Providing Family PACT Services During COVID-19 Part 2: Understanding Benefit Changes Webinar Transcript September 17, 2020

Nicole Nguyen:

Hi everyone, good afternoon and thank you for joining us today for our webinar titled "Providing Family PACT services "During COVID-19: Understanding Benefit Changes." We hope you are all doing well and staying safe. My name is Nicole Nguyen, Health Educator at the California Prevention Training Center, the CAPTC, under contract with the California Department of Healthcare Services Office of Family Planning is sponsoring today's event.

Nicole Nguyen:

So, before we get started with the webinar, let's go over some really quick housekeeping slides so that you can join us. First, make sure that you check your audio and select your desired settings to join through your computer audio or to call in through your phone. If your internet is shaky, we recommend that you call in through your phone for the best possible sound.

Nicole Nguyen:

And then also second, please check that you're able to see the viewer screen with the slides on the left and the go to webinar control panel on the right.

Nicole Nguyen:

And then these are just some of the controls. So the first one at this orange box with a white arrow to just how you can hide or show your dashboard if you don't want to see it or if you accidentally clicked it, this is how you can make it appear again. Under that is the audio tab is where you can change your audio preference at any time. And then third, please submit all your comments and questions via the questions box below. Today's webinar will take about 90 minutes and will include time at the end for the presenters to answer all your questions. So please send any questions throughout the webinar and our speaker will address it as many of them as possible at the end. The webinar will be recorded and responses to questions not answered today by our presenter will be sent out to participants later along with the recording and the slide deck. There is an evaluation at the end so please fill it out because your feedback is extremely important to us and help guide us in developing our future content.

Nicole Nguyen:

So, a little bit of a background info. This webinar is actually part two, the continuation to our first webinar back in May titled, "Providing Family PACT Services, "During COVID-19 Clinical Considerations" that focus on the adaptations that clinicians should make in order to successfully provide family planning care during COVID-19 and afterwards. If you have not watched that webinar, we strongly encourage you to go back and watch it because it does have some really important information regarding on how to provide Family PACT services. We'll also put the link in the chat box. And then for

today's webinar, we will provide an update on how Family PACT services, especially client encounters have changed since March 2020, focusing on the Medi-Cal and Family PACT policy for telephonic only remote visits.

Nicole Nguyen:

And then now I would like to introduce our presenter. We are really excited to have Dr. Michael Policar with us today. Dr Policar serves as Clinical Professor of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco School of Medicine. From 2005 to 2014, he was the Medical Director of Program Support and Evaluation for the Family PACT program administered by the California Department of Healthcare Services, Office of Family Planning. He currently serves as Professor Emeritus of obstetrics, gynecology, and reproductive sciences at UCSF. So, with that Dr Policar, the floor is yours.

Dr. Michael Policar:

Great. Thank you, Nicole. Will share my slide deck.

Nicole Nguyen:

There you go.

Dr. Michael Policar:

Okay. Just waiting for my slides to come up. Hey, there we go, great. All right. Let me make sure that I am full screen here, yeah. So, thank you all for joining us, especially for part two. I'm glad that Nicole was able to explain a little bit of the history of why we're, why we're doing this. Probably the most important reason is to tell you about a new Medi-Cal and Family PACT policy which was published on June 23rd that has to do with telephonic only visits. Was it, it's a particularly important topic because in the earlier webinars that I did both for the office of family planning and you may have heard an earlier one in April that I did for essential access health. Those policies were a little confusing at that time. Fortunately, there's much more clarity in terms of when you can build for a telephonic service now in Family PACT in Medi-Cal and I'm going to try to explain that in detail. And then also as Nicole mentioned, the previous webinar was primarily on clinical topics. This is going to also include some new clinical topics that we haven't talked about before. But in addition, we'll spend a fair amount of your time fine tuning giving you example with billing.

Dr. Michael Policar:

So first let me set up the timeframe. And that is that we'll be talking a little bit about the Family PACT policies regarding telehealth before the time of the public health emergency in March 2020 because Family PACTs tele-health policies actually go back about a year and a half for them to cover certain aspects of telemedicine. Then I'll be spending more time on current policies from the middle of March through the present time. But I do want to remind you that some of the policies that I'm going to be discussing now will sunset. That is to say, now phase out after the public health emergency is over but of course we don't know when that's going to be yet, and the California state department health services hasn't really given us any sort of timeframe.

Dr. Michael Policar:

Now I'm sure that at some point, some of you may want to actually look at the original policies and so I have a very complete listing of references at the end of the presentation. And as you go through those references, all you have to do is click on it and it will have a hot link to the source policy so that you'll be to look at the specific wording of a particular policy.

Dr. Michael Policar:

There's also a shortcut and that is that we have a wonderful web page for Family PACT which is familypact.org, a section that is on COVID-19 updates. So, if you click on that link, you'll go to this page and you'll see both Family PACT updates and then as you see up in the right hand corner department, health care services, COVID-19 updates as well. But if you don't have the handout from this site, you can go to this site and be able to get this information.

Dr. Michael Policar:

Now, let me start by telling you a little bit about the types of telemedicine visits that were covered before the time of the public health emergency. Then remember that there's a large majority of policies in the Medi-Cal program in California are developed within our state but some of them are actually driven by Washington DC by the Center for Medicare and Medicaid services. Also remember that basically virtually, all the Family PACT policies are necessarily consistent with Medi-Cal policies. So, there is some sort of flow through of things that start in Washington, go through the State Department of health services here and then become a Family PACT policy after that. So, the type of telemedicine visit that was covered last year in Family PACT was one called tele-health visit. And remember from the earlier webinars I've, I explained some of the features of that. I will do that again. And then after the advent, as a public health emergency, the center for Medicare and Medicaid services added on a couple of additional kinds of telemedicine visits that are called virtual check in visits. I will review those for you as well.

Dr. Michael Policar:

First is the initial definition of a telehealth visit that is covered both in Medi-Cal, Medi-Cal managed care and in Family PACT that is defined as a real time interactive audio-video telecommunication between a clinician and a patient. The clinician has to be a physician, a nurse practitioner, PA, a certified nurse, midwife, or a nurse anesthetist. Now in the earlier version of this, the requirement was that we could only do this for established patients and not with new patients but that's been waived during the public health emergency. So, you can bill for telehealth visits, both with new patients and with established patients. And remember the way that you do that is with standard E/M codes. So, if this is a patient that's new to your practice or someone you haven't seen in the last three years, you bill that with a 99201-204 in Family PACT. If it's an established patient, then it can be a 992, that's an error. Could be a 99211-214 for an established patient. The thing that's different with this is that the place of service is 02, typically in an office visit it's 11 but in the case of the telehealth visit, placement services' 02 and you have to put a 95 modifier after the, the E/M code to indicate that it is a telehealth visit.

Dr. Michael Policar:

Now, and another reminder is the fact that, of course, the telehealth visit can't be based on history, physical, medical decision making, E/M code has to be based on time. And so through the remainder of this year, these are the timeframes, both for a new patient and an established patient of the time that the clinician is interacting with the patient through an audio-video connection or as you'll see in a moment, an audio alone connection but that timeframe does need to be documented and then you choose the E/M code based on how long that interaction was.

Dr. Michael Policar:

Another thing that was offered through Medi-Cal and Family PACT before March of 2020 was something called an E-Consult and that is the ability for us to be able to get in touch with a specialist or a subspecialist, to be able to ask questions about the care of a particular patient. And then that specialist is able to bill for the interaction. So, do you have a question about a deep implant, a problem with an IUD, a patient who has a complicated medical history and you have concerned about whether or not she could use a combined hormonal contraceptive? You can email a family planning expert who is registered as a Family PACT provider. They can give you an opinion and then they will be able to bill for that using E-console code which in Medi-Cal and Family PACT that CP code, CPT code 99451. There are other additional codes added for longer consults but they are not available in Family PACT. And then there's also another series of CPT codes which I've listed for you which require the consultant to give both a written report and a verbal report. While they are payable by some commercial payers, they are not covered by either Family PACT or by Medi-Cal.

Dr. Michael Policar:

So, things changed starting in the middle of March, as you know, and basically the first thing that was added as a Medi-Cal and Family PACT visit were the two types of virtual check-in visits. The first is one which is a discussion typically done over the telephone, although it could be done through audio-video connection as well. And it's really intended to decide whether or not the person actually needs an office visit. Thus, it has to be a call which is initiated by the patient. Initially, the rule was that, that again had to be an established patient rather than a new patient but that's something which has been waived. There's rules about how recently a person has previously had an office visit, well will have an office visit, the patient has to verbally consent to having this telephone call and the way that it's built is with HCPCS code, G as in Gordon, 2012. So, as you have these conversations with your patients about whether or not they need to come in, it is a billable service. Of course, it does have to be documented.

Dr. Michael Policar:

Now, the other type of virtual check-in visits which is covered is one that I like to call sort of a mini version of tele dermatology. And what that is, is that a patient can take a picture of a skin lesion, basically send that to a clinician in your practice. The clinician can then look at the history, submitted by the patient at the photograph, and then render an opinion within 24 business hours of what should be done, recommending a diagnosis or a treatment or it's a patient come in for an in-person examination in the clinic. Again, some rules about how that should be done independently from other office visits. It has a HCPCS code of G2010. So an example of that is that a client has a genital skin lesion, can't really

tell if it's a rash or herpes or something else and she or he is willing to take a photograph of that and submit it to you for evaluation. Once that's done, that is a billable service as well.

Dr. Michael Policar:

Now, just one or two other things to say about how telehealth visits, the way that I've just defined them have changed is that in the past there were some restrictions on where the provider was located and where the patient was located. Those restrictions have gone away. So, the patient can be at home, she can be in her car, she can be somewhere else, and the provider can either be in the clinic or they can be at home or somewhere else. So as long as this interaction occurs, it really doesn't matter where it occurs. Second, is that any phone, tablet, laptop, or desktop can be used that allows this two-way interaction. And I know you'll ask this question, are these visits paid at the same rate as if the patient was seen in the office using the same E/M code? And the answer to that is yes, that there is payment parity in in-person visits and doing these telehealth visits the way that I just described them.

Dr. Michael Policar:

Now a problem that we started hearing about, in fact, there are many questions in one of the earlier webinars about this is, a lot of the patient that we've had in our clinic for years just doesn't have access to an audio-video platform. They don't have a smartphone, they don't have a computer, they don't have access to that or maybe they do have a smartphone but their internet access is really slow, it's sketchy, it is on and off, it's unavailable or there are some patients who are actually worried about the number of minutes that they have and that if they have a long interaction, they'll use up all their minutes for their month and then have to buy more. So, there are some people for whom doing an e-visit is just not realistic. And so, the question has come up, can we do these visits by telephone only? And the answer to that is yes, during the public health emergency, telephone only visits to substitute for office visits are covered by Medicare. Some commercial plans it's considered to be an encounter if you're a title 10 provider and they are now covered by Medi-Cal, Medi-Cal managed care and by Family PACT.

Dr. Michael Policar:

And when this started was a letter published by the department of health services on June 23rd of 2020. Here's a look at what that looks like and you'll be able to click on the link here so that you can get your own version of it. It is rather long; it's about 11 or 12 pages and I'm only going to talk about two pages. The ones that relate primarily to the Family PACT.

Dr. Michael Policar:

Again, the title is Medi-Cal payment meaning Family PACT payment as well for telehealth and telephonic communications relative to COVID-19. And it is how telephonic only visits can be considered the equivalent of that audio-video telehealth visit during the public health emergency. There's only one section of it that applies to Family PACT providers page seven through page nine but there are maybe seven or eight pages after that, that are specifically guidance for federally qualified health centers, rural health clinics and tribal clinics. If you are any of those, particularly if you're a federally qualified health center, be sure to read the sections that apply to you and the primary care services that you do as an FQHC. I'm not going to cover that. I'm only going to cover the part that specifically has to do with certain family planning services.

Dr. Michael Policar:

So basically what this policy says as it relates to Family PACT providers is that Family PACT providers including but not limited to physicians, nurse practitioners, PAs nurse midwives will provide and build for telephonic visits using appropriate and regular CPT or HCPCS codes that would correspond to the visit if it were being done in person. And as I mentioned earlier, for the billing that's done, the point of service is 02 and the modifier that is attached to the inner code five is a 95.

Dr. Michael Policar:

Now the next thing is, is that five conditions have to be met in order to build the E/M code and I'll list what those five conditions are. First is that documented circumstances involved that prevent the visit from being conducted face-to-face need to be documented. And some examples that they did is that the patient is quarantined at home because maybe she or he has been exposed to someone else who has COVID-19. Next is local or state guidelines direct the patient to stay at home. Again because of quarantine or other lockdown procedures that are going on in a particular locality or the patient lives remotely and doesn't have access to the internet, the internet doesn't support, HIPAA compliance and so on. Most of our patients are going to fall into that third category where the reason that we're doing this as a telephonic only visit is because of the fact that they don't have access to the internet. And I would go beyond saying that that patient lives remotely. I think they can live anywhere as long as they don't have access to the internet then you can do this as a telephonic visit instead of as an audio-video visit.

Dr. Michael Policar:

The second requirement is that the healthcare provider HCP stands for that, intends for the virtual or telephonic visit to take the place of a face to face office visit and you document this. The third is that the clinician believes that what's being offered is medically necessary. The fourth is that the covered service being provided is clinically appropriate to be delivered telephonically and doesn't require the physical presence of the patient. So, you have to be somewhat selective in being docked, in being sure that the document that this is something which is appropriate for a telemedicine visit and really does not have to happen immediately in the clinic.

Dr. Michael Policar:

And then the fifth requirement is that the provider satisfies all procedural and technical components that we would normally do for an office visit. Then you document a detailed patient history, describe what services you provided and the assessment does the issues being related or I'm sorry, I mean raised by the patient which in other words is your problem list that you've put together for this patient. And then medical decision making is applicable which includes diagnoses at the end of the visit, your recommendations for diagnostic studies, prescriptions, follow treatments or are another thing that could be on the list is the need to actually come into the clinic to be seen for a procedure or for further evaluation. So, all of those things need to be in your note on those low likelihood that your, that that visit actually was audited at some point. The expectation is that all those criteria would be met for doing this visit telephonically. Then the last part as a policy says that if you don't get all five requirements, that you should use the virtual check-in visit code of G2012 since this was a telephone only conversation. It

will pay considerably less though than if you use the HCPC code based on the income E/M code based on time.

Dr. Michael Policar:

So, this table basically summarizes all the Family PACTs policies now about telemedicine visit coverage. They do cover G2010, which is that tele-dermatology, As I mentioned G2012 which is the short virtual check-in visit by telephone, the E-Consult which is for you to be able to get in touch with a consultant to ask them question and then 99201-4 for new patients, 99212-4 for established patients adding the 95 modifier which in the past were for only for audio, audio visual telemedicine visits but now can be substituted with telephonic visits the way that I just described it. And by the way digital e-visits which means a visit which is basically an email interaction between the clinician and the patient or the telephone EM codes that are in the CBT book are not covered by either Family PACT or Medi-Cal like the ones I just explained to you.

Dr. Michael Policar:

I just, just before we get to a couple of cases, let me do a quick review of some of the things I mentioned last time about telemedicine capability. Remember there are a number of different telemedicine platforms that you can use in your clinic. The best one is one which is available to you through your electronic health record. And ideally if you have Epic or one of the others on one side of your screen, basically is the video image with your patient. And then on the other side of the screen is her or his electronic medical record and so you have everything in a single place. There are also a number of proprietary telemedicine products, all of which are HIPAA compliant, have a lot of bells and whistles that are relatively more expensive. And then quite a number of new telemedicine platforms that have become available just in the last six months, Zoom, doxy.me, eVisit and so on down the list. It seems like there are new ones every, a couple of weeks or so that are very simple, have very low fees for being able to sign up, to use these as your telemedicine platforms. In fact, a lot of them will give you three months for free just to see if you like it and you get used to it and then you pay your monthly or quarterly fee afterwards. In addition, during the public health emergency, it's acceptable to use Skype, Apple FaceTime, Facebook Messenger video chat, Google Hangouts video for the conversation between the clinician and the patient. But what's most important is that that has to be a confidential conversation and can't be open to others on the internet, has to be closed rather than open facing.

Dr. Michael Policar:

Next issue is what about HIPAA requirements and another way of saying this is what about confidentiality? And the answer is that the HIPAA confidentiality regulations historically were rather strict. They have been waived or loosened to some degree during the public health emergency for Medicare Medicaid correspondingly for Family PACT you know, they didn't get rid of any HIPAA requirements, they just basically said that we won't penalize you for noncompliance. So the basic rule is as long as you make a good faith effort for your telemedicine visits to be confidential, I'll give you some ideas about how to do that, just a second then you will basically be HIPAA compliant in that circumstance.

Dr. Michael Policar:

And what about getting consent for telemedicine visits? That too is something which had been previously expected would be routine for every telemedicine visit but in California, Governor Newson signed an executive order on April 3rd of 2020 which said that the telehealth consent requirement is suspended during the public health emergency. And so, you can continue to choose to get consent document that in the patient's note or you can also choose not to document that, not to do that until we hear otherwise about this executive order being rescinded.

Dr. Michael Policar:

Now, one of the things that I want to add is that I've been doing quite a lot of research on the internet to look for advice about how you do a high-quality telehealth visit. And one of the things that I found was particularly from the American College of Physicians where the internal medicine docs who I think had some really good ideas about that. And first off, if you're not doing telemedicine to recognize the benefits for your practice and by the way, if you are doing it and you think about it just being temporary during the public health emergency, there's some reasons that you need to be strategizing about how you will continue to do telehealth or telemedicine as part of your practice after the public health emergency is over with. So obviously the main reason that we do this is to keep patients and staff safe by reducing in person visits and to prevent having to travel to and from the office. But we know even before the public health emergency for telemedicine visits, either from commercial companies or between clinics and or practices and providers, or, you know, an organization like Kaiser, most patience really love the convenience of being able to do a telemedicine visit and clinicians like it because of the fact that we can work from home. We don't have to actually drive to the, to our site of care to be able to do these teller visits. Second is that it allows patients to access your practice instead of having the sense of, well, my practice is closed or restricted and therefore it's got to go to the emergency room. If I'm having heavy vaginal bleeding or having to go to a commercial telemedicine service, it's a way of retaining your patients. And therefore, if you do that, you enable continuity of care. They do have some advice about utilizing digital assessment, this physical exam. You can actually do a lot more than what they might think on a telemedicine visit with good quality audio. It allows you to save personal protective equipment for in person visits at your clinic. And let's face it, many clinics have noticed a substantial drop off in the number of patients that they've been seeing about family planning clinics, FQHC, community clinics, have kind of gone up and down in their patient volume. Over many clinics, took a fairly big hit in April, May and even into June. And so, in order to maintain financial viability, it's important to you to be able to continue to see patients, bill correctly and be paid for the services that you're doing.

Dr. Michael Policar:

Now, the next set of things that ACP recommends is some ideas about a practice logistics. Number one, if you're doing video visits to announce the availability on your website. If you have a patient portal, certainly on your phone system or sending an email to your patients to let them know that you are offering that. Make sure that your scheduling staff has a script that they can use to describe how to schedule a telemedicine visit with your particular practice and prepare a simple patient guide on how to connect for the visit and email it to the patient in advance. In fact, what many clinics do is they give the patient an opportunity, it's not a requirement but an opportunity to actually call in in advance and to do

a practice video visit with one of your front desk people or one of your IT people just to get the hang of how to do it before they're actually going to have their scheduled visit with a clinician. But having a simple patient guide prepared in advance can be quite helpful.

Dr. Michael Policar:

And the ACP gives you some examples of what they look like. When you're conducting the visit, and these are some rules for the clinician, the clinician should be in a quiet, private, well lit room, ensure that the patient can see and hear you clearly. That's one of the first things you ask, can you see me? Can you hear me? And if the patient says, "No, not very well. "I particularly can't hear you," you might want to switch to a telephone call. And of course, that would be the permission calling the patient rather than the other way around. Verify that the patient's identity with at least two identifiers, explain the benefits and the limitations of a telemedicine visit and obtain a consent if that's something you want to do or you don't have to do and then keep your electronic health record available either on the same screen or a second device. And what most clinics have had to do in this circumstances on one side of the screen is the audio video as a patient, on the other side of the screen, hopefully you have a big screen or this could be your cell phone or somewhere else or tablet or something like that is you've been able to call up the electronic medical record and that's where you're going to be typing in notes, checking labs and that sort of thing. But you do want to acknowledge to the patient that when you look away from the camera in the direction of the second device, then you explain to her or him that you're checking labs or writing notes so that they don't think that you're not focusing on them and losing eye contact.

Dr. Michael Policar:

Other things about the clinician set up for the tele visit is to ensure a clutter flip free environment. In fact, behind it and make sure that you don't have personal artifacts and remove them. Try not to make it too busy like an app in the background, look professional as you would in an in person visit in clinic. So, if you normally wear a white coat, do that during your tele visit. Smile, you're on camera. Position the computer or the tablet or the phone that two way, two feet away at eye-level, make sure that the door to your room is closed and in fact, you might even put a note on the door asking people to stay away and that you're doing a confidential visit. The patient can actually show you monitoring data. So if you want to know her blood pressure and she has a blood pressure cuff at home, you can actually ask her to show you the reading on the blood pressure cuff or the blood pressure monitoring machine and then you can document that or she can read it but if you want to do it directly, you can do that with a video camera. And lastly have a clock or a watch nearby so that you can record the length of the visit because again, you have to document how long the face to face time was with the patient, either with your telephone call or with your video hookup in order to be able to choose the right level of the evaluation and management code.

Dr. Michael Policar:

That ACP also has some really helpful tools that have to do with literally doing a physical exam with an audio video. And they say that you can do a visual assessment just by your initial look at general appearance, skin tone, eye redness, respiratory rate and so on. And then with patient assistance, they can palpate areas, show you closeup cameras, use of skin lesions or oral searing. So, I've already

mentioned home monitoring devices and they have actually a lot of job aids basically that will help you to be able to do much, even more of a physical assessment at home.

Dr. Michael Policar:

And then now getting near the end of the ACP recommendations, they give us some ideas about how to document a telehealth visit. We should always start our note with, "this is a telemedicine visit". Do note whether this is in the audio video visit or whether it's a telephonic only visit, whether the patient consented for the tele visit, the patient location at the time of the visit and the provider location at the time of the visit, who else is present with the patient? Is there a family member, a friend, a partner that's also being seen on camera or off camera, whether you used an interpreter, which language and identification through the interpreter was and then any other unusual components of the in person, of this visit. So basically it's what we would typically document at the time as an office visit but there's a little bit more detail, particularly in terms of the location of the provider and of the patient and clearly flagging the fact that this is a telemedicine visit rather than an inpatient visit.

Dr. Michael Policar:

Alright, so now let's do a couple of, of cases and I want to let you know in advance that the focus of the cases has to do with prioritization templates. We talked about that last time but that is hopefully a policy that you have in your office which says which patients or which conditions I should say are appropriate for doing a telemedicine visit as opposed to those conditions where a patient should come in for the in person visit. What you should do for protection of patients and staff during an office procedure, some ideas about curbside pickup, clinic and pharmacy dispense medications and a little more about demos with you and syndromic manual we didn't talk about last time.

Dr. Michael Policar:

So, the first one is what's called a hybrid visit which is a visit which starts with a telemedicine visit once or twice and then eventuates consequently in an office. So, it's a combination of the two. New client calls to request a visit to initiate contraception. She's informed that the clinic is open only in limited circumstances and that nowadays most visits are done by telemedicine. So, she had an audio video telehealth visit that she and the clinician discussed available methods, did share decision making, the time with the clinician was 27 minutes. The patient chose to have a copper IUD and after discussion, she verbally consented the placement. By the way, I want to point out here that I know that when you do an IUD placement, you get a consent beforehand and you have the patient sign it. This can be done in the telemedicine visit. She can actually sign the form when she comes into clinic or the clinician can document during the telemedicine visit that the patient verbally consented to the IUD place. Then she was seen in-person for the IUD placement procedure three days later. Because she had kind of a confusing menstrual history, a urine pregnancy test was done, it was negative. And of course, this is a reminder that you don't need to do a pregnancy test for every IUD insertion but in this case, it was necessary because of her confusing menstrual history. She had the placement of a copper IUD without difficulty.

Dr. Michael Policar:

So, this gets into just a quick review about the prioritization templates that I mentioned a moment ago. Your clinic should have a written policy that prioritizes which of the client visits are going to be done in person as opposed to done, be done remotely. I'm sure you have this already. But what I want to remind you about is the need to frequently revise that probably every week or no less than every two weeks. To revisit that policy, you may need to change things based on local or state physical distancing laws, the availability of staff and personal protective equipment, whether or not your patients are utilizing curbside pickup or you're mailing prescriptions and so on.

Dr. Michael Policar:

You may remember this prioritization or triaged template that I showed you last time which basically has five different baskets of how the front desk might triage different kinds of visits into it and do a telephone visit or telemedicine visit or to schedule a patient to be seen in person. The first column on the left are the types of visits which can be postponed. The next are ones that can be handled by telephone calls, things like method refills or emergency contraception. The third are telemedicine visits which of course in the past were A/V now could be telephonic as well for things like contraceptive counseling, discuss instruction and how to use DMPA-SQ, syndromic treatment, diagnosis and treatment of sexually transmitted infections or urinary tract infections. We'll come to that in just a minute. Even pregnancy testing and diagnosis can be done in a telemedicine visit. The next column over are things where we do need to see the patient, but they can be scheduled as available. And then the last column over has to do with those circumstances where we really should be trying to see the patient today or tomorrow if we can as soon as possible.

Dr. Michael Policar:

So first let's talk about how to build these two visits. First is remember that first visit, the first interaction we had was a telemedicine visit, visit number one. So, point of service is 02, the CPT code is 99203 based on how long that visit was for a new patient that has a 95 modifier on it. That's the what we did. The reason that we did it was Z30.09 which was for counseling and advice on contraception. Then she came back three days later for visit number two which was her IUD insertion. The point of service is 11 which refers to an office. But I will remind you that if you're a community clinic or an SQHC, there are different numbers that your biller uses. What we did was insertion of an IUD and a urine pregnancy test. I've listed the CBT codes for you. I'm sorry, the ICD-10 codes of why we did these two Z codes. And then... Of course, remember that whenever we do an insertion of an IUD or implant, it's important to include the HCPC code for the insertion kit, in this case, J7300 for a copper ID because your clinic has to be reimbursed for that insertion kit. And you may not realize this but both Medi-Cal and Family PACT will also pay for the supplies of that IUD insertion and that's billed as a 58300UA modifier indicates that you're billing for supplies that were related to the insertion. And so that, that's the answer in terms of billing.

Dr. Michael Policar:

Just some additional comments basically or that the first visit was because it had video, was the CMS defined telehealth visit. Although it could have been done entirely by telephone based on the policy of June 23rd. And then you'll notice for visit two, when the patient actually came in that the ICD-10 code is

different than it was for the first visit. Now it is the ICD-10 code for doing an IUD placement and there is no E/M code at the time of the face to face visit, the in person visit for the IUD placement because of the fact that all of the counseling had been done before. She just came into the clinic, got her IUD, left very quickly. So, you build a CPT code for the procedure but there is no traditional E/M code.

Dr. Michael Policar:

Now, let me take a little sidetrack here, just to remind you about the kinds of things that you should be thinking about when you're doing office procedures. So, IUD insertions or removals, the implant insertions or removals, colposcopy endometrial, biopsies, vulvar, biopsies, and so on. What is it that makes transmission of the virus between an infected person and an uninfected person more likely? You're talking about protecting staff and protecting patients. Well, easy way to remember this is that there are four requirements. Number one is that you have to inhale a large dose of the virus. If you only get a tiny bit of the virus, either you won't get infected or you might get a viral, a mild case but if you get a large dose of the virus, a large viral load that you're exposed to, you're more likely to get severe disease. Number two is you have to breathe someone else's air, that's referred to as their plume. So particularly when they talk loudly, they shout, they sing, a plume is expelled with droplets and aerosol fluid in it that could contain high levels of the virus. Next is that's much more likely in an enclosed poorly ventilated space. And then lastly, there needs to be exposure over an extended period of time. Okay? Very quick, very transient, the likelihood of infection is less likely than it is. It's far more extended periods. So, this is the easy way to remember.

Dr. Michael Policar:

There is a more complex way to remembering it, we say acronym of PETAPPSS. So, this tells us about things that are higher risk for transmission and lower risks. And just to remind you about the things that are higher risk is having contact with an infected person within six feet. Although there's more recent data which says if a person is singing or shouting that they can project their fluids even further than six feet that may contain the virus. The E stands for enclosure so the risk of infection is greater in a small room particularly one that's poorly ventilated. Time exposure seems to be around 10 minutes that if it's longer than 10 minutes, the risk of transmission goes up substantially. If it's a very transient exposure, minute or less then there's much less of a likelihood of infection. The A stands for activity. When people are projecting the poem through singing or loud speaking or shouting, it's more likely for someone else to get infected. The next is a P for protection. So higher risk with no hand washing mask, personal protective equipment, or cough etiquette. The next has to do with prevalence. So, transmission is more likely to occur if you're in contact with people from high risk groups. That might be a person who works at a meat packing plant or someone who works in the skilled nursing facility or of course, coming into contact with someone who actually has COVID-19 symptoms. The next has to do with silent spreaders. And that's because we've come to realize that the people who are expelling the most virus are the ones who have been infected but they're not symptomatic yet. You're in this pre-symptomatic phase before they get symptoms and they expel most virus, the highest viral loads in a day or two before their symptoms start, those are the asymptomatic or the silence shadows basically. And then the last is a super spreader event. That's many people in close proximity who were not using masks, who are seeing or shouting for extended periods of time. Then of course, the classic situation, there was a choir practice that occurred up in the state of Oregon. This was, I'm sorry, in the state of Washington, this was described in that morbidity and mortality weekly reports a little while ago of one person in the choir

having a COVID-19 case which was asymptomatic at the time but the majority of people in the choir actually became infected. And that's because of the fact that they were in close proximity, they weren't wearing masks, they were singing for extended periods of time and that's how this turned into a super spreader.

Dr. Michael Policar:

So how does that relate to what we do in clinic? Well, in clinic practice, we should try to have as few staff in the room as possible when we do an IUD placement or removal or was an implant. Either maintain a physical distance if we can, use your largest exam room, hopefully one that has negative pressure ventilation. What does that mean? Think about going into a bathroom where you slick on the sand and when it goes on, it's sucks the air out of the room, that's negative pressure ventilation. So hopefully you'll have that at least in one of your exam rooms if you don't open the windows as long as it's not too cold outside. Next is time. Minimize the time that the client and staff are in the exam room, limit loud pocking, everybody in the room, patients, staff, clinicians should all have face masks on and the clinician who does the IUD placement or the implant placement should consider having a plastic face shield as well only during the placement, not going the whole visit but just in case there's any kind of either fluids flatter or a lot of, you know, talking and maybe even shouting going on the face shield may help. Next is to prescreen clinic and staff. And of course, initially we asked about shortness of breath, cough, and fever, now we've added to that list, chill, sore throat, muscle aches or a new loss of taste and smell. Next is you might ask your patients whether or not they've had contact with a COVID-19 patient within the last 14 days, whether they've participated in what could be a super spreader of it within the last about 14 days.

Dr. Michael Policar:

So other things that can be done to minimize exposure risks during inpatient visits are remote advanced administration of registration, counseling, and consent. All of this is being done as a tele visit in advance. Number two have the client wait in her car or outside prior to intake, screen her for symptoms before the visit and at her arrival to the clinic. And if there's any suspicion, then of course you should delay her procedure. If she symptomatic or suspected of having had an exposure, better to refer her for testing. Now, what about doing a screening temperature check? You may have an electronic forehead thermometer that you're using. The CDC now recommend some but they do have very limited utility and that's because there's misses asymptomatic and some pre-symptomatic people because they just don't have a fever or that might be masked by the use of nonsteroidal anti-inflammatory drugs like ibuprofen. Forehead thermometers are prone to inaccurate readings and the CDC is really clear that we should never use a temperature check as the sole way that we evaluate people for infection before they turn into our facility. It should be asking some of the questions that I just mentioned.

Dr. Michael Policar:

And then again, all staff and clients must wear face mask. Ideally, if the shield for your clinician is doing the procedure, you use your largest room, open the windows, minimize the number of people in rooms limit or even prohibit non-client visitors. Try to minimize moving between rooms and keep track of your personal protective equipment supply and adjust it accordingly. Lastly, for this case study was our patient. She had her copper IUD put in, does she need to come back for a follow-up visit or a screen

check. Well, those were considered to be optional even before the public health. The only people that really came in subsequent to an IUD placement, sometimes were adolescents or people who have multiple medical conditions just to check and see how they were doing. Nowadays, that can be done as a telemedicine. So once you've done that IUD placement, schedule a time to talk with her a week or two or maybe a month later about side effects or problems and be able to give her a counseling over that subsequent tele visit rather than having to come back into the clinic.

Dr. Michael Policar:

All right let's do another hybrid visit. An established patient wants to speak with a clinician about an implant that's been in place for a little over four years and she wants a new one. She has no side effects or other problems. She had an audio video telehealth visit with a clinician that took 15 minutes and after the discussion, she verbally consented to an implant replacement. So, she was seen in person for that procedure. Five days later, the expired next one was removed and replaced without difficulty. Okay.

Dr. Michael Policar:

Now, first off, I want to remind you, I did this last time but I want to update this a little bit that given the fact that this patient had had her implant in for four and a half years, there was no pressing need to have her replace it now. We of course gave her that option, but it did not have to be done that way. In the middle column you'll see how long LARC methods are FDA approved. And in the far column, you see evidence-based duration of action. So, it probably would have been reasonable to at least offer her replacement. I'll throw a maximum on it five years rather than the FDA approved three years. I also want to point out the fact that within the last few months, both Liletta and Mirena have now being FDA approved for a six-year duration, although evidence says that they'll work for a full seven years. So again, in order to keep patients out of the clinic, if she's had her Liletta or Mirena for six years, they can actually push through another year if they want to. And remember if you're using DMPA-IM or DMPA-SQ, that the hour limit of giving those injections is at 15 weeks. The benchmark is to get the injections at the 13 weeks, but they can be pushed to as long as every 15.

Dr. Michael Policar:

So, the way that we are going to build for this visit is the first visit, remember was a telehealth visit, that's an established patient. It's a 99213 with a 95 modifier. The reason for the visit was surveillance of an implantable subdermal contraceptive. Then the second visit was when she came into the office for the swamp, removal of the expired implant, the insertion of the new one. Remember that in Family PACT, you use two separate codes, 11981 for insertion, 11976 for removal and ICD-10 code for that again is Z30.46 and the supplies are the HCPC code for the insertion kit, J7307 and then again, you will be paid for the removal supplies, 1197611 with a UA modifier. There is payment for the supplies would have to do with the removal.

Dr. Michael Policar:

All right, a quick case study that has to do with Depo SubQ and we did this with Dr. Carlin last time, but I'll give you a little update on this, okay. We didn't talk about the billing. So, miss V is a 30-year-old established client who has been using Depo-Provera IM every 13 weeks for the last two years. She called for an appointment two weeks before her next injection was due, but she was hesitant to come in. So, if

she had an A/V telehealth visit, a 15-minute discussion with a clinician about her alternatives, that could have been done telephonically. And at the end of that 15-minute discussion, she decided to try self-injection Depo SubQ. One unit was delivered to her curbside at a pharmacy to Ms. B. And so, the question was, did she have any alternative other alternatives to the use of Depo IM and how I'm going to code this visit?

Dr. Michael Policar:

Well, remember that there are a number of alternatives for our patients who are using Depo-IM who like it, want to continue, there's only health concerns about actually coming into the clinic. So, the default is you can have an in person visit as an IM injection, a Depo-Provera in the clinic, we try to get her in and out as quickly as possible. The second, if she can have an in person visit but a curbside injection and there are quite a number of family planning clinics who have now developed a capability of having a patient drive into the parking lot. You verify who the patient is and then a staff member wearing appropriate personal protective equipment literally goes out to the patient's car, gives her depo injection while she's sitting on the driver's side or on the passenger side without actually coming into the clinic. She can make a switch to self-injected Depo SubQ or she can switch to what's called the bridge events or just normally pills that combine hormonal method is still bad drink or to a barrier method until the public health emergency is over with.

Dr. Michael Policar:

Now, if you were with us last time when we talked about Depo-SubQ, remember that it comes as in prefilled, ready to use injector with a needle and they use at home so the client is in control of it and it uses a short, small needle. It's injected in the skin instead of into muscle and therefore it's potentially less pain. And that's particularly true because of the fact that it's really a very nonthreatening needle, quite honestly, given the fact that it's so short and the sharp skinny 26-gauge needle. Also remember that Depo-SubQ has 30% less hormone depo. IM is 150 milligrams, Depo SubQ is 104 milligrams and therefore people may have fewer side effects when they use it. Some clients have experienced local site irritation and soreness in the first few injections. It does have a tendency to go away over time.

Dr. Michael Policar:

And then also just to remind you about Depo- SQ, the contraindications and side effects are about the same between Depo SubQ and Depo IM. We don't need to adjust the dosage of Depo SubQ or Depo IM based on body mass index but we really do need to use clinical judgment in deciding whether self-injection of Depos SubQ at home is really the appropriate method for this patient. You have to be fairly confident after speaking with her about the fact that she's comfortable injecting herself with a needle, at home without a clinician around or if she's uncomfortable with that, then having a family member or a partner learning the technique of doing the injection. Now of course, there are lots of other drugs that are injected at home, fertility drugs, drugs for multiple sclerosis. Sometimes people have to use low molecular weight heparin and other types of injections at home. So, there's nothing revolutionary about this especially given the fact that it's a short skinny needle, people can learn this pretty quickly and be comfortable, but you shouldn't do this routinely for all of your Depo patients. You really have to check with the patient to make sure that she's comfortable in doing this.

Dr. Michael Policar:

By the way, there are quite a few resources out there both educate yourself and your patients about SubQ Depo Provera and the package inside, reference developed, a nice fact sheet on self-administration of Depo so is Bedsider and the reproductive health access project has actually developed an explanation of how to do Depo SubQ in about 10 different languages and those are free and available through the link that you see in front of you.

Dr. Michael Policar:

So how are we going to build for this one? Well, the telemedicine visit is a 99213 with a 95-modifier given the fact that it was a telemedicine visit, the point of services is 02, to the ICD-10 code is Z30.42 which is surveillance of an injectable contraceptive. She's already using that Depo Provera but this is an appropriate time to remind you about the fact that while Family PACT and Medi-Cal cover self-administration is Depo SubQ, they will do so only when it's dispensed by a pharmacy during the public health emergency. So, in other words, if you had that Depo SubQ available in your clinic, you can administer it in your clinic but you can't dispense that to a patient to use at home. The Medi-Cal policy that I've included in references at the end is really quite clear that it's only pharmacies which are authorized to dispense Depo SubQ injectors to patients rather than the clinic being able to do that during the public health emergency. That may change over time but that's where we stand now.

Dr. Michael Policar:

All right, one last case, there's some very important information here about sexually transmitted infection screening that I want to tell you about. So hopefully you can hang on with me for at least another 10 minutes. So, this is Ms. L who as a 35-year-old established client who states that she developed a vaginal discharge which has a malodor every couple of months. She was diagnosed with bacterial vaginosis 18 months ago. Since then she's been treated four times, each time with a different topical drug. And we all know that BV has a tendency to recur. Each treatment improves the malodor for a while and she's actually started doing vaginal douching to manage the malodor. However, due to the public health emergency, she would like to avoid an in-person visit. She had a telehealth visit, let's say either by phone or audio video that lasted for 27 minutes and at the end of that, she was prescribed metronidazole vaginal gel suppression and she picked up two tubes of medication curbside at the clinic, not at a pharmacy but at the clinic. So, this brings up a topic that we have discussed before which has to do with what's called syndromic diagnosis and treatment of sexually transmitted infections. In other words, based on history, the description of physical signs but without actually being able to do laboratory test. I will tell you about that in just a minute, but I want to remind you of something that was posted on the Family PACT website about a week ago.

Dr. Michael Policar:

And that is that the CDC issued a letter on September 3rd which pointed out the fact that there is a current shortage of sexually transmitted infection test kits and laboratory supplies, most notably for the gonorrhea and chlamydia NAAT test. I don't know if you've been working with laboratories that has complained about this shortage but apparently it is a national issue. There's a pretty good reason and that is that most laboratories, particularly the companies that produce these tests but also the laboratories that do them have had to switch over and devote so much time and effort and focus on

COVID viral testing or antibody testing is that they now have not been able to put as many resources into producing STD test. So what this CDC letter said and by the way, I've included a link for you at the bottom with, so you can go to the CDC letter, it's about four pages long, I think it's something you could read is that it tells you that if testing tips for gonorrhea and chlamydia are in short supply, that there is a priority of who should be given these tests for screen, okay? And of course, they point out that for females, people who have a vagina that this should be done with a vaginal swab rather than a cervical swab or a urine set. So, they basically say that we do routine screening of females under 25, targeted screening of women 25 and older. Remember that as patients who have had more than one sex partner in the last 12 months, people are having new sex partner in the last 90 days, people who have a reason to believe that their partner is having sex with someone else or someone who's had an STD within the last two years, those are all circumstances and females 25 and older who should be screened. They point out that screening the throat and the anus routinely is not recommended for females but based on those practices could be and for men having sex with men to prioritize rectal and pharyngeal screen above urine based testing of the urethra because in men having sex with men, it's more likely that the rectum or pharynx will be positive, okay. And they say, if there's a severe shortage of supplies, prioritize rectal testing over pharyngeal testing. Now there is also additional information in the CDC letter that goes into using these tests as a diagnostic test, not only is it as a screening test. But I just wanted to put this on your radar spring that this may be a problem that be notified by your lab of the fact that they're running out of testing for gonorrhea and chlamydia and so the CDC has given you guidance about who has priority for either screening or diagnosis of gonorrhea or chlamydia.

Dr. Michael Policar:

One other thing to mention and I just found out about this morning, there was a report last week and an STD meeting about the fact that as a result of many, many fewer office visits including sexually transmitted disease clinics, that there has been a significant drop in cases of gonorrhea reported versus those that are projected. So, if you look at the dotted line, it's expected reports for gonorrhea that by the way, this is CDC data nationally. And if you look at the green bars, you can see this really sharp drop off in March, April, May, and June of reported cases of gonorrhea. Probably doesn't mean there's less gonorrhea being transmitted but it does mean that people are not coming into their usual sites of care to have gonorrhea and chlamydia screening performed. So it's something that we really need to continue to consider that you don't want to have, you know, people staying away from clinics actually lead to this sort of echo problem, those now undiagnosed and untreated cases of gonorrhea and chlamydia. Looks like that might actually be having, happening to some degree.

Dr. Michael Policar:

So, let's finish up with the patient we were just talking about. Remember she had what sounded like recurrent bacterial vaginosis and what syndromic management means basically is diagnosis and treatment based upon a best guess of symptoms and a description of physical findings but without the use of laboratory tests. Studies primarily in Africa showed that this is fairly sensitive as a way of making a correct diagnosis especially for bacterial vaginosis and candida vaginitis, kind of more plus minus for a rash that could or might not be herpes. It's not very specific which means that when you're giving your best guess about the diagnosis of this STD, they may err on the side as over diagnosing and overtreating but that's better than just missing the diagnosis altogether.

Dr. Michael Policar:

Now here's something that might help with our patients. Read the whole thing but I'll tell you how it works and that is that, looks at a variety of symptoms and signs of a vaginal discharge that she complained of itching and burning, bad odor in the discharge, is it frothy or bubbly? What color is it? And each of candida, trichomoniasis, bacterial vaginosis, DIV which is discriminated inflammatory vaginitis or just a normal physiological have its own kind of unique combination of itching, burning odor, frothiness, and color. And so, use something like this as a way of getting a best guess as to what her vaginal infection is even if you're not able to do testing.

Dr. Michael Policar:

So, what the CDC tells us is that if we're thinking about a recurrence of bacterial vaginosis or candidiasis, we treat based on what we learn telephonically or in telemedicine visit. On the other hand, if it's a brand-new problem, patient hasn't been diagnosed with those, we didn't need to get a better history, a thorough history via a telehealth visit and then consider empiric treatment. So for example, the CDC recommends that if a patient has a malodorous discharge, suggestive of bacterial vaginosis or trichomoniasis, both of which have sort of a fishy odor to treat with metronidazole for a week and it will treat either one without having the patient come to the clinic and having a look at the vaginal discharge under the microscope. If she has vulvar irritation where itching in a white discharge, chances are really good that this is vulvovaginal candidiasis. So, treat her with fluconazole 150 milligrams orally or a three-day topical antifungal and only if it fails, then she might need to come in.

Dr. Michael Policar:

Now, I also mentioned this last time and that is that some clinics have used curbside interactions for pickup and drop off of vaginal discharge sampling. So, let's say for example, we treated the patient I just talked about with even more metronidazole gel, she called back and said, you know what? I'm not getting that. And normally what we would do is to say, come on in, we'll have a look and we'll take a sample of the vaginal discharge and look it under the microscope. So what could be done is to collect some plastic or glass tubes where you can put a stopper, put in a CC of fresh saline in a pack of cotton fit swabs, put that in a brown paper bag and then the paper, I'm sorry, the patient comes to the clinic and a staff member will take that to her car. And if you really wanted to avoid a face to face interaction with the patient, once you've identified that that's actually her and her car, you can literally put it on her hood. The staff member walks away, and the patient gets out of the car, picks up the sampling kit. Then what she does is go home, she samples her vaginal walls, put the swab in the test tube, put a cap on it and then brings it back to the clinic and the clinician can look at it under the microscope. You can also do that to sample for gonorrhea and chlamydia with appropriate collection containers the one that you're routinely using for your GC including the index but there's no reason why a person couldn't sample themselves at home. Then they take that sample back to you in the clinic and you send it to the lab as you normally would.

Dr. Michael Policar:

Now for a patient with a recurrent bacterial vaginosis, does she need to be screened or treated for gonorrhea and chlamydia? And the CDC guidelines don't recommend empiric treatment for GC and chlamydia just because she has a vaginal discharge. But the point is that if in her history she meets one

of the criteria that I mentioned earlier, she's under 25, she has multiple partners or a new partner or has reasonable leads that her partner's having sex with someone else, then I would evaluate not only her vaginal discharge but I'd also have her sample herself for gonorrhea and chlamydia from her own vaginal fluid and then drop that off at the clinic as well.

Dr. Michael Policar:

So how are we going to build this very last visit then? The answer is, is that the telephonic or telemedicine visit is a 99214, basically based on the amount of time that it took. The diagnosis is N76.1 Subacute and chronic vaginitis. Interestingly, bacterial vaginosis does not have its own ICD-10 code, so we asked to use N76.1. And if Family PACT is going to pay for the metronidazole gel, if you use the generic version of the gel, the HCPC code which is uses S 5000, if you use a brand name of metronidazole gel, it's S 5001 and those are covered in the, in the formula of Family PACT. One very last slide and this is kind of a preview of what you're going to be seeing later in the year and into next year, that is the E/M coding is going to change substantially in 2021. Remember nowadays, the way that we choose an E/M code is either on the basis of history, physical, medical decision making or time. Well in 2021, what's going to change is you either the base E/M code on medical decision making, history and physical are no longer counted or time but there's a new definition of time.

Dr. Michael Policar:

The new definition of time starting January 1st, 2021 where you will hear from Medi-Cal and Family PACT about the start date is the time it takes for you to prepare to see the patient that is reviewing test results, getting a history, performing a medically appropriate exam, giving a patient counseling and education. The time it takes you to document that information in her health record, to actually look up test results and care coordination. So you will get credit for far more things than you currently get credit for now in regard to time because now you can only deal for face to face time but when this starts next year, you get credit for much more. Now I will say that the timeframes will have changed so you'll need to change either your electronic medical record or the forms you use in computing the E/M codes because you'll, you can do more things with the time that you have and you'll get credit for it but you'll have to use these new timeframes as a way of figuring out what the correct thing E/M code is but that's not now, that's not until January, January 1st of 2021 or later, we'll wait and tell Medi-Cal and Family PACT tell us that that is official.

Dr. Michael Policar:

So, with that, I will go ahead and wrap up. We actually have this whole 20 minutes for questions, and I look forward to being able to answer them for you.

Nicole Nguyen:

Okay, wonderful. So, I've been assigning all the questions to you in the questions chat but before you get to those, we did have one question that came in through email. So, I'm just going to read that real quick for you Dr Policar. Are you ready?

Dr. Michael Policar:

Yes,

Nicole Nguyen:

Okay. So, I am a Family PACT provider for over 18 years. I have two clinics and one of my clinics, Family PACT application is still pending due to COVID pandemics, waiting for site visits to be completed and approved. In your lecture, you mentioned a provider can provide care at any location due to the pandemic. In that case, may I see patients at my clinic that the application is still pending for?

Dr. Michael Policar:

Also, what I was talking about with specifically in a telehealth visit, okay. And that the clinician can either be in the clinic at home or somewhere else. The way that I understand the question is you're talking about providing face-to-face care at a clinic which has not been formally approved by the Office of Family Planning yet for face-to-face services. So now I would not include that as something that you could do but what I'm saying is very specifically for telehealth visits that the patient can be at home or somewhere else or that the clinician can be at home or somewhere else but that's only in the context of the telehealth visit.

Dr. Michael Policar:

Okay. So, let me look at some of the other questions. It's not, not a huge number but let me see. Family PACT has been idle. And I will tell you in advance, even though I'm going to read these, for a lot of these denials, it's something that you're going to have to talk with OFP staff about or the staff of the fiscal intermediary because you know, when denials happen, there were just so many reasons that that might be the case and the course I'm not familiar with all the denial codes but it says the Family PACT has denied all 99201 telehealth visits we have served. Is anyone else having that problem? I don't know. We'll have to see about that. I'm not sure why they would have been denied but that, that's definitely one that I would think about appealing and trying to find out from the Cisco intermediary about why that's happening.

Dr. Michael Policar:

Next question, that I would see. Another one about a denial code is 0225. And again, I'm not going to be able to help out with that. You should call the Cisco intermediary or email the office of family planning. What if the patient's out of state since family factors are federal program? There are really only applies to people that are Family PACT beneficiaries that reside in California. Now, if a Family PACT beneficiary was let's say seasoning a relative in Reno for example, and called in through your clinic, wanting a visit, given the fact that her site of care is in someone that's home out of state in Reno or Phoenix or somewhere else but she's formerly a Family PACT program or a Family PACT enrollee, then in that circumstance, as long as you're documented it, I don't think there would be any problem there. The clinic, the clinician of course has to be licensed in California. It has to be a patient who is a resident of California. She just happens to be out of state at the time of this telehealth visit. And of course, she is interacting with a family type clinic for the telehealth. I think that that part of it would be acceptable.

Dr. Michael Policar:

Let's see. So, they can be anywhere, however, they need to be in the same state or the same state where the provider can legally practice. Well, I think I just answered that and that is that the clinician has to be in state, they have to be licensed in California. In fact, they have to be a Family PACT enrolled clinician in order to be able to conduct this telehealth visit. And the patient of course has to be a California resident, has to be enrolled in Family PACT when she has this.

Dr. Michael Policar:

So, I read that place service 02 is for professional claim were submitting institutional claims and instead of place of service though too, we've learned that we should use revenue code 0780. Does this sound right? I've quite honestly do not know the answer to that. And what I would do is to look at that communication of June 23rd that I mentioned, just click on the link. It's quite lengthy and we'll probably have that answer for.

Dr. Michael Policar:

I missed that, let's see, if we can or cannot initiate the appointment. Well, the point here with these telemedicine calls is the fact that they are, they are intended to be where the patient calls in and request having, having an appointment. So, in other words, it's not supposed to work in such a way that the clinic calls the patient and tries to initiate a visit in that way. What I'm talking about here and what my assumption is that this was an effort to try to avoid fraud because something that could happen fraudulently is that the clinic hypothetically could call a patient, could ask, how are you doing? How's your method of contraception going? Ask a bunch of questions, hang up the phone and then they'll Family PACT. That's not considered to be acceptable. It has to be a visit which is initiated by the patient where the patient calls up and says, I want an appointment. And then there's some discussion about whether that can be a telehealth visit or whether it should be a face to face visit or a combination of the two. Now certainly a clinic could call a patient and say, you know, we know you were scheduled for your well woman visit in May, that didn't happen. Would you like to be able to reschedule the appointment so we can see you in October? That would be perfectly reasonable to do that. As long as you just can't bill for them, that's the front desk calling the patient asking whether or not they're interested in scheduling a visit that's not a health visit, that's this sort of more administrative than anything else but in order to actually initiate the need for the visit that has to come from the patient rather than having to come from, rather than coming from the practice itself.

Dr. Michael Policar:

Next question is, G2012 require a modifier and the answer to that is no, it doesn't. G 2010 and G2012, both of them virtual visits do not require a modifier.

Dr. Michael Policar:

Next is where not being paid, we're receiving denials for G2025 and I can't quite read that whole clown there with a rad code of 9993 like. So, I'm going to be honest with you, I'm not familiar with the HCPC code of G2025, okay because what we're talking about, what I'm doing referring to here as the virtual check-in codes are G2010 and 2012. G2025 maybe another Medi-Cal HCPC code. I don't think it's a Family PACT HCPC code and so we'll have to do a little more research. I'll try to put that in the written

Q&A afterwards if I can find out a little bit more about what the G2025 is and why that would be denied in Family PACT. And I'm not in any situation to be able to tell you about that for Family PACT. Let's see, does billing unless of course, and again, I don't have the whole manual in front of me. The G20, I wonder if G2025 is something that has to do with that facility codes. And that is for some telehealth visits that are initiated in a facility and this is, not since the public health emergency that was long before that, that in the kind of more traditional way of doing telehealth, not only could you bill for the clinician interaction but in some cases of facility code, particularly in a hospital could be built as well but I'm not sure if that's what the G2025 is referring to.

Dr. Michael Policar:

Let's see, does billing telehealth visit audio visual or telephonic as an E/M service also apply to FQHC? We bill on a UV with a 95 modifier be a required. And again, what I'm going to refer you to is the, is the Medi-Cal policy of June 23rd. There are about four or five pages that are specifically for FQHC. You need to read that, understand it because of the fact that they really made the effort working with CMS in Washington to make sure that CMS, that the FQHC are as well as rural clinics and health service clinics are addressed in a very specific way. And not only because that's not my area of expertise but I think that's a whole lecture. So that's something where you really need to look at the original policy to find out about how you're going to be billing that as an FQHC. I need to give you correct information.

Dr. Michael Policar:

Does one need to be a Family PACT provider in order to sign up a patient to a Family PACT? And the answer is where your practice has to be enrolled as a Family PACT providing practice in order to be able to do enrollment. Now you do know or you may know that of course at moments in the past always had to be done face to face and starting in March, and I talked about this in the previous webinar, not in this one but the point is you can do enrollment of patients in the Family PACT based on a telephonic or easy conversation with that patient. So now you can do that at least temporarily in a way that doesn't require the patient to come into the clinic to complete the enrollment forms. Okay. And it's easy to find that it's listed in my references for you at the end. It's part of the FAQ document that was published in March. However, you have to be a Family PACT provider in order to do that. If you're not a Family PACT provider, you have to be enrolled as a Family PACT provider in order to be able to do that. And it's another part of that from Rebecca was we had not yet enrolled the answer is no, you can't, you can't do that until you are formally enrolled.

Dr. Michael Policar:

Which conditions are best for telehealth and which would not be? Well here I'm going to refer you back to the and I went through it quickly, to that prioritization template that I showed you. And by the way, I developed a three or four page, what's called a Job Aid for the Family Planning National Training Center, FPNTC on how did, how to develop these prioritizations templates for, so for family planning services. So, when you go to that slide or when you look at the references that are in my slide, go to the FPNTC section. There will be a link that you can click on about prioritization of patient visits. Click on that and you will get very detailed advice and instructions about which services you can do by telehealth and which services you have to do in person. And again, I absolutely want to reiterate the fact that that is a moving target. You are going to start with a template which is best for your clinic. What you're having a

staff to do is when you have enough clinicians to do, it's when you have enough personal protective equipment for it, it's what's going on in this community in terms of, you know, what the prevalence of positive test is and that sort of thing and it's something that's going to change over time and I really want to emphasize again that once you put together that template, that grid, that policy or protocol in your office about what can go to telehealth, what has to go to an in person visit, you have to revisit that every couple of weeks and updated for what the conditions are in your community.

Dr. Michael Policar:

So, another one then is our center doesn't have any policies in place for which visits should be remote. Do you have, do you have a policy to use as a reference? Yeah, it's the one that I just mentioned. And in fact, what I may try to do in a minute, once I do a couple of more questions and let's see, maybe I can get some help with staff members from the training centers to get my slides back up. But if they are, I will show you the reference that I'm talking about that has to do with putting together templates.

Dr. Michael Policar:

Okay, let's see. I can't see anymore. And by the way, whatever questions I don't get to, but we usually do a written Q&A which we'll post on the website afterwards. Okay, what are the five criteria mentioned as that what we need to document to show that the telephone visit is appropriate. It'll be in the slide set, number one and number two which is far more important is that it's on page seven of the policy. So, if you click on the link for the policy, it's very quick and easy to download it, you go to page seven and eight in the policy. You'll see exactly what those questions are. I've given you a shortcut to those five criteria in the side set but I'm not going to go back to the slide down and repeat.

Dr. Michael Policar:

Let's see, are there any different or special considerations for services provided for minors? And the answer to that is the ones that we've always dealt with in providing family planning services to minors, you know, the issue of whether they're emancipated minors or not, what their ages, it really applies to telemedicine as well. The only thing that I would say for telemedicine with adolescents is I would really make a point of discussing with them the confidentiality and security of where they're having this conversation early on, upfront. What I mean by that is that, you know, normally what I would say is, can you hear me? Can you see me? But if like I'm having this conversation with an adolescent, I would be asking questions like, is there anybody in the room that's... Are you comfortable with the fact that nobody else or is there someone else...? Is there anything else that we can do to make sure that this is confidential as possible? You know, we've all been seeing reports about the fact that interpersonal violence has been going up as a result of, by going through with the COVID-19 pandemic. And, you know, so when we do these telemedicine visits, we really need to take into account that that's something that you need to bring up with patients about whether there has been interpersonal violence and also to check in with them about in this conversation we're having either by AV or by telephone, are they comfortable with the fact that this is being done in a, an environment which is confidential to them?

Dr. Michael Policar:

Next is for documentation of time and the telephonic is it should the start time and the stop start time be documented or just the time spent. And the answer is just the time spent. I mean, I think it's perfectly fine to document start time and stop time. Then what you'll do from there is to calculate the appropriate level of the E/M code but it's just as reasonable to say, this was a 25-minute visit. You don't need to document start, stop.

Dr. Michael Policar:

Next is, can a patient bring in her urine for gonorrhea and chlamydia testing, vaginal swab was mentioned? Well she could. I mean, that's possibility. The reality though is that the CDC says very clearly that the sensitivity, particularly the sensitivity of the gonorrhea and chlamydia and that test is substantially better with a vaginal swab than it is with a urine sample. There's a significant drop off in the accuracy with a urine sample in women. And therefore, the vaginal swab is better. If the vaginal swab is impossible, patient's not comfortable with it and so on, then you could use as a substitute, you'd rather go with a vaginal swab.

Dr. Michael Policar:

Next is where can we find the tele-health rights? That's a great question. So, first off, if you're using the E/M codes that I mentioned, standard E/M codes, new patient, established patient, based on time, 95 modifier, those payments are exactly what you would get for an office visit, okay and for one thing. Next is you also may want to know what the payments are for the virtual check-in visits that I mentioned which have been added on. So, if you want to know what the payment is or anything that's covered in that account, anything that's covered in Family PACT, you go to the Medi-Cal.ca.gov website. You go to the general Medi-Cal website. And then in the question box or the search box is a better way to say it, what you type in is Medi-Cal rates and then that will take you to a page where it says you've hit the Medi-Cal rates page, you want to download all the rates. You just want to do a lookup of a particular rate. So, you're going to click I want to do a look up of a particular way okay then that second circumstance what you're going to do is you're going to type in G2010 or G2012. It's going to take you to a big table and it will tell you exactly what the Medi-Cal rate is for paying for them or if you want to know where you're going to be paid for 90 days, you will find specific Medi-Cal rates in those tables. Thank goodness Medi-Cal is very transparent about the CPT codes that are covered. If it's not listed, then it's not a covered benefit, if it is covered, they will tell you exactly what the payment is, but you will find that on the Medi-Cal.ca.gov website.

Dr. Michael Policar:

Let's see, can we use symptomatic diagnosis for a Family PACT tele-visit? And secondary diagnosis, cell smelling discharge or vaginal itchiness instead of acute vaginitis or a subacute vaginitis? Okay, so I'm really glad that question was asked because I have to remind you about a couple of things in going for Family PACT visits. You probably know this but I'm going to remind you as well. Whenever you bill for a Family PACT visit, you always have to have at least one ICD-10 diagnosis which is the method of contraception that the patient is using. And then usually there's a second ICD-10 diagnosis if you're doing something like screening for an STD or treating an STD or let's say bleeding problem or something like that. So here in the example that Catherine is giving, is that a person has a telemedicine visit

because she has a foul-smelling vaginal discharge turns out to be bacterial vaginosis. What are the ICD-10 codes that you use for that? Okay. Well, one is you have to have the ICD-10 code for whatever methods you use. So, if she's using pill, patch, ring, then you're going to use the ICD-10 codes respectively for each of those. If she has an IUD in place, you're going with list that code, maintenance of that IUD and so on. And then the secondary diagnosis is what the diagnosis is of her condition. So, if you made the diagnosis of BV then you use the code for bacterial vaginosis, N76.1. If he only has a discharge and you're not sure what's going on and there's probably going to be a separate code for that. And Family PACT is very, very transparent in the acceptable ICD-10 codes. If you look at the PPBI, the patient policies, procedures, and billing instructions for every method, for every STD which is covered, for every service which is covered, they list quite explicit, the ICD-10 codes that are considered the covered or not covered in Family PACT. So, the point is, is that in addition to the ICD-10 codes for what method of contraception, which is mandatory, it's got to be on every single claim. Then in addition, you would choose secondary diagnosis code which is the best description of what you've diagnosed or what you suspect is going on or what her complaint was but it has to come from that list of available codes in the Family PACT PPBI.

Dr. Michael Policar:

Let's see, I'm just looking at time one 30. Let's see. Okay, well what I'm going to do is there are this a handful of more questions that we didn't get to but the point is, the fact that I will answer these in a written Q&A, one that I'll look up very quickly is the very last one or BP checks require blood pressure test required for birth control pills and DMP refills. And the answer is absolutely not for the DMPA. There's no requirement to checking blood pressure. For pill, patch and ring, whenever you're initiating an estrogen containing method or when you refill a prescription for those methods, at least like to ask about blood pressure but it's not required that the patient come in for a blood pressure or that she show you a blood pressure leak. She can tell you that or she can say, "Look, I just have no way of getting a blood pressure." And then you can say, okay, well, we'll give you a three-month grace period to have your blood pressure checked. And I'll put a little bit more of that into the written Q&A. Okay. Oh, I see you're back.

Nicole Nguyen:

Yeah, no I've been going through... I've been stealing the questions and trying to answer some of it to help you out but thank you so much. So yeah, that concludes our webinar. We're right on time at one 30. So please remember to fill out the survey that will appear at the end once this webinar ends so we can get your feedback, so we know what kind of future content to provide. I'm sure everyone was really excited. We've been getting really good feedback about these webinars. This information was so much needed. Thank you so much, Dr Policar. And so, yeah.

Dr. Michael Policar:

They have said it and I missed it but how can people get access to the handout?

Nicole Nguyen:

Yes, yes. So, we are getting the handouts. This webinar is recorded and so we will be sending that out in follow up emails with the slides and the list of questions that if we can, any questions that Dr. Policar

didn't get a chance to answer, we'll send that as well. So, with that, thank you so much Dr Policar for presenting and thank you all for joining us today. We hope you stay safe and have a great rest of your week.

Dr. Michael Policar:

Thank you.

Nicole Nguyen:

Bye everyone. Take care.