Transcript for NC AHEC and the Office of Rural Health (ORH) Telehealth Webinar Series
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Lakeisha Moore:
 Good afternoon and thank you for joining us. Happy National Doctors day. Welcome again and we appreciate you joining us for the Telehealth Office Hour Webinar Series. I'm Lakeisha Moore with the North Carolina Office of Rural Health and I'm joined today by John Jenkins and Chris Weathington with the North Carolina Area Health Education Center, or AHEC for short. We also have Robyn McArdle, Office of Rural Health Telehealth specialist. A special welcome today to our safety net sites throughout the state. We appreciate you and your support through this COVID19 pandemic.

Today we want to spend some time talking with you about how to get started with telehealth amid the COVID19 pandemic. We recognize that many healthcare organizations throughout the state are being thrust into seeing patients virtually and we want to assist you in your transition to virtual care. Dr. Jenkins will start with the role of virtual visit and responding to COVID19. Then Chris will briefly share some resources for Telehealth billing. Robyn will be monitoring the Q&A section for your question, so please submit your questions through Q&A on Zoom, you will see it on your bottom panel. If you need technical assistance, maybe you're having trouble with audio or having trouble getting connected with us, you can email technicalassistanceCOVID19@gmail.com. We will assist you from there.

Also, some quick housekeeping items before we get started. This Webinar is being recorded and will be available on the Office of Rural Health or ORH at AHEC website with the slides. If we are unable to answer question today during the session, we will consider your question for future Webinar topics, so we appreciate those questions coming in so we know how to provide additional technical assistance getting up and running with telehealth. The goal of today's Webinar is to introduce you to using telehealth in your organization and go over some associated workflows specific to COVID19. At the end of the webinar we will also share additional resources for Telehealth technical assistance specific to your site or organization. Right now, I'd like to introduce you to Dr. Jenkins, who started the Center for Connected Care at Cone Health in Greensboro, North Carolina for their virtual business solutions. Welcome to Dr. Jenkins.

Dr. John Jenkins:
 Thank you so much. I appreciate the opportunity to share with everyone who is involved with this webinar today. I am reminded of a quote that Maya Angelou said: We may encounter many defeats but we must not be defeated. There will be a lot of bumps in the road as we deal with this pandemic - the first pandemic I've dealt with in my entire lifetime and

I'm sure for all of us involved - hopefully it will not be repeated. But today we have to address how we are going to, as North Carolina providers in the offices that support North Carolina providers, address this crisis. The CDC has advised that healthcare facilities are supposed to explore virtual options for seeing our patients, both screening for COVID, and also for treating patients in our normal day-to-day activities we do. The resources from across the state have combined to help with these webinars each week to help our providers provide safe and effective virtual visits to each of our citizens.

Here are some important definitions I like to start with today. First is digital health. Digital health is the convergence of digital technologies with health, health care, and living to enhance the effectiveness of healthcare delivery. It has the opportunity to make healthcare more personalized through data and precise for the communities we serve. It is a big umbrella, and underneath that umbrella there's telemedicine, which is the use of medical information exchanging from one side to the other using technology. And it allows health professionals that are gathered together today to evaluate, diagnose, and treat patients in remote locations.

Telehealth is the new catchword for Medicare because this is what Medicare uses to describe audiovisual technology. It provides real-time and has sometimes referred to as a virtual visit, an M-visit, or asynchronous visit. The terms telemedicine and telehealth are often exchanged in literature, but when Medicare is putting something out - when CMS pulls something and uses Telehealth - it is referring to audiovisual technology. Virtual patient communication is important because this is a North Carolina Medicaid definition. It's the ability to use remote technologies to evaluate and consult in support the provider patient as they communicate with one another. These could include telephone, could be through virtual portals which is secure messaging, could be stored forward which is like taking a photograph and sending it to a provider for evaluation.

The originating site is where the patient is located. And here is an important difference, because prior to this crisis the originating site was rural or in an office that was remote to the consultant or provider providing care. The originating site now can be where the patient is located in their homes. The distance site is where the provider is located. And again, an important change has occurred because now the provider can be located at home as well. Clarity is a concept that the same payment is being paid for virtual visit as inpatient care, and this has occurred in Medicare's newest guidelines.

So what is the role of virtual visits in responding to COVID19? Let's look at a busy diagram. But I want us to take home the far right-hand side of the diagram and the far left-hand side of the diagram.

First, we will start with the patients we serve. We are serving patients who are concerned about COVID19. A lot of those patients will just have questions to be asked and need to be referred to appropriate web portals, appropriate information site so they can get the right information about COVID19 and be reassured as they are asked by the Governor and state officials to stay at home and protect themselves. Some of those patients are symptomatic, some of the symptoms are somewhat scary for COVID to them, and they want to ask questions of a medical provider as to, does this indicate that I need to be screened,

or do I need to quarantine myself? That symptomatic patient is a key focus of some of the work we are talking about today.

But also, there are the others - the majority of our patients who just have routine health concerns in this crisis. They have diabetes, they have hypertension, they have heart failure, and they may need guidance as to help best to manage their disease and they are afraid to come to our offices because of the COVID crisis. And then there is occasional urgent demands that a patient might have that we can provide via telehealth. Things like sinusitis, or perhaps someone is under stress and has developed shingles. Or perhaps they have a rash they don't know. And telehealth becomes a great opportunity for us to deliver care to those patients.

Let's go on to just talk briefly about what telehealth requires. We got to be innovative and think outside the box. We have to do creative work around. Sometimes we will be using the telephone, sometimes audiovisual technology. Sometimes we don't have the ability to use a telehealth provider, we will have to become a telehealth provider ourselves with the option of some of the free WebEx devices that are available to us and we will talk about that in a second. We have to remember that although many things have been waived, HIPAA is not completely waived and we have to keep the patient's information secure. We have to be careful as we provide telehealth services that even though we have these new portals, we have to on either end of the portal assure compliance with safety, and then we have to remember how to proceed. Most of us are so used to interacting face-to-face with patient that we can create this bond. But now we have to create that same bond with our voices, and with the images that we project on a tele-monitor.

So many of you have different tele-health platforms today. Some of you have been built into your EHRs, and that really makes it easy for you. But the vast majority of the providers across the state of North Carolina don't have a telehealth platform. And there are vendors out there - I urge you to be careful and be cautious and work with the Office of Rural Health when you're looking at some of these vendors and also with AHEC - but there are vendors that are offering quick deployment of a telehealth platform. Or, as we're going to talk largely about today, you can start out with some free and basic audiovisual technology that's available for anyone to create their own telehealth platform and use their electronic medical record to document the visit.

We have to build teams, and you have to create roles for those teams because they are different than they were in our traditional offices. We have to determine the hours of operation and sometimes we forget that but as we communicate to patients when we are going to be available for telehealth, we have to know exactly what are those hours we're going to provide that. And does it interfere with some of the bricks and mortar activity that is going on in our office, will we have to schedule time we will provide telehealth. We have to follow up and have notification protocols, and we have to coordinate with all of our clinical operational staff. As well as when we are talking about COVID, to coordinate with our local health department in our state.

Informing patients about our abilities is going to be really key. Using social media's multiple methodologies to get the message out that our offices do telehealth visits. We have to promote telehealth as our new front door. Here's an ad - it is not copyrighted, you can use it – call

and click before you come in, your team may be able to provide the care with you did with the telephone call or virtual visit without you having to leave home, especially now that our state is on, not lockdown, but stay in place. Safer choices - there's a couple of ones we recommend. We try to stay away from some of the more social media things like Facebook because you don't know who is entering the room with you and again, we are going to try to provide as much confidentiality as we can in these visits. You can download Zoom for free, and there's a link for you and the slides will be available on the web, and you can download WebEx, or download Skype for free. And you can use these as your web RTC or your video connection with your patients, and audio as well.

This is a slide I'm not going to spend a lot of time on but I put this in here for you guys to use in your practices. You guys can look how you might go through using WebEx. And this is through Outlook 365 going in, and setting up preferences in your WebEx account, so that your staff can schedule the visits. And then using Outlook to put them in your Outlook calendar, so you can click on the visit when it is due, and then how you can safely give that link to your patients so they are not actually getting your personal email address, as well as the information you need to provide to your patients. A lot of information in the slide and I think it takes some time to look through. And if you have questions, that is what our offices are for, to help you guide you through setting up these types of visits.

This is a super complex slide. I look at it, and my mind blurs, but there is a visual diagram in the corner that really explains what this is. It's about how we start with the triage call and how our clinic staff actually then determines who needs what service, through routing them either to information or routing them to a provider for a video or phone visit. This was adapted from the Atlantic health system which is in New Jersey, which is at the epicenter of our crisis.

Here is it in a more simple version. If you look at this we see that it starts out with the basic three questions: do you have fever, do you have cough, do you have shortness of breath? There's some modifiers in there we want to know: travel risk, exposure to someone who has the virus, tested positive or was a person of interest whose been put on quarantine, and then occupational exposure. Sometimes we have our healthcare team members, perhaps they are in support services in the hospital or the office and they feel they've been exposed to the COVID virus, are symptomatic, and need some advice. This becomes the basic three with the modifiers that we start out.

Then if any of those are positive, and the patient just doesn't need reassurance, we escalate to the next step where we try to find out are there extended symptoms that are going to help our providers triage them into Low risk, Moderate risk or High risk. What's their fever, are they having difficulty breathing or talking, and little commonsense tasks like giving the patient a 10-word sentence to repeat. Blue lips, acting confused, slurred speech, coughing up blood, signs of orthostatic hypotension, high comorbidity risk such as diabetes, heart failure, and other chronic diseases that could immunosuppress.

Then provider assessment comes: determination of the care plan based on the presentation. So if the patient has symptoms and high risk comorbidities that are becoming unstable, then that person may be

someone that we refer the our local protocols to be evaluated in a bricks and mortar location such as a tent at the emergency room or the emergency room themselves. Always remembering to call ahead and communicate with the emergency room before sending the patient. Then some people may simply be told to isolate in place for the next 14 days we're going to want you to stay at home and we're not going to test you because testing protocols currently do not indicate to test low risk or moderate risk patients. But we do believe that there's a chance you have the virus based upon your symptomology and we're going to ask you to stay at home. But we're going to try to be right there with you, and this is a key thing I will encourage all practices to do, is to create that telemonitoring or monitoring process where we continue to be in touch with those patients who we are asking to isolate. This is very critical because a breach in isolation can result, for someone who actually has the virus, can result of spread of the virus to a large number of people in a short period of time. So being able to offer support to these people, and we're going to have a diagram in just a second that offer specifics on how you might operationalize that, is absolutely critical in this crisis. They need help not only with their medical needs, but if something changes, if they develop another problem, they need to be able to can communicate to the office without feeling like they need to get up and get out and get in the car and go someplace.

Key compliance issues we talked about this before so I'm not going to spend a lot of time on this, but the waiver applies to the technology, not to the environment that you provide the visit. So you can't be at home and have your kids and your wife entering into the field of view or being in earshot of the communication that you're having with the patient. You need to be in a private place. Same thing in your office, you can't be in the hallway with people who are not involved in care being in listening range to the communication.

You want to have informed consent. Different practices are doing this in different ways. I've heard one innovative practice actually puts the informed consent on the link so that when the patient clicks the link to start the video visit, it says you are giving us consent to treat you virtually. There's some great guidelines for what that consent looks like in the AMA telehealth playbook. Another way consent is by actually expressing to the patient as you start the visit in a few sentences, saying "During this crisis we are doing this by telehealth. I'm going to ask you question, you're be able to ask questions for me we're going to interact together. There is no physical examination in this conversation but we will try our best to get the bottom of your condition and create a treatment plan for you. Are you willing to accept this treatment?" And document in the note that you have had that conversation.

Consider also when people are waiting for their telehealth link that you have some sort of a helpline that people can contact and say "Hey, I cannot get my video to work." And then you can convert that to an audio visit at that point without delay without trying to fix that video connection because we are not technical engineers, we are like the guy on Star Trek said, "Dammit Jim I'm a doctor."

Documentation - be sure to develop a protocol for COVID19 business for your office that is clear to all of your staff so everyone knows what is going on. In your note be sure you document the assessment and plan

including any referral you might make, recommendations and follow-up. Those are the key things that need to be in your notes. The recommendations and the follow-up are critical for this. Also, some offices are documenting a smart phrase they put in every note saying due to the COVID crisis, I was unable to perform a physical examination. And this is to help with future coding issues.

Track through your referrals. Be sure you are communicating to the health department the people who you suspect to be positive. Provide all necessary forms that you may have, including contact forms and any testing you may recommend when they meet the protocol that is put out by our state labs. And that protocol changes, I think it was a new protocol put out Sunday. You should try to look and be aware of exactly what the state recommends. And this is shifting ground folks. It is going to change fairly regularly, so maybe someone should be the point person in your office to look for the latest information from the state as to what our recommendations are for testing. Then, update your written protocol at least weekly during this crisis as to what you are doing in your office.

Components for a successful virtual visit: let's look at some pictures. What is wrong here in what is right? What is right is you see clearly the providers – they have great eye contact, they're looking directly into the camera, giving you was that they are trying to communicate directly with you. They have their white coat on and the stethoscope again communicates to them that they are a provider, that they are here to help them, and they are medically competent, and that is very important.

The backgrounds very a little bit in the visits. Some the backgrounds are busy, some of the backgrounds are plain. What we know from telehealth before this crisis is the plainer the background can be, the more simple the background, the less distracting it is to the patient, and the more reassuring that it is to the patient that you're in a professional place and you are just communicating with them. So if you can avoid medical equipment or a bulletin board in the background, that is really better.

Here are some key guidelines about website matter. Be sure to adjust your camera so it appears you are looking right at your patient. It is a simple thing but boy, does it make a difference for the patient. Consider the room setting and lighting: if there too much light from below, if there's too much light from above, you may appear to be Count Dracula and that is not reassuring. Sit at a desk or table, with your computer facing you - that also help to create that professional status. Improve efficiency by being on time when these are set up. There is nothing worse than someone sitting in a blank computer screen waiting for to be seen. Dress appropriately, we addressed that. Addressing the patient by their name, that is critical. Introduce yourself and explain your role, whether or not you are someone who is collecting triage data, whether or not you are one of the clinical team, whether you are a provider or social worker, explain why you are interacting with the patient. Validate their concerns: tell them yes, I'm listening to you. Clarify your actions with the patient.

One of the things you can do is use a technique that nurses have taught me and that is the Teach-back technique. Many of you out there use it every day when you are with patients. When the patient explains

something that bothers them, you take the moment to repeat it simply and ask them, did I get that right? So when they say "I've had a fever and a cough and aching all over," you say, "I hear you, you have been having a fever and a cough and are aching all over - is that right?" And that really tells them you are listening and that is critical.

Don't be afraid to admit when you need help. Some patients will have a specialist and have specialty complaints or problems that need to be referred back to the specialist. Hopefully their specialists are also using video techniques to communicate with their patients, so say listen, let me get a hold of the cardiologist and let's talk about this and we will see what we need to adjust. In the meantime, let's do this together, and then I'm going to get the advice I need to figure out the best plan for you.

Ask patients about feedback, did I cover everything, do you have any other questions, and tell them - reassure them - that you continue to be available by the phone.

Telemonitoring - these are examples quickly I'm going to go through and not going to spend too much time because we want to get to questions. Leverage your visit - you can do asynchronous visits by questionnaires, you can push out a questionnaire through the portal that may say, what are your symptoms, what are you feeling? This is really good for problems like hypothyroidism where you will check with TSH, maybe a T4, and refill the medication. ADHD medications that require face-to-face communications via video visit, questionnaires about stability on cholesterol medicines, hypertensive drugs, really works well.

Proactive conversions of follow-up visits. You can look through your schedule and see people who are coming in for stable follow-up for chronic problems, convert those to Virtual Visits. Offering Virtual Visits for simple acute issues like sinusitis or rashes. The CDC.gov actually says sinusitis is diagnosed not by any testing or x-rays but is diagnosed by a clinical presentation. And so it is really apropos for a virtual visit.

And then practice management of at-risk patients. This is where you may use other team members to call and make sure that their weights are stable, make sure that they're getting her medications on time, make sure that their diet changes - because a lot of people have died because of fast foods or the food being provided to them by the families during this time, they have more salt, may be different and may cause an imbalance in their ability to control their fluid levels.

Here are some good examples that I'm going to share with you guys about how you might use this idea of telemonitoring. In this case you set up a protocol by which your CMA or your MA will reach out and contact the patient at different intervals during the 14 day period of isolation. The first one is the basic check in, saying hey - this is how we are going to do it and you're going to be able to reach us in the office and we can provide urgent services via telehealth as possible. And the first provider that explains that says, I will be available for you, this is what to expect during the next 14 days, and this is what would cause you to need to see me more urgently. Then optional visits for new problems or complications can occur during that 14 day period. And then the checkout visit at the end of the period by the provider. These two telehealth visits will pay for this entire protocol because they can be

charged at office rates or face-to-face visits. Then the discharge instructions should be written and given to the patient as they are discharged from quarantine.

AWVs through telehealth, annual wellness visits, this is a great opportunity for you to reassure the patient who are well. So, we have a lot of Medicare patients out there, I talked to one this morning, who are scared. Healthy, 66 or 67 years of age but concerned that – what's going happen to me? The annual wellness visit can be done by your clinical staff under your supervision. And they can go through a protocol of connecting via telehealth to the patient in the scheduled visit with the link and everything we provided here, and then they can spend 30, 45 minutes with the patient going through the health assessment, which is part of the Medicare wellness visit, the annual wellness visit, and can then spend some time reassuring them about COVID and giving them links about what's really happening with COVID and how they can protect themselves. Vitals which are a key part of this can be obtained by watching the patient weigh, by taking the temperature or blood pressure in visual range and recording them, or recording patient-reported data or stating that during the COVID emergency vital signs were not able to be obtained. Now, physical examination is not part of an annual wellness visit so that does not have to be put in the compliance part. The key part to an annual wellness visit is giving them a written plan as to what is next, so developing an after-visit summary or written plan that you can give them that talks about, here's what we expect this year and what we expect in the COVID crisis, to be able to send out the text via email or via your patient portal to complete the annual wellness visit. And there you have it, there's a couple of examples that we can do.

There are some myths of telehealth that we want to address, that telehealth reimbursement doesn't match office visit pay. Well we just talked about that, Medicare is going to pay for the at the same rate of bricks and mortar. That older patients can't use telehealth - the statistics say that over half of our older patients are already using their virtual technology on their smart phones. Many of them communicate with their grandkids, many of them communicate with other family members. Give it a try and ask them, would you like to do this via video? Or if you can't, if the answer is no, then change it to a telephonic visit. But always ask first. I think you'll be surprised. And practices will need expensive telehealth equipment – no. You can use a lot of different things that patient may have, to get them to step on a scale in front of you and hold the camera down and look at that or phone down and look at the scale weight when looking at patients with heart failure. You could ask them to record data for you. Certainly, some of the smarter Bluetooth connected devices that type information into our EHR will be the future of what we are doing, but we can think about different ways to do this in the future now.

It is time for me to stop for a second but we will have questions at the end and I want to turn this over to Chris Wethington. He is going to take you through a brief primer on reimbursement that's important for us to operationalize this. I will turn it to Chris. Chris, take it away.

Chris Weathington:
 As result of COVID19, Blue Cross Blue Shield, Aetna, United, CIGNA Humana, are just several that have recently shifted to this technology

to expand access to care and minimize unnecessary exposure to the health care work force. Many of these plans are paid at parity with regular on-site office visits as long as they are medically necessary and meet the criteria of the health plan. Healthcare providers and administrators should contact the commercial payers for more details on reimbursement rates, claims filing, and coding requirements. Next slide.

CMS recently broadened coverage of audiovisual telehealth during COVID19. For example, Medicare covers audiovisual services for new and established outpatient visits with payment at parity with an on-site visit. In addition, Medicare covers telephone, audiovisual, secure text, email, and portal communication with established patients. These are normally brief 5 to 10 minute check-in's. These types of services may not be related to a medical visit within the previous seven days and can't lead to a medical visit within the next 24 hours. Medicare also covers communication between an established patient and a provider through an online patient portal with several codes based on time duration. This type of communication can occur over a seven-day period. For all of these services, the patient must verbally consent with documentation in the patient's chart. Next slide.

Finally, North Carolina Medicaid recently expanded its telehealth policy to include both telephonic and audiovisual telehealth. Days of service should be on or after March 10. Telephonic visits only available for established patients, and should include the CR modifier to indicate this work is performed as result of the COVID19 pandemic. Medicaid's coverage of audiovisual services is available for new and established patient visits, provider to MD or DO consultations, and portal communication. The GT and CR modifiers need to be utilized. Telehealth codes can be found on the Medicaid North Carolina DHHS website. Next slide.

North Carolina Medicaid allows telehealth to be provided in the patient or providers home, allows all enrolled medical providers to provide telehealth services. The new policy removes the prior authorization requirement with the full coverage of physicians, APPs, and behavioral health specialists. Phase II expands to dentists, clinical pharmacists, specialized therapies, and diabetic educators. Covered telehealth services allow for a broad utilization of video cell to knowledge and also parity payments in line with office visits. There is flexibility with HIPAA compliance. Verbal consent may be obtained as long as documented in the patient's chart. Finally, FQHCs and FQHC look-alikes and rural health centers are able to bill assistant sites. I will turn it back over.

Dr. Jenkins:
Great, Lakeisha did you want to take the slide?

Lakeisha
 Yes, thanks so much Dr. Jenkins. And we will get ready to go to any questions that you may have. Looks like we have a little time for questions here towards the end. We were trying to basically get a balance of giving you information that you need to get started with telehealth at your site, but also leave time for questions.

One big thing that I know a lot of the sites that office of rural health has been working with – a lot of our safety net providers had

asked specific to their site. Sometimes it is very specific questions you may have about getting telehealth started at your site. So I do want to want to leave resources and contact information before I turn it over to Robyn who will go over some questions. As a reminder, if you have a questions that you would like us to go over with you now, please put those in the Q&A. You will see it on the bottom of the zoom Webinar that you are joining now, so you can put your questions in there and we will try to go through as many of those as we can. In the meantime, safety net healthcare providers, if you go to the Office of Rural Health website you will see right on our homepage a link that you can click on to request Telehealth Technical Assistance, and then one of our HIT specialists - our health information technology specialists - will follow-up with you depending on your region. You'll fill out just a short web form, put in your primary county of where your site is located, and from there one of the HIT specialists can follow up with you to provide telehealth Technical Assistance. You can also email us, we have assured email account that we will get routed to the HIT specialist that covers a region – that is ORH_telehealth@DHHS.indices.gov. It is on the website now.

Another question we got a lot is will the slides be available. Yes, the slides will be available on the office of rural health website and then also on the AHEC website.

Other healthcare providers, if you do require additional Technical Assistance or maybe have some specific questions to your site as you're getting up and running with telehealth, the North Carolina Area Health education has a support team available to assist you. You can go to their website and fill out the practice support web form there to request Technical Assistance, or you can email directly support at practicesupport@ncAHEC.net and we are happy to have a practice support specialist in your area contact or follow-up with you to provide additional telehealth Technical Assistance. So two ways we work together very closely, the Office of Rural Health and AHEC, to make sure we are helping the providers - supporting you guys as you are seeing patients and implementing telehealth in your respective practices.

With that I will go ahead and turn it over to Robyn McArdle, the Office of Rural Health telehealth specialist. She will go through some questions thus far.

Robyn:
 Thank you so much Lakeisha, I appreciate it. We've had a few questions come up in the Q&A that have already been answered. Just real quick one of the common questions is, will we be providing the slides after the Webinar. Yes, we will - they will be available as well as the recording. Another question came up that has been answered is, if you do a scheduled telehealth visit and in the course of visit decide the patient really needs an office visit, how do you code that since insurance will probably not pay for two visits in one day? And Dr. Jenkins responded that the time for bricks and mortars have been waived, so both visits actually can be charged during this exception period.

So with that question, I will move to the next one, that Chris or Dr. Jenkins if you don't mind answering: I may have missed this, but if a

new patient does not have access to video can we do audio only visits? Would either you all like to take that?

Dr. Jenkins:
 So I will jump in - so the way I understand the question is that, we have a new patient coming in, and they don't have access to telehealth - they must be a Medicare patient I assume by the question - and you want to be know how to provide service to them. So unfortunately, Medicare is not going to let you do 99-212 through 99-215 visits but you are going to be able to intake as a telephonic visit or as a telemonitoring visit because those can be audio only. But for Medicaid, they can be audio only. So if it is a new patient Medicaid they can be audio only. Chris do you have any further insights?

Chris:
 No, I do not. That is a very good answer.

Dr. Jenkins:
 I saw a question that I thought was really key. There was a resource on one of the slides for this. Coding is such a hodgepodge, is there one source that we can look at all the different types of visits? I will tell you for Medicare, there is one source and that is the AMA's guideline. And there's a link on one of the slides to that that you can click on when you get the slides live, or you can copy and paste or you can type it in and go. The AMA actually has - I think it is about 17 pages - it is either a PDF file or a PowerPoint that you can look at. And not only does it have coding guidelines, it has scenarios, which can help you to post the charges for Medicare patients. I think our office of rural health as well as our practice support that we have through AHEC, they have lots of tools also to help you with coding and there have been multiple seminars around this, so keep watching and I'm sure seminars will continue.

Robyn:
 Great thank you so much Dr. Jenkins. So the next question is related to the one earlier about billing two types of visits, and it says, to build on the previous question about changing telehealth visit to an office visit, can you bill for the telephone conversation and then bill for the office visit if you feel like the patient needs to come in?

Dr. Jenkins:
 I answered the other one so I will jump in for this one, so I will take accountability. The way I read the Medicare guidance and Medicaid guidance is that the time between the visits has been waived as a part of the waiver. There were some really odd rules in the original telehealth policies for Medicare in which you had to be so many days after a visit or so many so many hours before a visit, and that I believe has been waived.

Robyn:
 Okay great. Thank you so much. **The next question is: can new patients get billed for telephonic visits for Medicaid. That was just one simple question. So I know you mentioned that earlier, if you could recap that real quick.**

Dr. Jenkins:
 Chris, you are a Medicaid specialist and I'm going to turn that would over for you.

Chris:
 For the Medicaid, the telephonic visits can be used for established patients only.

Robyn:
 Great thank you. Is the new patient with no-video the same for third-party billing?

Dr. Jenkins:
 So different players have different players have different policies on this. There is a great guideline that I shared this morning to the team that I think we can put in, that one of our ACOs has developed and Chris - Lakeisha - can we share this on the website, the Medicare Medicare Advantage exemptions? And policies?

Chris:
 Sure.

Lakeisha:
 We will add that to our website and I know - AHEC had put together some nice five-minute - when it comes down to COVID19 and other third-party payers, what you code for and also what they will cover for telehealth. We will make sure to put them on the website.

Dr. Jenkins:
 Good. Some of the important things that providers should be aware of is, that almost every third-party payer has waived early prescription refills and refill limits, which is really great because a lot of people get nervous about that. And that some of the pharmacies have waived delivery fees for these. Really good news to share with your patients in terms of their fear for getting their medicines for their chronic problems.

Robyn:
 Okay, next question: if somebody else reaction to poison ivy for example and they want a telephonic visit so they do not have to come to the office, can the provider do just a telephonic visit and prescribed them prednisone if the patient is self-pay?

Dr. Jenkins:
 The brief answer is yes. The reimbursement issue is varied. If that patient is a self-pay patient and you do a telephonic visit, and you can collect all of the information to assure yourself that that is poison ivy - the exposure, type of rash, the horrible itching, all those good things, and you feel comfortable prescribing prednisone either cream or oral depending upon the severity of the symptoms, that can be done. I think that I would put in my note that disclosure, that this was during the COVID crisis, and I was unable to do a physical examination, I provided a telehealth visit for this patient, in my note. Just for added protection and as disclosure because you will disclose that to the patient at the beginning, but you can't physically examine the rash, that you are doing your very best to know what it is.

Robyn:
 Great. Is it okay to drop claims now without risk of denials? Will major carriers have rules updated in their system?

Chris:

I will take this. My advice for Medicaid is, you can do so now with your Medicaid claims, but for all other payers, most likely you can but I would double check with your payer to be sure. Lakeisha you may have some insight as well.

Lakeisha:
I know – definitely the Medicaid calls going into this quite a bit so that may be also a better resource when it comes down to specific Medicaid questions and in so far as, I know the person posed a question was asking specifically about denials. Right now, of course as Chris mentioned, Medicaid will go back to March 10, so it is taking time to get those codes into NCTracks. I can't say for sure that if you billet right now that you won't get that initial denial, but know that it is retroactive back to March 10. So go ahead and do it, just recognize that, whoever posed that question, that's been a topic that's come up on the Medicaid calls quite a bit, the fact that those codes are being added now and you may be in the interim. And just a little bit of a plug for the Medicaid calls - the next one is tomorrow Tuesday at 5:30, if you have really specific Medicaid questions, and also on both of our websites, AHEC and the office of rural health will also put the Medicaid email address cause they are really good about getting back to you about Medicaid billing. The other payers will very as Chris mentioned.

Robyn:
Thank you. Chris, do we use codes 99212-215 for virtual office visit or use 99421 and 99423?

Chris:
Yes. The 99201 through 99215 should be used for office or other outpatient visit that is given to telehealth. Your question about 99421 through 99423 is really for communication between the patient and their provider through an online patient portal.

Robyn:
Great. Follow-up: do you have a resource we can link to showing it to would be allowable to have telehealth visit and face-to-face visit in the same day if needed?

Dr. Jenkins:
I will have to look at the CMS guidelines and find that exact quote, but we can get that out to the participants.

Robyn:
Do you have a date for phase 2 implementation?

Dr. Jenkins:
I'm assuming that question is related to Medicaid, and the Medicaid Phase 2 implementation was effective March 23rd.

Robyn:
For noninsurance billing free care clinics, are any considerations we should be considering regarding telehealth?

Dr. Jenkins:
So when you are any non-billing situation, you are providing care you want to use everything you have to your availability. I would encourage you to try to start first, with video if you can, because that's the

best way of collecting data. You see who the patient is, you see the patient's general condition, you can get some ideas as to how they are doing, and you can also get some physical - you can do physical diagnosis with them by getting them to show you a rash or getting to touch a point or palpate a point; or, look down their throat with the camera if they have a light on their phone. So that is the very best. The next best would be to do telephonic with Store and Forward. They can forward you photographs through their smart phone, texting them to you when you're having a conversation, and you can augment the telephonic visit with the Store and Forward technology, the photos. And of course, if we fall back to telephonic then I think telephonic is what we need to do in this situation, where we assess risk to the patient of leaving home and coming to the office.

Robyn:
Thank you. We have some confusion with verbiage "telehealth," is this an umbrella term for audio and/or audio-video, or just for video visits?

Dr. Jenkins:
So, telehealth and telephonic are the two different terms Medicare uses. Telehealth is audiovisual - audio and visual. The confusion comes with the media you use, because sometimes the media is all-in-one, sometimes that media is two different things - you have a web connection for the camera and a telephonic connection like some of the ways you guys are connected here today. Some are you are listening on the phone and looking at the web RTC through your computers. So that is where the confusion arises about telehealth. So it's uniquely separate from telephonic, where telephonic is just using audio only.

Robyn:
All right Chris and Dr. Jenkins, thank you so much. I think we have completed all the questions in the Q&A. So Lakeisha at this time, I'm going to pass it back to you. Thank you.

Lakeisha
Great thank you Robyn and I will try to speak up. Sorry, I saw some of you putting the chat it was a little hard to hear me. I'm working on getting a professional headset over here - we are updating our telehealth equipment on this side, too. I just want to take a moment and thank you again for joining us for this telehealth virtual office hours Webinar Series. And once again if you do need additional technical assistance implementing telehealth at your site, we left that information on the slides there. These slides and the Webinar will be available on the AHEC website and also on the office of rural health website. And you can use the emails also on the screen there if you would like to request additional technical assistance.

We want to thank you for taking out the time to join us, we appreciate the questions coming in. This is a virtual office hours series that we look to keep going on Mondays at noon, so your questions definitely do help us guide what areas you may need additional technical assistance in. I saw some folks asking about Medicaid different phases, so definitely encourage you to keep up with the state website and then also some of the specific Webinars that are available to Medicaid. And then also there is another call on Friday with DPH. A lot of those calls are listed on the AHEC website also, so you can keep up with different aspects of the COVID19 pandemic. But for today we will go

ahead and conclude and thank you again for your time. Take care
everyone and please be safe. Goodbye - we will see you next time.
 [Event Concluded]