Transcript for NC AHEC & Office of Rural Health Telehealth Webinar Series
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Presenters:
Lakeisha Moore, Office of Rural Health
Dr. John E. Jenkins, Greensboro, AHEC
Tina Lee, Director of Business Operations AMCHC
Jessica Brehmer, NC Health Informaiton Exchange Authority

Lakeisha Moore:
We will work to answer as many questions as we can, time permitting. If you need technical assistance, please email technicalassistanceCOVID19@gmail.com. And someone will assist you. We always like to send a very special welcome to our safety net site across the state. The critical access hospitals, rural health centers, local health department providing primary care and so many others. Thank you for joining us. During today's webinar we will be sharing telehealth best practices and other resources from across the state amid the COVID-19 pandemic. We hope that you will be able to incorporate and adopt some of these best practices into your organization and workflow. This week, Ryan Wilkins from AHEC will start us off by sharing information on how to receive continuing medical education for this webinar. Then Dr. Jenkins and special guests from AHEC will join us to look at some of the adolescent and pediatric telehealth best practices and provide updates on telehealth billing.

Tina Lee, Director of Business Operations at the Appalachian Mountain Community Health Centers will share some of their telehealth best practices and out at their site out in western NC. And to confirm with the NC Health Information Exchange Authority (HIEA), they will be joining us today to talk about the information that is available to practices through our statewide health information exchange called NC HealthConnex. Robin McArdle with the Office of Rural Health, our telehealth specialist will monitor the Q&A as your questions come through. Please make sure you get your questions in, other housekeeping items before we get started, speaking of questions, this webinar is being recorded, that is a question we get quite a bit and the recording will be available on the ORH and AHEC website along with the slides and if you have a question during the webinar, if you can include your name and email address in case we need to follow up with you directly. Especially for the billing and coding questions. We like to reach out directly so we make sure we are getting you the correct information. Right now, I am going to turn it over to Ryan who will share of share with us how to receive CME for this presentation.

Ryan Wilkins:
Thanks. To obtain CME or contact hours for participation in this webinar, you must have a myAhec account with an up-to-date cell phone number listed. If you do not have an account or cell phone number associated with your existing account, you will be prompted to create or update your information once registration is complete. To register your attendance, please text 0EDDA to 336-793-9317. For additional instructions on how to register using the text-registration system, please visit nwahec.org/textreg, the website is on the slide currently. The registration code and phone number will be shown again at the end of the webinar. Next slide. The continuing education for this program as being provided by Area L AHEC and in partnership with the Office or Rural Health, the Program Office, Northwest AHEC and Greensboro AHEC, specific credit information is listed on the slide. And now I will turn it over to Dr. John Jenkins.

Dr. Jenkins:
Hello everyone, glad you joined us on this webinar. I know it is tempting to go outside, wonderful sun. Today we are going to talk about telehealth best practices for special populations and again our why is always access. This is episode number 6. I can't believe we have had six sessions. Nido Qubein, the CEO of High Point University says "change brings opportunity". I would tell you that what we are learning here in this crisis is there are multiple opportunities for us to begin to leverage telehealth to improve the way we provide access for all of our patients. Part one we will talk with Liz Griffin about a special project for the behavioral health specialists. Part two, I will share some Leader's ideas that have been shared on webinars over the past few weeks. Dr. Cora-Bramble from Children's National Hospital, Dr. Cable from Kaiser Permanente in the west and Dr. Mankin from Mainline HealthCare. Part three will be coding questions with Paula and Felicia, our experts, and part four we will talk about measurements and measuring what matters. So first, let's talk to Liz, you and your team have been working on a toolkit for behavioral health visits. Tell us about why you undertook this project?

Liz Griffin:
Sure, hello everyone. The Greensboro AHEC Practice Support team had a direct need from a large behavioral health organization in our region who was new to telehealth and requested tailored telehealth and telepsychiatry guidelines for behavioral health clinicians.

Dr. Jenkins:
 How did your team develop and vet the materials?

Liz Griffin:
The Greensboro AHEC Practice Support team worked in conjunction with Greensboro Behavioral Health Continuing Professional Development to research various telehealth resources and we consulted telehealth specialists across the state including Dr. John Jenkins a Greensboro AHEC. And Dr. Sy Saeed at the North Carolina statewide tele-psychiatry program in Greenville, North Carolina. We compiled the toolkit materials and sent them to regional behavioral health providers making necessary updates based on their expert feedback.

Dr. Jenkins:
That is a great tool, tell us about the product and where we can find it.

Liz Griffin:
The toolkit consists of a behavioral health tip sheet that includes guidance for pre-telehealth session preparation, tips to remember during the telehealth session, special age-related considerations for both pediatric and geriatric patients. Mental health emergency information and HIPAA compliance and security regarding telehealth visits as well as links to several additional resources. The toolkit includes a COVID-19 billing and coding matrix for behavioral health professionals by payer. There is an additional crosswalk of HIPAA compliance telehealth platforms approved for the COVID-19 state of emergency and beyond that is currently available through email from your local North Carolina AHEC practice support coach.

Dr. Jenkins:
That is great. Go ahead.

Liz Griffin
You can find it, you can find the toolkit on the North Carolina Practice Support Coding and Telehealth Resources website. At https://www.ncahec.net/covid-19/telehealth-resources/

Dr. Jenkins:
I understand your team and you are working on other project about transitioning after COVID and using telehealth in our practices.

Liz Griffin:
That is correct.

Dr. Jenkins:
We will be looking forward to some more great information from you. This is a great tool, easy to use, clear. I hope you can take a look at the link that Liz is providing.

Let's talk a little bit about learning that we have received from talking to leaders across the United States. We all know what the current state is and over the weekend I was reading some of the CDC.gov and American Academy of Pediatrics sites. We are looking at some crisis because a significant number of scheduled wellness visits, scheduled checkups, and immunizations especially, have been missed over the last two months of COVID-19 crisis. This has the potential to create what many experts are calling secondary health crisis. With kids being -- opening up our states and returning to school, not being immunized. We also find our patients are still very wary of in-person services. And we know that not every service can be provided virtually such as procedures and immunizations. Distancing guidelines will challenge us, too. They will remain in place for quite some time, especially if we are faced with a second wave and this will affect our inpatient, in-person capabilities.

So in transitioning care, some of these experts have shared some key insights. One of their key suggestions that I heard over and over again was to assemble your stakeholders. This is from the front desk to the providers with administration and provider teams represented. To write the policies and procedures for reopening your practice. The key to address both staff, provider concerns and what about patient concerns? Many of these sites are involving a patient on their planning teams. Which is a great idea. And you want this to be data driven. You want to have the data about the populations that have missed care, the immunizations that have been missed and the vulnerable patients, because they didn't get their immunizations they may be at risk. Identify them as the first that you may want to bring in for the face-to-face visits. Kaiser did this by opening four regional offices for in-person care while the other offices are still focusing on virtual care. Mainline and Children's are preparing for measured re-openings with most offices to meet the mitigation rules. And what they have had to do is limit the number of providers who could be in the office. So they could allow more rooms to be used for flow and cleaning and turnover so no one is waiting. More space in a waiting room is then created so they can appropriately social distance.

And the other half of the staff that aren't going to be involved in the inpatient world or the in-person world will remain a significant focus of care with virtual visits. And they will schedule virtual visits and follow-up virtual visits as appropriate. When we address our patient's concerns we have to remember the with you there will be some walk-ins and we have heard some great ideas from our own NC practices about using virtual visits for in the parking lot visits, with a smart phone or tablet. Some leading practices are registering by phone or online and waiting in the car until texted by the nurse that your room is ready for you. Drive-by or designated safe times for immunizations, labs and other services are being used by many practices. Special customer hours, opening one hour early for immunizations or labs only. Or having special times for well patients and sick patients. Hybrid visits where the visit starts out with a virtual visit but then is linked to a lab order or an immunization order and is then provided by an inpatient service. And finally, developing a communication plan. Putting out exactly what you are going to do, once you determine your policies and procedures to all of your

patients using social media, the news media, webpages, so that the community understands how they are going to access care in this transitional period after COVID.

We have had lots of questions about billing and coding and luckily we have some great experts, Felicia and Paula have joined us, we will turn to them to answer some of your questions and also to point out some great new things. I will start with Felicia. Blue Cross Blue Shield and Medicaid billing for telephonic office visits. There has been a lot of confusion. Can you share some clear guidelines?

Felicia Coats:
I can sure try. It is confusing. Medicaid, Blue Cross and some of the Medicare advantage plans now allow for telephonic visit between a provider and patient, those can be billed as an office visit using the regular CPT codes for established patients. Providers should document just as clearly as if a patient was sitting in the office having a face-to-face visit. The documentation has to be there. Medicaid will pay 80% of the visits, 80% are their allowable. Blue Cross will pay at parity. There is a special bulletin, a Medicaid bulletin that explains all of this in detail. Medicaid requires the plac eof service to be the actual location. So whatever you would normally bill as an office visit, and Medicaid requires the CR modifier. Blue Cross wants place of service code 02 and also the CR modifier. And then Medicare has new rules and reimbursement for telephone management visits and there is a link on the slide. The link is there.

Dr. Jenkins:
Good deal, excellent. BCBS, Medicaid telehealth visits, so these are the ones that use audiovisual, how are they addressing telehealth visit?

Paula Locklear:
Both BCBS and Medicaid will cover audiovisual, telehealth visits at parity. With Medicaid, like Felicia said you can use that place of service code through where the actual location was of the provider. You would use that CR modifier for the catastrophic disaster and Blue Cross Blue Shield requires that you bill those visits with the place of service too in that CR modifier. Just remember, as we know there are guideline changes, Medicare requires you to use the place of service 11 so that you can receive full payment.

Dr. Jenkins:
That is key. So new coverage for Medicaid well child visits, pretty exciting news that came out last week. I know we have a link to the bulletin so people can get all the details. We will share a couple of guidance issues, share with us a couple guidance about telehealth for these Medicaid well-child visits.

Felicia Coats:
It is exciting, especially for pediatricians and family practices who have not been able to do well visits and get reimbursed. Just a few things to remember. These audiovisual visits are recommended for children over 24 months of age. The little ones still need to come into the office. The audiovisual where the provider can see and hear the patient, those are allowed and covered and recommended for children over 24 months of age. You can use any platform, FaceTime, Skype, any of those things. And FQHCs, look-alikes and rural health centers are now considered eligible distance sites. The Medicaid bulletin did reference on the previous slide and it is bulletin number 66 in case the link doesn't work for some reason. All the details are there. How to bill for them, what modifiers do you use and all of that is covered in the bulletin.

Dr. Jenkins:
And we are encouraged to figure out creative ways to get immunizations done. We talked about that a little bit so the learning from other practices. So Medicaid either wants us to have an in-person visit afterwards to do the immunization or figure out a creative way to get those immunizations done.

Paula Locklear:
That is right, and the medical assistance or nurses could actually go out to the car, practices just have to be creative. We definitely don't want to miss immunizations that are vital.

Dr. Jenkins:
Perfect. Finally, Paula, we have some exciting news from Medicare. On the 28th Medicare announced about telephone evaluation management. Can you give us a brief overview about that new rule?

Paula Locklear:
The new rule was very exciting to read as we see so many changes happening. A broad range of clinicians, including physicians, can now provide certain services by telephone for their patients for Medicare. Medicare is calling them telephone evaluation and management codes. Those codes will be billed under 99441 through 99443. And Medicare is going to allow those to be paid effective March 1st, they will be parity on these office visits so they are time-based codes so make sure when the doctor is doing their evaluation with the patient, it is important they are reporting it just as they would as an inpatient visit with that telehealth, using audiovisual only, practitioners may bill those codes providing it will furnish the services to meet all the guidelines. And again they will be billed under the 99441 through the range of 99443. There is a link we provided in the slide that will take you to those guidelines.

Dr. Jenkins:
I think that is key to remember that Medicare is suggesting these have to be billed under the codes they have provided. It is going to pay like an office visit but they have to be documented as telephonic. That is key for us to understand. And they are provided by the providers themselves. So pretty key information, great link for you to look at.

Let's talk a little bit about what we have done in the past several visits. We talked about how can we leverage telehealth in our practices and a couple things that keep coming up is the idea of how we can remember to prototype and learn from our prototyping and to do this, we have to measure to improve.

A couple of things we want to point out is, how do you do that? Measuring what matters is key and these are key performance indicators, they have two different types: leading indicators, which are inputs and they tell you if you are on track to meet your KPIs. And lagging indicators, which are outputs or outcomes and they tell you if you are headed in the right direction to reach the desired results.

Some possible leading indicators that we might measure are the number of virtual visits per provider by age, demographics, type (check-in, acute, management, wellness), and the measurement of the time to complete. This helps to give a picture of what we are doing.

And some lagging indicators to look at our outcomes is: are we advancing the levels of charging complexity? Are we getting to that level three, level four visit, for people with multiple medical problems and leveraging telephonic medicine to the best of its capabilities? Has it resulted in a

referral, to a specialist, a laboratory or immunization? And improvement, we want to look at trending data and what visits had to be converted to a face-to-face? And technology failures, that's really important for us to understand as we evaluate the technology we are using to know if it is what we will use in the future.

This is all really important stuff that we're going to do and we will keep pointing this out as we work together on this journey towards a post-COVID world. We have a great guest speaker today. I will turn it back to Lakeisha to introduce our speaker from Appalachian Mountain Community Health Centers.

Lakeisha Moore:
Great, thanks Dr. Jenkins and the AHEC team. Tina Lee is joining us, she the Director of Business Operations at the Appalachian Mountain Community Health Centers. We are glad you are able to join us and give us an update on what is going on in the western part of our state. Thanks for joining us Tina.

Tina Lee:
Thank you for having me. So, COVID-19 has really forced us all to think outside the box and try to come up with creative ways to provide healthcare for our communities. We are doing parking lot visits for acutely ill patients, for our high-risk patients, to avoid them from coming in to the office for unnecessary exposure to things.

Telehealth is something we have been working towards implementing for quite some time and now it is part of our daily lives to provide primary care, behavioral health and pediatric visits. Next.

We are currently using a platform called doxy.me to connect our patients with providers, it is very user-friendly, the patient's find it easy to connect. They schedule their appointments, they are getting a link to log in to. Before the appointment, the medical assistants will call and do a review of medications, allergies, obtain any vitals the patient is able to give to them, if they're able to give them the blood pressure, that is great. And then the medical assistant ensures that the patient is connected for the virtual visit with the provider. Next slide please.

Something else we have been using is iPads in our parking lot. In western North Carolina we have some challenges with our telehealth with connectivity. Our Internet service is spotty in some areas. We may have patients that just don't have access to a smart phone or computer to log in to their visit. So we have decided that we can actually use iPads and they can come to our parking lot and they will be checked in by medical assistants in the parking lot and then able to connect with the provider via the doxy.me on the iPad. That way they can receive their healthcare while they are sitting in their car. Next slide.

Being a community health center we are also a safety net provider for the vulnerable patient population. We provide healthcare for uninsured, underinsured and homeless patients. We have found using iPads is instrumental in getting these patients the care that they need. Our peer support specialists are able to go into the community, into the camps, the housing projects, the shelters, or on the street and connect a patient to a provider via the Microsoft teams that is installed on our iPads. We are just continually striving to come up with innovative ways to meet the needs of our community in this time we are in right now and hope to continue to use after COVID-19 is over. Back to you Lakeisha.

Lakeisha Moore:

Great, thank you so much Tina for sharing. It is interesting, as you shared your story, I feel like it is resonating with a lot of other centers and safety net sites that we are seeing across the state and some of the innovative ways they are finding to incorporate telehealth in their practice. Thanks for sharing some of the things you guys are doing out West.

I will remind everyone, if you do have a question, and I see several coming in, so thank you for bringing in your questions, we will try to leave a good amount of time at the end to go through those. If you can submit them through the Q&A, I see one person has their hand raised, so I didn't want you to feel like we didn't see you there, it's because we have the audio option disabled because of the number of participants. But definitely if you put your question in through the Q&A, we will work to get to those questions. And once again, when you're putting your question in the Q&A, if you can also put your name and email, especially for those billing and coding questions. A lot of times we will want to follow up with you directly just to make sure we're getting you the exact information you need for your billing and coding questions. Thanks for that.

We are excited today to also have Jessica Brehmer back with us from the North Carolina Health Information Exchange Authority. She will talk with us about some of the information that is available through our statewide health information exchange called NC Health Connex. Thanks again for joining us today Jessica.

Jessica Brehmer:

Thanks for having me Lakeisha. As Lakeisha mentioned, my name is Jessica Brehmer, I work on the business development outreach team for the Health Information Exchange Authority. I want to level set with the first slide and explain to you if you do not already know, there is a mandate in North Carolina and the law says if you receive any type of state funds for services rendered to your patients, you would have to connect to the Health Information Exchange and send demographic and clinical information on those patients. That is actually how we are getting the information, we're connecting directly to the EHR at the provider location and getting the information either real-time or once daily.

And by the numbers, we have over 55,000 providers that are already connected and sending records to the Health Information Exchange. 6000+ healthcare facilities are live and submitting data, including 113 hospitals. We have around 5000 healthcare facilities in the onboarding process and what that means is that those locations or organizations have signed a participation agreement and they are waiting on our technical team to connect their EHR to NC Health Connex.

We have over 100 million continuity of care documents and within that we have 9 million unique patient records and we are working with over 225 unique EHR vendors. And then we are also connected to the five border and interstate HIEs. So I will talk through that in a couple slides. Next.

In this presentation, I am going to touch a little bit on the clinical portal. I will also touch on direct secure messaging and then also notification service, which is called NC Notify. I want to let everyone know this is available to full participants and what that means is there are two different participation agreements that individuals can sign. I should say healthcare organizations can sign. There is a full agreement and a submit only. The full agreement gives you access to all the services you see on the screen here including the registries and integration. We are just going to touch on three today. Next?

So first will be the clinical portal. This is where you would be able to log in as a provider or healthcare staff member and you can see the longitudinal patient records. If you joined us for the call a couple weeks ago, I did a demonstration on the clinical portal and I gave some COVID-19 cases so a lot of the providers needed to see if their patient had shown up, had a test and the result of that. You can see on the left-hand screen, summary, allergies and alerts, the alerts would be if we had a DNR on file. We don't actually keep the DNR, it would just be showing the location where it is stored. Then you can see encounters, medications, history, conditions, procedures and results, this would be where the COVID-19 result would display, vaccinations, and then documents.

At the top of the screen you can see awaiting results from and the e-health exchange is how we connect to the bordering state. If your patient had shown up at a healthcare facility in one of the bordering states that was connected to the e-health exchange, we would actually get that continuity of care document and then that document would be displayed in the documents tab to the bottom left of the screen. Next?

In order for you to have access to the clinical portal, there will be a participant account administrator assigned to each organization. That PAA is listed on the participation agreement. If you do not know who your PAA is, reach out to me or that HIEA team and we will point you in the right direction. That PAA would be able to assign you a role, and these are our roles that you see listed on the screen.

I want to point out that just because the front desk staff person is not a clinician, if they need clinical access where they can see patient clinical data, they can be assigned a clinician role. Just because they are not a clinician does not mean they cannot have the clinician account. They would be able to do that. Common examples that you can see on the right-hand screen. Next.

I mentioned we are connected to the neighboring states via the e-health exchange. I wanted to show you who we are connected to, so we have East Tennessee, Georgia, state designated HIE as well as the regional HIE in Georgia. We have Richmond, Virginia, South Carolina and we are also connected to the Veterans Administration, as well as the Department of Defense. That is all via the e-health exchange. Next?

Just to give you a little bit more information on the e-health exchange, I will focus on the numbers on the right-hand side, so you can understand more about how the e-health exchange works and how we are getting that data. It spans across all 50 states and this represents four federal agencies, 75% of all U.S. hospitals, 70,000 medical groups, 3400 dialysis centers, 8300 pharmacies, 120 million patients and of course 47 state and regional HIE's. As you can see, there is a lot of data on the e-health exchange and being that we are connected to the e-health exchange, remember we are connected to the bordering states. So we may not be getting something if the person had recently traveled to California. Next?

Touching a little bit on direct secure message. This is another service that we offer and this is how providers can send PHI through our messaging center within the clinical portal. I know some EHR vendors, the do provide a DSM address for providers or healthcare staff members. We actually also provide a DSM address if your EHR vendor does not, and when you log into the clinical portal there will be a tab at the top that says messages. That is where you can send PHI, any type of clinical information to any other provider in the state of North Carolina that has a DSM address. And this cuts down you having to pick up the phone and call another provider or having to wait for that fax.

Different types of information that can be sent, I did say clinical documents, so that could be referrals, transitions of care, anything related to the patient's care. I also want to point out that within the direct secure message it has a box for attachments. So within our clinical portal, like even in the results section, you will not see the actual image of the results, if it was like an MRI you would not see the image. But if you wanted to take that image and you wanted to send it to another provider, you can do that through the direct secure messaging tab. Next slide.

So now we are moving to notifications and our notification service is called and NC Notify. So some of the challenges that we have encountered when speaking to providers is that providers sometimes don't know when patients receive care outside of their organization or outside of their EHR network. Then also, within the clinical portal you actually have to go search for a patient and it doesn't automatically alert you, that hey, this patient has been seen by you and also showed up at the emergency room.

And then providers are not being notified in a timely manner of when their patients are actually seen. We took those challenges and we wanted to address those and that is where we came up with NC Notify, which is the event notification service. Next slide.

The way that NC Notify works is that you would actually send us a list of your patients. So we have to know that these patients are attributed to you. When you send that list over to us, we would scan NC Health Connex and if one of those patients on your list has been seen at any other healthcare organization, we would push you an alert. So you will receive back a file and it will say and I will use my name for example. Jessica Brehmer showed up at this hospital and had this test performed. And they could say here is the result and any other type of information that you wanted to know about that encounter, you would be able to log in to the clinical portal and be able to pull the CCD from that encounter, and if we are receiving any type of note which we do encourage all the healthcare organizations that are connected to us to send notes, you would be able to go into the CCD and pull the notes about that encounter. Next slide.

I really like this slide, it shows you a roadmap of where we started with NC Notify and where we are going with NC Notify. So of course you can see that we are on version 3. You are able to receive real-time notifications. From October of 2018 to April of 2019 you could just receive those notifications daily, but we have moved to real-time. And if you look at the bottom of the screen, the content that is available to you, so when we switched that alert back to you, you will receive basic details that include the date, visit type and location, the chief complaint and diagnosis and the provider details as well as immunization gaps and any other information that you would like to know, you can log in to the clinical portal and be able to pull the CCD, which we also parse the CCD, so we pull the information from the CCD and put into those tabs that you saw on the previous slide. Next slide.

So future state of NC Notify, we have V3 and V3 plus. What that really means is just version 3 and version 3+. We know a lot of healthcare organizations have a hard time pulling their patients out of their EHR and providing us that list. So if you are already connected to NC Health Connex, and so you're sending that clinical and demographic information, then we are able to look to see which patients you have sent to us. There is auto attribution where you no longer have to send us that patient list. There is also going to be a patient panel loader and that is with us looking on the backend. And the other part of that is when we were sending out alerts to providers, it was either through sFTP or direct secure message. Whereas now we are going to have a section within the clinical portal. So if you are already accessing the clinical portal, you can very easily just get the alert within the clinical portal instead of having to check a DSM account or getting it through sFTP.

Some of the major benefits here, two I want to touch on. Of course, reducing avoidable readmissions and achieving financial goals. Being alerted where your patient shows up, when they show up, what you can do to further their care after they maybe showed up at the emergency room or another provider.

If you would like to know more, you can go to our website at HIEA.nc.gov and if you click on each box it will tell you how to access the service. I mentioned earlier the participant account administrator at each organization would be the person that would be able to grant you access. So more than likely that person is going to be the person that you are going to speak with to get access to each service. If you have additional questions you can feel free to reach out to the HIEA team or to myself. There is the information to the HIEA team as well as myself. Back to you Lakeisha.

Lakeisha Moore:
Great, thanks so much Jessica. I want to send a quick reminder before we jump into Q and A that if you would like to receive CME credit for today's webinar, make sure you have a myAHEC account and that your cell phone number is also included in your AHEC profile. A reminder, you can visit www.nwahec.org/textreg for full details if you want to get CME credit for today.

We are going to get ready to jump into our questions. Glad that we have some time, another quick reminder of the slide you see on the screen today: we do have technical assistance available through Office of Rural Health. We focus our team on the safety net healthcare providers, so let us know if you need help or have specific questions around telehealth or telehealth implementation, anything telehealth we are happy to assist. Also, our NC Area Health Education Centers, AHEC, CCNC are also available to help with telehealth technical assistance.

A lot of questions have come in Robin, through the Q&A. I will turn it over to you to get through some of these questions and have some great discussion. Thanks Robin.

Robin:
Thank you so much. We have had the questions rolling this session. I want to start off with Dr. Steve North, he had a question for clarification. Lakisha or Nevin, I'm not sure if either of you would like to address this, but he just said that **his understanding was that the session was going to be marketed on adolescent or marketing to be focused on adolescent care and wanted to know if that was something that might be discussed.** I didn't know if there was follow-up for that. He said he was **interested in hearing how others were handling confidentiality and consent issues.**

Lakeisha Moore:
Great, thanks Robin. I will start off and also bring in Dr. Jenkins. I know he has been our virtual boots on the ground and speaking with a lot of the pediatric and adolescent practices out there, so Dr. Jenkins we would love to hear your feedback. And thank you Dr. North, I feel like we should have you on this side of the presentation, we always look to you as our telehealth subject matter expert, so thank you for taking out the time to join us today. We did touch a little bit and we lumped in special populations because we also have been getting questions from behavioral health and then also we've had some updates with Medicare. So you are right, we did a small slice on pediatric and adolescent and kind of piggybacked off the Thursday webinar last week with the well-child visits, now that that's something that Medicaid is covering. But Dr. Jenkins, let me open it up to you if you have some things there that you wanted to share around what you're doing. Robin, I might need you to repeat those if I didn't get them because I think Dr. North has specific questions about the consent piece.

Dr. Jenkins:
I think I got it Robin. So, Dr. North, thank you for that great question. That is one of the things that we have when we're with pediatrics and adolescents. First of all, we have to understand our particular area, what is the age of consent to treat. And then who do we have on file in our EHRs who can give that consent if they are not up to that age. And who can participate in the visit? These are critical things because the healthcare information of our peds and adolescents are controlled by the relationship of who has guardianship of those people and who has been designated. There have been cases over time where someone who was not appropriate participated in care and that resulted in a conflict that had to be resolved, or even perhaps malpractice.

So first of all, it is key on step number 1 to make sure that we have documented in our EHRs who can be involved with the care of the adolescent and clearly what kind of permissions we have from them. That is number 1. Number 2 is the concept especially with adolescents of verbal consent. And documenting that verbal consent during the course of the virtual visit.

Let's give a case where a patient has some concerns about a sexual issue. And the provider senses the person doesn't want to discuss it with their parent present. So clearly, the ask has to be, we did this in our practice over the years, where we would ask the parent, would you mind us having a moment so we can discuss this issue with your teenager and we could help them to seek appropriate care for whatever question that they have and they are not wanting to talk about it fully with you online and would you give us this permission. That would be key to document that in the course of your note documentation that you were granted that permission and that you able to have that conversation with the adolescent alone.

And in many cases, part of the conversation with the adolescent is the importance of maybe sharing this information with the parents. And in some cases also we understand that there may be confidential information of why they can't share the information which may involve other agencies, so we have a duty to report that to another agency if there was some sort of fear or mistreatment issues.

That is number 2. Number 3 is unique to telehealth. Unique to telehealth is the ability to include people in the conversation who are distant. So, if you have an adolescent who is at school or home and you have a parent who is working or perhaps they are an essential worker and at their job and you need to have all three present with the provider, the responsible parent or caregiver, the adolescent because they are under age, and the provider. It allows us to leverage that technology to bring all three members into the conversation. Again, getting that consent, that oral consent even though it is not required right now by law to have a different consent to treat when you do it virtually, it is best practice in the industry to mention we are doing this virtually, the limitations of virtual care, that everybody involved understands and grants permission to proceed forward with the virtual visit.

I hope that covers many of your questions. That is certainly something that perhaps in the future we will invite someone like Dr. North to put up a few slides and share with everyone his experienced as someone who has expertise in dealing with adolescents.

Robin:
Great, thank you so much, I appreciate that and I am sure Dr. North does, as well. We have several questions specific to billing that came in initially. Paula or Felicia, I want to ask these questions

while we have you and see if you can help. The first is a combination question, two-part question that came in but by the same person.

Gary Madsen asks, I thought Medicaid was still using telephonic codes but reimbursing at 80% of parity. So, are they not using telephonic codes? He says bulletin 80 does not say what you are saying during the session. He said I thought this is how Medicaid was moving forward with this and he was a bit confused. I didn't know if you could clear up those questions for him.

Paula Locklear:
This is Paula, I am not sure, Felicia may have had some issues staying on the call. To Bulletin 80, which was just recently put out over the course of the weekend, Bulletin 80 does talk specifically about telephonic visits and it is saying that to support primary care providers in conducting telephonic visits, when a face-to-face or a telehealth is not valid or viable option, NC Medicaid is temporarily increasing the telephonic rate to 80%, which is comparable to the E&M visit codes. That [indiscernible] is -- they are paying the telephonic codes for those audio, what we call audiovisual or telehealth visit, which we may call audio only visit which is the 99431-99443.

Dr. Jenkins:
Yeah, and I would add, the confusion comes for the purpose of the visit so you have to go back to Medicare, where these visit codes were developed and defined. There are two sets of codes, one is for telephonic management. And one set of codes is for office visits. So I believe that for the purpose of assuring that you would get full compensation for the work you are doing, a provider engaged a patient, a Medicaid patient, and did an intervention, a clinical intervention for them, similar to what would occur in a face-to-face office visit, they would bill that on the codes based upon the ENM codes, and Medicare would go ahead and pay that at 80% of the published rate of that ENM code.

Robin:
Okay, great. Thank you for those answers, we appreciate it.

One question that came from Becky Johnson says is Medicaid allowing FQHC's to Bill T-1015 for telephone visits? So Paula or Felicia, do you have an answer for that?

Paula Locklear:
We have addressed this in a previous email. The first guidelines that came out from North Carolina Medicaid had the allowed CPT codes that you could bill for Medicaid services at that time. FQHCs, identified as being a billable entity, they could use T-1015 for the audiovisual visits.

Robin:
Okay, thank you so much. The next question we have is -- were you trying to say something?

Paula Locklear:
No ma'am.

Robin:
Ok, the next question is anonymous. I wasn't able to figure who sent it in but they said, **when billing for audio only visit for Medicaid, use the office code with CR modifier and it will pay at 80%, that is a question. Are we not using 99441 through 99443?**

Dr. Jenkins:

I will jump in. You have to look at the definition of what is the purpose of the visit. If you are doing a management visit, telephonic management visit, then you would use those codes. That is like a check in or management or getting data about blood pressure or things like that. The key thing is to remember those are timed codes. The time can be accumulated over a seven-day period. That is what the confusion is. If you are actually doing what would be considered an office visit, someone calls up and says let's give a clear example. Someone says I have dysuria, well they wouldn't say that, they would say painful urination. They say I am going a lot and it's burning and I have never had anything like this ever before. I drink a lot of water and cranberry juice and I don't know what is happening and you engage them in a conversation and talk to them about taking bubble baths because they are home alone now and under quarantine and they are bored and they have done things that have put them at risk for a urinary tract infection. You believe their symptoms are a simple urinary tract infection that you can treat by history and knowing their past history and there are no contraindications for you to prescribe something for that, then you would complete an office visit. That would be an office visit. That would be coded as an office visit. If it is an established patient, that's 99213 at least, wouldn't it be? You would then publish that based upon the billing guidelines of Medicaid and you would be paid at 80% parity. Does that make sense? I hope?

Robin:

Thank you. We are getting a lot of follow-up questions in the chat. I am mentioning to those folks who are still sending in some follow-up questions about the answers that we will follow-up with you all via email. It may be easier if these answers are not giving you the responses you need for your questions that maybe we do some individual emails. For those who have sent additional feedback, we will follow-up with you.

I have a question for Jessica from Jane Simmons. Can we get a link to the recent demo of the clinical portal NC Health Connex, are you able to share that in the chat or send out to the group?

Jessica Brehmer:

So I believe the last presentation I did with AHEC and ORH was recorded, so Lakeisha, didn't you say the link was posted on maybe the AHEC website?

Lakeisha Moore:

Yes, that is correct. On the AHEC website, if you go to the COVID-19 page, I will put that in the email here. I think I can do a direct answer back. For those on the call, if you go to the AHEC webpage, there is a COVID-19 section and when you go to that section of their webpage you will actually see not only this webinar, but all of the webinars that AHEC has been hosting and you will see categorized by the date, the actual slides, you will see the recording and then even the transcript from that particular date. That is available on the AHEC website. There might be some different information on the AHEC website because you're trying to navigate and get to this different thing but if you specifically go to the COVID-19 webpage, that's where you will see the list of webinars and you will see the links to those slides. Yes, Jessica, it was recorded.

Robin:

Thank you Jessica and Lakeisha.

Jessica, coming back to you, **Lisa Defieyes asked, for Health Connex, if our EHR is not able to connect to NC Health Connex but we completed the original deferral paperwork, are we okay after the June 1st deadline?**

Jessica Brehmer:
Yes. I say that because we are actually waiting on final extension language from DHHS. I know it is sitting with the Senate and just as soon as the Senate approves it and signs off on that, we will get the final language. We will also send out an email to our participants once we get that.

Robin:
Thanks, Jessica. Dr. Jenkins, a question that came in about HIPAA, and says **is the use of Microsoft teams for provider patient communication considered HIPAA compliant?**

Dr. Jenkins:
So, no. Many things - remember we are in the exemption period - the exemption period lasts as long as the state of emergency exists. So we have to be careful about using non-HIPAA compliant technology. So what makes a technology HIPAA compliant is encryption. Many of these devices like teams, Skype, other things, depending upon the platform in which they are based, they are not encrypted so they don't protect healthcare information from anyone who might join in inappropriately. However, we are allowed to do this for now. But best practice is to move towards something that is HIPAA compliant.

Robin:
Thank you, Dr. Jenkins. I think we have time for one more question and I know we did not make it to a lot of the questions but we will follow-up with everybody.

The last question comes from Donna Laucher, and she asks, is there paperwork or a template the health department needs to be completing before telehealth can be started in a health department setting and if so, where would we find this paperwork?

Dr. Jenkins, I will come back to you for that one.

Dr. Jenkins:
So, that is an interesting question. I have never thought of that. Under the exemption we are allowed to do telehealth and if it's done by a qualified healthcare provider, I am not for sure there is additional paperwork. But that is something we should research for you and make sure that the uniqueness of government doesn't have a separate set of requirements.

Robin:
Dr. Jenkins, I just want to ask real quick while we have you here, there are a couple questions that have come in asking **who the coders are on the call**. I didn't know if you could share that. That will be the last question.

Dr. Jenkins:
Ok, our coders are Paula Locklear, are you still there?

Paula Locklear:
I am.

Dr. Jenkins:
Your partner, Felicia Coats.

Paula Locklear:
That is correct. I have -- we did send out our email addresses and we have asked for if you would like to have a private conversation or personal conversation, please send us an email and we will be glad to reach out.

Dr. Jenkins:
I would encourage everyone, having spent a lot of time this weekend looking at some of the guidance that has been published, there have been multiple different guidances and we heard that Medicaid has over 80 different guidances. I think AHEC has prepared some good summary sites that you can go to, to see what is the current guidance based on some of the changes that have occurred. The most significant have been around our wellness visits for our pediatric and adolescent patients and also for Medicare now paying for the telephonic management visits done by a provider. That is critical and they are paying for that. It is kind of confusing, but they are paying for that at the same rate they would pay for a level one, two or three office visit, although they are management visits and the documentation should match the time requirement of a management visit.

Robin:
Thank you, Dr. Jenkins. Since there are a lot of coding questions I encourage you to reach out to Paula and Felicia if you have questions. I will pass it back over to Lakeisha to wrap us up. Thank you so much.

Lakeisha:
Thanks Robin, and thanks everyone for sending your questions and also for those that put in your direct email address. We definitely have been taking a lot of the billing and coding questions and just following up directly. As long as you put that in there, we should be able to follow up with you directly, and for the others as long as you put your name in and email address, typically what we will do is take the transcript from this call and make sure we get to all your questions. As Dr. Jenkins mentioned, there have been a lot of changes, so we want to make sure we are giving you the most updated information so that you have what you need.

Thanks again for taking out the time to join us, we will next week have another session as we have sessions for the next couple weeks and then like I said, we are always available between the Office of Rural Health, AHEC, and CCNC for direct technical assistance with telehealth.

But starting to transition to the digital health best practices, we will have someone from Columbia University talk to us about trends that they are seeing that are staying with us past this pandemic and also many of you have been asking about remote patient monitoring equipment and how am I able to check blood pressure and do other things remotely as telehealth is being incorporated into your practice. We have Jordan Berg with the National Telehealth Technology Assessment Resource Center joining us to talk about some of the things that he has seen out there, since that is what they do, when they look at telehealth technology that's out there and available to us.

So, we look forward to seeing you again next Monday, virtually at noon. Thanks again for taking out the time to speak with us today. Hopefully we can continue to reach out and connect and answer your questions and share a lot of this information back to the group during our webinars. Enjoy this beautiful, sunny day, have a great rest of the week and we will see you next Monday at noon. Thanks again and goodbye.

[Event Concluded]