Transcript for NC AHEC Telehealth Virtual Office Hours Webinar
April 13, 2020
12 pm – 1 pm

Presenters:
Lakeisha Moore
John E. Jenkins, MD
Kathy Wibberly, PhD

Please stand by for realtime captions.
The webinar will begin in about five minutes.
Or Moderator will begin in about one minute.

Lakeisha Moore:
Good Monday afternoon. Welcome, I thank you for joining us today for the Telehealth virtual office hours webinar series. I am Lakeisha Moore with North Carolina Office of Rural Health Initiatives. I am joined today by Dr. John Jenkins with the Greensboro area health Education Center (AHEC) and some of our partners from AHEC, and other special guests. Dr. Kathy Wiberly, director of the mid-Atlantic telehealth resource center, will be joining us as well.

During today's webinar, we will be sharing some telehealth billing best practices and other telehealth resources across our State. If you would like to ask a question during the webinar please type your question by clicking on the Q&A icon, and we will work to answer as many questions as we can, time permitting. Also, if you need technical assistance during the webinar you can email Technical Assistance COVID-19 at Gmail.com and someone will assist you. Also, a very special welcome today to our safety net sites across the State. Thank you all for joining us today.

Once again, we are excited to talk with you today about telehealth billing best practices that we have seen across our State amid the COVID-19 pandemic. We hope you will be able to incorporate and adopt some of these best practices into your organization and workflow.

This week, our agenda for today starts off with Lisa Renfro from AHEC who will share information on how you can receive continuing medical education or CME for this webinar. Then Dr. Jenkins and Josh Halverson with ECG Management Consultants will share telehealth best billing practices. Then Felicia Coates will share case studies. Kathy Wibberly, Matrix director, will share telehealth best practices that she has seen across the region and additional resources that are available to you through Matrix. And then we have Robin McArdle, office of rural health telehealth specialist with us, to share your questions.

Some quick housekeeping items before getting started. This webinar is being recorded and will be available on the Office of Rural Health and AHEC website with the slides. If we are unable to answer questions during the session today, know we will consider that question for future telehealth webinars. So without further ado, we'll turn it over to Lisa who will share with us how we can receive CME for today's presentation

Lisa:

Thanks, Lakeisha. To obtain CME credit, CEU or contact hours for participation in this webinar you must have an updated my AHEC account with an updated cell phone number listed. If you do not have an have an account or cell phone number associated with your existing account, you will be prompted to create or update this information once registration is completed. To register your attendance for today's webinar please text 5D6B7 to (336)793-9317. Both the code and phone number are listed on the current slide. For additional instructions on how to register using the text registration system, please visit www.nwahec.org/textreg as shown on this slide.

Next slide.

The continuing education for this program is being provided by area L AHEC in partnership with the office of rural health and the NC AHEC program office, Northwest AHEC in Greensboro. Specific credit information is listed on the slide. I will now pass it over to Dr. John Jenkins.

John Jenkins:
Hello. So this is episode four of our best practices for telehealth. I will start off with a quote, that we usually do, from Brene Brown: "to me a leader is someone who holds herself or himself accountable for finding potential in people and processes" and what Brene said is really important is sustainability. And we are going to talk about the why and access to telehealth during the crisis. And today we are going to talk about how to sustain our practices during the crisis.

Today we are going to have a conversation with Josh Halverson, who is a principal at ECG management consultants, and he is in Texas joining us remotely. And we are going to talk about some of the things we have been hearing from the people participating via the webinar. They are experiencing a decline in in person visits across the nation as we have rapidly deployed virtual visits to meet the COVID 19 crisis. There have been practice tensions. Guidelines are variable, each payer has different guidelines and this is frustrating our staff and providers. And documentation required under the exemptions are not as well-known as they need to be. And how we determine if it is a telephonic versus telehealth, and what are the requirements by insurer. What are the types of visits by specialty covered under the new exemption? And what are the additional documentation and coding requirements. Especially for FQHCs and rural health clinics, and some have expressed that this is burdensome. Some need financial support to be viable.

There have been delays in reporting. Is this going to create a back backlog that will eventually affect our practices and finally financial worries. They seem to be mounting daily. An email on Friday from our practice group talked about how physician salaries might be impacted by this crisis. Now we have ambulatory care, is this going to be forever changed by telehealth after COVID 19?

Some good news, which I really do like to share. This is about flexibility for rural health clinics and this was published late last week and it was shared by CMS. And I think this is great news for your practices.

So Josh, let's talk about some of the data that ECG has collected. And in March we saw a crash in the market but ECG talked about the crash about practice productivity during March 2020 by all specialties. Can you comment on what this means for healthcare?

Josh:
Yes, a few caveats, John. We took a snapshot of a couple of organizations and comparing March 19 to March 2020. This is not representative or increasing our sample size. On this chart, we see that primary care preventative services that were particularly hard hit by the reduction in volume, because people were staying home. There are issues around how people are coding for virtual visits and telehealth episodes but the complexity around this, as you can see, is that all specialties are being impacted. There are different stories for each specialty. For example, surgical specialties, have been negatively impacted because elective surgeries are either delayed or they are canceled. And this is going to probably look worse in April. This is challenging news.

The impact is different by location and geography. Group A is Northwest, which is an epicenter of this, and group B is in the Midwest, which for whatever reason you can see they have been impacted more.

John Jenkins:
On the next slide, you give us a graphic representation of what happened when production decreased due to covid 19, a surge of back to normal and a new normal. What does ECG think of these three scenarios?

Josh:
We think there will be a version of each scenario for each organization across the country. Let's go back to the more complexity, within the organizations, the future state may be different by specialty. So there might

be a demand in some specialty areas that will create a surge, that is the number one scenario. And other specialties will not get back to normal, so we are contemplating a new normal for some specialties. So it is dependent on geography. And what happens to patient preference. We do think, and we will talk about this later in the session, the cat is out of the bag on virtual services. And organizations really need to think through how they are going to use those services moving forward.

John Jenkins:
The new normal might be driven by consumers, who have experienced virtual visits and they really do not want to go back to the same level of face-to-face visits prior to this.

Josh:
Yes, even before COVID 19, there was a pretty significant push by consumers for convenience, to have virtual options. We see that intensifying and accelerating, and frankly staying after the crisis.

John Jenkins:
So you talked about some of the drivers of the downslope in RVUs, I am going to turn this over to you, please comment on what is happening with our practices and viability of our practices causing the instability?

Josh:
This is a graphic representation of a simplistic practice. Basically on the left-hand side, the revenues or collections of have went down because volume and ancillary services have gone down. And overhead, benefits, and compensation is staying the same. So essentially there is pressure, due to the sharp decline in visits. Practices are really feeling a lot of pressure to maintain their labor force by paying out compensation. But the virtual model does take time to implement. We are seeing providers delaying, frankly because they do not have iPads or other kinds of equipment that you can use for a virtual visit. And again we will talk about what we are seeing during those virtual visits, that they do not replace productivity (in RVUs or collections), just because coding is different and the providers do not have a lot of experience with those codes. And when we think about staffing models and other things we are seeing a lot of rigidity and the lack of flexibility based on the volume demand. So we do see tremendous pressure on practices, and that does create concerns about sustainability.

John Jenkins:
Can you share your practical interventions that are useful at this time? To stabilize our practices and prepare for the future.

Josh:
The way I think about practice economics, or the income statement, we have revenue and collection at the top, and you have practice expansion in the middle and what is left over is for physician compensation. When you look through all of these categories, practice collections are based on patient volume, performance and payer rates. And trying to prioritize and maximize these virtual services will be key. And also, wellness visits which helps provide value to the patient panel can be prioritize. Making sure that your revenue cycle is in order. Prioritizing payers and having short payment cycles. And then you have coding procedures, that is related to virtual services. And again, from our perspective, payer mix making sure that we have, you know, one would think about safety in the practice, and we know that this is limited, but maximizing commercial payers when appropriate. Let's go quickly to practice expenses with supplies and other variable expenses. Making sure that purchasing and supply chains are optimized so that you are not building up unnecessary inventory. The goal is to have the private practice maintain liquidity by avoiding unnecessary inventory buildups. And match your staff to the patient demand. Across the country right now, when we think about making sure that the staff is reassigned to the most productive use of their time. And utilizing PPE and other loans and programs for non-for profits that are available. Those are useful in preserving the workforce. And lastly, provider compensation. This is another great thing to look forward to. As with other sectors in the economy, the shock of COVID, we believe will impact the provider compensation especially when RVU

compensation models are used. So planning for that and be proactive, and evaluating what productivity will look like is very useful when projecting compensation. I will stop to see if we have any questions.

John Jenkins:
Josh, we will save those for the end. And Josh will stick around for your questions at the end of the presentation. I want to turn this over to Paula and Felicia, who are from our NC AHEC office. They are going to give us some case studies for guidance on billing and coding.
Ladies?

Felicia:
Thank you John, this is Felicia. I want to thank Paula for her work as she prepared these case studies. The first one, is telehealth. This is a 30-year-old established patient with hypertension needs a follow-up visit. They are going to see the provider through Skype, an audiovisual platform. So the first column that you see, is the CPT code/HCPCS code. And because this is an established patient, we use the code whatever the provider thinks is appropriate. Same with BCBS. And for the commercial, commercial plans are payer specific. The practice would need to check with the individual payer for the patient. Then you have place of service, Medicaid and Medicare use code number 11. BCBS would like a 02 which is telehealth. And for Modifiers, Medicaid asks for GT saying it's telehealth, and CR says it's catastrophic because of the pandemic. For BCBS, no modifier is needed. [Inaudible] and the place of service is normally billed at 72 or 50. Please go to the next slide.

This is a telephonic, meaning there is no audiovisual, it's audio only. So this case, the patient had an appointment but they do not have Internet access for follow-up for diabetes and medication refills. So because it was audio only we will use telephonic code. And for Medicare, and Medicaid, we have 99441 99443, which are time-based codes. For BCBS, it's not covering telephonic right now. For commercial, contact the specific payer. Place of service, again we use the usual place of service. And for Medicaid it would be 11, and 72 or 50 depending on if it's FQHC or rural health center. And the modifier, none required for medicare for telephonic. Medicaid would only be CR since it's telephone, not audiovisual.

Paula:
Hello and good afternoon everyone. The next case is another telehealth case study. 28-year-old new patient, contact with positive COVID 19 patient and reporting symptoms. And in this case, we are looking at different payers. Since different payers are doing different things at this time. We have a CPT code, 99201 through 99205. Those can be reported for Medicare, Medicaid, BCBS. Other commercial payers use the same new patient CPT code, but you do need to be specific when you are looking at the place of service.

And again as shown on the previous slide, you have the place of service codes for Medicaid and Medicare are 11 for FQHCs and 72 or 50 for RHC. When you go to the modifier section, Medicare is requiring 95, Medicaid has GT and CR, and Blue Cross Blue Shield do not require modifier if it isn't audiovisual. But if you do start the visit and for some reason the video goes out, then you use the CR modifier so that it will indicate that you had to complete the appointment by audio only.

And the next one is a telephonic case for the FQHC that patient called in for an ADHD refill. And you have to look at the G0071 HCPCS code for Medicare Medicaid. And for FQHC the code is 72. For rural health clinic, it's 50. And here you have Medicaid, that requires GT and CR. BCBS North Carolina do not cover telephonic, so you will not be able to bill that. For the commercial carrier, it is specific to that plan so you do have to contact the payer.

NC AHEC has tip sheets and guidelines by clicking on this link down below.

One of the frequently asked questions that we have is 2019 MIPS changes due to COVID 19. Data submission deadline were extended until April 30, 2020 at 8 pm if you want to submit for 2019. If the QPP receives no submission, the providers will receive an automatic extreme and uncontrollable circumstances policy apply and receive a neutral payment adjustment for the 2021 payment year. If you already submitted

and want to take an exception, you still can. You can look at the QPP website and apply for hardship. The extreme and uncontrollable application is on the QPP website.

And of course you can follow us, by clicking on our Facebook link and our Twitter link. We have tip sheets, resources, and you can find this on our sites. I will pass this back over to Lakeisha Moore.

Lakeisha:
Thank you all. I know we have several questions regarding billing, thank you so much for going through all of this. We do want to save time for Q&A. Next we have Dr. Kathy Wibberly, who will talk about some of the resources available through MATRC or mid-atlantic telehealth resource center. So welcome, Kathy.

Dr. Kathy Wibberly:
Thank you. I want to talk about telehealth best practices. I think this slide tells us that in the blink of an eye, telehealth and healthcare have become synonymous. Those of us in the telehealth world that have been in this world for 30+ years, we are somewhat thrilled and somewhat surprised that telehealth has been an overnight sensation. And we thank the good Lord for 30 years of pioneering and best practices. Next slide.

A couple of things that I really encourage people to do, especially at this juncture where everyone is trying to start telehealth yesterday. Ask yourself this question before you jump into finding a solution, and that is, what is the problem I am trying to solve or fix? If you were talking to me about this two years ago I would say take one month and look at your data to do a needs assessment. But we are not in that time right now, we are in the place where we had to start yesterday. But what is the problem I am trying to solve? Is this could be temporary or is this something that I am doing during the pandemic and I am never going to do this again? Am I just looking for a short-term, temporary fix? Or, you might say, this is something I want to continue for at least a subset of my patients, if not all of my patients, after the pandemic.

So where is the starting point? If you are looking for a temporary fix, you can jump in and do whatever you can. But if you are really thinking long term, this is something that I have been wanting to do for 10 years, and now I have this opportunity so let's just do it. So then start thinking about what the problem you want to solve. Because a lot of times we let technology drive what we do. That is the first best practice, what are those best practices? Next slide.

So the next thing you should think about, is my organization actually ready to make these changes? You might have a provider or two who wants to do it, but you really need to engage all of the people in the organization. If you have an organization that has 20 or more employees, you really need to start asking some questions about who is willing to make this change or who is not willing to make changes? Because if not everyone is on board, you are going to end up having unanticipated issues or challenges. Next slide.

I think one of the things that we always say in terms of best practice, every practice needs to have a clinical champion. Who in the organization sees a problem and is motivated and willing to do the hard work to find a solution? We like to think that telehealth is easy, but it really is not that easy. Because it requires changes to certain protocols and workflows. So it takes someone who has the vision on why we want to do this. Many times people think, I have to do this, because my revenue is sliding down, I need revenue, and my staff don't want to come in because they do not want to be exposed. So this is a key problem and a very big driving factor and motivational. And I think everybody can see that. So who is your clinical champion? Who is willing to say I am here, and I really want to fix this problem? That really is a person who will be your clinical champion. Next slide.

The next thing I want to say is, just because you have to start this yesterday does not mean there are not a lot of people who did not start this years ago. So take advantage of some of the best practices and lessons learned. Think about what has already been done successfully to address this problem in similar settings. So take an advantage of all of the resources that are available. Next slide.

So as I mentioned before, when you select technology, your requirement should be defined by the program model and not the other way around. If the program model is that I need to reach my patients who are in a rural underserved areas and do not have bandwidth for broadband access, and the other half cannot pay or are uninsured. All of that has to be factored into the technology you select, ease of use, what platform you use, and the wifi connection. So you do have to take all of this through before you think about technology. So keep that in mind, and we can help you with this. Next slide.

This goes back to my point about how to involve everyone. It is inclusive planning. Do not work in a silo. Include everyone who will be impacted. And this includes the front desk person, the receptionist, the person who answers the telephone and the billing team and the clinicians and the IT people. I often use this example. When a patient calls, and they say I do not want to come in because I am afraid of being exposed, or I live with an older parent and do not want to risk their health. What is the front desk person going to say? Are they going to say, you know what, we have a telehealth option, how about if we schedule you for a telehealth option? Or will they say we can reschedule you in a few months after the pandemic is over. So if they are not trained, they are most likely going to say, we will try to reschedule you later instead of saying I have other options for you. That is why it is important to engage every single person in the organization. And there are some practices that will do this automatically whether there was a pandemic or not. Sometimes people need to cancel because they do not have transportation or childcare, for whatever reason, the next word is offering telehealth. So think about that. Obviously for the IT folks, they do need to be involved. And the billers need to be involved so they know what is going on and how to bill. Next slide.

So I cannot stress this enough, have clear protocols. Who does what? When the patient calls, you know who does what. Who is going to document the patient's chart? What information do you need from the patient? Let's say you are a provider and you are working from home now, and not going into the office. What information do you have access to? If you do not have access to the EMR, how are you going to see the record? What information do you need? What pieces of information are most relevant to the visit? So everyone really needs to know their roles and responsibilities. How does a patient make a telehealth appointment? What if you need to reach someone? What happens if Internet goes down in the middle of an appointment? Do you call the patient or does the patient call the provider? So you need protocol. If somebody is having a medical emergency, you would call 911. But if the patient is at home, and you are at home, if you call for 911 they are going to come to your home. So you need protocols to establish where that patient is at the start of each visit, writing down the address. An understanding of who you would contact, if the patient does have a medical emergency or a mental health emergency. You also need clear protocols on what to do if the patient needs to go to the emergency room or acute care center because you cannot take care of them by telehealth. Where should they go? What is the referral source? And how you document all of that? So all of this should be written down. And so having a clear written protocol is a great way to do that. So get that clear protocol down before starting these visits, and we can work with you on this. Next slide.

Quality improvement and program evaluation. This is probably the last thing on your mind. But think about this in terms of, if I want to continue this program after the pandemic is over or if I want to apply for a grant, how do I convince my funders? They are giving leeway now but how to I convince them after the pandemic? How do you capture key metrics now. So how are you going to demonstrate the value? There are a few metrics that you can capture right now. It really is hard to capture after the buses left the bus station. So what happens to a patient's outcome when I am doing a telephonic visit versus telehealth visit? What happens with the quality of care? Have two or three key points that will convince the funder or the payer, that this will add value or it is a valuable thing to do even after the pandemic. Next slide.

I cannot emphasize this enough, start small, have a pilot test, and get feedback. Do a pilot test with your staff member, family member, best friend, or a colleague. Let's say you have a protocol, and you have all of the key points. You are going to have weird situations. My patient is sitting in a car because they do not have Internet access at home, or maybe they do not have privacy in their home because they are living with 10 different people, so they are in their car. And they are sitting in the car using their smartphone. So think through each scenario and test it and see what happens. Do a pilot test of each scenario and test it.

Try to get it right before the very first time in a variety of protocols or scenarios. Update your priorities and protocol when you pilot test, so you know what to do in those strange situations. Recently I had a provider who contacted me while they were driving in a car to go to a provider in another state, but after they cross the border I will not be licensed to care for them, what do I do? So you really do have to think through those scenarios. Next slide.

You need to train and retrain. Let's say you did a pilot test. And I think this is working very great with my family members or my mock patients. Then, you train and retrain your staff. We know there is a lot of turnover in small practices, especially those were you can't pay that much. Think about how you will scale up and how you will train and retrain people. Maybe they drop out because they are sick? Maybe a volunteer can take over for them, even if they are retired. So how do you retrain that person?

So make it hard to fail but have a system in place. Make it as idiot proof as you can, so that neither you or your patients are confused. Ultimately, you are going to need to do it. You are never going to get it perfect. But just do it. You are going to have to take some risks sometimes. And notice, you might have as a situation like you forgot to contact them. But you are going to have a frustrating scenario as we all do. But it will get better. But take some risks because it is going to be worth it. It is not going to be perfect, don't expect the perfect. Next slide.

Telehealth resource centers. I just want to give you a good idea of who we are. We are federally funded by HRSA, we cover the entire nation. I am from the mid-Atlantic telehealth resource. We are here to provide technical assistance, here to answer your questions, we are here as a free consultant. People do pay consultants big money to start their telehealth program but we are here, and we are free resource for you. We are here to answer your questions, even simple ones. Like how do I select technology? What question should I ask the vendor? What do I need to know about HIPAA and telehealth? What do I need to know in order to be reimbursed? All the way to I need somebody to hold my hand me from start to finish. That is who we are, and why we are here.

And the next slide, this is our website. I am going to share my screen. Just to give you an idea on the resources that we have developed in response to this pandemic. And everything is available to all of you.

When you go to our website, MATRC.org, you see this pandemic virus icon. If you click on this icon, it will take you to our telehealth resources for COVID-19. We are adding frequently asked questions, resources, and I am just going to walk you through the basic definitions. Because everybody needs to know that. Getting started with telehealth, this is geared for the provider who has no idea where to begin. We have toolkits and training videos. I went over some of this content with you already. This will give you, why do I need in order to get started? And this is a checklist that you can download. We have training courses that are available, some of which are for CME credit. We also will give you information on how you can request assistance from us. And for telehealth and behavioral providers we have a resource for you. We also have tele-mental health center of excellent for all things telemental health. This is a quick start guide.

We also have links to best practices. We have links to telepsychiatry information. But if you scroll further, this link, substance abuse, we have a lot of materials on addiction resources. We also have remote monitoring and policy guidance. And technology, we have information on technology and HIPPA.

We have a section on working with vendors. We also have a toolkit for the service provider. We have collected a number of telehealth platforms that are free or low cost during the pandemic. There is everything from remote monitoring to covid screening to secure text messaging. And this is what people ask me for, sample policies and procedures. What do I have to think about in terms of the workflow? What do I have to think about from the patient perspective? We have sample workflows for outpatient and inpatient. And here we have consent forms. And how to document in the medical records. We have telehealth etiquette. For those who have never done telehealth before, we recommend you look at this video on telehealth etiquette. There is a telehealth etiquette series of videos. We have a downloadable checklist for telehealth etiquette, that you can print out and put on your computer monitor before you have a telehealth visit. And we also have

telephone visit protocols for etiquette. And again, how do you do a clinical assessment/physical exam if I do not have peripheral devices in the patient's home? So we do have some guidelines. And information about if my patient needs an interpreter whether that is ASL or language interpreter?

We collected other useful resources from professional organizations. We have videos on teaching your patients about telehealth, and how to communicate via telehealth. We have infographics that you can send to the patient. And there is a really nice section for the specialty provider. We have a toolkit on tele-genetics, tele-hospice and pallitative care. Also tele-rehabilitation, tele-autism care.

Here we have licensure, interstate practices. And so we pulled together frequently asked questions. As well as general program development and resources. We do have the telehealth reimbursement questions, such as billing and coding, Medicare, Medicaid. And just some food for thought questions such as what will happen after the pandemic is over? I am going to stop sharing my screen. But these are all of the resources that are available to you. When we get back to our slides, I will show you how you can contact me. I am always willing and happy to answer your questions. We do have a team of consultative service partners that will be happy to answer your questions. And again this is a free resource for you, and we want to be there for you and help you with you with your program development, whether you have issues or questions. Thank you so much, I will have Lakeisha jump in from here.

Lakeisha:
Thank you so much Kathy, wow those are a lot of resources. But thank you for sharing all of these resources that are available to us. As a reminder, if you do have a questions please submit them through the Q&A. The audio has been disabled because of the number of participants, but we would love to answer your questions via Q&A.

We want to remind everybody about the opportunity for CME credit. You will need a My AHEC account with your cell phone number, you can visit this website right here for all of the details in order to get credit.

We will go ahead and get started with Q&A. Also, if you need technical assistance information, I am going to leave that up here. I know it is a lot of info to take in. We are definitely here to provide you with telehealth technical assistance. We have an office of rural health technology team that is dedicated to working with safety net health care provider so do not hesitate to reach out to us. We also have ahec practice support. And CCNC does have a lot of resources and can provide technical support. So we are going to take your questions.

Robin McArdle:
Thank you so much, we do have quite a few questions. I will try to run through these quickly. If anybody would like some expansion on the questions, please send us an email or reach out to us. And we will make sure that we will get you an answer. There were several that we did not get to finish up from last week. So the first two are for you, Paula. **For an annual wellness visit, do we bill the G0438 with O2POF?**

Paula:
We would correct that because the G code is for Medicare, which requires place of service 11 instead of 02.

Robin McArdle:
Thank you. **Where can we find the billing codes cheat sheet?**

Paula:
On the North Carolina AHEC.net website, on the slide right here, we have a link at the bottom of the slide. www.ncahec.net/covid-19/telehealth-resources.
You will be able to find the tip sheets and the cheat sheets that we have provided.

Robin McArdle:
Great, thank you. This one is for Felicia. **Does commercial insurance pay for telehealth?**

Felicia:
Most do. Because there are so many plans, and because payers contract individually with providers it is always best to reach out to the commercial carrier and give them the patient plan number to get the most accurate information. It is hard to do a blanket yes or no due to those reasons.

Robin McArdle:
Great, thank you. Now we have another one. **I heard that all insurance except Medicare will pay in parity for tele-visit regardless of type, whether it is audio or video, did you guys hear that?**

Paula:
This is Paula, Medicare is paying parity and Blue Cross Blue Shield. Medicare is still looking at guidelines, you do need to use the resources that are available to you for billing. Some of the fee schedules are not in place currently but we will continue to look for those when they are available.

Robin McArdle:
Okay, thank you. I do want to say we cannot individually email a link to the slides, but everything from the slides, the transcript and the recording will be available on the AHEC website. That way you can access all of that, and you will be able to see all of the information that you need.
The next question, is Blue Cross paying for telephonic for COVID but not for other visits?

John Jenkins:
Blue Cross and Blue Shield is paying for telehealth for different visits as well as for COVID visits. They are paying for telephonic visits as well. You can go to their website, Blue Cross Blue Shield of North Carolina, they have clear guidelines of what they are paying during the covid crisis.

Felicia:
This is Felicia. When we prepared this slide, Blue Cross was not covering, but this was a couple of weeks ago. So thank you for the update.

Robin McArdle:
Yes, thank you both. **A quick clarification, the Rural health center POS is 72 and not 50. The 50 is for RHC and 72 is for FQHC. If you have any other questions do not hesitate to reach out.**
Next question. Paula, do you have a verbal consent form that you can share?

Paula:
There are several scripts that are available, I will have to see if we have that on our tip sheet. But if we can get that information, we definitely will get that information to you.

Dr. John Jenkins:
Go to the AMA telehealth website, they have a great example of a telehealth consent. I suspect that our speakers have that on their website.

Dr. Wibberly:
Yes. We do have a section on consent that has sample forms.

Robin McArdle:
Perfect. Thank you. If we do not finish with all of the questions we will do a follow-up, but if you have an urgent question, do not hesitate to email us. Last question. **My nine primary care providers are all over the place about teleahealth, some want to do it and some are ambivalent. Should I push them to participate and get on board or just direct patients who want telehealth to providers who are open to it?**

Dr. Wibberly:

The best care is always the provider who knows the patient because of continuity of care. If you can push your providers a little bit, I would start there for your first attempt. If they are resistant completely, and they do not want to do it, you can direct them to someone who can provide them with care.

Josh:
This is Josh, this is where data is useful. You can demonstrate to the providers, that changing a preference pattern and other things will allow them to rethink things or see things in a different perspective.

John Jenkins:
This is John, I would advise you to start with the reason, why. Start with a story, to the provider, why the patient needs access to you, and that is why the patient is not seeing them. I think the best salesman always starts with a story why.

Robin McArdle:
Great. Thank you so much. I think at this point I will have to pass it back over to Lakeisha and we will wrap up. And like I said, I promise we will get these questions sent out.

John Jenkins:
I want to remind everybody because we got a lot of Blue Cross and Blue Shield questions. On the BCBS North Carolina website, they have a COVID update and details. It was updated March 6. You can go through it, it is very clear on what they will pay for with telephonic and audiovisual.

Lakeisha Moore:
Thank you everybody. We definitely appreciate your questions. This does help us to make sure that the content for the webinar series addresses your questions. And that we answer all your questions that are on your mind. And I want to thank you once again for your time. Robert mentioned, we will have these questions, and the transcript available. We will utilize the questions and try to lump them together and try to get them out next week. We do have behavioral health questions that are timely, since we have a behavioral health specialist next week. So once again, we are available to answer your individual questions. Please utilize information that you see on the screen right here. We are happy to follow up with you directly. And you can contact us directly if you did not get your question answered and once again thank you so much for your questions and your participation. We are going to continue this series on Monday at noon. It is slated now at least through May 18. Until next week, take care and be safe everybody and we will see you next time. Thanks again.
Goodbye.
[Event concluded]