me directly on the problem. Because my inbox is overflowing right now and also the same for calling, I got a strange number of calls this week from people with random questions that I was not the best person to answer. That COVID , we turn around questions quickly.

We have a few minutes for questions and answers. While we are queuing up the first question I want to say that some people asked about written consent and that came up in the first WebEx and verbal consent will be acceptable right now. From a privacy content standpoint it can be done verbally..

First of all thank you for the work you have done. You said earlier this doesn't happen quickly and easily but think you for that. We now argue that all car leagues are working. A few quick things. One related to when will the slides be available? I will make you crazy as I go back to the initial website that I showed you when we set started, slides are being posted as we speak. And if you go to the NCC or [Inaudible] and you get links to the so you will not need all these links that I put back up here. A couple questions, remind us again about the CR modifier and why it is important?

The CR modifier is what we use and in Medicaid to help us know when we allow the original rules of a code to be bent and respond to the emergency. Examples where if you have a seven day before 24 hour after, that claim gets kicked out and they don't get paid. We don't think that is the right thing to do in the middle of the pandemic. We want you to get paid even the next day so we want to make sure that we don't kick that claim up and that's how we know that we can bend the rules and also track from an auditing standpoint that we paid you intentionally for the red thing. The CR modifier will help us later make sure that we recognize the things we did as a response to the pandemic.

Since Medicare and Medicaid have different rules one of someone is eligible [Inaudible] and to have an answer to that?

Daniels, can you pick up that question?

Bath are you there -- Beth are you there?

Can you hear me?

Yes.

All I can say is you need to file as you would to Medicare for right now to go and I'll and send it through to us and this is the first time the question was asked so I have to go back and ask my people who are in the know about claims processing. If that changes we will get you a better answer later.

Will question about hospice patients, when you think about doing for hospice patients?

Hospice patients are in a unique world because they are in a capitated rate.

I am not the best person for hospice. I apologize. I don't know.

We will file then see if we get an answer for us next week. We started telehealth next weekend it will be covered if the code does not go in to effect until 330?

It will go into effect for medical behavior in 323 and retroactive to 310. We want to do that because we know some of you are doing the work anyway and not getting paid for it and some of you are ready and waiting. When you to be able to go on and use the codes if you are able to. We are not sure, some of the things that go 11/30 and on April 7 and we don't know exactly what are covered so you want to do it and take a chance, you can't but if you are a specialist therapist we have not done the policy work to know what we are covering. It is a risk for you.

My practices IDD patients [Inaudible] patients normally come to a telehealth clinic and can I still bill for if the caregiver is present at the originating site or does the patient have to be present? All patients are established with the prior and if we cannot do this, how can we bill the group home patients?

What I would say, I'm thinking about my practice when I the ID patient and caregiver that I'm having the interaction with. And sometimes it requires [Inaudible] but if you do a telehealth visit or a telephonic visit and it doesn't require you to physically interact with that patient and you would normally need to have that [Inaudible] interaction to provide care for them. Then you have to practice medicine the way you see fit. We not going to go back and know where people are sitting when the visits happen. I would caution you that there is a lot with looking at a patient and listening to sounds their making and breathing. Not having the patient in the eyesight might make them of these things are possible but I defer to your judgment.

We need to list a location code without too?

But Daniels only explained that to me 48 times. Beth can you explain that?

We decided to put the 02 which is provided as a component of a telecommunication. Not sure exactly, cannot remember the exact definition but we put on the code so whether you are documenting the patient location, if you are a practice for the patient and sitting and talking to the doctor, the old-fashioned way through Telus and you can use 02 instead of trying to, if the patient is in the home and don't have to debate, how do I tell where the patient is or where my doctor is is in the home, and they can't get out to do telemedicine from the home. We don't need that differentiation. Use the 02 modifier to say that the service that I am billing for was provided through the telemedicine telecommunication and we don't need to worry about whether the doctor was in an office or at home or wherever. We talked about [Inaudible] and bringing them into the fold. And they haven't been able to use it before a local help the parents are also able to use these codes. If you are a physician and doing family planning services or other services, you can use these codes. Will Medicaid pay for nurse telephonic visit?

There's not a payment for nurse telephonic visits.

With a telehealth is it for an established patient only and can we see a new patient this way?

Telephonic codes have to be established patients. For telehealth they will be times when it's appropriate to see a new patient on telehealth. Use the judgment and make sure the documenting all parts for an EN and visit and I think we are going to ask [Inaudible] to do follow-up on helping practices understand what they have to be able to document to cover the bases. If providers work from home during telehealth services, what address needs to be outputted [Inaudible] locational acclaim in providing sees visions or face-to-face location?

We answer that with 02.

Clarification patients still responsible for co-pay? With telephonic visit?

Medicare patients are still responsible for co-pays with [Inaudible] and telephonic and telehealth visits. As far as Medicaid, Beth I will kick that to you.

We are waiting for our response to the 1135 and I think it will take care of the co-pay getting rid of co-pays. Once we hear back from CMS. To correct the question about the location, there is a place on the claim that actually asked for the address and the service providing and my understanding is you can put where the physician was but I believe for those codes in the time being, they are not going to edit that as closely. That address field new to be filled in but were not going to check to see if the addresses tied to this group across. We will not do that.

We have a question about how to submit further questions. [Inaudible] division of public health are sponsoring additional forms that are focusing just on public health side of. A specific web address for those questions and it does not apply to these questions and I know it seems bureaucratic and I apologize. For the specific questions, look on the deck it is Medicaid [Inaudible] and we can get those answered for this context. We have time for one more question. This will be considered of telehealth? Direct all providers. --

All physicians and nurse practitioners and physician assistants and certified and wife are in that bucket of telehealth. So it is not specialty specific. So it's really specific around who can do it and now we are readily opening that up and we want you all to use it to keep patients at home as much as possible.

We are out of time so thank you for your team and you for the great work. There's a lot going on. We look forward to doing this again next week and as far as I know we will continue every Thursday from 5:30 PM to 6:30 PM until no longer needed. Please submit questions to [Inaudible] so we can be prepared in advance. And if you have any

constructive observations about how we can do this better, we welcome those as well.

Thank you everybody.

[Event Concluded] >>