Transcript for NC Medicaid, CCNC, and NC AHEC Webinar Series for Providers
April 30th, 2020
5:30pm - 6:30pm

Presenters:
Shannon Dowler, MD, Chief Medical Officer, NC Medicaid
Tom Wroth, MD, MPH, President, Community Care of North Carolina
Hugh Tilson, JD, MPH, Director, North Carolina AHEC

Hugh Tilson:
Good evening everybody, it's 5:30pm. Let's go ahead and get started. Thank you so much for participating in this evening's COVID-19 webinar. This webinar is part of a weekly series of informational sessions put on by North Carolina Medicaid, CCNC, and NC AHEC.

Next slide. We have got a ton of great timely information tonight, including an update on Medicaid policies, followed by a panel focused on telehealth and well-child and -adolescent care. We'll then respond to your questions and close with a list of resources. My name is Hugh Tilson and I'll be moderating today's forum. We have a star-studded panel again tonight led by Shannon Dowler, Dr. Dowler, who's the Chief Medical Officer for Medicaid, Dr. Tom Wroth, who's the president of CCNC, and Dr. Christoph Diasio, who's joining us again -- he's a pediatrician from Sandhills Pediatrics -- Dr. Steve North, he's a family physician and Medical Director of Eleanor health -- and he's an adolescent medicine specialist -- so welcome back, Steve. Dr. Theresa Flynn who's a pediatrician in Wake County and Dr. Martha Perry, who's a pediatrician, an associate professor, a Medical Director of UNC Children's Primary Care Clinic, and also an adolescent medicine specialist. So thank all of you for making the time out of your busy schedules to be here for tonight's presentation. As I frequently do, let me just also thank all of you who are practicing in the trenches for making time to hear tonight's presentation. We really appreciate all that you do and I hope the information that you get tonight will make your practice a little bit easier and make navigating these trying times a little bit easier as well.

Next slide. After our presenters provide their updates, we'll turn to your questions. You can submit questions either by using the Q&A feature at the black bar at the bottom of the screen, if you're on the webinar or if you're on the phone, submit your questions at questionsCOVID19webinar@gmail.com. That's questionsCOVID19webinar@gmail.com. We ought to be able to get to all of your questions, but know that if we can't, we'll send them all to Shannon and her team, so that she can respond directly to any questions we can't get to on our webinar tonight. We'll also record the webinar and send a transcript of it, and these slides – available, probably as early as tomorrow. Shannon let me turn it over to you now for your Medicaid policy update.

Dr. Shannon Dowler:
Great, I've gotten -- this is sort of like going home every week, we have our Thursday night gathering where we get together a few minutes beforehand and catch up with each other and I wish I could see everybody's faces out there around the state who are -- been consistently coming back week-after-week and joining us on these updates. So just a reminder that last week we released our great well-child visit provisions with telehealth and I'm not going to spend much time on that now because the second half of our session today, we're going to be hearing from practicing docs and how they're deploying and implementing these well-child visits and kind of helping troubleshoot -- to give you some words of wisdom on some of the nuances and ways you might be able to do it as seamlessly as possible, in your practices. So I want to tell you about some of the new things that we're turning on.

Next slide. So I'm really excited about this. I presented it to the Secretary and others at our report out tonight, almost like an ad. So you know like -- the hybrid cars are that blend of electric and gas so they get improved fuel efficiency and they can go further. I'm thinking of this new visit, our hybrid home telehealth visit, is a similar kind of thing, where it allows everybody on your team to practice at the top of their license. It extends the reach of the practice further into a patient's home and really allows us to take the best care

possible of some of our vulnerable patients, who really can't safely get to the office for the foreseeable future. So what this hybrid home telehealth visit is, is it's a telehealth visit being done by the provider -- so that physician, nurse practitioner, physician assistant, or certified nurse midwife – is paired with a home visit that happens simultaneously by an appropriately-trained delegated staff person. You might notice that that's an extremely vague definition and we did that on purpose, we went around and around and around on what is the right degree or person to go into the home. And the bottom line is you guys know who that is. They're the people in your practice who are rooming the patients and doing all these things anyway. They're asking them the questions, they are your go-to people that you trust, and some of them might not have certain degrees, but they've worked in the practice for 20 years and you would trust them any day to do the best care possible. So we left that vague on purpose. We want you to use your judgement about who in your practice is appropriately trained to go out and do the home part of the visit. When we think about this visit and how it might be helpful or useful, we think about a few circumstances like a hybrid pregnancy, maybe, were the woman's not able to get in or you don't want her to come into the office. But you really want someone laying eyes on her and doing some measurements, maybe more than you can do in a telehealth visit. Someone with uncontrolled chronic illness that really needs closer follow-up; maybe they need lab draws, maybe they need to get an injection, maybe you want their feet really looked at and checked because they've got uncontrolled diabetes. For a well-child -- for an infant, maybe. We're not recommending well-child routinely for the under-24-months, but maybe you've got a younger child or a really medically complex child, that you don't feel comfortable just doing the telehealth visit. This gives you an ability to reach out and do a little bit more. Things that could happen by that appropriately-trained delegated staff person, assuming they are appropriately trained and that you delegated them to do these things in your office, they -- you could have them do vaccines in the home, draw labs, and monitor vitals. You know, in the right patients, so folks -- you would of course have to use your judgment. So the way we figured out how to do this is from -- almost all of the folks, it's going to be the home visit E&M codes that already exist. So we already have E&M visits for home visits -- we reminded everybody about those, gosh, probably six weeks ago and encourage people to use them. They reimburse at a much higher level than the office-based E&M visits. But usually it has to be the physician, nurse practitioner, physician assistant, or certified nurse midwife that is doing the home visit. In this model it's not. It's your staff person doing the home visit while the provider is on telehealth doing the telehealth visit. There is a nuance for people that are billing for pregnancy in the pregnancy global package so that you can get reimbursed for this part of being in the home -- is a little bit different. All that detail is going to be in the bulletins that will be out tomorrow on our website. These codes will be turned on next week. So we're following our normal pattern that we do every week, where we tell you about it in advance, we release the bulletin so you can read about it and understand it and figure out how you might want to use it in your practice, and then the codes turn on the following week.

So, next slide. This is just a reminder of the different home visit codes that already exist and they're already in our system. And they're based on the amount of time that are spent at different levels of visit, that you might choose to code for based on what you're covering at the office visit type. We are allowing well-child checks to happen in this way, but you're going to use that home visit code, not the well-child code. But you'll use the well-child modifier in it. And so our bulletin's going to have all that detail. I didn't want to go into a ton of detail on the phone because it's a lot to follow. And really this is more about, tonight, talking to you about the concept of it and why we created this visit type. So I hope you're excited about it. I'm sure you're probably scratching your head to say: can we make this work in our practice -- is this financially feasible? Those are questions that everyone's going to have to wrestle with. But it seems like a potential for something that could change the way we practice medicine and helps some of our patients that we've had a harder time accessing, in the past. Even after the pandemic.

Alright, next slide. So another new thing we've turned on this week is our skilled nursing facilities being able to provide telehealth. This is -- skilled nursing facilities have been allowed to have patients see specialists outside through telehealth, for some time. What we have changed is we've added the originating site fee for the nursing facility. So that nursing facility can actually bill the originating site for doing these telehealth visits to outside providers. Now they can't do it for their own medical director or the persons -- the patients' attending within the nursing home facility. They can't bill that originating site in that situation. But for all other telehealth visits they can. And so that's just another way we want to encourage our high risk

patients to stay in the environment where they're safest. It's really, it's -- the skilled nursing facilities, out of necessity, have had to get really tight with their rules. My aunt fell out of her bed last night, EMS took her to the hospital where she got some stitches on her arm from where, you know, a flap of skin tore. She was only there a couple hours. And then, because it happened in the middle of the night, you know, they didn't follow the process of calling my mom -- they just took her by ambulance. But then she's stuck quarantined for two weeks because she left that nursing facility. And so when we're make the patients leave or asking them to leave for medical visits -- when they come back they are super isolated. And that's not ideal for our elderly population. Anyway, so hope that folks will consider using this in their practices.

Next slide. We also -- thanks to some feedback from the field -- added some telehealth codes around end-stage renal disease and dialysis. Historically, renal dialysis patients with accesses had to have a monthly hands-on vascular site evaluation. That's being allowed to be done by telehealth now. We're also allowing for telehealth for other routine medical care, including the dialysis training. The eligible providers are the same as they often are: physicians, nurse practitioners, and physician assistants. And these dialysis telehealth codes do not require prior authorization. So again, tomorrow the bulletins will all be out and you'll get all the details if you're someone that would use the codes.

Next slide. So I always like to give you an update on where we are with the pharmacy. I've been impressed with how quickly our pharmacy team has been able to mobilize some of the changes we've made. So we are now paying for mailing or home delivery of prescriptions from retail pharmacies. A lot of retail pharmacies have done this anyway, just as a courtesy to their patients. But we are now including a reimbursement fee to those pharmacies. So we encourage you to encourage your patients to ask for their medicines to be mailed to them or delivered to them, so that they have less exposures. And then the others are just things we've already covered. But for those that haven't maybe been on the call on a regular basis, it's a chance to update you no some of the changes we've made over the last two months and that remain in effect right now.

Next slide. Alright, so in the DME side we also have the advances -- nothing new this week, this is again just a reminder of some of the things we have done. The big ones to me as a provider who often wanted these things for my patients was providing blood pressure devices, pulse oximetry, and scales for our Medicaid beneficiaries. This is not something that I expect will stay on forever, but it's definitely on right now during our COVID pandemic. And we have gotten some feedback that some practices have had trouble with the Durable Medical Equipment process. And so if you're really getting stuck on it, we do have on our website the link to the Medicaid-approved DME companies. But our DME team is awesome. And John did the -- leads that up, and if you send us an email in that medicaid.covid19@dhhs.nc.gov -- that will come up again later in the slide deck. That's where you send your questions that you can't get resolved. If you're really struggling with -- we need you to send us the messages and let us know so that we can respond and fix things on our end, or in the DME side. And so let us know, don't just sit and suffer silently, give us that feedback.

Alright, next slide. This is from some of our data that we're looking around virtual and telehealth visits. This is a new dashboard that is on the DHP side and it's -- I'm just so impressed by the increase in how quickly the field has responded. I mean we went from zero to 60 with very little -- I mean just almost no prep time. This moved much faster than I think any of us were expecting, and I'm just impressed. When you see the downslope, where it peaks and goes down, that is just because the claims haven't come through yet. That is one thing I will say, we've heard rumors that some practices and systems are holding their claims and not releasing claims, for some period of time. We sure hope you start sending those in for a lot of reasons. One we want to make sure that our beneficiaries are being seen and taken care of. It makes us nervous when we don't get claims. But also because we're approaching the end of our fiscal year and it's really important for us in the way our funds and budget work, that we get claims through in our fiscal year, as much as possible. So folks that are holding onto their claims, if you're in health systems that are really holding onto claims, we hope that you will start moving those along and getting them out so that we can pay them -- we can work through any kinks. That's the other thing, is we're learn about what works and doesn't work when you send the claims in. And if there are claim denials, then we can fix issues.

Okay, next slide. Alright, this is my 'Hit Me with your Best Shot.' So I'm turning it over to Tom Wroth to ask me questions that they keep getting -- we keep getting, everybody keeps getting, around telehealth in general, right now. So Tom, hit me with your best shot.

Dr. Tom Wroth:
Alright Shannon, here it goes. We had some great questions from the last webinar and some good questions about ready to come in, in real-time, about what you just went over. So, here we go. So you just showed the data -- and tell us a little bit more about how different routes are responding to telehealth. What are you seeing? The specific question was about the non-English speakers, the Latino population.

Dr. Shannon Dowler:
Yeah, so definitely we are seeing a decrease in telehealth utilization in the Latino population. No question, it's lower than the non-Latino population. I do believe -- I heard that Univision just did a big piece on telehealth, where we're translating all of our information on telehealth into Spanish. My video, that little educational crowd source video that a bunch of you guys helped me make, on teaching patients about telehealth -- that's on the DHHS website. We're actually going to do that as a Spanish overlay. So we're going to be like one of those -- the badly, what's the word for it, when you have the, like the soap operas, you know, and it's in one language and they do it in the other. So we're going to have the voiceover. That's not going to match the words, but we're going to do the best we can. We're trying to do as much as we can and our DHHS website actually has information on COVID in over 40 languages -- good to know. But not specific to telehealth, so we're working on that.

Dr. Tom Wroth:
That's great, so more to come. So this is related to some of the really exciting news about the PMPM adjustment, and also the telephonic rates going to 80% of parity. When will those changes come into effect?

Dr. Shannon Dowler:
Good question. So, I asked this only an hour ago, on the PMPM. Everyone got their April payment in the second week of April. So you'll get that change -- the increase -- on May 12th. And then the May payment and the June payment will just be in the normally scheduled payment. We'll actually put that out in a bulletin, for more information. But it's coming, I promise. On the phone, the telephonic code rate increases – so we increased those to 80% of E&M parity. And that's retroactive to March 10th. Those did go into effect this week, and our team is going to go back retroactively and adjust your claims. So you do not need to resubmit them. If you do resubmit them, apparently there is -- I don't know, the finance team explained it to me and it just like people speaking in another language, because it's finance. But pretty much the bottom line was, just let us do it. We're going to – we're going to take care of it on the backend. You don't need to resubmit your claims.

Dr. Tom Wroth:
Great, a couple of questions in real-time which I thought were great. So the skilled nursing facility and telehealth provision, does this apply to assisted-living facilities, health care homes?

Dr. Shannon Dowler:
Hmm, that's a very good question. I'm going to turn to my expert on the phone, Beth. We didn't specifically talk about those. Beth can you help me answer that question?

Beth Daniel:
I think I've unmuted everything. Can you hear me?

Dr. Shannon Dowler:
Yep, I can hear you.

Beth Daniel:
Okay, so we haven't specifically dealt with it, we will -- I do not see why it will not work. We will go back and check on it and see that we can issue something, the first of the week.

Dr. Shannon Dowler:
Sounds good.

Beth Daniel:
Just to confirm.

Dr. Tom Wroth:
Beth, you might want to stay on the phone for this one too, it's a great question. For the home visit codes, we had a pediatric dentist ask if this applies to dentistry? So for example, could they have a team member go into a home and take a picture of a child's mouth?

Beth Daniel:
Well Dr. Casey has been really proactive in putting out information about tele-dentistry and I would say that there is going to be a bulletin -- I think the first of the week. But you can contact Medicaid through the medicaid.covid19 and specifically request that it be directed to them. They can provide you information, but there's going to be a well very-much informative bulletin soon.

Dr. Shannon Dowler:
Yeah, but this specific code is for medical, that we're really seeing the home.

Beth Daniel:
Oh yeah, we're talking about medical, not dental. There are specific D codes, dental codes, that they're going to be putting out.

Dr. Tom Wroth:
So don't use the codes that we just showed you. The D codes are coming.

Hugh Tilson:
And Dr. Casey is hosting webinars like this, every other Wednesday -- so next Wednesday there'll be one where there may be even more specific information about oral health.

Dr. Tom Wroth:
Great. Shannon and Beth, we had a couple questions about the OB bundle billing mechanism. And if you're billing under the OB bundle can you still use the home visit code? And can you still do some of the telephonic codes that we talked about, I believe last week?

Dr. Shannon Dowler:
Beth do you want to take those? I can take the second one if you can get the first one.

Beth Daniel:
The providers billing the OB bundle will be not using those E&M codes that we presented tonight, but will be allowed to bill a facility fee -- in essence what a facility fee is -- for having the person in the home. So will get reimbursed for the person in the home, in addition to the services that are under the bundle.

Dr. Shannon Dowler:
And then our telephonic codes do not count as a pregnancy visit. We are reimbursing for telephonic care, but it's outside of the pregnancy bundle -- it doesn't count as one of those visits. Did I get that right, Beth?

Beth Daniel:
That is correct. The telephone visits -- the telephonic visits do now count.

Dr. Tom Wroth:
Alright Shannon and Beth, I think those are my best shots for now.

Dr. Shannon Dowler:
Alright, I think we did pretty well. We'll see. Alright, next slide, Nevin. Wanting to make sure all of you are aware of this. This week HHS launched a claims portal for reimbursing for the care of uninsured individuals related to testing and treatment. I feel like a lot of you have probably been involved in providing that care. Like all things that are federal funds -- that are limited -- my guess is, they'll run out of money. And so I would encourage you to be getting onto this portal and submitting your claims as soon as possible. You can see that there's a training date on there. And it's, I think the first week of May, when you're able to get in. But my guidance to you would be to get your ducks in a row and get on that as soon as you can, so that you can get those reimbursements. Because, I know that for those of you that are taking care of a lot of uninsured patients, that's been a major financial impact on your practices and this will help you out.

Alright, next slide. Alright, now I get out of the hot seat. Tom, turn it over to you.

Dr. Tom Wroth:
You're out of the hot seat Shannon. Do you want to say anything about the beautiful pictures?

Dr. Shannon Dowler:
Oh yeah. Okay, so I was working on the slide deck today and I was feeling kind of sad, because I miss my kids. Because I got kicked out of the house after I went to the poultry plant last week, and tested people for 2.5 days. So I'm in my Raleigh apartment for two weeks in a quarantine, which means I haven't gotten to see my family. And so as I was going through the different slides, through the different ages, I just pulled up pictures of my kids. So there's not a lot of diversity here, but there's a lot of love. So that's it.

Dr. Tom Wroth:
That's great, alright. First slide. So I want to thank Theresa and Martha and Christoph and Steve. So we're going to have a few cases here and -- let's see, so Christoph this one is for you. And this 16-month-old boy wants to -- parent wants to have a well-child check done but doesn't want to come to the office. And this child is actually overdue for immunizations -- for their 12-month immunizations. And how would you handle this situation considering the policy changes we just went over?

Dr. Christoph Diasio:
Sure, well thanks for the opportunity to talk about it. I think the -- you know the overarching concept is we need to be really appreciative to DHHS for giving the flexibility that we'll have with this new policy. And I think it's nice that there's sort of a soft blind, that, you know in general we really do want kids under the age of two -- under the age of 24 months -- to be seen in the office, so you can get height, weight, vision -- there's a lot of things that go on and it's just, you know a very vulnerable age. And I think it becomes a question of context, right? So we said okay -- we said nobody under 24 months, but what if you're the 75-year-old pediatrician and coronavirus is raging in your local community? We want a telemedicine option for those kind of docs. What about if you talk to mom and say why don't you want to come in and she's seen this terrible stuff on television, and then, you then step through and you explain what you're doing for infection control, that maybe you've divided your office in half -- and the sick doctors stay on the sick side and the well doctors stay on the well side. Or maybe you are doing well-mornings and sick-afternoons. And so, you know, it's not just they say they don't want to come in the office -- they want to do a telemedicine -- it's a conversation. What if you go to the next step and you find out -- you know, mom recently had a lung transplant, and is maybe immunosuppressed. Well a lot of us would argue that, you know, it's super important to get that kid protected, so he doesn't bring cooties home to the mom, eventually. So I think all those are things that we play and this is what makes us physicians, right, that we can think these things out. And so, you know there's lots of different approaches. So let's say it's the immunosuppressed thing – grandma's immunosuppressed, they don't want to come in, or whatever. You know you could really do a very effective first-half of the checkup talking about nutrition, diet, all the other things, and then have them

come pull up in your parking lot, have the nurses give the vaccines in the car seat. It's hard to get too far away from the nurse when you're in a five-point car seat. You know, so maybe use some of those things to your advantage. You could -- if you needed to do a blood draw, you could do a lead test -- you know, a finger prick lead test. So there's a lot of things that we can do in a different way. It's certainly important that we're careful about our staff safety and we're not putting them in unsafe, you know, positions. So, definitely want to think about that. But I look at this as not -- the telehealth policy is not as -- I guess some of my friends have responded to it: 'is this really a good idea? are you telling us to do everything by telemedicine?' No, this isn't -- once you have a hammer, everything looks like a nail. The concept is that we have flexibility and that there will be situations where this can be tremendously helpful. It's just another tool in the toolbox.

Dr. Tom Wroth:
Christoph, can you or one of the other panelists talk a little bit about developmental screening and how best to do that part of the visit?

Dr. Christoph Diasio:
Sure, you know there's lots of different tools for that. You know one option is if you can send them in your patient portal, you send them the PDF of the peds screen, or an ASQ, or whichever developmental screening you like. They have the opportunity to print it. They could fill it out at home and take a picture and send it back to you -- you know, through your portal, hopefully. You know, failing that, you could even verbally ask peds questions. We have had conversations about -- Dr. Dowler and team -- and agree that while we're in this catastrophe situation, that you could just verbally read the peds screens. You know, another idea that Dr. Perry had on our call was, if you can do a share my screen, you show them the form and you go over it together. So there's lots of ways that we can get there and, you know, we're going to innovate and try new things. And document in the chart that -- parent unable to print peds screens, reviewed questions, you know, all results normal.

[Unknown Speaker]
And Christoph, the other thing that we could think about, which is not a new method, but is to send it in the mail, depending on your timing.

Dr. Christoph Diasio:
Absolutely. You know, we can go old-school and new school. So, you know, lots of different ways to get there. You could have them pull up the screen on their -- you know; you could give them the web link, that they could go to the screen or online. They could look at it on the screen while you're talking to them. And there's a lot of ways to get there.

Dr. Tom Wroth:
And Christoph, I think you talked a little bit about documentation and really you talked about it's a conversation. And is that part of the documentation, you would do?

Dr. Christoph Diasio:
I would, I mean because you're trying to explain the rationale of -- well in general Medicaid wants you to, you know, under 24 months in-person; why did you do it differently? And I don't think you have to come up with an elaborate reason. You know, grandma is immunosuppressed, parents terrified of COVID, unwilling to come in. You know, some of my colleagues in my own office have been sort of upset about the idea of telemedicine and the concept I keep coming back to with lots of people is, we are not choosing between perfect and another option. We are choosing between doing the telemedicine well-visit or it not happening. And that's really the choice, that something is better than nothing. And then, you know, we can do part two later, whether that's -- they get the vaccines that afternoon or the following Friday. You know, hopefully for vaccines it's sooner than that, but does the second part visit, you know -- does that become two or three months later once things improve?

[Unknown Speaker]

And Christoph, one thing that's so incredibly important about the visits in the second year of life, is that the main thing we're screening for is language delay. And that is something that is accurately and easily diagnosed via telehealth. And if the child has a significant hearing -- speech delay, then you can refer for audiology and you could also put in place for the referral to CDSA and start getting those developmental services.

Dr. Christoph Diasio:
And I love that. And you know, you've got a terrified kid in your office because he's afraid you're going to poke holes in him, right? Let's compare that to, you're just like granddad or grandma on the screen, that they talk to all the time and you can actually really assess their speech probably, better than you can at the office when they're nervous.

[Unknown Speaker]
The other piece is the anticipatory guidance, especially at this age when we're talking about safety. You have the advantage that you are actually somewhat in that child's home. And reviewing safety may involve not just talking about it, but actually looking at areas -- parts of their house, to look at what's safe or not safe, and giving some guidance about what might be a little more concrete and applicable, when you're dealing with it.

Dr. Christoph Diasio:
I see the 3-year-old got the kitchen -- the cabinet under the kitchen sink open. What's in there?

Dr. Tom Wroth:
That's a great insight. That's really an enhancement in care. Things that we usually don't get to see.

Dr. Christoph Diasio:
You keep hearing the smoke detector -- or one of my calls I kept hearing the smoke detector chirping. And I was like, 'is that your smoke detector -- you know that needs a new battery, that's what that means, right, that's really important?' So there's a lot of things that we can do that we -- you know, there are things that we lose with a telehealth, but there are things that we absolutely gain and it will give you a level of insight into your families, that you've never had before.

Dr. Tom Wroth:
That's a great point. Let's go onto the next case. So we have got a three-year-old for a well-child visit. So Theresa tell me about your approach to the 3-year-old well-child check.

Dr. Theresa Flynn:
Well in many ways the three-year-old is the ideal visit for telehealth, in the well-child check universe, because that's a child that's not going to be getting a whole lot of immunizations. That's a child that doesn't need lab tests. And there are parts of the exam -- the vision screen is very important at age three -- that is in almost every office, is going to be done in-person. There are some actual commercial telehealth video ways to do it remotely. Though most of our practices aren't set up to do that. The main point of the three-year-old exam is looking at growth, development, nutrition, safety, all of those things. And the plan with these -- the ideal with these well-child checks is to have a telehealth portion followed, maybe a month later, by an in-person exam, were you can complete the parts you weren't able to get done. So even in that initial part, the child can stand against the wall and the parent can use a pencil to mark it, and measure the height. You can use a scale in the home to measure the weight. You can certainly do the pediatric response screen or the ASQ or other screening tests to look at the language, the development. Three-year-olds tend to talk a lot, so you can actually get a lot of that exam in real-life. And a lot of the anticipatory guidance, including looking into the preschools and making sure that they apply for more at four, before they lose that spot. The importance of early literacy and exposure to language. So there's actually -- the three-year-old visit is a really nice fit for this planned part A, part B of the telehealth well-child exam.

Dr. Tom Wroth:

That’s great. You make the three-year-old visit sound like a really fun telehealth visit, even if it’s a part one and part two.

Dr. Theresa Flynn:
Absolutely, and especially in these telehealth visits where they get to show you all their favorite toys and you may need to do some directing to manage your time.

Dr. Tom Wroth:
You’ve got to love the three-year-olds. So let’s go to the next case. So this one’s a little more complex because there’s a lot to do in this visit. We’ve got a five-year-old who is getting ready for kindergarten. So we’ve got forms to think about with immunizations, potentially labs. How do you handle this during COVID?

Dr. Theresa Flynn:
So the five-year-old visit has a lot of the same features as the three-year old visit, so there are some things you can certainly get done through telehealth. And again that developmental piece is really important and if there are delays in development, a lot of those referrals to get the child a formal evaluation -- through the school system, for example -- to make sure that hearing is okay. A lot of those things can still be done; a lot of the nutrition, safety -- those pieces. But a big part of the kindergarten physical is the physical, which is a hands-on physical exam and the parents’ main goal is to get the paperwork complete, so they can register their child for school. So that's a part that will need the hands-on aspect. Certainly if there are catch up vaccines, there's a whole slew of booster shots that happen between the ages of four and six, and so many five-year-olds need to catch up on all of those. So that’s going to be an important part A, part B. One advantage of the part A, part B plan, though is that it does reduce the amount of time the child and the parent is in the office -- so it reduces their exposure. It allows your staff to socially distance more because there's just less time. So you can get the whole history and counseling piece done and then make a shorter visit later for vision screening, hearing screening, physical exam, immunizations, and labs, if those were needed.

Dr. Tom Wroth:
We’re talking a lot about part ones and part twos. What do you think about the use of the home visit, where another team member could do some of these things? Do you think there’s a role there for the five-year-old visit?

Dr. Theresa Flynn:
There’s certainly that option. Certainly the vision screening, the hearing screening, the immunizations, labs, if necessary, could be done. I think it would require again, as far as the hands-on physical exam there’d have to be some thought given to, you know, who exactly is doing that and is that the person equipped to do that exam. But again it may be that -- to try to get the child equipped to go to school, you may just try to get as much of it done as possible. Because we’re in extraordinary times and we’re trying to take the best care of the children that we can, given the situation that we’re in.

Dr. Tom Wroth:
Great. Panelist, any other thoughts before we go to the adolescents? Good. It's such an important theme that this -- you know Christoph articulated and you too, is that these are such unusual times and a lot of this is around pragmatism and prioritizing the most important things.

So let's go to the next case. So we’ve got Martha and Steve, our adolescent-focused physicians. And Martha we’ve got a 13-year-old that comes to you who would like to get a camp physical done, assuming that camp happens this summer. So this is our opportunity with this 13-year-old and how do you get some of the really critical things done during this visit?

Dr. Martha Perry:
Again I think this is where there’s some opportunities from telehealth that we don't have in the office. The formality that is in the office is often intimidating for a 13-year-old, or as you mentioned for a three-year-old,

for that matter. So I find that they're more relaxed and more forthcoming when they're at home and relaxed, sometimes curled up in their bed with their laptop, or sometimes on the phone -- mostly on the couch. So I find there's a little bit more honesty and I'm actually getting to see the real child as opposed to the nervous one that's sitting on the edge of the seat in the exam room. This is a time when -- if you haven't already -- you want to address confidentiality. What's interesting is that I find parents being a little bit more comfortable leaving their child alone to have a conversation with me. And I think that's because they're not leaving their child in a room with someone alone and going off to a waiting room, they really don't know. They're in the comfort of their own home, so they'll do something else around the house and they know that their child's safe in another part of the house, and able to have that open conversation. I use it too as an opportunity to kind of observe the interaction between parent and child. Which, again I find is different in the home than it is when they're in the office. And also adolescents to have some ownership of their medications and things like that. So 'which inhaler are you on? I'm on the blue one. Well can you go grab that? Let's look at that together. What's the expiration date? How many puffs have you used?' And so it gives the opportunity to do a little bit of teaching with them. We can make sure we know what their teaching for medication is. I actually had a patient today who was taking double the amount of magnesium and she had been having a lot of nausea and we were able to determine that because she went and got her two different supplements she was taking and realized one of them contained a large amount of magnesium. So that's one of the great opportunities to -- about telehealth is they're able to go grab the medicines and look at them with you.

The other piece that people often get concerned about is how to deliver a developmental screen and how to do that potentially. And as Christoph alluded to, there's a lot of different ways to deliver them. Again adolescents tend to be a little bit more comfortable with screens. So I've had some pretty good success with sharing screens to do the rapid assessment for adolescents. So adolescent preventive services, [Indiscernible], a variety of adolescent risk behaviors, and also the PHQ9, sometimes [Indiscernible] answers and it actually often times gives an opportunity for discussion. Those reinforce healthy behaviors as well as to potentially change behaviors in a healthy way. Starting the visit with the parent -- they do emphasize again that, just like in the office, we'll want to take some time to talk with your teen confidentially. So once we're done making sure that all your concerns are addressed, you'll have to step out of the room [Indiscernible] so that we can have the confidential and private conversation. And then once they're private I'll say to the teen, 'do you feel comfortable talking privately right now? Do you feel like --

Hugh Tilson:
I think we lost Martha.

Dr. Tom Wroth:
We might have lost Martha. Any of the other panels want to pick up on that theme?

Dr. Martha Perry:
I'm here, can you hear me?

Hugh Tilson:
Yeah, we just -- you are fading in and out.

Dr. Martha Perry:
Oh, sorry about that. So I was just talking about when an adolescent tells you that they can't answer questions confidentially, how do you address that? And there are a variety of different ways. They can put headphones on and they can answer yes or no questions, or they can use the chat box to give you some more confidential information. So there's a variety of different ways that you can still ask about confidential things without compromising their privacy. And finally I would say that, you know, again there is part one and a part two, that we talk about. So as you identify things that need more exploration, that are non-urgent; those are things you can do in part two. And of course there may be some things that are more urgent that need to be addressed sooner. Certainly for example, with their mental health issues. And thankfully we're able to do a fair amount of mental health interventions now through telehealth.

Dr. Tom Wroth:
Martha, do you have experience getting a mental health team member involved, sort of in real-time or have other panelists? And what about the billing on that, can you bill on the same day?

Dr. Martha Perry:
Yeah, so we actually will sometimes -- we have an integrated behavioral health clinician, so we will actually pull her into the visit using some of the telehealth techniques to add participants and introduce her, and do a true one handoff. But you can have a separate visit that bills for psychotherapy, similarly to what you would do if they saw a mental health professional separately, in the office -- if they were seeing you on the same day for a physical. And then the mental health providers have those unique codes that they'll use in those circumstances for billing.

Dr. Tom Wroth:
Great, thanks. I think you covered a lot of the issues that we think about in the adolescent visit, in general.

Dr. Steve North:
So let's go to the next case, and this is for you, Steve. And everyone has to notice the boutonnieres on the jackets there in the picture. There'll be a quiz at the end to see if you can identify what those are.

Dr. Shannon Dowler:
Yeah, so you have to let everybody know that STDs are my favorite thing. You know? So I made condom corsages and boutonnieres the night before prom last year for my boys and all of their friends. And they all sported them and we had a great photo shoot. It was impressive. And then promptly they all wanted to keep them and took them to college with them. So there you go.

Dr. Steve North:
And look for Dr. Dowler's Etsy shop to open up soon as well.

Dr. Tom Wroth:
Steve, we've got this poor 18-year-old that has been traumatized on prom night.

Dr. Steve North:
Right, exactly, so right off the bat, you know -- if we think about the college physical exam and really what you're trying to do there. Is it about actually making sure that they don't have a new S2 murmur or is it really about prevention and risk screening? And if you take the focus that this is about prevention and risk screening, you set a great opportunity to spend a lot of time with the adolescent who's getting ready to go away to college. And -- but you want to have follow-up plans in place so if they may have used some of the condoms off of their corsage, they know they can come in and get the STD testing, HIV testing, that would be recommended in that adolescent. One of the things that happens at this age is that this is an 18-year-old and so they can consent for their own care. And sometimes we as providers and also parents are quite aware of that, so that's an important conversation to have upfront. You've been doing this in your office for five-ten years and asking the parent to step out during part of the adolescent well-child check, and the same thing should happen in their home; and Martha touched on that as well. So different colleges require different things. You're not going to do a complete unclothed exam, that's probably not appropriate. But enough parts of the physical exam to satisfy the college's form, but also to make sure that there are not any big red flags that you want to investigate further. And you can do enough by exam and a lot of times that's -- look for pupillary reflex, just with the iPhone camera. And a pretty good ENT exam can be done with, well the eyes, the nose, and the throat, not the ears so much. But the ability to hear would indicate and if there has been a change the hearing, what may have happened there -- do they need to come in and get that evaluated further? I think that other things in the college exam are chronic injuries that may continue to give individual some trouble. And so doing a visual exam of their ankle that they sprained two years ago while running track, or just going for a hike, and making sure that that's okay, would an important thing to do. You can ask the individual to palpate their own lymph nodes. You can ask them to press on their abdomen and see if there are

tender spots, if that's appropriate. So I think that the physical exam part of this is definitely doable and then, you know, having the conversations as part of the -- I think that's an essential part of what you want to do during this visit.

Dr. Tom Wroth:
Steve, that's great. There's a great question in the Q&A, that's just sort of a logistical question. What if – well this might be before the age of consent. Can the parent give consent from work, but the child is at home? So this might have been a little bit more our previous case, but can you comment on that?

Dr. Steve North:
Yeah, I think you definitely can because verbal consent is something that's now allowed. The parent -- you could either do a screen share or have that done under -- on the telephone, just like a telephonic exam, and then begin the exam via video with the adolescent at their home. One of the things you always want to do, whether it's adolescent exam or an adult exam, is make sure that you know who's in the room. And reassure the parent, the patient that you're alone. But also are they being influenced by someone off-camera? To answer one way or another, is someone off-camera preventing them from fully sharing?

Dr. Tom Wroth:
Steve, what if you are concerned about -- what have you done in real practice when there is a concern about an eating disorder, or depression, or other things? How do you address that in real time?

Dr. Steve North:
So in real time, Martha brought up screen sharing, to bring up some of the evaluation tools. You can ask the questions on the PHQA verbally; you can do the Columbia suicide risk screener verbally, as well. The other part to make sure you know where that individual is and that's essential so that, if needed, you can get care to them. If you have an individual with major depression, they have a positive score on the Columbia suicide scale. Then you can dispatch mobile crisis to their home and you can get people there to help them.

Dr. Martha Perry:
The other thing that you mentioned was an -- was eating disorder. It's been kind of a hot topic, in terms of how to manage that amongst our adolescent medicine colleagues. And there are some challenges, but one of the things that's really important to remember is that while we often emphasize weight when we're talking about eating disorders. Really, it's all about the thoughts and behaviors, and much of that can be assessed and asked about through telehealth. And in fact you can see their cabinets, and their kitchen, and other things potentially, on how -- in that you're able to go in the kind of eating disorder management that you do. You can also have them check a resting pulse or use some kind of an exercise watch to check a resting pulse. And those are some good parameters.

Dr. Steve North:
Absolutely. Absolutely and you can look for cyanosis on lips and see that, or in the extremities, you can see lanugo. You know, eating disorders can continue to be evaluated even when it is not in person.

[Unknown Speaker]
And one trick that can be used in the adolescents and adults is actually have them count out their heartbeat aloud, so that you can assess the rhythm. That doesn't work so well with little ones.

Dr. Tom Wroth:
These are great tips. I'm looking at the time, it's 6:20pm. I know we've got a ton of questions in the Q&A. And Hugh, do you want to kick us off with questions?

Hugh Tilson:
Yeah, we actually got a lot of questions about claims denials and I know they're not particularly to our panelists, but since we have Shannon and Beth on the line, let me just start with this one. We refiled our denied telehealth E&M codes and our telephonic codes – telephonic to be paid at the new rate --

on our last EOB. However, the E&M codes were most still denied and telephonic codes were denied as duplicate. Some of the telephonic codes are paid at the old rate, some are paid at the increased rate. Should we file these claims again? Please advise.

Dr. Shannon Dowler:
So Beth, do you want to talk about the claim denials?

Beth Daniel:
Sure. My first impression from that was that the next filing would be a void replace, but you may have already done a void replace. We have at the medicaid.covid19 -- the email address we have, I think three of my staff are on standby every day, and a couple people on claims and denials are on standby every day to get these questions that come in. We ask to identify yourself in your question and that you have specific claims, questions -- do not put the PHI in there but ask them to contact you and give them a number that they can reach you at, and they will call you and actually get the PHI claim number -- whatever they need to do and have you on the phone and look them up. If they can or will call you back if you provide them with some information. Not every one of my staff has access to fax machines so we just prefer to do this by phone. They can call you back, get the PHI, and do the research. And even get someone on the claim sides to walk you through things if there's some difficulty. But our staff are familiar with these new policies and are also good at looking at denied claims. So that's -- for any of these denied claim questions, no matter which of these services, this is the best way to do it, is just to identify yourself in the email, give them a phone number so they can contact you for PHI, and let them go from there.

Dr. Shannon Dowler:
Yeah, and I would say we probably can't get enough information in this webinar to really answer a claim denial question. But encourage you to follow best guidance to use that email address. Our teams are trying to respond really quickly to sort out these things and they can pull it up and often resolve it while they're on the phone with you.

Hugh Tilson:
Nevin, can you advance to that slide that has it on there? Just to make it easy for everybody to find.

Dr. Shannon Dowler:
It's the one that's got the medicaid.covid19@dhhs.nc.gov.

Hugh Tilson:
So while he's doing that, let me ask another question about parity of telephonic visits to FQHC bills, the G0071. We got some questions about that, too.

Dr. Shannon Dowler:
Yeah, so telephonic visits are not billed at the core rate. They're fee-for-service, that's how they've been from the beginning. So yes, they will qualify for that parity, for the 80% of E&M parity, in a fee-for-service world. That's how those telephonic claims will be paid for the FQHCs and the RHCs. There have been some other accommodations made for FQHCs and RHCs, specific to the financial needs and recognizing that they're seeing so many of the uninsured people in the state. And they're such an important safety net for our Medicaid patients. So there's actually a special bulletin release this afternoon, specific to that. So if you're a provider in an FQHC or an RHC you can find that on our website from this afternoon.

Dr. Tom Wroth:
This is Tom. We are on a roll with some billing questions, got some interesting ones. So the physician is in North Carolina, the patient lives in South Carolina as the originating site; can you bill telehealth?

Dr. Shannon Dowler:
Steve, I'm going to lean on you for that.

Dr. Steve North:
Yeah, that's pretty clearly a no. Well you shouldn't be providing the care unless you're also licensed in South Carolina. I think that's the first step, is that you need to address that. If your licensed in South Carolina, then it's legal to provide the code -- or provide the care. Is the insurance company cover it? That's another question. Is it North Carolina Medicaid? Somebody smarter than me will need to answer that part, but the licensure is definitely the first issue at hand.

Dr. Shannon Dowler:
Yeah, I think the key part of this question is you have got to be licensed in the state that you're seeing the patient in.

[Unknown Speaker]
I know there was some loosening of the federal guidelines, in terms of that. But really we're still following our state guidelines. So from that perspective, that's one of the important elements in terms of the ability to treat someone who's in another state.

Dr. Christoph Diasio:
And this is Christoph. I mean this is one of the problems where the law hasn't really caught up with the technology, right? Because Medicaid, I think has a rule that if you're within 20 miles of the state border, or something like that, that's when those folks are coming to North Carolina for care and you know, this, that, and the other. But where the patient is physically located is where you have to be licensed. However, if they lie to you, there's a not a lot you can do about it unless you're smart enough to define from their IP address where they're actually connected. So, you know, I think this is a real muddle -- you'll actually notice this on some of the telehealth portals that were built in the past by CMS, they actually explicitly ask the patient to sort of validate where they're actually sitting right now. And the issue is you're trying to a prevent, you know, a big national venture-capital-funded company from coming in with yahoos from wherever, that the medical board has no control over from past -- you know, practicing terrible care.

Dr. Shannon Dowler:
Yeah, so Tom, do we have time for like one or two more questions? We are almost out of time. I know there are resources that you wanted to highlight.

Hugh Tilson:
Absolutely, the questions are more important. You can find these resources at the CCNC/AHEC website. So if you go to CCNC there's the COVID-19 website; you can get all these resources there. So let's take advantage of all this expertise to answer those questions.

Dr. Tom Wroth:
So another about place of service, just a technical question. When we're doing the home visit code, what POS or place of service code do we put in?

Dr. Shannon Dowler:
Beth, I believe the answer is place of service 12, for the home. Am I right?

Beth Daniel:
It's the service home, that's correct.

Dr. Shannon Dowler:
I am learning so much. Who knew, 7 months into this Medicaid gig I would have gotten knowledge. Alright, next question.

Dr. Tom Wroth:

Okay, so a question. You're on the -- you're doing telehealth and you determine that the patient needs to be seen face-to-face. So you've done telehealth interaction and then they come through to the drive through clinic to do face-to-face. Can you bill for both those on the same day?

Dr. Shannon Dowler:
Hmm, Beth? You're doing so well.

Beth Daniel:
Typically, the answer in something like that, is that you combine the time you spent into the E&M that you bill for the in-person visit in your office. Now if they're out in their car -- you know there's so much flexibility we have to have, here. But the typical answer would be to combine everything into the one office visit code if you can do that.

Dr. Shannon Dowler:
That's good guidance, yeah.

Dr. Tom Wroth:
That's good. There's a question about dental varnishing and I assume that's part of the -- part one and part two framework that we talked about -- that we tried to do dental varnishing. That we still want to do it?

Dr. Shannon Dowler:
You know, Mark Casey asked me that today. And I think yeah, if you're wearing the appropriate, you know, PPE and you feel safe doing it -- you can have the kid in your lap -- you should do it; probably not on telehealth. I don't think we've figured that one out. But for that part two of the visit, I think you have to use your judgment of where your comfort is.

[Unknown Speaker]
Was that something that could be done as a home visit -- as part of the home visit also?

Dr. Shannon Dowler:
The only thing I am not sure is who actually has to apply the varnish. Beth, do you know that off the top of your head?

Dr. Christoph Diasio:
This is Christoph. I mean, I think the policy in the past has been: nurses can provide it as long as they've trained by the child dental varnish program. And you can become a trainer for your own office.

Dr. Shannon Dowler:
Yeah, then it seems very reasonable that you would do that in the home.

Dr. Tom Wroth:
Shannon I know you are working with payer counsel. Can you talk a little bit about whether they are going to start covering well-child care via telehealth or other hybrid-type visits that we discussed?

Dr. Shannon Dowler:
Yeah, I'm not aware. We've had a payer council meeting on Monday and I'll tell you, our main focus coming up for the next meeting, is we're now all thinking we've done all this wind up and soon we have to think about how we unwind it all. And hopefully not all of it, hopefully we get to keep some of the great things turned on. What we really want to do is make sure that all the payers around the state are being consistent and that we're trying to do the same things. So it's not every payer is a different one off for practices to figure out. So what I'm going to be asking the payer counsel on Monday -- when we tell them about these new codes that we're doing and encouraging them to follow suit. But we're also going to be talking about what are things that we all agree we want to keep turned on after the pandemic. What -- how

have we made our provision of care better, as our emergency response to the pandemic? And some things we are doing now, I think are better -- and they're better for some patients, some of the time. So we've got to sort that out and figure out how long we can keep things turned on for, and what the ramp down is going to be on things that we have to turn off. So we're going to work with that payer's counsel to try to align as much as possible.

Dr. Tom Wroth:
That's great, a great way to wrap it up. And just to kind of cover a bunch of different questions that AHEC and CCNC have created a two-pager to assist folks with the billing of the well-child codes and the modifiers that need to be used. So the slide set will be posted and all the resources will be in there. And Hugh, what else would you like to say to wrap us up?

Hugh Tilson:
I just want to thank Shannon, Tom, Christoph, Steve, Theresa, and Martha for making time to be with us tonight and for a great discussion. Shannon, as always thank you your team so much for all that you're doing. We say this every week, but holy cow, y'all have been busy and doing great things. And for all the people that are listening, thank you so much for the work that you're doing and for making time to listen to us tonight. We hope that this is helpful.

Dr. Shannon Dowler:
Yeah, thank you. Thank you everybody that's on. Next week we're going to give you some practical ways to use this new hybrid visit and to work through some of the logistics with that. So I hope you'll join us next week. Thanks.

Hugh Tilson:
Thanks everybody.

[Event Concluded]