Phillip Stringfield (00:00):

Awesome. Okay. So everyone can hear me? Awesome. Awesome. Awesome. All right. Well, thanks everyone for chatting in and welcome. We can go ahead and move to the next slide. As we get started, I just wanted to remind you all of some upcoming housekeeping reminders and some events that we have coming up.

Phillip Stringfield (00:21):

Awesome. So first things first, I just wanted to give you all a heads up that we will be having a two-part cybersecurity webinar series happening this month, May 18th and 25th from 2:00 to 3:30 PM. And we'll be focusing around cybersecurity understandings of Sustaining a Culture of Cybersecurity. Part one, we'll be looking at understanding the essentials and really looking at some basic tool sets that you can utilize within your organization. And part two, we'll be looking at cybersecurity risk and preparation, so that's going to be really focused around how to quantify IT security risks. And there's also going to be some nice practical exercises that our faculty will be having for those participants to practice at their health centers and then also share that information with upper management and leadership as well.

Phillip Stringfield (01:16):

And we can go ahead and move on to the next slide. And then something special about that, I'll just note that that session is being led by HCCN and a health center, so we're definitely looking forward to that next week. And then lastly, I just wanted to give you all a reminder of our upcoming EHR User Groups. So of course, NACHC currently hosts six EHR user groups, EPIC being the last one that we just added to our group. And each of these groups will meet on a monthly or quarterly basis, so if you're interested in finding out more information, you'll see my email address located at the bottom of the screen, feel free to email me which group you belong to, and I'll make sure to send you the information on how to sign up. And then also just wanted to highlight that these groups are also led by PCA, HCCN and Health Center leaders, so if you're interested in joining one of the leadership teams for those groups, you can also email me as well and I'll make sure to get you connected.

Phillip Stringfield (02:14):

And then, without further ado, we'll go ahead and move on to our last slide. I'm handing things over to one of our trusted partners, Dr. Jonathan. Jonathan Neufeld with the Great Plains Telehealth Resource and Assistance Center, who's going to be covering some best practices and strategies for improving etiquette, assessing and maintaining patient risk, and giving you some updates on telehealth billing and policies related to the COVID-19 pandemic. So without further ado, I'll go ahead and hand things over to Dr. Neufeld to get us started. Thank you.

Dr. Jonathan Neufeld (02:48):

Great. Thank you, Phillip. All right, everybody. Welcome from me as well. I will be lining up these windows in front of me so I can see them okay, and then... So I'll be going over a number of things related to telebehavioral health. I think a lot of you, probably some of you at least, have heard me talk before. We are now starting year three of this pandemic and a lot of things have changed, of course, along the way. And you folks have been at the forefront of that. Believe it or not, the data that I see suggests that health centers tend to do a higher percentage of telehealth in general than most healthcare providers, most primary care and mental health providers. Mental health of course is higher, behavioral health is higher than primary care, but you folks, by the numbers anyway, tend to use telehealth at a higher rate than many, so that makes it all the more appropriate that we talk about this.

Dr. Jonathan Neufeld (03:56):

I will try and move fairly quickly through a number of things. You have these slides, or you will very soon, so you can go back and review them. I'm going to try not to belabor any point. Some of this is going to be reviewed to you, a lot of it will. I hope to leave some time at the end and we can have some questions and discuss a little bit more about some details. Hopefully all of you know who the Telehealth Resource Centers are by now. I direct one of them, the one there in the middle, gpTRAC, at the top. And there are 11 other regionals, and then two nationals coming soon. The Center for Connected Health Policy, our national TRC for policy, is developing some specific resources for health centers. And those will be coming available here in the next few months, so stay tuned. I'm sure you'll be hearing from Philip, and Gina, and others, about those as they become available, as those resources become available on CCHP site.

Dr. Jonathan Neufeld (05:02):

And in the meantime, as you know, your regional telehealth resource centers can provide direct consultation. We like to have direct communication and answer questions for you, because general information can only go so far. And if we don't know it, we'll figure out what we need to help you out. By now, everybody knows telehealth launched exclusively in 2020. And of course now we're just doing a few minor course corrections. It seems like every week, things change, although it's been a little bit more stable for the last few months and that's a good thing, I think. There is an awful lot of fatigue out there, an awful lot of burnout out there, and hopefully we can help today. I'm just going to be commenting on a number of things, as well as helping... It's just kind of going through a checklist of getting providers comfortable, getting patients connected, triaging around hybrid models, deciding when to use telehealth and then talking a little about billing and payment models.

Dr. Jonathan Neufeld (06:06):

But before that a little background. Just so you know, and you know this already because you live it every day, but these are data for Medicare, so it's not specifically your data, but this holds true across a number of settings. In primary care, telehealth is a supplement. The distance between the blue line and the yellow line is telehealth. The yellow line is in-person care and the blue line is total care, that's the in-person plus the red line at the bottom, which is telehealth. And as you can see, through 2020, a lot of telehealth was done relative to what was done in the past, which is basically zero, almost none, but it's supplemental in primary care. In behavioral health, it's different. In behavioral health, it is a requirement. Behavioral health is about 50% telehealth across the board. It's higher in FQHCs or it's around 50% in safety net providers. It's a little bit lower in commercial providers and across the healthcare spectrum. And it has tailed off since 2020, so we're down.

Dr. Jonathan Neufeld (07:12):

I mean, it's not uncommon to hear folks saying, "Across our health center, we're doing 10% or 15%," but again, still behavioral health is higher than that. And there are some providers that are still doing the vast majority virtually, and there are some that are backed down to, "We only do it when we need to," etc. So it's a range, but telebehavioral health has definitely become part of behavioral health. You all know that. What we've also learned is that telehealth is not a rural or an urban phenomenon. Regardless, I'm not going to dig into these slides too far.

Dr. Jonathan Neufeld (07:46):

Telehealth is often not related to need, at least need across the community. It is related, and I'll make this point a number of times, to the needs of the individual. I'm working on a presentation for our upcoming conference and I hope that those of you who are in our region are thinking about coming. May 23rd to 25th, actually 24th and 25th in Minneapolis, we do our annual conference. But one of the things we're going to talk about there is that telehealth can be responsive to individual patient and participant needs. And even though it doesn't necessarily respond to community-wide need, these data show that in parts of the country where COVID was higher or lower, the line is COVID cases, the blue bars are telehealth cases. And you can see there's almost no relationship between the two. It doesn't matter if COVID is going up or down, if there's a lockdown or not, telehealth is basically determined by providers deciding to allow it, to provide it. And as providers, I think we can go just one step further than that and make it available as patients need when they need.

Dr. Jonathan Neufeld (08:55):

We also know that telehealth impacts equity, but it isn't a panacea, it doesn't fix it all. Telehealth relies on two underlying processes, infrastructures that are both fundamentally inequitably distributed. Healthcare is inequitably distributed and technology is inequitably distributed. So when you have telehealth, it's relying on those two inequitably distributed infrastructures sets of infrastructure. And so telehealth also is inequitably distributed. However, we do have a little bit of a secret weapon. I'm going to bounce through this slide, because it's a little hard to see it here, but here you can see it. This is some data that came out of HRSA along about a year ago, that looked at the use of audio-only telehealth versus video-only. And they provided a bunch of tables that were confusing. I took those tables and changed them into these graphs.

Dr. Jonathan Neufeld (09:50):

But what you can see in this graph is education is on the horizontal access from low to high. And as education goes up, audio use in telehealth goes down in this graph. And likewise or conversely, as education goes up, video use goes up. What that's suggesting, and I'm going to show you one more and then I'll talk about what it means. Here, there's an overall drop. The big dark bars show an overall drop in telehealth use from low to high, so less, and this is SES, income, household income. Less household income tend to use more telehealth. Not a surprise. But the percentage is what's really interesting. From low to high SES, the higher you go in SES, the lower the percentage of audio-only visits. Fewer people at high SES use audio-only, while video stays mostly flat, despite the fact that the overall total is falling, meaning basically it's rising with income.

Dr. Jonathan Neufeld (11:05):

What that's suggesting to us, and I think we need to recognize this, when we're working in safety net populations, is that audio and video are two different lifelines for individualized healthcare. Telehealth is not one thing, I've said that for years. And this is another example of that. Audio telehealth reaches a different set of folks than video telehealth. Some are the same, and there's a lot of overlap, but we need to recognize, and I suspect many of you do. Sometimes I'm making this argument to regulators and others researchers saying they're not used in the same way. You use audio when you can't do video.

Dr. Jonathan Neufeld (11:47):

I talked to a bunch of health centers and I asked them, "How much audio are you doing? How much video are you doing? Are you trying to increase audio or video? Are you trying to decrease either of those two and why?" And what I found is that most health centers were kind of letting video be what it

needs to be when people need it, when providers want to use it, they let it happen and they make it happen, and they do a lot of video. But most of them said, "We don't really like to do audio-only and we would like to do less, but we have to use it because sometimes that's all our patients have." And in fact, the health centers that were serving the most disadvantaged populations were the ones that reported doing the most audio-only services. It makes sense.

Dr. Jonathan Neufeld (12:34):

And I think by now, most of us are starting to realize that this is the case. And I hope, fingers crossed, until we see it actually in black and white, but I hope that regulators are getting that message as well, as congress and others, who are making rules in your state legislatures, making rules about whether we can continue to use audio-only services and for how long. So we need to recognize those two lifelines. And we need them both, we need to use them both.

Dr. Jonathan Neufeld (13:04):

All right. So for the rest of the time that I have, and this will be... Yeah. Again, I'm moving fairly quickly through this, but you'll have these slides, so you can look at them. For the rest of the time, I want to go through a little checklist of things just to kind of keep everyone up to date, bring up these issues, talk about them a little bit and help you think a little bit about keeping up to speed and keeping fit in the world of providing telebehavioral health.

Dr. Jonathan Neufeld (13:35):

First thing, provider skills. I mean, early on, we all had to deal with this and hopefully we are all very aware of this by now, but just a quick reviewer. Ideal framing, video framing, if we're talking about video, I suppose we could do a whole session on audio etiquette, although that's even more obscure. Nobody's going to tell somebody how to talk on the phone, especially not a highly educated professional, like a doctor or psychologist, but for video, just a little bit of etiquette.

Dr. Jonathan Neufeld (14:14):

If you're going to maintain rapport in the best way possible and do ideal framing for eye contact, of course the camera is on the top of the screen, as close to the top of the screen, no higher than that, as low as possible, so it's right against the top of the screen. And then you want to frame yourself so that your eyes are up at the top of the screen as close to the top as possible, so that when we are looking at each other's eyes, or at least pictures of each other's eyes, we're looking as close as possible to the camera that's sitting right above that. We want to minimize that distance. And that's the way that we support the idea. I'm moving myself up to the top of my screen. That's the way we support the idea, the impression of eye contact in live video. And it's a minor thing, it's a small thing, but it does... I tell this to providers all the time, when I get a chance, it does differentiate you. It shows that you're a professional when you know how to do that.

Dr. Jonathan Neufeld (15:09):

And when you don't do that, most people won't matter, won't won't care and won't notice, but other professionals will notice. And so I encourage you all to monitor your screen and keep yourself at the top of the screen, because the top of the screen is where everyone's eyes are pointing, or you want everyone's eyes pointing at the top of the screen.

Dr. Jonathan Neufeld (15:26):

Let me show you a couple examples here what I mean. Some pictures I just pulled off the internet of telehealth. This first one here, of course the provider here is looking at the screen and I don't even know what's going on here. The camera's pointing off into space, so that's just a staged picture. We can ignore that. In this one here, the camera is looking down on the provider while the provider is looking down on the eyes of the patient on the screen. And so that camera, you can tell what angle that camera is going to get. That camera is going to get a person looking down. The camera's here and the eyes are here. That wide angle is going to not provide any sort of illusion of eye contact. It's just not going to happen.

Dr. Jonathan Neufeld (16:08):

This one in the bottom right, it's an awkward kind of a setup, but if you watch, if you look closely, the providers know what they're doing here, because he's looking at the screen, the provider is looking back, the camera and the provider are close together, and so you end up with a narrow angle. And so that provider and that patient will have that impression that they are talking to each other face to face, eye to eye. And that's how you want to maximize the impression of eye contact in live video.

Dr. Jonathan Neufeld (16:40):

All right, the other side of the coin, equally important, and boy did we learn this fast, patient support is absolutely critical. And that can be done in a lot of ways. Different health centers do it differently, you each have figured out what you're going to do and how you're going to do it. We have some sort, but the best practices, that seem to be bubbling to the top. We have some sort of patient virtual check-in procedure. So somebody calls the patient, somebody does a test call, somebody somehow connects with the patient to find out what technology they can support, what do they prefer to maybe get their consent and enroll them, or register them, or check them in or whatever, but to make sure that that's all taken care of, so by the time the provider gets on, we're done with that. We've taken care of that. And maybe it's just the first time, maybe it's until the patient is comfortable, but there is some system in place for checking in, virtually checking in, to smooth out that on ramp.

Dr. Jonathan Neufeld (17:37):

Second, there are some designated staff to provide tech support, whether it's to providers internally or to patients who are logging in, someone is designated to do that, or some team is designated to do that. And the more proactive they are and the more customer-focused, patient-focused, customer-service oriented they are, the better because those issues come up and it's helpful to have somebody who, "Oh, yeah, I've seen that before. You just need to click there, or maybe I've never seen that before." And they can get on the phone with tech support, who probably is busy doing other things, and they don't want to deal with every patient, but this sort of patient representative person or this front desk person who runs into a problem can then access their own tech support. And in turn, relay that to the patient to iron out issues.

Dr. Jonathan Neufeld (18:28):

Some people have gone so far as to call this tech check and often doing something like a tech check, one to 24 hours before an encounter can, as I said, smooth out those issues. When issues arise in an encounter folks, successful programs have some sort of an offramp, where you can, okay, divert them to technical support, so the provider's not trying to figure out what to click or getting frustrated that they can't see, or they can't hear, or whatever. You have an offramp and you have a way that they can quickly put that person in touch with somebody who can fix the issue while they go on to another appointment and come back or something like that. These are pretty sophisticated workflows and not everybody has

them. I recognize that, but these are ideas that you can consider and possibly might be helpful. Backup plans as well, like following up a drop video call with an audio call, we all have those sorts of things in place as well.

Dr. Jonathan Neufeld (19:26):

Policies and procedures. As of course you've all developed some sort of a workflow for your telehealth program, this is just a generic one, but you've also figured out that workflows have to have, or they need to have, some things that happen every day, even though they're not in the course of workflow, this hexagon here is a thing that happens every day that the IT person does. Also, your workflows have to cycle around, it's not just the patient comes in and the patient leaves, but the patient has to go back to check out. Many health centers don't do a checkout procedure, I understand. And that checkout procedure can be really important in helping the patient understand what happened in the clinical encounter, but also understanding what comes next and how to do it better. And virtualizing a checkout procedure can a challenge, something else you can reach out to the telehealth resource centers for, or the folks at NACHC to help with developing that. And then there are lots... Well, yeah, that's enough on the workflow.

Dr. Jonathan Neufeld (20:36):

Emergency procedures, of course, are a best practice in telebehavioral health, in all kinds of telehealth, but in telebehavioral. And these include parts of the consent or initial session process that we need to be considering and working in, somehow to our workflow, like discussing what are emergency procedures and what are the foreseeable risks? We as behavioral health providers, I'm a clinical psychologist, our ethical guidelines suggest that we evaluate patients for appropriateness for telehealth and make sure and document, and make plans around any foreseeable risks. Now, a lot of risks are not foreseeable, granted, but at least having phone numbers for somebody else in the house or for emergency contact, or local fire, or police, or some plan in place.

Dr. Jonathan Neufeld (21:39):

And it doesn't have to be elaborate. I mean, I'm suggesting some things that are pretty elaborate, but it's not a bad idea at some point in the process of initiating telehealth care to make sure that you have some sort of backup number, so that when you see that the patient is living in a community 20 miles away, that you can call the police in that community, for example, or do something to respond if a patient starts choking, you notice some emergency on the far side. I mean, granted this rarely, rarely happens, but you just don't want to get into that situation and that be the first time you've ever thought about it. And what you're thinking about is, "What would be a reasonable response for us here at the clinic to do? If something is happening outside our control on screen, do we have any steps in place or we're just going to make it up when we get there?"

Dr. Jonathan Neufeld (22:36):

Something in writing so that you're not making it up when you get there. Even if that thing in writing is, "We'll consult with clinical lead, or consult with nurse in charge, or consult with whoever and make a plan." Even something like that, just so you have a procedure that you're not caught off guard thinking, "Wow, I never realized I'd have to deal with this." We just don't want to be in that situation. And then in an emergency situation, often those plans include, the general rule is you're working to transfer care or transfer the patient, whoever's on call with you, to some sort of local appropriate onsite responder, whether that's a parent, a caregiver, a neighbor, police, EMS, whoever, you want to be able to

document. "We transferred care to the local police who had just arrived and provided guidance and then signed off."

Dr. Jonathan Neufeld (23:28):

You think about what your notes are going to look like. You want it to be something like that, not, "I could see there was nothing I could do, so I ended the call." You want to have something a little more planned to say there. And then to document, of course, that transfer of care and make any mandated reports or anything else that is related. So these are emergency procedures. These are examples of emergency procedures. Your clinical teams will probably want to sit down and come up with something using, you could use these as a template, they may have their own ideas about what needs to happen. And it may be very, very simple. It doesn't have to be complicated, but let's move on.

Dr. Jonathan Neufeld (24:07):

Use of scripts. I recommend this all the time. Some sites use them, some sites don't, we're all kind of familiar with telehealth and we've figured out ways to do it, but it never hurts. And in healthcare, we do this all the time to use a sort of a scripted flow and say things like, "Hello, James. Can you see and hear me clearly? Okay. We're going to adjust. All right. As you know, I'm Dr. Smith, can you confirm for me your name and date of birth, please?"

Dr. Jonathan Neufeld (24:32):

We do this all the time in healthcare, so they do that. "Can you confirm your location? Are you still at home? Are you home? Like usual? It looks like you're in your kitchen there, or you're sitting in your car in the garage. Great. Okay. In private, anyone else around? Anyone else in the room? Anyone else at home with you? What's the emergency number I should use if a problem arises or is it still X, Y, Z, 1, 2, 3, whatever? And then if we get disconnected, just reconnect using the same link once. And if that doesn't work, then I'll call you at this number or you'll call me at this number or whatever." Whatever the plan is, just so you're not making it up when it happens. And you can review that in all of 15 seconds and then you're off and running. A simple script like that can be really, really helpful.

Dr. Jonathan Neufeld (25:21):

Of course, I'm just going to list other things here as a lump before we get into billing. Of course, broadband reliability is key. And sometimes there are things you can do about that, sometimes there are things you can't. A lot of organizations are finding creative ways to make broadband more accessible to their patients, including cranking up their Wi-Fi so that folks can come to the parking lot and see the doctor from within their car, which is the only private space they have sometimes.

Dr. Jonathan Neufeld (25:53):

Technology platforms are moving so fast it is hard to keep up. We're always reevaluating and looking, can we find something a little better? What's it going to cost me? Trying to have something that's flexible and useful across a wide range of use cases. And I always make this point, I hope that it's becoming commonplace. Really everybody on staff ought to be able to use our video platform, if we have one. I guess we're mostly all there, we go to webinars all the time, but everybody should be able to use the platform. It just makes things run more smoothly if somebody has to jump in and cover for somebody else or help troubleshoot a problem or whatever. Just like we want everyone to be able to type in our EMR, we also would like everyone to be really comfortable with our telehealth platform.

Dr. Jonathan Neufeld (26:45):

I mentioned a couple things. Well, I actually didn't say anything about professionalism of appearance. We had early on in the pandemic, we were all figuring out if seeing patients by video meant we could be in our pajamas. Well, no, you can't. I'm just going to say, I'm just going to tell you that. If you're a doctor, look like a doctor. If you're a mental health boat person, look like a mental health person. Look like a professional when you show up. We've all worked on operations issues, consents, workflows. Self-care, as we know, as I mentioned before, burnout is big and it takes time. To get up and move around, we have to add that time into our day. When we were walking from office to office, it was different. Now, we're sitting at a screen and we need to provide that self-care and keep track of policies as they change.

Dr. Jonathan Neufeld (27:34):

All right. Coming at the homestretch here, let's talk a little bit about billing. And I had to date this, had to put a time stamp on here, "As of May 1," because it really literally could change any day. Although right now, I don't think there are any... Nobody's holding their breath for something that everybody knows is coming right now. We're working. Congress has a number of vehicles in place to make some changes permanent. We had some permanent changes made early in this administration, and I'll go over some of that, but right now it seems like a bit of a lull, but fire season and hurricane season are coming, so we do need to just be aware. Those are analogies, I guess, or metaphors. I don't know. They don't affect billing.

Dr. Jonathan Neufeld (28:33):

Okay. So just a general update, Medicare looks like it's going to be steady now through the end of 2022, probably longer. We've got both an extension to the PHE and we've got a little tag on, that was part of the CARES Act, or shortly thereafter, that added 151 days to the end of the PHE for reimbursement, so that we've got at least through the end of 2022. So not a burning platform, not a hair on fire kind of situation, but still not terribly comforting, at least around a lot of what we do.

Dr. Jonathan Neufeld (29:11):

Behavioral health though, is on a little bit better footing. Like I said, there are several bills in play right now that have the major provisions that we would like to see, that most of us in the field would like to see made permanent. Among them, of course, is payment to FQHCs and RHCs for the medical side of a telehealth encounter. Without that, I don't know what telehealth looks like at health centers, if that goes away for some reason. Elimination of the rural restriction, of course we've wanted that for a long time. The patient's home as an originated site.

Dr. Jonathan Neufeld (29:46):

I have not seen information on this because I don't think... That there are a lot of payers and a lot of claims, a lot of encounters for which this was never accurately recorded, but I strongly suspect that the majority of telehealth that was done in 2022 at least was done to the patient's home. And that before 2022, that would not have been reimbursable by just about anyone, except some commercial plans that had a third-party add-on, like telehealth, or Teladoc, or American Well, or some sort of a plan as a supplement to your commercial insurance. Medicaid, very few Medicaid plans, and no Medicare plans, allowed telehealth services to the home. So we'd love to see that made permanent. And then of course, new providers, and remote monitoring services, and some other services, we'd love to see go longer as well.

Dr. Jonathan Neufeld (30:43):

Audio-only is the big question. We've got it for behavioral health, and I'll say more about that in a bit, but I think going forward for medical services, it looks to me, my opinion, my unofficial opinion here, is that those 9944X telephone E&M codes, or 9942X series, are going to be where Medicare goes to make audio-only care permanent, so that you can very clearly differentiate it from other types of care and adjust payment based on that and I don't know what the payment's going to look like. Medicaid, unfortunately, boy, for a few minutes there in the middle of the pandemic, I thought maybe, maybe we'll see some standardization across Medicaid, but it doesn't look like that. It looks like we're going to have state-by-state variation for the foreseeable future. So hope I'm wrong.

Dr. Jonathan Neufeld (31:41):

So let's talk a little about telehealth during the PHE, so I'm going to start with general telehealth, medical telehealth. You're billing a G2025 and you're getting $97.24 for all those medical services that would otherwise not be covered during the PHE and you'll get that for the duration of the PHE. Interesting, the bold there at the bottom, "These services are not..." Oh, well. Let me back up a second. That paragraph at the bottom there is actually talking about virtual communication services, e-visits. And I'm talking about those in just a second here. And they're differentiated from regular healthcare, regular medical visits. So just hold tight with that, but Medicare does a little trick here and the more you're aware of it, the more you'll be able to watch as they make some changes going forward.

Dr. Jonathan Neufeld (32:40):

Those medical visits, like I said, bill that G2025 modifier 95. Any healthcare practitioner on your staff working within their scope and your scope can build this code and get paid that same amount as an encounter. The CARES Act made that possible throughout the PHE, so that you can do that across lots of services, lots of providers that are on your staff, any qualified provider can do that. And I've got a link there to the fact sheet, if you need it.

Dr. Jonathan Neufeld (33:23):

Mental health is different because Medicare CMS made mental health visits permanent as part of the new provider, the new fee schedule, new provider fee schedule. So that video and audio-only both can be used according to the client's preference and ability. And you can report these and get paid in the same way as in-person visits as of January 1. There's a standard rate for it and actually it's not a standard rate, it's your PPS rate or your APM rate. Video visits bill exactly as if it were in person, but you add a modifier 95, which means you're using video for a mental health visit, mental health only, telebehavioral health.

Dr. Jonathan Neufeld (34:19):

Audio visits, you can do the same thing. A mental health CPT plus FQ, the new modifier. And reimbursement is the same as if it were in person. This is different. Your behavioral health is different than your medical care. And those medical services are still just temporary, related to the PHE. This behavioral health stuff has been made permanent. Now, a question that has come up, actually it might be in the Q&A, I don't know if it is or not, but you remember Medicare said, "Hey, you got to have these in-person visits within six months before and every year following." That's been also postponed because of... Through either in the CARES Act or another related piece of legislation, that's been postponed at least until the end of the PHE. So we also don't need to do that yet, but a lot of people are thinking about that. And of course, it's good to be prepared for that.

Dr. Jonathan Neufeld (35:21):

It's hard for me to imagine that it won't be modified in some way, because it makes it impossible for a lot of the telehealth that we need to do. If you've got a clinic up in Minnesota and your provider's in Kansas City, through a contract, there's just no way they're ever going to see each other in person. Now, I suspect what will happen, at least with FQHCs, is that that patient will need to be seen in person at the FQHC. In fact, we've seen guidance to that effect, that as long as the patient is seen in person at the FQHC, that counts and you're good for that in person encounter. They don't actually have to see Dr. Kansas City in person in order to continue that service. I'm sure there will continue to be clarification of this point, but that's the current interpretation that I provide. Again, I'm not your lawyer, I'm not your OIG investigator, but that's what we understand in the CRCs to be the case.

Dr. Jonathan Neufeld (36:26):

Okay. A little bit about virtual visits. These are not used very often, primarily because they don't pay very well. There's a set rate. It's $24 for any of these things. The top three are ones that are planned and provider initiated, as it were, the bottom one. The bottom two are ones that the patient can actually initiate as long as it's within some... They have to have a couple of days before a visit and a week after or something, there are some guidelines there about when they can use these, but as long as it's not closely related to an actual visit that they have, they can initiate a G2010, upload an image for you to look at or do a brief check in by phone. And so these services, all of them pay the same. They all get the same billing code, G0071. And I believe that in addition, you build that specific CPT code to indicate the service as well, but they're not getting used very much, because again, you can do encounters with that time, rather than those exact codes.

Dr. Jonathan Neufeld (37:44):

Verbal consent is required for those services, those e-visit services, but only once a year for a whole package. You don't have to consent each one. I still think it's a good idea to do that. And then here's the point I was going to make earlier and I'll expand on this just a little bit. These virtual visit services, like the brief check-in and the evaluation of an image, etc., these are not considered telehealth services. And you think, "What? What kind of doublespeak is this?" But this is something CMS is doing to help get itself out of the restrictions that are in law about what telehealth can and can't be. I mean, it's in the law right now that FQHCs and RHCs cannot get paid for telehealth. So it's only because of the Public Health Emergency that that is possible for CMS to pay us, Medicare to pay us, for telehealth visits at all.

Dr. Jonathan Neufeld (38:48):

And CMS is saying, "Okay, we're going to have to fix that at some point," recognize that. But these other kinds of things like virtual visits, like seeing patients through our portal, virtual check-ins, phone calls, there are lots of ways, there are lots of other services that are different than the standard live video patient to provider encounter. And Medicare CMS is really trying to push as much as it can into those edge cases and say, "These are not telehealth." And virtual visits are one example of that. I don't know that they're going to be able to do that with behavioral health. They've done it somewhat differently in the new regulations about behavioral health, but regardless of that, if you see that sort of thing, be aware that that is a thing that CMS is doing, is saying... Defines certain things that obviously use telehealth technology, telehealth-type technology, CMS is saying, "We're not going to regulate it as telehealth, because telehealth is too problematic until Congress acts. So we're going to say it's not telehealth."

Dr. Jonathan Neufeld (40:01):

And so in those cases, like for these virtual visits, for all these codes here, you don't put Place Of Service 02 and you don't put modifier 95, because they're not being billed as telehealth. They are what they are. They are a virtual check-in. They are a patient-initiated review of an image or whatever the CPT code describes. Finally, and I'm no expert on cost reporting. Actually, this isn't quite final, but these expenses do have to be reported, but my understanding is they're not being used to count toward the FQHC PPS rates, or any kind of re-rating that's going on.

Dr. Jonathan Neufeld (40:46):

I really don't understand all the intricacies here, but basically CMS is just saying, "We know you're going to incur a lot of expenses, we know all of that is part of what you're doing now, but we don't know how that's going to affect rating. And so we're keeping it outside of the rating for now." And it's partly not just because we don't know how it's going to affect it, but there are legal reasons why, if telehealth is not something that is in the statutes for you to be able to be reimbursed for, and it's kind of hard to incorporate it into how you're rated. So for now, they say, "Enter it into the other FQHC services line, Worksheet A."

Dr. Jonathan Neufeld (41:33):

And then finally, oops. Somebody had asked a question earlier about prescribing controlled substances. This is almost verbatim off HHS website. I've edited just a little bit, during the PHE, and DEA is regulating providers, not necessarily locations, although they do license locations as well. But what DEA is saying, that the core of the flexibilities DEA is allowing, is they're saying, "Wow, the PHE is in effect, the practitioner can prescribe a controlled substance to a patient using telemedicine, so remotely, live video, telemedicine in this case means live video. Even if the patient isn't at a hospital or a clinic registered with a DEA." In other words, if they're at home, or they can be at another clinic that doesn't have a DEA registration, but this was a kind of a hiccup that got caught fairly early on with telehealth, realizing that the doctor might be at a registered facility, but the patient was somewhere else and we needed to clear that up. So DEA added that flexibility.

Dr. Jonathan Neufeld (42:49):

And then secondly, in the case of buprenorphine specifically, and I don't need to speculate about why this is, but my hunch is that there are fairly codified, fairly algorithmic ways of using it, it's a fairly safe medication and it's got a good history of use. And so DEA felt comfortable allowing the prescription of buprenorphine simply with a telephone evaluation. So those two things are flexibilities that we can make use of, and get used a lot, in situations in clinics where controlled substances are being prescribed. And then I've got a couple of links to a couple of other supplemental materials where you can see that spelled out.

Dr. Jonathan Neufeld (43:39):

All right, I see we've got some questions lined up. There's my contact information. Please feel free to reach out to me or to all of the telehealth resource centers, any of us, at telehealthresourcecenters.org. And I will stop sharing there and start looking at the Q&A. You guys are going to... I'm sure you've got some tough ones in the Q&A.

Phillip Stringfield (44:04):

Yeah. So we got a couple of good questions. And thank you so much, Dr. Neufeld for providing that overall comprehensive, seems like an update really packed in with some tips and then also some insights in. Folks have put in some questions in the chat and also in the Q&A, so I'm sure you're reading the one from Ann, but I want to say that you ended up saying that it was postponed, but if you would like to [inaudible 00:44:30.

Dr. Jonathan Neufeld (44:30):

That requirement has been postponed, yeah, till the end of the PHE. So it's not imminently crushing down on us, but it's not going to... Yeah. It's another one of those things we would love to see suspended indefinitely, or at least specified a little better. Early on, yeah. Having a visit at the health center was kind of a workaround. And so now we've got kind of two ways around that for now.

Phillip Stringfield (45:09):

Perfect. Do you want to go to Susan's question?

Dr. Jonathan Neufeld (45:11):

Next one, Susan. "Mental health visits are only valid for therapy, not medication management by psychiatrist." This is a really good question. And I would say... Okay, so what makes a mental health visit? I think it's the diagnosis. I don't think that it's the code bill. In the regulations around mental health visits, there are not lists of codes given, it is if a patient is being seen for a mental health condition. So a psychiatric medication management visit would count, in certainly my understanding of that, of those rules, regardless of the fact that yes, you're billing an E&M code. And there are lots of confusion around that, because you have a physician billing an E&M code, you kind of think primary care, but then you realize, "Oh, wait a second. That could also be psychiatry as well." But I think that is actually the case, that it's based on the client, patient's primary diagnosis for that encounter.

Dr. Jonathan Neufeld (46:24):

Now, that leads to another sort of confusion there. What if our primary care doc is managing the psychiatric medications? Telehealth is full of these gray areas. I don't have a good answer for that one. And I suspect, as I'm sure I imagine this is kind of coming out of that, what if the primary care doc does a little of both? Is it possible to take advantage of the behavioral health flexibilities in that case? I can't say a solid yes or a solid no. And I would expect that there are people on both sides of that one. Hopefully we'll get it clarified.

Dr. Jonathan Neufeld (47:06):

Right, your comment there, Susan, is correct that I saw. So yeah. I'm afraid, Susan, that question is going to stay a little gray, at least as far as my understanding. You might get somebody who's more confidently going to answer that one. Unfortunately, confidence isn't always the same as being right.

Dr. Jonathan Neufeld (47:31):

So moving on, Kelsea, "Curious about the documentation side for an in-person requirement for mental health services, specifically documentation, but the provider does not have to be the same as the provider performing telehealth." I'm not following that one. And so perhaps, Kelsea, you could clarify that a little bit with a follow-up question there.

Phillip Stringfield (48:05):

Yeah.

Dr. Jonathan Neufeld (48:05):

In the meantime...

Phillip Stringfield (48:05):

And Kelsea, if you'd like, you can also raise your hand and we can unmute you.

Dr. Jonathan Neufeld (48:05):

Yeah. Going on to Melissa's question and I'll circle back. "We are an FQHC in Georgia, behavioral health was instructed that for Medicare, all audio-only psychotherapy are coded 9944X along with the FQ. Is this consistent with what you're saying or is that instruction coding only related to medical visits?" So Medicare for FQHCs is its own kind of little weird space. And I think that right now, there are still sort of two standards out there that you can build the FQ modifier. The FQ modifier means conducted by telephone. The 9944X code means and intervention using the telephone. So there is no time, no case in which you would use an FQ modifier on a 9944 X code. It's redundant. You don't need a modifier on the code. The modifier is only for your 90834, 9836, your individual psychotherapy or your therapy codes. And my understanding is that billing that therapy code with the FQ modifier to indicate that this was done by telephone is a valid way of billing the code. And you will get a PPS rate for that claim. The 9944X are not evaluated the same way and probably don't pay the same amount.

Dr. Jonathan Neufeld (49:57):

So now, this is still a challenge you could go. I mean, the source of truth, so to speak, on this is going to be your MAC, but it may not be once and final for all information, if you call your MAC about this, because MACs have been known to misinterpret some of the billing requirements from Medicare. And medicare every now and then issues clarifications for the MAC on how to build this or on how to edit this or how to code this. But my understanding from the most recent updates from CMS about this, and the links in my slides are a good resource for this, those educational links that I put at the bottom of those slides. Specifically, the one about FQHCs and the number of something like 200021, it talks about billing behavioral health codes with the FQ modifier, so I would suspect that that's the better way to go ultimately. But yeah, I'm one guy reading documentation. I'm not in the billing department, and so you'll definitely want to confirm that.

Phillip Stringfield (51:26):

That might have been the last one we got in, but Olivia told me that there is a hand raise.

Olivia Peterson (51:32):

Yep. Kelsea, you should be able to unmute yourself and clarify your question. Go ahead.

Dr. Jonathan Neufeld (51:38):

There we are. Okay.

Kelsea Frazier (51:39):

Hi. Can everyone hear okay?

Phillip Stringfield (51:43):

Yep. We can hear you.

Kelsea Frazier (51:44):

Awesome. I'll put my hand down. Thank you for taking me off mute and thank you for all the information. I jumped in halfway through and I was like, "Oh, I'm going to have to listen to the beginning of this," so I really appreciate all the information. The question was, I thought I heard you say that the in-person requirement for mental health services, there is some documentation that says that the provider who does the in-person portion, doesn't need to be the provider who does the telehealth portion?

Dr. Jonathan Neufeld (52:13):

Yeah. Okay. So thanks for clarifying that. I'll just go over that one more time. At the time, when CMS came out with this rule at first about an in-person visit every year, and six months before, health centers were given an interpretation, and I believe this came from CMS, that what that meant, or at least there was the question raised, what that could be interpreted as the patient needed an in-person visit with the health center. And so they didn't need to see necessarily their remote psychiatrist or their remote mental health practitioner in person, they just needed to show up in person at the health center, through which the services were billed.

Dr. Jonathan Neufeld (53:08):

This was viewed as a legitimate way to meet the in-person requirement. Now, right now, that in person requirement has been postponed, so it shouldn't be an issue, but there is still that question of whether that... My understanding is that will be a valid way to have the in-person requirement met for FQHCs if this becomes a requirement in the future, if this requirement is reinstated. That's my understanding. It's not final and I'm not the boss of you, so your mileage may vary, but that's my understanding of the situation with that one.

Kelsea Frazier (53:51):

Thank you.

Phillip Stringfield (53:54):

Awesome. Thank you.

Dr. Jonathan Neufeld (53:55):

All right. Thank you, Kelsea.

Phillip Stringfield (53:56):

And thank you Kelsea for your question.

Dr. Jonathan Neufeld (53:59):

I see one from Josh.

Phillip Stringfield (54:00):

Go ahead.

Dr. Jonathan Neufeld (54:00):

How about I read Josh's? "Not billing payment related, perhaps this question will be addressed in your future, but if you have time, what are some feasible methods for evaluating patients safety such as suicidal ideation when they're in a vehicle or other confined space?" Whew. Yeah, a lot to unpack there. The vehicle thing comes up because people have said, and I've heard this more than once, that providers have been even sometimes recommending to their patients, "Hey, let's go out to your car, take your cell phone out to your car, sit there, close the door." That's the only private space people have sometimes. And so they're still within range of their Wi-Fi, but they're not within range of any of the kids or others in the family, or whatever. And so that's their only private space.

Dr. Jonathan Neufeld (54:41):

Now, if they're driving down the highway, doing their telehealth visit, that's a different issue. And I think that the best course of action there, and this is part of that sort of standard scripted intro at the beginning of every session when you confirm the patient's location, because remember, also just as an aside, if the patient is in another state where you're not licensed anymore, that now is a licensure issue. We had some flexibility for a while, which you have to make sure, so you're on this side of the border, right? For patients, for whom that's an issue. But the other one is, you're in a car, you're driving, you're at Starbucks, people can overhear you, you're not alone at the house. And there's all kinds of issues that might impact safety and privacy of the encounter.

Dr. Jonathan Neufeld (55:25):

There are not hard and fast rules about this, but what I recommend is that the clinical team at the health center get together and come up with a set of guidelines or a set of statements, or the kinds of things that you all think together are good practice, because two things you don't want to happen. One, you haven't thought about it at all, you're just making it up. And two, everybody's doing their own thing. You don't want those things to happen. So the guidelines don't have to be specific. Like, "We will allow this, we won't allow that. You can be at McDonald's, but not Starbucks," or whatever. They just say something like, "Clinicians, evaluate the safety of their clients in every call and take action to make sure the client is in a safe and secure place during a telemedicine visit." Something as simple as that.

Dr. Jonathan Neufeld (56:15):

And then some discussion amongst yourselves about, what do you do about this and what do you do about that? Just so that you all are on the same page. Those are my best recommendations in a nutshell for that. And I hope that's helpful. And yeah, a person could do a whole session on this kind of thing.

Phillip Stringfield (56:30):

Awesome. So I know we're right at time. Did you want to quickly answer the last one we got from Bertha around how to handle consents for children, and then wrap this up if you have any last insights there?

Dr. Jonathan Neufeld (56:48):

I can give you a real quick one on children. Every state is different, because especially if you have separated parents or any kind of question about custody, some states are going to say, "Either parent

can consent and either parent can veto can de-consent. And sometimes only the custodial parent, sometimes the non-custodial parent can de-consent." I mean, this is complicated. So I can't answer that question, but check with your local licensing board about that, because that is a state-by-state issue.

Dr. Jonathan Neufeld (57:27):

As far as telehealth though, telehealth is no different than in person, as far as that goes. Consenting for telehealth is the same as consenting for any other kind of healthcare. All right. Back to you, Phillip.

Phillip Stringfield (57:40):

Awesome. I just wanted to say thank you again, Dr. Jonathan Neufeld, with the Telehealth Resource Centers. You will get a copy of the presentation and you'll also see it going to be located in the chat if you haven't seen it as of yet, but we'll make sure to send it out to you all. And we'll recap the questions as well. So I want to thank you all for attending. Thank you for your time. And we'll see you all next month for our June telehealth office hour session as well. So thanks again, everyone. And take care.

Dr. Jonathan Neufeld (58:11):

Thanks, Philip.

Phillip Stringfield (58:13):

Thank you.