

## **Chronic Care Management in Rural Health Clinics**

Rural Health Clinic Technical Assistance Series Call  
January 19, 2016  
2:00 pm ET

Coordinator: Welcome and thank you all for standing by for the Federal Office of Rural Health Clinic Technical Assistance Webinar. At this time, I would like to inform all participants that today's conference call is being recorded. If you have any objections, you may disconnect at this time.

If you would like to ask a question, please press Star 1 on your touchtone phone. You will be prompted to record your name prior to asking the question. I would now like to turn the call over to Bill Finerfrock.

Bill Finerfrock: Thank you operator and thanks everybody for participating in today's call. Prior to starting this out, I'd like to turn it over briefly to Wakina Scott with the Federal Office of Rural Health Policy for a brief announcement.

Wakina Scott: Okay, thank you, Bill. Again, my name is Wakina with the Federal Office of Rural Health Policy and I just wanted to let everyone know, in addition to today's call, Webinar, we'll be having another follow-up Webinar sometime in February mainly related to today's topic as well.

There were some recent awards for the Transforming Clinical Practice Initiative one of which award has a specific rural health focus, the National Rural Accountable Care Organization, and so we're going to be working with them as well as some (other) presenters to come on and do a Webinar to provide some additional follow-up and informational resources available for chronic care management services.

So again, we've invited, (Lynn Barr), who is the head of the National Rural Accountable Care Organization and - for the next Webinar, and will be looking at inviting some other presenters, too, just as a follow-up, so that you can continue having that information and those resources as it pertains to chronic care management services as well as other resources and grants from our office. So thank you, Bill.

Bill Finerfrock: Sure, Wakina, and so thank you everyone. Again, I'm Bill Finerfrock, and I'm the executive director of the National Association of Rural Health Clinics, and I'll be the moderator for today's call.

Today's topic is the chronic care management benefit (in) rural health clinics. As you know, this series is sponsored by the Health Resources and Services Administration's Federal Office of Rural Health Policy and is done in conjunction with the National Association of Rural Health Clinics.

We're supported by a cooperative agreement, and as you can see in your screen, for those of you who haven't for those of you are following along on the slide you downloaded previously, through the Federal Office of Rural Health Policy, and that allows us to bring you these calls free of charge.

The purpose of this series is to provide RHC staff with technical assistance on RHC specific information. Today's call is the 69th in a series that began late in 2004.

During that time, there have been over 17,000 -- I think we're going well over 18,000 today -- combined participants in these national teleconference calls. As you know, there is no charge for participation and we encourage you to refer others might benefit from the information to sign up and receive announcements.

I want to get right to it since we are starting late. I did want to mention that during the Q&A period, in addition to asking your questions orally, for those of you who are watching live on screen, in the lower right-hand corner is a dialog box - or in the middle is a dialog box - on the left-hand side, I'm sorry, of your screen and you can type your question in there and we'll read it to our speakers and get those insert as well.

Without any further delay, I'd like to turn the meeting over to our speakers. We have Corinne Axelrod and Simone Dennis and Alex Baker, all from the Centers for Medicare and Medicaid Services.

And they're going to be talking to you about a chronic care management benefit as well as the new advance care planning benefit that were announced in rulemaking a few months ago. We'll start off with Corinne. The time is yours.

Corinne Axelrod: Okay, thank you, Bill, and thank you for inviting us to do this presentation. We're very excited to talk about chronic care management, CCM, and advance care planning.

Let me just note that Simone and I are the presenters. We do have several other people on the call with us available to answer questions, including Alex, but Simone and I will be the only presenters.

And we're not in the same location as Bill, and we were not able to actually log into the Web site, so that's why Bill will read to us any questions and Bill will be our page turner, so thank you, Bill, for that.

Bill Finerfrock: Not a problem.

Corinne Axelrod: I'm going to jump to Slide Number 4 which is CCM services. Beginning on January 1st of this year, RHCs may receive an additional payment for the cost of CCM services that are not already captured in your all-inclusive rate.

For CCM services to Medicare beneficiaries, having multiple - which means two or more - chronic conditions that are not expected to last at least 12 months or until - I'm sorry, that are expected to last at least 12 months, or until the death of the patient, and place the patient at significant risk of death, acute exacerbation, decompensation or functional decline.

These are the two criteria that your patients must meet to be eligible for CCM services. On the next slide, we have a copy of the top part of the MLN article on chronic care management for rural health clinics and federally qualified health centers.

If you're considering offering CCM services, please download this MLN article. Its ten pages of detailed information on CCM that is specific to RHCs and FQHCs.

There are some key points that I want to review before we start talking about the required components. Starting on Page 6, Slide 6, I mean, CCM can only be initiated by an RHC practitioner during an E&M visit, an AWV visit, or an IPPE visit.

CCM can only be billed when a minimum of 20 minutes of CCM services have been furnished. We have several "Frequently Asked Questions" in this presentation regarding the 20 minutes period.

I do want to mention here that the time spent discussing CCM during the evaluation and management, the E&M, the AWW, or the IPPE visit, that time is not counted towards the minimum 20 minutes a month required to bill CCM, and we'll talk more about that a little bit further on.

Slide 7. CCM payment will be based on the Medicare physician fee schedule, national average non-facility payment rate, when CPT Code 99490 is billed alone or with other payable services on an RHC claim.

So just to be clear, CCM is not billed under the physician fee schedule. It's just that we're using the physician fee schedule rate. The rate will be updated annually and has no geographic adjustment.

The RHC face-to-face requirements are waived when CCM services are furnished to an RHC patient. Coinsurance and deductibles apply as applicable to RHC claims and RHCs cannot bill for CCM services for a beneficiary during the same period as billing for transitional care management or any other program that provides additional payments for care management services outside of the RHC all-inclusive rate for the same beneficiary.

Okay, Slide 9. There are three required components. The first is patient agreements, the second is scope of service elements, and the third is EHR and other electronic technology.

For the first one, the patient agreement requirement, you're required to inform the patient of the availability of CCM services, obtain written agreement to have the services provided, and that would include the authorization for the electronic communication of medical information with other treating practitioners and providers.

You're required to document this discussion in the patient's medical record, noting the patient's decision to either accept or decline the service. You're required to explain how to revoke the service, and you're required to inform the patient that only one practitioner can furnish and be paid for the service during a calendar month.

The patient agreement requirements are more specific than usual because this is a service that will not be very visible to the patient but they will be charged for the service and will be responsible for coinsurance and any deductible.

We want to make sure that they understand what they're paying for and understand the value of the service even though it's not a face-to-face service. Patient agreement requirements also require that you discuss with the patient - - this is on Slide 11 -- discuss with the patient and, if applicable, the caregiver as well, what the CCM service is, how to access it, how their information will be shared among other practitioners and providers, how the cost-sharing, which is the coinsurance and deductibles, applies to the service, and how to revoke the service.

The second element is the scope of service elements on Slide 12. This includes structured data recording, care plan, access to care and care management. Please refer to the MLN article for the requirements for each of these scopes of service elements.

The third component is the electronic health record requirements. You're required to have certified EHR technology for some of the scope of service elements.

I included on Slide 13, the link for more information on acceptable EHR technology. The EHR technology certified to the 2014 additions of

certification criteria is the only one that's acceptable for CCM in 2016. Earlier versions are not acceptable.

And in the MLN, there's a very nice chart with the scope of service and billing requirements and which ones have EHR requirements associated with them, so please refer to Table 1 for a list of the requirements and their associated electronic health records requirements.

On Slide 14, there's also - I wanted to mention, on Table 2, in the MLN article, we have two examples. One is a billing example when CCM is furnished as a stand-alone service and the other is an example of when CCM is furnished with a billable visit.

I think these are pretty straightforward but please look at those examples to see how to bill in both the situations.

I want to move now to the "Frequently Asked Questions" section. Some of these FAQs were adapted from the physician fee schedule FAQs. Some of them are based on questions that we received from RHCs and also from the National Association of Rural Health Clinics. Some are questions we thought people may have once they start getting more familiar with the CCM program.

Our plan is to revise these after this call based on your feedback. If you have any other questions, I'm sure we didn't think of everything, or perhaps some of these aren't as clear as they could be. So after this call, we'll make revisions and then we will post them on the RHC Web site.

Let's start with the FAQs on Slide 16. What is the payment rate for CCM services in RHCs?

In 2016, the rate is \$40.84. You can always look up the rate and there's a link to the physician fee schedule lookup tool which will always have the current rate. As the years go by, you will always have that available.

The rate is set based on the average non-facility payment rate paid under the physician fee schedule for CPT Code 99490 and again, you're not billing under the physician fee schedule. We're just using their rate.

The third FAQ - Will the rate change throughout the year?

No, it's set annually and will be applied to CCM claims from January 1st to December 31st. It is not geographically adjusted. I just wanted to mention that because the rate is adjusted for those billing under the physician fee schedule, so you may hear that from other people, when they are billing CCM, that their rate is geographically adjusted. In RHCs, the rate is not geographically adjusted.

Number five - Is the coinsurance/deductible waived for CCM services?

No, it is not. It is applied to both the coinsurance and deductible, and again, this is why the patient consent information is so important.

Number six. Does CCM have to be billed on a claim with an RHC visit?

We specifically set this program up so that CCM services can be billed either alone or on the same claim as the billable visit, either way.

If an RHC submit the claim with a billable visit and CCM services, would the total be subject to the RHC payment limit?

The answer to that is no, RHCs would be paid 80 percent of their rate for the billable visit, subject to the RHC payment limit, plus 80 percent of the CCM payment. The CCM payment is paid separately and not factored into the RHC rate.

Okay, Slide 19, FAQ Number 8. Can CCM costs, such as software or management oversight, be included on the cost report?

Any cost incurred as a result of the provision of RHC services, which would include CCM, should be included on the Medicare cost report. So the answer to that is yes.

What revenue code should be used for CCM services?

Most of the time that's going to be 52X, but there are no revenue code restrictions so whichever one is most appropriate.

Okay, Slide Number 20, FAQ Number 10. What date of service should be used on the claim and when should the claim be submitted?

The service period for CCM services is one calendar month. RHCs can bill for CCM services when at least 20 minutes of CCM services have been furnished, or any time after that until the end of the calendar month. The date of service can be the date that the minimum of 20 minutes has been met or any date after that but before the end of the month. So basically, the date cannot be before the 20 minutes of CCM has been provided and it cannot be in a different month than when the 20 minutes has been provided<sup>1</sup>.

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<sup>1</sup> Note: This FAQ will be revised to distinguish between the service period (one calendar month) and when the service can be billed (when the minimum of 20 minutes of qualified CCM services has been furnished or any time after that within the filing requirements.)

Next slide. Who can determine if a patient can, is eligible or CCM services?

An RHC practitioner must make the determination that a patient meets the criteria for CCM services and initiate CCM services during a comprehensive E&M, AWV or IPPE visit.

How does an RHC practitioner initiate CCM services?

If the RHC practitioner determines, during one of these visits, that the patient is eligible for CCM services, and again, that would be based on the criteria that we mentioned at the very beginning, the RHC practitioner would discuss CCM services with the patient. If the RHC practitioner does not discuss CCM services with the patient during one of these visits, the visit would not be considered as an initiating visit for CCM.

The next slide. If the RHC practitioner initiates the discussion of CCM services during an E&M, AWV or IPPE visit, can a nurse or other auxiliary staff person continue the discussion, including the consent requirements?

The answer to that is yes, as long as the RHC practitioner initiates the discussion during one of these visits - the E&M, AWV or IPPE - than other qualified auxiliary staff, and auxiliary staff means clinicians such as nurses, medical assistants, therapists, et cetera, can complete the process.

Okay, Slide Number 23, FAQ 14. If the RHC practitioner discusses CCM with the patient during an E&M, AWV or IPPE visit, but let's say the patient doesn't decide until the following week that he or she wants the service, can the patient still get CCM services or would they have to wait until a subsequent E&M or AWV visit?

Written consent is not required to be obtained at the initiating visit but CCM has to have been discussed at that time and the consent obtained prior to the start of CCM time. If the patient comes back a week later and says they thought about it and they want to go ahead and sign up for CCM services, that's fine as long as the discussion was documented in the patient's medical record and they complete the process by signing the consent form.

The next slide. Once the patient has consented to receive CCM services, can other staff furnish CCM services?

The answer to that is yes. Once the RHC practitioner has initiated discussion and the patient has consented to receive the service, then other RHC practitioners or other auxiliary staff can furnish the CCM services.

Must some portion of the 20 minutes of time per month be performed by the RHC practitioner or may the clinical staff furnish the entire 20 minutes of care?

Once the CCM services have been initiated by the RHC practitioner, who is the only one who can initiate the service, then either the RHC practitioner or other clinical staff can furnish the CCM services. In other words, an RHC practitioner can furnish the ongoing CCM services but they don't have to. It could also be done by other clinical staff.

Bill Finerfrock: And, Corinne, if I can stop you a second, by RHC practitioner, you're referring to the physician, the PA, the nurse practitioner or the certified nurse midwife?

Corinne Axelrod: Correct, because those are the people that would be qualified to do the E&M, AWW or IPPE.

Bill Finerfrock: So the psychologists and clinical social worker who are also typically recognized in the RHC would not be recognized for purposes of the CCM?

Corinne Axelrod: Well they would, once the service is initiated.

Bill Finerfrock: Right, right, but as the RHC practitioner, they didn't - they don't meet that requirement.

Corinne Axelrod: Right, because I don't believe that they are, in their scope of practice, able to provide the E&M, AWV or IPPE.

Bill Finerfrock: Right. Right. Okay, just wanted to make that clear. Thank you.

Corinne Axelrod: Thank you for that. Maybe that's another thing we should add to our FAQs.

Okay, Number 17 which is on Slide 25. Would the time spent performing secure messaging or other asynchronous non-face-to-face consultation methods such as email count toward the 20 minutes required?

Any time spent furnishing CCM services would count toward the 20 minute minimum, even if it is non-face-to-face.

Is contact with the patient every month necessary to bill for CCM if the 20 minutes of clinical staff time is otherwise met?

We would expect that RHCs will keep the patient informed about their care management but no patient contact is required to bill for CCM services if at least 20 minutes of CCM services have been performed.

The next slide. Does the time spent during the E&M, AWV or IPPE discussing CCM services come toward the minimum 20 minutes?

As we mentioned earlier, the answer to that is no, the E&M, AWV or IPPE is separately paid and the time cannot be counted towards CCM services.

Do face-to-face activities count toward the 20 minutes of CCM time?

Services that are furnished as part of a billable visit cannot be counted toward the 20 minutes of CCM time. However, if there is no billable visit and a CCM service happens to be done when the patient's present, the time can be counted toward the 20 minute minimum.

Twenty-one. Can CCM services be contracted out to a company that provides case management services?

RHC practitioners must furnish services in the RHC and auxiliary staff are subject to direct supervision requirements. There is no exception to the direct supervision requirement at this time for CCM services furnished by auxiliary staff in RHCs.

I think this is one that we're going to revise our answer to, to make it more clear.

There is no prohibition on contracting CCM services out to a third-party contractor, but RHCs cannot contract out for nursing services, for example, because the services must be furnished under direct supervision.

Again, RHC services can be contracted out. There are no restrictions on contracting that out. However, the RHC practitioner must furnish services in the RHC and the auxiliary staff must work under direct supervision. So at this time, that's not going to be feasible for RHCs. This is a little bit different than

under the physician fee schedule where the requirement for direct supervision of clinical staff was waived.

Number 22. What are the requirements for direct supervision?

Direct supervision requires that an RHC practitioner be present in the RHC and immediately available to furnish assistance and direction. The RHC practitioner does not need to be present in the room when services are furnished.

Okay, the next slide, number - FAQ Number 23, Slide Number 28. When is a new patient consent form required?

If a patient continues to receive CCM services from the same RHC, a consent form is only required when CCM services are initiated.

Obviously, if the patient goes to another RHC that's not part of your RHC, they would start the process at that RHC all over again, but for your RHC, as long as the patient continues to receive the services there, you only have to do the consent form at the initiation of services.

The next question. Can RHCs bill for CCM services furnished to a patient in a skilled nursing facility?

RHCs cannot bill for CCM services provided to SNF - skilled nursing facility - inpatients in Medicare Part A covered stays because the facility is already paid for extensive care planning and coordination services.

However, if the patient is not there for the entire month, the time spent by the RHC furnishing CCM services to the patient when they are not in the Part A

SNF could be counted toward the minimum 20 minutes of service time that is required to bill CCM for that month.

The next slide. Can RHCs bill for CCM services provided to beneficiaries in nursing facilities or assisted living facilities?

If all the CCM billing requirements are met and the facility is not receiving payment for care management services, then RHC's can bill for CCM services furnished to beneficiaries in nursing facilities or assisted living facilities.

Are there other restrictions on when CCM can be billed?

RHCs cannot bill for CCM during the same service period that care management is being provided by another facility or practitioner. This includes home health care supervision, hospice care supervision, certain ESRD services, et cetera, or any other service that would result in duplicate billing.

The next slide. If RHC has the ability to send clinical summaries or the electronic care plan via an acceptable electronic technology other than fax, but the receiving practice or provider, which is not billing for CCM services, can only receive the required information via fax, can the RHC fax the information and still meet the transmission requirements for billing CCM?

There are two options in this situation. The first option is that a clinical summary can be electronically transmitted to a third-party, who can then transmit the clinical summary via fax, or, if a practice or provider who is not billing for CCM is only able to receive care plan information by fax, the care plan information may be transmitted by fax.

Okay, and the last FAQ on this that we have here. Does the RHC have to provide 24/7 access to care management or 24/7 access to an electronic care plan that may be reviewed by other practitioners furnishing care to address a patient's urgent chronic care needs?

The RHC must ensure that there is 24/7 access to care management services. This includes providing the patient with a means to make timely contact with RHC practitioners who have access to the patient's electronic care plan to address his or her urgent chronic care needs, and the RHC must ensure that the care plan is available electronically 24/7 to anyone within the RHC who is providing CCM services.

Before we stop to take questions, I'm going to turn this over to Simone Dennis who is going to go over the other new benefit that began in January - advance care planning, ACP in rural health clinics. Simone.

Simone Dennis: Thank you, Corinne. I'll be presenting on advance care planning, also known as ACP. Next slide. ACP furnished in RHCs - ACP is a face-to-face visit between a RHC practitioner and the patient to discuss advanced directives.

Beginning on January 1, 2016, ACP CPT Code 99497 is a billable visit in a RHC when furnished by a RHC practitioner to a Medicare beneficiary. If ACP is furnished on the same day as another billable medical visit, only one visit will be paid and coinsurance and deductible will be applied to ACP.

Next slide. On this slide, I have a billing example for ACP furnished as a stand-alone billable visit. In this example, the RHC bills for CPT Code 99497. The RHC also includes relevant claim information such as the date of service, units, charges and revenue code.

Payment is made under the all-inclusive rate. Coinsurance and deductible are applied to ACP. Next slide. ACP furnished as part of an annual wellness visit or AWV- RHC practitioners may furnish ACP during an AWV. If ACP is furnished as the same day as AWV, only one visit will be paid and coinsurance and the deductible will be waived for both AWV and ACP.

Next slide. This slide shows a billing example for billing ACP furnished as part of an AWV. The RHC bills for the appropriate AWV CPT code, so G0438 or G0439, and enters a service date on or after January 1, 2016 through March 31, 2016.

On the next slide I'll explain why I specified those dates. The RHC should also include relevant claim information such as the revenue code, units and charges. Payment for the AWV is made under the all-inclusive rate (AIR) and payment for ACP is included in the AIR.

Next slide. Billing continued - beginning on April 1, 2016, RHCs will be required to report HCPCS codes for every service line. We're currently working on a Medicare Learning Network (MLN) article, which will include a list of stand-alone billable services and it will be available soon.

For ACP and AWV claims billed from April 1, 2016 through June 30, 2016, coinsurance and deductible will apply to ACP when billed with AWV. We're working with the Medicare Administrative Contractors (MACs) to correct this issue. Beginning on July 1, 2016, contractor shall adjust affected claims brought to their attention. All right, and that is it on ACP.

Corinne Axelrod: Thank you, Simone. So, Bill, we'll turn it back to you now.

Bill Finerfrock: All right, operator, if you would give the instructions on how to call in and then we've got questions that have been submitted online and we'll start working through those. But if you would, operator, give the instructions for those particularly who were not able to participate online.

Coordinator: Thank you. At this time if you'd like to ask a question, please press Star 1 on your touchtone phone. Again, you will be prompted to record your name prior to asking your question. If your phone is muted, please unmute your phone prior to recording her name. Again, if you have a question or a comment, please press Star 1.

Bill Finerfrock: Okay. We'll take the first question or two here from online and then we'll go to the phones and we'll just kind of go back and forth to the extent that we have questions.

Nathan Baugh: And everyone who's asking a question, please ask your question in the everyone chat online. Don't ask the question directly to Bill because that way everyone can see what you're asking.

So we're going to start with (Elaine) who asks - she says CCM doesn't require face-to-face. Does the provider have to sign each time documentation - I'm assuming each time they do some portion of the 20 minute for the patient. Corinne, do want to take that one?

Bill Finerfrock: Yes, how do they document that they've actually done the - met the 20 minutes?

Nathan Baugh: Yes.

Corinne Axelrod: One of the things that I neglected to mention is that we have several people, either with us - or maybe I said this - in the room or on the phone who are other experts on CCM.

So I'm going to ask if anybody from the physician fee schedule side has addressed this question because I personally don't know the answer. (Pause) Okay, it doesn't sound like it, so this is another question we will add, about how the 20 minutes of non-face-to-face time is documented.

Nathan Baugh: I think - yes, I think auxiliary staff, does the RHC practitioner have to sign off on any time or a session that auxiliary staff within for that 20 minute requirement? I believe that's the question (Elaine) is asking, so...

Corinne Axelrod: Okay, that's a great question, thank you. Sorry we can't answer it.

Nathan Baugh: Thank you, (Elaine). The next question is from (Tim Walters) who asks, on FAQ eight, can you confirm that CCM costs are allowable RHC costs on the cost report and don't have to go to a non-reimbursable section of the cost report?

Corinne Axelrod: The cost reporting people are not with us today so I can't tell you what part of the cost report this would go on but that's, again, something that we can get back to you with more detail on. The only information that I have from them is that CCM costs, like any other costs, should be on the cost report. But what part of it, I don't know.

Bill Finerfrock: Yes, I believe it has been our understanding from our conversations, that you would deem those to be allowable costs. So, okay, operator, do we have calls on the phone line or questions?

Coordinator: I do have some questions on the phone.

Bill Finerfrock: Okay, we'll take a couple of questions from the phone.

Coordinator: (Martha Masini), you may ask your question.

Bill Finerfrock: Go ahead, (Martha). Are you there, (Martha)?

Coordinator: Your line is open.

Bill Finerfrock: (Martha), if you've muted, you're online. If not, we'll have to go on to another question.

Coordinator: I'll go on to the next question. (Martha), if you would like to ask a question, please press Star 1 again. (Keisha), you may ask your question.

(Keisha): Can you hear me?

Bill Finerfrock: Yes, we can hear you, (Keisha). Where you calling from?

(Keisha): Okay. Oh, I'm sorry, I also tied to this in as well. This is my first time, so I apologize for that. I just have the technical assistance call, the little flyer that came with the invitation and it says that rural health clinics, we can provide the CCM service under direct supervision but not RHCs - can provide the service under general supervision. Is that true?

Bill Finerfrock: That's correct.

(Keisha): Why is that?

Bill Finerfrock: Corinne.

Corinne Axelrod: Yes, thank you for that question. Auxiliary staff are required to provide services under direct supervision in RHCs. Under the physician fee schedule, they waived the direct supervision requirement for clinical staff furnishing services under the fee schedule for non-face-to-face services for CCM.

We did not waive that, so this is the standard for services. It's not like we added it for CCM, we just did not waive it. And at the time, we had gotten some comments on this when we issued the proposed rule. The comments were from third party vendors, and we didn't hear anything from RHCs or FQHCs. We discussed it here and we really were not sure if this was something of benefit to the RHCs themselves, so we thought that it would be more prudent to wait and see how this would be implemented in RHCs. We said in the final rule that if it's a barrier, we would reconsider and look at that.

We've heard from quite a few people that they believe this is a barrier, so we appreciate that information. But I do want to just make it very clear that this is a regulatory provision. It's not something we can just wave away, and so auxiliary staff are required to furnish services under direct supervision at this time.

(Keisha): Okay, so this is something that is being - it's going to be reverted?

((Crosstalk))

Corinne Axelrod: Well, we've heard from RHCs that some of them believe that this is a barrier and so we're interested in hearing from Bill and from others about this. But we can't say at this time if that will be changed or if so, when.

(Keisha): Okay, and is there anywhere, like, we should go as an RHC to, you know, to be heard or...

Corinne Axelrod: Well, we certainly heard that this is a concern from RHCs. We did hear from one clinic that gave us actually a very detailed breakdown of their implementation plan and how this would affect them, and so that was helpful.

If there's specific information that you feel like we haven't heard already, then certainly feel free to let us know or let Bill know, whichever. But we certainly heard from several.

Of course, the program is just beginning. It hasn't been implemented yet. We'll continue to listen to the RHCs, and it's the same situation for FQHCs and we'll see, as time goes on, just how it works out.

(Keisha): Okay, thank you.

Bill Finerfrock: Yes, and we've been in communication with Corinne as she has suggested. We've provided some additional observations and comments. Corinne, did you want people to communicate directly with you? I know you provided your email in the slides, but I mean, would you rather that we kind of compile those and maintain that or do you mind if people contact you directly?

Corinne Axelrod: Well, either one. I mean, it's very helpful when you kind of aggregate similar questions and see what is percolating up, that's very helpful. But certainly, people can always contact us about that or any other questions.

But I think on this issue, we know it's of concern and so I think just keep us informed and if there's anything new- especially as RHCs begin to implement

this, we're interested to see - although, I think at this point I'm not sure very many RHCs have actually started to implement this service.

There may be certain things that seem like a barrier now but may not actually be a barrier. There may be other things that we didn't think of at this time that may emerge. So, to answer your question, it's very helpful to us when you aggregate these questions, but people are also free to contact us.

Bill Finerfrock: Okay, great. Okay, I think we're going to take - try to knock out some on the chat, some questions on the chat now. (Deborah Redman) asks, will a clinical pharmacist qualify? And I'm assuming she's talking about the CCM- as an RHC practitioner...

Nathan Baugh: Yes, that's an auxiliary personnel

Bill Finerfrock: As an auxiliary personnel.

Corinne Axelrod: Clinical pharmacists are not RHC practitioners. The RHC practitioners are defined in the statute in the Social Security Act, and do not include clinical pharmacists. Not to say that they're not an extremely valuable member of the team, but the practitioners that can bill for services in RHCs are statutorily defined and clinical pharmacists are not RHC practitioners.

They would be in the category of clinical staff and as clinical staff, they could provide CCM services once the CCM service is initiated by the RHC practitioner.

Nathan Baugh: And they would be subject to the direct supervision requirements.

Corinne Axelrod: Correct.

Bill Finerfrock: Okay.

Nathan Baugh: All right, so (Chris) asks, how is the 20 minutes documented?

Bill Finerfrock: That's one we've already had.

Nathan Baugh: I think that was a question we had previously that you're going to try and you'll go back to the appropriate staff and put out an FAQ on that.

Corinne Axelrod: Yes. I mean, I would assume it's documented in the medical records of who did what and when. But I will definitely go back and get more clarification on that.

Nathan Baugh: Okay.

Bill Finerfrock: Yes.

Bill Finerfrock: Okay.

Nathan Baugh: One is from (Lisa Watkins). We have a PA and an NP on staff but our MD is not on site. Can the PA initiate CCM or would only the NP be able to do this since the MD is not on-site? So this is about initiation.

Corinne Axelrod: Yes, thank you. PAs and NPs are RHC practitioners and they practice under general supervision. This would be no different than any other RHC service that is furnished by a PA or NP in that they have to meet the general supervision requirements and any other state requirement that they may have.

Man: But they - any one of them can initiate the CCM - the doc, the PA or the NP?

Corinne Axelrod: Yes. That's correct.

Bill Finerfrock: Operator, do we have any phone questions? Operator?

Coordinator: Yes, I do have some more phone questions.

Bill Finerfrock: Okay.

Coordinator: (Cristina Hamilton), you may ask your question.

(Cristina Hamilton): Hello. I just had a question about ancillary staff. Once the CCM is initiated, when we talk about auxiliary staff does include certified medical assistants and any of the nursing staff that work with the in that position?

Bill Finerfrock: And, (Cristina), where you from?

(Cristina Hamilton): Family and internal medicine, Kentucky.

Bill Finerfrock: Kentucky, okay. Thank you.

Corinne Axelrod: Yes. The term auxiliary staff has been used in the RHC manuals from before my time here so I'm not sure what the history of that is, but it's referring to any clinical staff which would include the medical assistants, nurses, therapists, and other clinical staff that are not RHC practitioners.

Bill Finerfrock: Okay. We have another question on the phone?

Coordinator: (Theresa Jeffers), you may ask a question.

(Theresa Jeffers): Thank you. I am interested in knowing, are we supposed be using the diagnosis codes that qualified them for chronic care management as a diagnosis code when billing?

Bill Finerfrock: And where you from, (Theresa)?

(Theresa Jeffers): Sorry, (Mid com) Family Physicians in Washington State.

Bill Finerfrock: Great. Thank you. Corinne.

Corinne Axelrod: I'm going to put you on hold for one second.

Bill Finerfrock: (Theresa) brought the whole thing to a halt.

(Theresa Jeffers): I'm sorry.

Bill Finerfrock: That's all right. It's all right.

((Crosstalk))

Corinne Axelrod: I was checking with our billing and claims processing expert. Claims have to have a diagnosis code and you would use the most appropriate diagnosis code for CCM.

(Theresa Jeffers): So if -- sorry -- if you are doing documentation or working on a referral that is not associated with what made them eligible for chronic care management that is still a proper diagnosis code. Am I understanding that correctly?

Corinne Axelrod: Well, it could be. Whatever is the most appropriate diagnosis code is what you would put on there.

(Theresa Jeffers): Okay.

Corinne Axelrod: Thank you.

(Theresa Jeffers): Thank you.

Man: We'll take some of the online questions.

Nathan Baugh: All right, so this question is from (Pam). She wants to know, when does a care plan have to be initiated and finished? And does it have to be in place prior to starting the timer and/or the billing? Does that make sense, Corinne?

Corinne Axelrod: Okay, that's a great question. I'm going to put you on hold one more second.

Nathan Baugh: Okay.

Corinne Axelrod: So I'm not entirely sure. The 20 minutes cannot be billed until the consent form has been signed but I personally don't know if the care plan has to be finished before the 20 minutes starts or if that's part of the 20 minutes.

Again, I'm sorry. We were expecting that some of the experts from the physician fee schedule side would be here with us to answer some of these questions but unfortunately they were not able to be here. So that's another one that we'll have to clarify and we'll put in the revised FAQs.

Man: Okay. So I'm actually going to - (Jennifer), I'm not skipping you, but this is kind of a follow-up to (Pam)'s question. She asked if the patient comes into the clinic on a day after they sign up to create the care plan, can I count that

time towards the 20 minutes - is - I believe she's talking face-to-face. But then she also wants to know, same, if it's done over the telephone as a virtual visit.

Corinne Axelrod: Yes, as you know, CCM services are not required to be face-to-face, once they have been initiated. They could be done face-to-face but they are not required to be.

If the patient happens to be there when CCM services are furnished, they can still be counted except if the patient is there for a visit that's a billable visit because basically you can't count the time for a billable visit in for CCM services.

I know that's only answering part of her question but the CCM services could be face-to-face but not if that face-to-face time is being included as part of the billable visit.

Man: Okay, thank you, Corinne. (Jennifer), I believe we answered your question about the procedure codes, I'm going to jump to your second question which is, how often can we bill the CCM for a patient?

Corinne Axelrod: CCM can be billed once a month. It's a calendar month, and it cannot be billed more than once a month, with a 20 minutes minimum. It could be more than 20 minutes but the minimum 20 minutes all have to occur within that month. So it's one billable CCM service per patient per month.

Man: Okay, operator, questions from the phone.

Coordinator: Yes, (Ed Cutter), you may ask your question.

Man: And please remember to identify where you're calling from, the state you're calling from.

(Ed Cutter): Calling from Mississippi. Someone asked my question already about the reimbursement and the cost for it. I just wanted to emphasize that there's a difference between, quote, "allowable costs," and reimbursable costs. So that question still needs to be addressed.

Corinne Axelrod: Yes, thank you. That's one that we will follow up with, with our cost reporting folks and ask for clarification on. Thank you.

Coordinator: (Laura Hertsinger), you may ask your question.

((Crosstalk))

(Lana Hertsinger): This is (Lana Hertsinger), yes, from (Boundary) Community Hospital and Rural Health Clinic in Idaho. And we just are still trying to figure out the rural health clinic billing.

And I know currently, if we have an E&M visit by the doctor and he does an office procedure, maybe removes a mole, those - the charges for those - both of those procedures roll into our rural health clinic code and are billed as one unit.

Are you saying, with the CCM, that we bill additionally on that claim if CCM was done on that same day but that we wouldn't have to roll it into our other visit? It would be a separate line item and be addressed separately?

Corinne Axelrod: Yes, that's correct. You could bill the CCM on the same claim as other services if there are other services on that day, or you could bill for CCM

services with nothing else on the claim. But if the CCM services are on the claim with other billable visits, it's not rolled in. It's paid separately.

(Lana Hertsinger): Okay, I just want to verify that thank you.

Corinne Axelrod: Thank you.

Man: Okay, we'll take one more from the phone. Operator.

Coordinator: (Tawana Tedd), you may ask your question.

(Tawana Tedd): This is (Tawana).

Man: And where you calling from?

(Tawana Tedd): (Onakala) Hospital in Mississippi.

Man: Okay.

(Tawana Tedd): But we - the question has been answered already.

Man: Okay. All right, very good. We'll take a couple from online.

Man: Okay, (Pam) - again, (Pam Lawder), wants to ask, how often does the care plan need to be scheduled for review or revision - is it an annual review or revision?

Corinne Axelrod: I'm not aware that there is a required time that it needs to be reviewed or revised. But we will confirm that.

Man: Okay. (Marcella) asks, by auxiliary staff, can it be a medical assistant? And I think we've already answered that. Let's see, the next question is from (Jennifer Campbell) who asks, how do you know if someone else is billing for a care management service? Is there a way to know other than the patient?

Corinne Axelrod: No. That's another reason why the beneficiary consent is so important to explain to the patient that only one practitioner can bill for the service and to be clear that they have not already signed up with another practitioner. That's really the only way that you'll know in advance if the patient has signed up with anybody else.

Bill Finerfrock: Otherwise it will be when your claim is denied because they've already paid somebody else for that service and then you'll have to go back to the patient and ask them if they remember signing up with something else.

Corinne Axelrod: Well, yes.

Bill Finerfrock: Okay.

Man: Okay, do we have any on the line? Coordinator:

Coordinator: Yes, I do have more questions on the phone. (Ann Duffy), you may ask your question.

(Ann Duffy): Hi. I'm from New Hampshire, and my main question was answered but I have a second question. Just in general, are RHCs required to provide CCM services?

Corinne Axelrod: That's a great question and the answer is no, they are not required to. It's totally an optional service. We hope that many will take advantage of this because we think it's an excellent service but you are not required to offer it.

(Ann Duffy): Thank you.

Coordinator: The next question comes from (Heather Bonnemineo).

(Heather Bonnemineo): Yes, I was just wondering, since annual wellness visits and other codes are allowable on telehealth but yet the CCM CPTs are now listed through telehealth, and I realize this is for - CCM is face-to-face but the CMS publication states that telehealth services are considered face-to-face. Will they allow the CCM on telehealth?

Corinne Axelrod: I'm not sure I completely understand your question. So let me just...

(Heather Bonnemineo): Well, like, the AWV, if they come in and they have the AWV but they also have their CCM, and AWV is billable through telehealth but the CCM is now listed as billable. So how would you capture that charge as well?

((Crosstalk))

Corinne Axelrod: The AWV is a billable visit. If any CCM is discussed during the AWV, that would not count towards the 20 minute minimum. That wouldn't be two separate events, that - the CCM services provided during an AWV would not count towards the 20 minutes.

Bill Finerfrock: I'm also a bit confused as to what might constitute a telehealth for CCM, but having even said that, let's say you had a Skype communication between a medical assistant and a patient who was a CCM patient, that would qualify as

minutes spent meeting the 20 minute time because there's no requirement as to how that communication should occur, whether it's over the phone, whether it's through a Skype communication, whether it's via email. So I'm not sure what you're referring to in the context of a telehealth visit as it relates to CCM.

(Heather Bonnemineo): Okay, the medical assistant you're talking about would be on the originating site, correct, for the patient to be seen?

Bill Finerfrock: Okay. I'm not sure what the purpose of having another health professional - if the medical assistant is sitting there with the patient, the medical assistant is perfectly capable of engaging in the CCM delivery. You don't need somebody else there. What's the telehealth component doing?

(Heather Bonnemineo): If the physician who is initiating the CCM, as well as the AWV at the same time, through telehealth, auxiliary personnel would be at the originating site and they would bill originating site fee. But I'm asking if the distant site provider, who is the physician, were providing the rest of the services, can we not capture both - the AWV and the CCM?

Bill Finerfrock: Well, I think as Corinne mentioned, the CCM and the AWV can't be provided simultaneously, so in that specific situation, I think the answer would be no.

(Heather Bonnemineo): Okay, so it would need to be a separate visit. I was looking at the slide and I guess I misunderstood what it said.

Bill Finerfrock: Okay.

Corinne Axelrod: And maybe I can just also clarify that the CCM can be discussed during an AWV visit but you cannot count that time towards the 20 minutes. It's not that

you can't discuss CCM during the E&M, AWV or IPPE visit, but that time is not going to be counted towards CCM.

(Heather Bonnemineo): Okay, okay.

Man: Okay, we'll do a few questions on the chat now.

((Crosstalk))

Bill Finerfrock: Yes, we're - if we can just hold - Corinne, we're up at - we're at 3:05. I don't know what you have in the way of time or, Wakina, can we go over time here?

Wakina Scott: Yes, I think we have a few more minutes that we have for the Webinar and on the phone line.

Bill Finerfrock: Okay, and Corinne, do you have a few more minutes if we keep taking questions?

Corinne Axelrod: Yes, we're available. Thank you.

Bill Finerfrock: Okay, sure. Then go ahead.

Nathan Baugh: This is actually a question on the ACP. Someone wants to know how many times can an ACP be billed? Is there a time limit on the visit?

Simone Dennis: Well, at this time, there is no frequency limitation similar to CCM which is billed once per calendar month. ACP is a standalone billable visit, so it can be furnished as appropriate, per Medicare's medical necessity guidelines.

Nathan Baugh: Okay. Excellent, thank you. Now we have another question on direct supervision. If we're billing CCM under Provider A and CCM services are being provided on a day when that provider is out of the office, can we still count those minutes as long as the provider is available on site for the direct supervision requirement?

((Crosstalk))

Corinne Axelrod: The direct supervision requirements are no different than they would be for any other service. If you're able to do that for any other service, you'd be able to do it for this one.

Man: So if you - so let's say that you have a physician and a nurse practitioner at the RHC. The physician, in this situation, is out of town. As long as a nurse practitioner is on-site when this CCM services were being provided, the nurse practitioner can fulfill the direct supervision requirements for the medical assistant, let's say, in the situation. It does not have to be the physician even though the physician may be the medical director of the clinic.

Corinne Axelrod: Yes, that's correct. It's possible that there may be some state requirements that might impact on that but we do not have any. What you said is correct.

Man: Okay. We have another question about minutes that occur prior to enrollment, the initial enrollment, for CCM. Can they count minutes from prior - from the same month before the enrollment towards the 20 minutes?

Corinne Axelrod: No, they cannot. The 20 minute clock cannot start until the service is first initiated by the RHC practitioner during an E&M, AWV or IPPE visit and the patient has signed the consent form. Anything that occurred prior to that cannot be included in the 20 minutes.

Man: Okay, we have another question. How does the patient opt out of the CCM program?

Corinne Axelrod: Well, I don't think we have any specific rules on how they opt out, whether that has to be in writing or not - although I think that's usually a good idea but maybe it's not always possible. I don't know, so I will confirm. But as far as I know, there are no specific requirements in terms of how they can opt out.

Nathan Baugh: Okay, we have a question on the coding requirement. Can you - this is from (Gary Lucas). Can you please speak briefly on the April 1 coding requirement? We look forward to the (MLN) article and any going to have at this time.

Nathan Baugh: I believe this is on the CPT requirement that begins April 1.

Corinne Axelrod: As Simone mentioned earlier, we're going to come out with some information very soon on this so I think we would prefer to wait until then and let you all have an opportunity to look at the information and then see what questions you have. And we'll work closely with Bill on that. I think for right now, we'd prefer to just stick with CCM and ACP and if you have any other questions on that.

Nathan Baugh: Okay. And - but is there any reason to think that it won't begin on April 1?

Corinne Axelrod: No, I think we're good to go. I'm looking around the room here and I see nodding heads, so good to go April 1, and it's not a joke. I know April 1 is not a good day to start something!

Bill Finerfrock: Okay. All right, operator, do we have one or two more questions we'll take on the phone line and then I think we'll finish up?

Coordinator: Sure. Our next question is from (Tammy Schneider).

Man: Go ahead, (Tammy), and please remember to tell us where you're calling from.

(Tammy Schneider): Hi. I'm calling from Missouri. And I just needed some clarification. When you say the CCM can only be initiated by an RHC practitioner during a comprehensive evaluation management visit, are we talking about a specific E&M level or does it just need - can you just clarify the criteria under what you define as comprehensive?

Corinne Axelrod: Yes, thank you for that question. The E&M visits that are billable visits in an RHC start at 99212 and up. 99211 is not a standalone billable visit in an RHC because that's a visit furnished by a nurse. So anything 99212 or higher is acceptable.

(Tammy Schneider): Okay, thank you.

Corinne Axelrod: Thank you.

Nathan Baugh: Okay, and next question. This will have to be our last one from the phone line.

Coordinator: (Kelly Harris), you may ask your question.

(Kelly Harris): Hi. I'm from Washington state. And that was wondering, what is the incentive for a patient to accept CCM when they're basically getting the services anyway and now they have to pay their 20% or deductible?

Corinne Axelrod: That's a great question and I think we've really tried to distinguish between the care coordination that is already provided and is included in your all-

inclusive rate versus this level of chronic care management which requires electronic health records and a lot of coordination external to your practice.

I think those are things that need to be explained to the patient because it's a very reasonable question and one that I certainly would want to know if I was the patient.

But we really view CCM services as something that's not currently being provided by most RHCs or included in the all-inclusive rate because it's really at a much more involved level and has requirements that are not required for just your general care coordination.

I think that's definitely something that you'll want to really explain to your patients why they may want to sign up for the service and how it would benefit their health.

And in the long run, it could very likely reduce their costs because the care coordination will hopefully reduce perhaps emergency visits or other types of unfortunate things that could happen without appropriate care.

Bill Finerfrock: Let me just make an additional observation on that, and as the National Association of Rural Health Clinics, this is an important benefit. I think Corinne really is on target here, not just for the RHC community, but for other providers as well.

I hear folks saying, "Oh, you know, this is an additional \$40 a month we can get for really doing nothing." I've literally heard people say it that way. And if that's the way that you're going to look at it, I can almost guarantee you that your patients are going to react the way that you suggested, Kelly, of you know, gee, I'm paying this money. What am I getting for it?

So that even though the 20 minutes of time may not require you to reach out to your patients and have actual contact with your - whether it's the medical assistant or the nurse or whomever, I think you might be well advised to look into doing that kind of patient outreach and communication in order to help demonstrate to them that they are getting something more than what they got before and that you're actually doing something to try and do a better job of perhaps communicating and integrating your patients into the care delivery.

The other thing - and Corinne alluded to this at the end - is that this benefit was created because there's an expectation that it does create the opportunity for long-term savings, through reduced ER utilization, through reduced hospitalization.

And I can tell you that, if the data does not support that, if we get, you know, two or three years into this benefits and it does not seem to be that there is any cause and effect, we see no demonstrable reduction in ER utilization and we see no demonstrable reduction in hospitalization, then I think it would be very likely that Congress would turn around and say, "You know, we created this. We had great expectations but it's not working out as we anticipated," and therefore, they would make changes and potentially repeal the program.

So, you know, this is not just a way to try to get additional revenue to providers. It's a way to try and encourage a level of communication that historically hasn't been encouraged.

You know, we had policies that essentially required patients to be sick with an acute episodic event to warrant interaction with the patient. This is saying we want you to have - be thinking about your patients and not just the acute

episode and engaging them in ways that may prove to be beneficial in the long-term.

So I think this is an important benefit but I think it's important that folks take the proper approach in terms of what it is that can be achieved as a result of this.

(Kelly Harris): Thank you.

Corinne Axelrod: To follow up on that, as we mentioned earlier, this is not a required service so if you choose to furnish CCM services, it is an option. You're not required to do so, but I think Bill has spoken very well about the potential benefits of it, so thank you.

Bill Finerfrock: Yes. Thank you. And I'd like to thank everybody on today's call and especially our speakers, Captain Corinne Axelrod and Simone Dennis for their presentations and ORHP for the RHC TA series.

Please encourage others who may be interested to register for the technical assistance series to do so. In your - they can do that by going to the NARHC Web site. I believe in your emails you received the link there.

In addition, we welcome you to email us with your thoughts and suggestions for future call topics or as we discussed today, if you have thoughts on the CCM benefit that you'd like us to kind of collate and bring together and share with CMS, we're happy to do that.

And you can send that all too info - I-N-F-O at NARHC.org and put it in the subject line either RHC TA or CCM, however you'd like to do that. We anticipate scheduling the next RHC TA call in February, as Wakina

mentioned at the very outset of this call, and a notice will be sent by email to those who registered for the call series with the details on that next call.

Again, I want to thank everyone for their participation and that concludes today's call. Operator, it's all yours.

Coordinator: Thank you. At this time, I would like to thank all participants for participating. You may disconnect at this time.

END