

Transcript for NC Medicaid, CCNC, and NC AHEC Webinar Series for  
Providers  
March 26<sup>th</sup>, 2020  
5:30pm - 6:30pm

Presenters:

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Tom Wroth, MD, MPH, President, Community Care of North Carolina  
Hugh Tilson, JD, MPH, Director, North Carolina AHEC  
Steve North, MD, MPH, Senior Policy Consultant, NC Medicaid

Hugh:

Hello, good evening, we will get started in five minutes.

Good evening. It is 5:30. Let's get started.

Thank you for participating in today's COVID-19 Webinar for Medicaid Providers. This forum is put on NC Medicaid, Community Care of NC and NC AHEC to discuss recent updates to Medicaid policy and their real world applications. My name is Hugh Tilson and I will be moderating tonight. Before we get started, I would like to take a brief moment to recognize the challenging times everybody is facing and thank all of you for your hard work and commitment to your patients, residents, families, friends and our state. Working together, we will get through this.

Tonight's forum will provide updated information on Medicaid policy and an opportunity for you to ask questions. Today we have Shannon Dowler, MD, Chief Medical Officer, North Carolina Medicaid and Tom Wroth, MD, MPH President, Community Care of North Carolina and Dr. Steve North, Senior Policy Consultant for NC Medicaid. Next Slide.

After logistics, Dr. Dowler will give a overview of recent policy changes. Dr. North will provide a telehealth 101. Then Dr. Dowler will present case examples to Dr. Wroth and Dr. North who will then describe how they will handle the case. We will provide links to where you can get help and then we will take questions from you. Next slide please.

You can submit questions using the Q&A function on the bottom of the screen. We have learned that presenters will often address your questions during their presentations. I encourage you to please wait until the presenters are through with their presentation before submitting a question.

Please note that we can only take questions from those of you on the webinar. We cannot take questions if you have dialed in.

Please do not submit your questions using the chat function, only the Q&A function. Lastly, we will record the webinar and make that recording available to the public as soon as possible on the website, both on Medicaid's website and the website CCNC and NC AHEC are maintaining jointly to update providers. Next slide please, Dr. Dowler.

Dr. Dowler:

Thank you. Who would've thought we would spend so much time together one month ago. We really appreciate the partnership we have with AHEC and CCNC and trying to get that in front of as many providers as possible. We had a call this afternoon with the behavioral health world and we had 1400 people there. I think we had 3000 on the Tuesday night call. We know that people are interested in getting information and we will continue to be here doing this as long as people are interested in hearing from us.

I thank you for taking the time to join us and learn the many ways at Medicaid that we are trying to reduce exposure for vulnerable populations, reduce your administrative burden and provide care and maximize access to care for everybody who needs it. Tonight, I'm going to start off with a high-level overview of policy changes to date. I will go quickly through the ones you have heard about before and then give you some specific updates that are new tonight, specific to our therapies and dental providers as well as tell you a little bit more about what is coming up with behavioral health. We did have a session earlier today for behavioral health specifically. You will find this in the appendix that will be available on the website. All of the code slides will be there and the recording from this webinar will also be available to you.

So, let's go on to the next slide.

As I look at the pharmacy modifications we have made to date, you can see where we are constantly adding and changing them. The few things I could highlight is at the very beginning; we want to allow up to 90-day supply, but that excluded controlled substances. We are considering extending the 30 days for certain controlled substance use. That is for stimulants, ADHD patients and Buprenorphine for medication assisted therapy for opioid use disorder. I am interested if people want to put in the comments or Q&A if you think that would be helpful for your patients to have more than a 30-day supply of those meds. I would be curious to hear your feedback.

Another modification that I will point out. Just a couple of days ago we recognized there was a nationwide shortage on certain inhalers. We have moved a ton of them over to the preferred side so that that will automatically happen. If the pharmacy is out of the one normally preferred, it will kick over to the ones that were nonpreferred and then they will become preferred. Another modification, we did this in partnership with the Board of Pharmacy medical board, was around adding prior authorization for chloroquine and hydroxychloroquine. There is a national shortage. The concern being that patients who need it for chronic disease or to treat malaria acutely may not have access to it. That does have a PA on it now. It will not be filled through Medicaid for the treatment of COVID-19 in the outpatient basis.

Next slide. DME and Outpatient therapy modification; the one to highlight is, I am excited about the third bullet. We are going to allow for blood pressure devices to be provided for Medicaid recipients to monitor their blood pressure at home. So, 20 years I have been taking care of Medicaid patients and I was always puzzled why we couldn't let them have blood pressure devices. We will do that starting Monday. Unfortunately, the only way we can get that covered is by using a DME provider. And I say

unfortunately, we love DME providers, they are fabulous, but it tends to be more paperwork for us. So I've charged our team, we are going to make that process as nimble and minimal as possible. We can't do it through routine pharmacy.

Next Slide. Home Service Modification; the one thing I will point out, we are adding on Monday, there will be home infusion therapy for hydration, so for patients who are dehydrated. You can order hydration at home. And then also, immunotherapy to try and avoid people having to go out to infusion centers unnecessarily. If you have ideas or suggestions for other medications that are only usually given in an infusion center that you would like us to consider for home therapy, please send us that feedback. We would like to hear that.

Next slide.

This slide goes over the virtual care codes that we turned over a couple weeks ago. On the bottom you see the three slides or codes for the Licensed Non-Physician Behavioral Health Providers. Originally those were not available for FQHCs and RHCs and we are adding that. On Monday FQHCs and RHCs will be able to bill to those codes.

Next slide.

Virtual care, this is just a reminder that we have the code for online portal communication with patients in a seven-day window and its around how much time you spent in that seven days. A patient can have multiple different providers bill for those codes and then also our provider consult.

Next slide. This slide goes over the broad telehealth modifications which we have gone over before. We have made it possible for anyone that is within one of the codes that has been approved to do this. So originating and distant sites, there are no restrictions and no prior authorization. Eligible providers are coming out in ways that are listed above and people will be getting these turned on. HIPAA compliance has been made much more nimble. The OCR recommendations have come out and you can use anything reasonable. We link to their website and in our bulletins we list things you can consider using face time or google chat. And then we have also allowed FQHCs and RHCs to bill as distant sites.

Next Slid. So, this is a reminder about our Medical and Clinical pharmacy codes that are live. I wanted to bring your attention to the OBOT or the outpatient based opioid therapy. These codes can be used for this. You will notice that the FQHCs and RHCs have that special designation, that T1015 code.

Next Slide. New today, after much anticipation, looking for the specialized therapies guidance to come out and our bulletin will be there tomorrow. That is for physical therapy, occupational therapy, speech therapy and audiology. The codes will be active in our system Monday and you'll be able to bill retroactively to the 10<sup>th</sup> of March, and that is true for all the telehealth codes. Coverage is based on clinical appropriateness and the ability to perform the service through two way

real time audio and visual. Audio only is not considered Teletherapy. Documentation standards are the same as they are for face to face. Payment is at parity and we are using the same modifiers that we've recommended for the other telehealth codes.

Next slide. We did put some specific things in here because it is odd to think about some of these therapies happening in the telehealth manner because we are not used to that. We know our field is expert in the state and they will do a great job with it. These are just some guidance around making sure and thinking about patient safety and the people around them supporting them, are they safe to do the things and are they conforming to our standards. Prior authorization is only required if it is a new patient. If you already have a patient you have a PA approved for, for doing regular face to face and then we have to convert to telehealth, you don't have to get a new prior authorization. You can use the one you are under. New referrals would need the PA.

Next slide.

This is the list of codes approved for each area. This will be in our bulletin in great detail tomorrow.

Next slide.

For those of you on the phone that are Dentists, we have dental health modifications going into effect Monday as well. We already have the D9995 live but no one ever used it. We are encouraging the field to use that and adding D9996. We are thinking about this for emergency care and there will be more information about how to use these codes in the guidance that comes out. For all of our telehealth codes they will be retroactive to March 10. Some of you have been providing service because private payers are covering it already and you want to do the right thing for your patients. So just know that going back to March 10<sup>th</sup>, you will be able to submit claims for these services. They will be turned on in our system until Monday. I would hold sending those claims until next week.

Next slide.

Okay. We are going to shift gears. A goal for tonight is to talk about how providers in the field might think about telehealth. A lot of people have not been doing this. We went to one of our experts, Dr. Steve North who has helped me with all of these policies, and asked him to give us tips on ways that we can provide telehealth effectively to our Medicaid beneficiaries.

Dr. North:

Thank you. Appreciate it.

I am interested in trying to help people who are just starting up in telehealth improve the quality of care that they are providing. Think about some of the nuances that we often miss. So, right off the bat, there is a huge amount of information available on the web for people who are trying to provide telehealth. Here is a series of great resources.

They are updated regularly. In addition, the State Medicaid website holds many of these resources as well.

Next Slide.

How do you do this? How do you do it successfully from home. One of the first things to do is make sure you have adequate bandwidth. Many people have been running into challenges already with their area seeing a slowdown in Internet service because everyone is now working from home. Try to use a high quality external microphone and speaker to decrease feedback you're getting from the audio system. Everybody hates being on conference calls where there is an echo coming through multiple times. And one the things to remember is you are trying to replicate eye contact with the person that you are seeing, we often try to focus on our own self view. But really, try to set your camera at eye level and look at your WebCam and not the screen while you are having a conversation. That can be difficult.

Next slide. One big change has been that you can now use just about any form of videoconferencing to provide care during this pandemic. That means that you can use face time, a Google hang out, you can even use Facebook if you would like to. You will not come into compliance issues with HIPAA.

Next Slide. Trying to create a professional space at home can be difficult. Trying to think about how to create a professional image is important if you're introducing a new way to see patients to people who have never used telehealth before. You want to make sure you have good lighting. There are two slides that are examples of good and bad lighting. Make sure you are in a private room with the door closed. Try to reduce all the external noises in the house and if your family of four or seven have all descended on your home to stay in place and avoid exposure, this can be incredibly difficult. Don't eat and drink while you are on a videoconference. You should conduct yourself the same way you would if you were seeing the patient in person. Sit at a desk or table. I know of people who have seen patients from their recliner or from the bed and that is not a professional place. Patients can tell you are not as engaged as you otherwise may be.

Next slide. Here are some tips on considering your appearance and your backdrop. From the waist up, wear the clothes that you would wear to work in an office. If you want to wear bunny slippers that is fine. Be aware that clothes and jewelry can interfere at times with what is seen on the camera. That can cause some distortion. You may want to create a professional backdrop or use a blank wall. A nice bookshelf or a set of closet doors. All of those are great backdrops that do not distract from you seeing the patient and from the patient seeing you. Although, I recently had a patient who wanted to read the titles of the books on the bookshelf behind me. That was a little challenging.

Next slide.

Several things that you want to do during the visit. You want to inform the patient where you are and that there is no one else in the room with you. That will reassure them of their privacy. Ask who else is in the room with the patient at the other end. If you are seeing an adolescent and their parents are in the room, you may want to refrain from asking some sensitive questions. When you're talking look into the WebCam. Remember that there could be a lag time in transmission so wait a couple of seconds before you begin your next sentence. When you need to look away to review the chart. Let the patient know what you are doing so they understand you're not checking Facebook and that is why you broke eye contact. And, charting during a telephone conference I find difficult. I am trying to engage the patient and keep good contact there but also look things up. Then finally, when finishing the visit, make sure follow-up plans are clear. In addition, if there is a situation that is an emergency, make sure you know how to contact local resources or a warm handoff to an urgent care center or emergency room.

Next Slide.

Documentation expectations that come with the use of telehealth. You document in the same way you would for an in person visit in your electronic health record. However, provide a statement that it was done using telemedicine or telehealth. State that consent was obtained by the patient. Your institution or clinic may already have a global consent for treatment that includes the use of telemedicine. Document the location of the patient and this may need to satisfy a Medicare audit down the road. Then document the location of the provider. Document the start and stop time and also document anyone who participated in the visit at either site other than yourself or the patient. So if the parent was in the room, or nurses aide, that would be great to document in the chart.

Next slide.

Okay. Thank you.

Dr. Worth:

So this is Tom Wroth, MD MPH from CCNC. We are going to try something a little bit different tonight. Our goal in this webinar is to build your confidence in using the telehealth and virtual health codes. Everybody learns a little differently. What we thought we would do is try some case scenarios. We will have a virtual panel here of myself and Dr. North and Dr. Dowler. Dr. Dowler will set up some cases and different scenarios and help you feel confident in getting this done in your practice. Let's go to the first slide.

Dr. Dowler:

**Thank you. Our first patient is an eight-year-old with ADHD and they are due for a follow-up visit. You guys should know this is not scripted so were going to be spontaneous while we do this. So Steve, what you want to do with that patient?**

Dr. North:

First, getting the patient engaged in the visit can be difficult. Or keeping them engaged. So asking questions about what's going on in the

room and who else is there and making sure you are speaking to the child as opposed to directing the questions to the parent. You need a level of showmanship with younger kids when you do a telehealth visit that you may not need when you see a 42-year-old patient with diabetes and hypertension. Additionally, you want to make sure that you get consent from the parent and not the child. Finally, other things that I think about are since these kids are out of school, are they continuing medication for the whole time. That is not so much a telehealth visit issue but a practice style for what the child needs. I guess finally, something I would consider is, does the eight-year-old need to be in the visit for the entire time? After you have done your initial exam and seen the kid and made sure they are doing well and not having side effects, if there are specific education or strategies you want to discuss with the parents, can the kids go back to building Legos. I think that is fine.

Dr. Dowler:

**Okay. So what would you do for billing for a telehealth visit with that eight-year-old?**

Dr. North:

Most likely this is going to be a time-based bill. I will use the GT modifier because it is a tele-visit. And then I will also use the CR modifier because I am seeing the individual from home. That is a new modifier for this pandemic. I would also um, let's see I would probably bill as a 99213 or 99214 based on time as opposed to complexity.

Dr. Dowler:

**Then what sort of exam would you want to document for that child on the telehealth visit?**

Dr. North:

The standard things, tics, tremors, their emotional status. Can they engage in conversation and focus? For ADHD you have the exam and the history are equally important.

Dr. Dowler:

**What about vital signs? How do you collect vital signs?**

Dr. North:

You could use home vital signs. You could ask the parents to check a pulse. You can easily use a scale and tape measure at home. When it is documented in the chart indicate they were collected by the family.

Dr. Dowler:

**Thank you. Those are great points. Okay. Let's go to the next case. I'm going to come back to you again, Steve. We will talk about a 30-year-old with opioid use disorder. You have been treating, they're on suboxone and they are due for a follow-up visit.**

Dr. North:

This is one area that is getting a lot of attention. Concern around what will I do without a urine drug screen. The American Society of Addiction Medicine yesterday just added a statement saying that you should reconsider the frequency of drug screens and the necessity in stable

patients. So, with this individual, I am going to see them from their home which might give me a greater level of insight into their life and lifestyle. I'm going to ask them to take out their medication and put a paper towel on the table in front of them and pour out their pills and we will count them together. Or their strips if it is Suboxone strips. We can have our therapists see them as well. That can be a combined connection so that I begin the visit and I leave and the therapist comes back. We can build that on the same day. Those are some considerations I have.

Dr. Dowler:

**Thank you. So how do you bill that visit?**

Dr. North:

Similar to how I did the last one. More likely based on time than on complexity. Unless I was making a dose change or adding another medication for their anxiety. So, probably 99213 or 99214 with the GT and the CR modifiers.

Dr. Dowler:

**A lot of people have been asking about the difference between a telephonic visit and a telehealth visit. Other than the fact that the reimbursement for telehealth is much higher whereas the telephonic codes are less, what do you document differently between the two?**

Dr. North:

The physical exam is the thing that is going to be distinctly different. You have nothing to really include on a telephonic visit. Beyond that, the history and the systems, the plan will pretty much be the same.

Dr. Dowler:

**I think the telephonic codes are something I would do for a patient that I know really well, that is just due for quick where a refill and I'm not getting into much depth or have concerns about and saving the telehealth for those patients that you want to spend a little bit more time with and maybe want to do some exam components.**

Dr. North:

Yes. I think that is a great way to differentiate the visits.

Dr. Dowler:

**Okay. Let's go to the next case. Tom, you have a 28-year-old with depression and panic disorder, that is not a new patient, you've been seeing them for a while. How do you handle this visit?**

Dr. Worth:

Okay. Great. I think this is where Steve taught me a new term this week called screen side manner. I think some things that Steve talked about a few minutes ago, the patient with anxiety and depression, you want to be able to project compassion and calmness. I think that set up he was talking about was important. I have a couple of other things, I might have one of my team members, a medical assistant call the patient first and ensure they can use the platform properly. We are using zoom in our practice. They may not be able to download that for whatever reason. We



might want to use FaceTime. I would go through and get the consent and the place of care. I think the key thing in these visits will be the history. That should be fairly straight forward with telehealth. One thing to think about is it is often helpful to do your PHQ 9 or do one of these validated scales and how do you do that in telehealth? Some ideas are some people are able to push that out through their patient portal and have the patient fill it out ahead of time and then share it during the telehealth visit. You could use the PHQ 9 on your side to drive the history and use those questions as you go through the history and fill out that and get the score at the same time. So a key part is the history in telehealth. I think this is where you can document the eye contact, the affect, whether the patient appears anxious, those sorts of things. Then I think in the planning, it has been talked about, it is important that we have good follow-up here and think about other team members like behavioral health providers and CWSs who might be able to come in during the visit or a little bit later.

Dr. Dowler:

**What would you do if this were a new patient? Would there be anything different?**

Dr. Worth:

With a new patient, we go back to some of our new patient guidelines just like in face to face. When we take the history it is a little more comprehensive and you get past medical history and family social history. The exam components we would attempt to do more exam components. It is hard to do during this visit. But really, it is going to be the same.

Dr. Dowler:

**Okay. How would you bill for this patient?**

Dr. Worth:

So this patient I made some medication changes. From a complexity standpoint I would bill a 99214 with the GT modifier and the CR modifier.

Dr. Dowler:

**Okay. Then what if you were at an FQHC seeing this patient. What would you do differently?**

Dr. Worth:

The only thing different for coding and billing is the core service code I'd use the T-1015 with a GT and CR modifier. Of course, in an FQHC you often have access to other team members. So hopefully I might have a virtually co-located behavioral health specialist that I might be able to bring into the visit or a pharmacist or other people that could collaborate.

Dr. Dowler:

**That is definitely, we are taking co-location to the next level. Okay. What if this depressed patient was in crisis?**

Dr. Worth:

That is challenging face-to-face and more challenging in a virtual space. I think the things I would think about is keeping the patient on the line

while.. and trying to think about how I can bring in more help. So what would be great, if I am using zoom, I could invite my LCSW to join me on the visit. That would give me some time to ensure we have had a safe plan for follow-up.

Dr. Dowler:

**Okay. Okay. Let's go to the next case. The next case is a 16-year-old with seasonal allergy symptoms and a history of persistent asthma. Steve, what are you thinking about with this kid?**

Dr. North:

I think what is on the front of all of our minds is, does this kid have COVID or this really just seasonal allergies? That is an important thing that we need to be thinking about. Not that I suspect that going into this visit, but instead, is that what is on the parents minds or on the patient's mind? So the things that I think about are, one, since this is not a protected visit around mental or sexual health issues, I need parental consent to see him via telehealth. Two, after I get the history, what am I going to do for physical exam? Often this is a place where some things we do as physicians have become second nature and reflexive. We automatically look for retractions and when we don't see them, we don't say oh, no retractions or rarely do we document that. Its when we see them that it stands out. So using those visual physical exam findings that I can pick up on as second nature now. Is there nasal flaring? Is there rhinorrhea? Is there nasal discharge? Does he have allergic shiners more present in a younger kid, perhaps. What about chest excursion? Is he answering in full sentences when I ask questions? That is where relying on something more than just your stethoscope is important.

Dr. Dowler:

I think also in a physical exam, you could probably look at skin turgor or capillary refill and other things that you might do to assess given our times. It is not ideal, in a perfect world, we would bring them into the office but right now we are trying to be really careful and keep the mild illness at home. So what if this guy had a 103 fever and his mother said she was worried about -- excuse me -

Dr. North:

So I think if he had a high fever and other signs and symptoms, I now need to think, is my management going to change based upon the high fever? Three months ago I probably would have wanted a chest x-ray. If he's got clear nasal discharge and a cough and I am thinking that this is Coronavirus infection and COVID-19, really, am I going to admit him? That's the reason I would bring him out of the house. So my thought would be, this is a great time for serial exams. See him today and tomorrow and have Medicaid pay for a pulse oximeter and get that to the home and those would be my steps on this.

Dr. Dowler:

**Okay. So how do you code for this?**

Dr. North:

I'm going to go this as level 4. I will document that he is home and I am in my home office. I document the start and stop times. We would probably

talk about over-the-counter medications and he can be using and he also expressed some concern to me about the frustration of being at home and maybe I diagnose adjustment disorder and provide some counseling there. Billing will be very similar to what we have used in everything else. 99214 with the GT and CR modifiers. This is not an individual I would feel as comfortable seeing or providing care for in a telephonic visit.

Dr. Dowler:

**Yes. You want to see what he is looking like.**

**Okay. Let's go to the next case. We are going to talk about a 62-year-old. Tom I will give you this one. Diabetes, hypertension, hypercholesterolemia, due for follow-up but you don't really want to bring him into your office. How are you going to see him with telehealth?**

Dr. Worth:

Great.

So yes. This is an example of somebody that is a nonessential visit and a lot of these visits over the last week or so we have been pushing into the future. Let's say we actually have made contact and set up a visit on our telehealth platform. I think what is interesting about this visit and what's kind of neat is there is a lot of data you can collect in terms of a physical exam and other monitoring data for diabetes. If you go to the next slide, I wrote up a mock note. This patient has a home blood pressure monitor and has been monitoring at home. They can take their height and weight and temperature. I can teach them to take their pulse over telehealth.

They can take their blood pressure so I really have a complete set of vital signs. I take my routine diabetic history on physical exam as you both kind of went through. There lots of different things I can pick up on an exam. For this visit of the most important thing is that they appear well and have no particular distress and there is a not a lot else going on. If you go to the next slide, there are some interesting things you can do with your diabetes follow-up. I might make some medication changes with insulin but I really we want a close follow-up so I can continue to titrate their insulins. They might use the patient portal on the electronic medical record to push me some their blood pressure readings. I think some other things to think about is the blood work that we do in diabetics routinely. We will have to arrange for a phlebotomy. We will think about how to do that, either do a drive by in our practice or some other method of getting the blood work. And then there are other things like foot exams and eye exams that I might have to defer until the benefits outweigh the risk during the COVID situation.

Just a reminder on the medication refills, make sure on the blood pressure medicine that I do a 90 day refill to make sure the person doesn't have to go back and forth to the pharmacy.

Dr. Dowler:

I noticed that you talked about your office flow and how you might use a medical assistant or nurse to help you with office flow. About contacting the patient ahead of time and making sure the patient has

whatever platform you are using available, I think that is a great way to use your team.

**Okay. Let's say with this guy, when you meet with him, he starts telling you about his blood sugar and he is off the chain. You knew if you're going to check A1c you would probably be worried about him but you maxed him out on everything. In a normal state, you would say, you know what, it's time, I am crying uncle, I'm sending you to the endocrinologist. Right now, you may not want to do that. What else could you do?**

Dr. North:

I think this gets back to some of the codes you were discussing before. There is the virtual health code, the interprofessional telephonic or telehealth codes and I could reach out to my endocrinology colleague, if I was in an integrated system, I could do that through the EMR. I could also do it telephonically or in a telehealth audio and visual visit. Then those conversations can go back and forth over a period of time and these specialists would bill based on the amount of time spent and they would do the documentation on their side to support that billing. I think that would be an effective thing to do during the COVID situation.

Dr. Dowler:

Yes. The complexity goes up for you because you have used another consultant as a part of the evaluation, for the time you have spent. So while the consultant bills for the actual services, it benefits and you as well and benefits the patient.

Dr. Worth:

**I have a question for you. What if I wanted to get a dietitian involved with this patient to help them with their diabetes management?**

Dr. Dowler:

Well, I would like to tell you you can do it right now but in fact our registered dietitians are in wave 3. So we are already starting to work on wave 3 because we will be ending wave 2 this week. We will have all of that code guidance out for the wave 2 folks by Thursday of next week and then their codes will be turned on in the system by the 7<sup>th</sup> of April and remember, all these codes that we are turning on will be retroactive back to March 10. So you will use your friendly dietitian.

Dr. Worth:

Great. Thank you.

Dr. Dowler:

**Okay. Let's do one more case. So Tom, I'm going to hit you with this one. We have a nine-year-old with eczema. She sent a message through the portal that she needs something for her eczema. How do you handle this?**

Dr. Worth:

Yes. Those of us doing these portal visits oftentimes it is like secure email. It can go back and forth, you might have to ask additional questions. Sometimes, depending on when they get back to you or when you are able to get back to them, this can go on for some time and over a few days. These portal visits you can do within a seven-day time period. On

the next slide, we mocked up a little bit of a portal visit so, Dr. Dowler, you got this on a Monday morning and were able to respond on Monday afternoon and then she was able to respond back to you Tuesday morning. You got her a good plan on intensifying her eczema treatment and getting her medication refilled and you could bill this under the portal codes, 99421 through 4. Those are all time-based codes with a CR modifier.

Dr. Dowler:

**Let's say, two days later she says oh my gosh, my area on my elbow is really red and weepy. I think I need something else. What you do next?**

Dr. Worth:

So, I think I would convert her to a telehealth visit. I would either arrange for myself or for a team member, arrange for her to get on facebook messenger or face time or our platform and we would look at the rash and see if we could treat it over telemedicine.

Dr. Dowler:

I like it.

Okay. Thank you. I appreciate you helping out with these cases to get the field thinking about using telehealth in a variety of ways. Why don't we turn it over to questions and answers.

Hugh Tilson:

Great. First let me run through some places where we can go to get some help.

We will make these slides available, as well as a transcript and recording. You can get them on the Medicaid website so [Medicaid.ncdhhs.gov/coronavirus](https://www.Medicaid.ncdhhs.gov/coronavirus). All of these links will be there. You can submit questions through that as well. You can see there are a number of Medicaid resources available for you.

Dr. Dowler:

Let me jump in. That website, the [Medicaid.ncdhhs.gov/coronavirus](https://www.Medicaid.ncdhhs.gov/coronavirus), that is where you need to send all your question. Don't try, try not to send them to individual people that you know at the Medicaid dept. Send them to that website. We have a whole communications team that are putting together frequently asked question. I've asked them to get back within 2 hours whenever possible. This is true for coding questions, billing questions, claims aren't going through. Please use this website. They will get you answers quickly.

Hugh Tilson:

Okay. I wanted to give you some summaries where you can go if you go to the telehealth billing codes summary you can click on the link and go to the community care website. That is a joint website that CCNC and AHEC have stood up to provide summary information as well as the special bulletins link.

Then, here is the website that I referred to earlier with all kinds of information about Medicaid and other things related to covid-19 to make it easy for you to gain access in one place.

Next Slide. I want to mention quickly that this webinar is about Medicaid questions. We are also hosting webinars with the Division of Public Health on public health questions, so testing and quarantine and those types of things. Those are Friday at 12:30. We hold this every Thursday from 5:30 to 6:30 and we encourage you to keep participating.

**Next. So, questions. First is, what wave are we in? Can you talk about where we are and we have lots of observations about the great work that has been done and how appreciated it is. But there is also a lot more coming.**

Dr. Dowler:

Yes. So I use the analogy of where we are right now with Medicaid is turning a huge tanker in a narrow canal it. And so the huge tanker is the Medicaid program and the narrow canal is the COVID crisis. It is hard to turn quickly in that canal. When we do that, we are making lots of waves which hence are different waves of releasing things. Some of you are in small vessels and others in larger crafts some of you are definitely worried about drowning. Our goal is to turn the tanker as quickly as possible. We have completed the first wave. I just signed off before this call on the bulletin for wave 2.

Our team is submitted to our vendor who does all our coding and billing stuff, all the changes that need to be made for wave 2. They should be implemented in the system on Monday. We are already working on wave 3. So by the end of the week, the next wave is announced with our bulletins and then at the beginning of the week our codes turn on. There will be wave four which is focused on preventive health. We wanted to get through the acute care and also through all our different provider types. We didn't want to do everything medical and leave out our specialized therapist or only focus on one group. We are trying to get through everybody so everybody has guidance on something and then we will focus on preventive care.

Hugh Tilson:

**Great. I have a question about does the order of the modifiers matter? So I thought it was an opportunity to emphasize the importance of using these codes and clarify whether the order matters.**

Dr. Dowler:

That is way above my pay grade. Beth Daniel, are you still on the call?  
>> She was on earlier. She was chatting with me.

Hugh Tilson:

We will get that.

Beth Daniel:

Can you hear me?

Yes. I forget to unmute myself in two places.

Right now, we have not found that the order of the modifiers make a difference. I would list them as GT and then CR. If we find it makes a difference in processing, we will let you know.

Hugh Tilson:  
Thank you.

**We have a lot of questions about the use of telehealth and telemedicine. Are there examples of virtual chart documentation?**

Dr. Dowler:  
That is not something we at Medicaid would provide. That is something our partners with AHEC and CCNC could provide. As a matter fact we have shared together for Practice Support to help with this work. I definitely would look to AHEC and CCNC to get you that guidance. You want to speak to that, Tom?

Dr. Worth:  
Yes. Hugh and I both would be happy to get some examples of documentation. On the slide there are some great resources there. The mid Atlantic Telehealth Consortium has some great guidance around documentation as do some of the societies. We will also reach out to Steve North to help with that.

Hugh Tilson:  
Great.

**Can Skype or zoom be used? Does it matter the platform?**

Dr. North:  
Yes. This is Steve. Skype and Zoom can both be used currently in their free versions. Long term you may want to look at a paid version that gives you more bells and whistles. Honestly, right now, providing care is what is critical. I do know that Zoom is having difficulty keeping up with the licensing requests. A friend of mine from a children's hospital told me that earlier today. Get on the free version and do what you can. Also, there are 50 platforms out there. Take a little time and look at what is available.

Hugh Tilson:  
**Great. There were some other more technical -- if clients don't have video capability or if video conferencing fails because of bandwidth, do you have to use telephonic codes and not use E and M? How do you distinguish if you start and then move from one to another? Is that too technical for this or does that make sense.**

Dr. Dowler:  
Yes. Audiovisual is required to bill it as telehealth. Otherwise, it's virtual care and needs to be telephonic.

Hugh Tilson:

**Okay. So what do you do if your patient does not have a smart phone or anything like that? Will a landline to work? Does it matter what they use for phone?**

Dr. Dowler:  
Land lines are great. I love land lines.

Hugh Tilson:  
That is what I thought. Just wanted to make sure.

**Okay. What is the best way to get a telehealth visit consent if off-site and virtual? Can patients verbally agree to a written note and what about children?**

Dr. North:  
This is Steve and I would say that yes, verbal consent is appropriate. You could develop a form and send it through the patient portal and children, you need to get the parents to provide consent.

Hugh Tilson:  
**Any tips about how to help patients use the video, maybe they are technologically challenged.**

Dr. North:  
There are lots of instructional videos on either the platforms website or YouTube that you could push to them. Coaching them through over the phone would be difficult.

Dr. Dowler:  
Yes. I have been surprised that the older patients that have grandchildren. They are used to Skype and communicating with grandkids that way. The ability to use the technology has been pretty impressive to me. My mother was group text messaging during the pandemic. That goes well sometimes and other times not so well.

Hugh Tilson:  
I just got a Zoom invite from my 80 year father. They are learning all kinds of new things.

**Our mid-level providers reimbursed differently than physicians for telehealth services?**

Dr. Dowler:  
That I need to give to Beth. I better not answer that. Can you answer that, Beth?

Beth Daniels:  
Its parity. My understanding is if you have a nurse practitioner whose providing a 9921 series service that whatever that person would get reimbursed for a face-to-face they would get reimbursed on the audiovisual.

Dr. Dowler:  
That is my understanding as well.



Hugh Tilson:

**Okay. The age of consent for telehealth. Is it 18?**

Dr. North:

That is a great question. Adolescence can consent for care on their own for behavioral health issues and issues around sexual health. There is not an 18-year-old age restriction. But for other care, they would need their parent's consent.

Hugh Tilson:

Got it.

**Okay. We have a question that has two components. Given that the telehealth parameters could change post COVID-19, are we better off using zoom, skype etc. or making a in investment in a sophisticated virtual platform.** Sustainability of this is what that question is.

Dr. Dowler:

I will take that.

I will tell you that we started the team Medicaid at DHHS back in December. We wanted to update and modernize our telehealth policies because we felt like we needed to do that. Having said that, we are functioning without a budget this year, so expanding telehealth broadly without a budget is not an option because it potentially has a significant cost. What we are going to be able to do during the pandemic is study how it's used and look at is it replacing face to face visits or additional. My hope would be that we will continue to offer broad telehealth services but I definitely cannot commit to that. So much depends on our budget flexibility and what we are able to do. These are temporary provisions right now.

Hught Tilson:

**From a reimbursement does it matter if you use free technology as opposed to others?**

Dr. Dowler:

No.

Not right now.

Hugh Tilson:

Okay.

**Okay. Is their a phone number or contact email to help with claims that are not getting paid as these are going into effect?**

Dr. Dowler:

Yes. We want to hear from you. Use that [Medicaid.covid19@dhhs.nc.gov](mailto:Medicaid.covid19@dhhs.nc.gov) email. We will have people and the person managing that will be sending things to the finance group or to the policy group. We want that feedback.

We did meet with our vendor on Tuesday after the first set went through and we did not have any denials come through in our last meeting. If you have a denial, we want to hear about it so we can fix it.

Hugh Tilson:

**Okay. I have a couple questions that are more specific. Let me -- can you explain PCS visiting hours being removed. You want to take that, Beth?**

Beth Daniels:

I can. What we have done is removed the limits on personal care, private duty nursing. Right now we have ceilings where patients could not go beyond a certain ceiling and number of hours. In this pandemic we said we were not going to hold those restrictions. If someone was hospitalized with COVID and they needed a lot more care than they would have expected. We don't want to keep them from that care. So from that perspective we are removing those limits. Prior authorizations are still in place for some things but not others. We are working on a guiding document for everyone to share. We will have that backed by the beginning of next week. We want to remove administrative burdens that we feel like they could be related in any way to the pandemic.

Hugh Tilson:

**Have a follow-up to the question line. It seems that some of the bills are being paid differently than some others for the same providers. All of those should go to the Medicaid Covid question line you suggested before?**

Dr. Dowler:

Yes. That is what I would do. Okay.

Hugh Tilson:

**Will LCSW use the same billing codes or are they for doctors only? If not, what codes would a LCSW therapist use?**

Dr. Dowler:

We have a whole set of behavioral health codes in the appendix of this slide deck. There was an hour-long presentation on behavioral health providers that at 3 o'clock today. That webinar and the bulletin will be out tomorrow. You will be able to get into that. We have a lot of codes.

Hugh Tilson:

**Okay. Some online platforms allow you to record a telemedicine session. What guidance you have about recording or not recording?**

Steve, do you want that one?

Dr. North:

I do.

Do not record your telehealth sessions. If you need to take a screenshot of a rash, that is fine. If you have the capability of putting that in your record. We don't record our in-person visits. Nationally, no one is recording their routine telehealth visits. It may open you up to a huge amount of liability and also, where you going to store that data?

Hugh Tilson:

**Okay. Last question. Can you confirm these codes apply to Medicaid for pregnant women as well?**

That is a great question. Medicaid for pregnant women fall into a special rate. Beth, do you want to speak to that?

Beth Daniel:

Yes. Medicaid for pregnant women, the services they are able to get in a face-to-face basis they can get via telemedicine.

Dr. Dowler:

And we have added the blood pressure cuffs specifically to keep pregnant women at home as much as possible during this. We want them to be able to track their blood pressure.

Hugh Tilson:

Okay. Great. One more question. Am I able to do telehealth visits if I do not have a direct contract with Medicaid. I am a locums provider who is unable to travel because I am immuno-compromised.

Dr. Dowler:

My understanding is you have to be an enrolled Medicaid provider.

Beth Daniels:

Yes. And as a locums who is not in the office providing care in place of a person, another doctor, then there would be no one to bill for you if you are not an enrolled provider.

Dr. Dowler:

But, we do have an expedited enrollment process right now for new providers because of the emergency order. It is much quicker and easier to do right now.

Hugh Tilson:

Great.

We are out of time. Let me just pause to say thank you, not just for the great webinar tonight but all that you are doing. Dr. Dowler you mentioned how quickly you have been moving this battleship. It is noted and appreciated. Please thank your team. Thank you for your time tonight. Do you have any last words for participants?

Dr. Dowler:

This is Shannon. I can't wait to get through all the waves so we can start floating in the pool and sipping on a Mai Tai

Hugh Tilson:

I can't think of a better way to end this. Thank you all very much. Take care.

Okay. [ Event concluded ]