VCHIP CHAMP VDH COVID-19

March 19, 2020 | 12:15-12:45pm Call Questions and Answers*

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Payments for Virtual Visits

Kate McIntosh, Senior Medical Director and Director of Quality, BCBS VT: BCBS is billing telephone calls exactly the same as we're billing telemedicine, with a 95 modifier and any acute office visit can be billed as telephone. Today we are turning on the established patient well visit codes and 96160 and 96161 (developmental screening), and the mental health screening codes and Vanderbilt scale codes, so med checks can be done over the phone. The goal is to get everyone who can be treated with the standard of care over the phone to be treated over the phone. Check communications from DVHA and BCBS VT for Z-codes. If you want your patient to have a $0 copay, you need to use a Z-code in the first line of the coding. We're working to develop a document that provides relevant coding information for providers.

Q: Colleen Moran, MD: can we have Kate's email to contact for direct questions? Specifically as FQHC is a different payer system.

A: Breena Holmes, MD, VDH: Send questions to Avery at VCHIP (vchip.champ@med.uvm.edu). We have several FQHCs on the list.

Mother/baby care: guidance forthcoming

A: William Raszka, MD, UVMMC: UVMMC is still working on protocols for mothers who deliver who may or may not have symptoms, PUI status, etc. and how to manage those infants. **Those protocols will be shared through VCHIP when completed.**

Practice Implementation Strategies

Barb Kennedy, MD, Timber Lane Pediatrics: To get to the earlier question about how to screen patients. We're giving out as much information out to our families as we can. The website is one modality, but we're also pushing out messages through the portal telling patients not to come in, but to call first. I'll be honest, we haven't seen a patient in our South Burlington office in the last two days, so it has been very effective. Our process is that we do want to video or do a telephone call with patients before they come in to the office. We set it up as an office visit. When we're doing these visits, we've been told that we do need to document consent in the note and document who is on the call. I'd like to confirm with Kate that we'll be using the telephone visit codes (99441-99443), which are timed visits. If we do have a patient that needs to be seen in the office, we first get the history via video. We're doing babies in the morning and sick visits in the afternoon. When they come in, we ask that only the healthiest parent accompanies them. If there are any respiratory symptoms, we have them put a mask on upon office entry. If there's a newborn that we feel needs a weight check or bilirubin assessment after a video call, they would go into a separate room. All of our PPE is in one location and we have cleaning supplies in every room. The only person who goes into the room is the clinician and as patients leave, they dispose

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of their PPE. The sick visits would go into a different room on the other side of the hall. Depending on the office site, we'll use a back door for exit. We recommend that when we do these visits, everyone has gowns, masks with shields and gloves. We are considering using johnnies if we run out of gowns. If the child is coughing, we are adding wearing bonnet caps. We have enough N95s for each provider to wear one of those nad booties if there is a respiratory concern. We're doing daily Zoom conferences for our 3 sites and emails about updated guidelines. We're also sending bright futures through our portal for families to fill before their well visit, which until April 6th, the well visits that we'll do over video chats are for up to 18 months. After April 6th, we're hoping to add older kids to this. We're delaying immunizations through April 6th as well and asking that patients schedule nurse visits to get caught up.

Q: How are practices screening office visitors?

A: Erica Gibson, MD, UVMMC: Only the screener wears gloves and the patient and family get masks.

A: Alex Bannach, MD, North Country Pediatrics: At North Country Pediatrics, we screen during every phone call and at the door. Greeter wears surgical mask and goggles. No PPE for public access due to shortage. Mask on sick patient only. Staff wear surgical mask and goggles for all encounters. MDs are the only ones meeting sick patients. Sick patients are aggressively triaged, the few we do see are seen in their car, parents placing mask on child, MD wearing surgical mask, goggles, gown, gloves as infants and toddlers are not good about keeping their mask on but very good at spitting snot at you ;-) We are successfully doing nebulizer treatments in the cars with an extension cord.

Questions/Discussion

Q: Wondering what criteria other practices and hospitals are using for N95 masks, DHMC ID head said she doesn't think it's airborn and regular masks are fine if not aerosolizing procedure.

A: Suzanne Picard RN, CVMC: We are only using N95s for aerosolizing procedures.

A: Breena Holmes, MD, VDH: I will find out about N95 procedure but I am sure we align with DHMC.

A: Alex Bannach, MD, North Country Pediatrics: Same at North Country, we are only using surgical masks in the clinic as well as goggles. No 95 masks unless confirmed or NP swabs.

Q: Follow up question from yesterday about Dr. Raszka saying most likely minimal spread from asymptomatic people, then why are we as a country massively cancelling medical appointments that are not emergencies, but important for ongoing health? and if we are saying not airborn, then are we needing to close rooms if we are doing good cleaning?

A: William Raszka, MD, UVMMC: Still a controversial issue. Currently, we do not think that completely asymptomatic children are the drivers of the pandemic. There is some experimental data to suggest that particles can remains suspended for a little while - which is different from TB and measles, which can remain suspended for a long time.

A: Breena Holmes, MD, VDH: Important question. Currently trying to await the surge which is why many are cancelling appointments as well as ongoing concern about exposure in offices or in public in general.

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Q: VT Medicaid is saying telemedicine policies will not be in effect until 3/23, can we get them to retroactively apply to this week?

A: Breena Holmes, MD, VDH: We have been promised retroactive Medicaid payments for telemedicine now.

Q: Kristen Connolly: What are protocols around health care provider quarantine/testing for our community? If patients of ours we have seen test positive? Or if children of health care workers at home become ill with fever/respiratory symptoms?

A: Ashley Miller, MD, South Royalton Health Center: There is a great table on CDC for risk assesment and public health managemetn of health care personel (link here: https://www.cdc.gov/coronavirus/2019-ncov/downloads/public-health-management-decision-making.pdf).

Q: Are practices having children come in for needed immunizations? (babies specifically)

A: Ashley Miller, MD, South Royalton Health Center: Yes, frist thing in the morning. We are offering car visits for older kid vaccinations.

A: Erica Gibson, MD, UVMMC: We are bringing in 12 month olds and under for immunizations at this time.

A: Anya Koutras, MD, UVMMC: We are bringing in 12 month olds and under and deferring immunizations for older kiddos until later.

A: Alex Bannach, MD, North Country Pediatrics: We are continuing to see all wcc visits and chronic care visits as we do not allow sick visits into the clinic. Patients and caregiver have to be healthy to come to wcc visit.

A: Greg Connolly, MD, Lakeside Pediatrics: Lakeside Pediatrics is bringing in 12 months and under well checks for immunizations. Designated well visit rooms. Almost zero sick patients coming in. Well rooms are in one hallway, sick in another hallway. Well visits only in the morning. Essentially all of our sick and problem visits are done via telemedicine using Doxy.me.

Q: Elliot Rubin: Are there any written guidelines for best practices of how to accomplish sick and well visits virtually?

A: Wendy Davis, MD, VCHIP: I don't have that consolidated all in one place, but there may be something coming out regarding best practices for telehealth from AAP colleages soon.

Q: Ashley Miller, MD, South Royalton Health Center: would love to hear about influenza and COVID, or influenza and RSV?

A: William Raszka, MD, UVMMC: At the medical center, we are in very short supply. Here, we will be limiting influenza testing for those likely to be hospitalized (and a few others). We will not be routinely testing for influenza in our immediate environment. Office-based practices are often not going to be using the PCR based. If you like the accuracy of your test and you have enough supplies, you can go ahead and test using your clinical judgement.

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Q: I feel like office based testing for flu increases our exposure risk.

Q: I agree. We are not testing at this point but using phone triage to diagnose.

Q: We are testing the sick kids that come in, and we were thinking if flu positive, they're less of a risk for COVID, (obvisouly not in the high risk groups), but is this accurate? Is coinfection possible?

A: William Raszka, MD, UVMMC: In theory if you're going to be doing the nasalpharangeal flu swab, you should use as much protection as possible. Knowing there's a real shortage of PPE, you should only be doing the flu swab if it's really going ot change your manahgement. How will I use this? Will I give oseltamivir? You should wear a mask and face shield over your eyes. If we know that other family members of influenza b positive, I am perfectly fine treating them as influenza b. The issue of coinfection is a problem. Of the first 20 patients in China, 40% had a coinfection. We don't recommend the viral panel, because that's not going to change our strategy.

Q: Elizabeth Hunt, MD, Timber Lane Pediatrics: Could you speak to the risk of well visits for infants in a "closed" office? e.g. only well infants coming in for PEs with shots in a space with no sick patients.

A: If you're separating out well visits in the morning and sick kids in the afternoon, you screen the patient and the guardian bringing them, have a separate clean room and do not see any epidemiological risks assocatiated, then there should be a low risk for transmission for that encounter.

Q: Ashley Miller, MD, South Royalton Health Center: NH is saying there is now community spread, is VT?

A: Breena: Yes, VT is now saying there is community spread.

Q: I know it is varying by state location, is VNA still doing any home visits?

A: Michelle Dorwart, MD, CVMC: I spoke to a UVM Home Health RN yesterday - she told me they are mostly doing telemedicine.

A: Breena Holmes, MD, VDH: There is written guidance about home-based services. We've asked the VNA to determine if services are essential. We have all the guidance out that most visits (lactation consults, etc.) are being done through telehealth. We've received confirmation that they can happen through non-HIPAA compliant platforms, so Facetime can be used.

Q: Just to be clear, if I order a "drive-by" COVID19 (obviously only if there is a very good reason to test), I don't plan on testing for RSV and influenza. RSV and influenza only for patients being hospitalized, correct?

A: Elizabeth Hunt, MD, Timber Lane Pediatrics: The last patient I sent for COVID testing had the other viruses run. That was not from an order I put in, I guess it was protocol.

Q: Ideas on how to check in on newborns or high risk patients, while minimizing exposure?

A: Alex Bannach, MD, North Country Pediatrics: Use telehealth, at least you can put eyes on the baby, even watch feeding, etc.

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Q: Have people had better success with certain telehealth?

A: Michelle Dorwart, MD, CHCB: At CHCB we're using Zoom - works well

A: Alex Bannach, MD, North Country Pediatrics: We use Zoom, a little cumbersome as it needs email invite. Would prefer facetime but our admin not allowing currently.

A: Breena Holmes, MD, VDH: check in with newborns by facetime, it works great.

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