Medicare Payment for Chronic Care Management Services

Rural Health Clinic Technical Assistance Series Call
August 6, 2015
2:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time all participants are in on a listen-only mode. During the question and answer session please press star 1 on your touchtone phone if you'd like to ask a question.

Today's conference is also being recorded. If you have any objections please disconnect at this time.

I'd like to turn the meeting over to your Bill Finerfrock. You may begin.

Bill Finerfrock: Thank you operator and thanks everyone for joining us today for this Rural Health Clinics technical assistance call. We're going to talk with you about some proposed changes that the Centers for Medicare and Medicaid Services has put forward.

Joining me on the call today will be Nathan Baugh who is working with me on Rural Health Clinic issues. I'm going to talk about the Chronic Care Management provisions and Nathan is going to talk to you about some of the other provisions.

And then at the end we'll open it up for your questions. Hopefully you'll find this new Webinar format very useful and helpful. If you can't participate via Webinar, hopefully you were able to get a copy of the link. You can go to the NARHC Web site and download the slides at any time they're available.

In addition, today's call is being recorded and a transcript and the recording of the call will be available in a few weeks. If you miss parts of it and you want

to go back to check, or you have colleagues who were not able to participate who may want to listen in later.

So there are a couple of things that Medicare is proposing to do as I said. One is to allow Medicare payments for Chronic Care Management services provided by federally certified Rural Health Clinics.

This would be for the physicians, PAs, NPs, and the administrative or the clinical staff; support staff who work in the RHC who are making this Rural Health Clinic visit.

CMS is also proposing to mandate the use of the HPCPS or what we more commonly refer to as the CPT codes on RHC claims, the UB O4 Form. And then CMS has some language in the proposed rule seeking to clarify the PQRS negative payment applicability to Rural Health Clinics.

What CMS is proposing with regard to Chronic Care Management is that beginning on January 1, Medicare will begin paying separately, under the Medicare fee schedule for -- and this is the really important part of what they're doing -- for non-face-to-face care coordination services provided by Rural Health Clinics.

So in terms of the importance of this, as you all know, in order for there to historically have been a billable visit as a Rural Health Clinic there had to be a face-to-face encounter between a Medicare beneficiary and a Medicare recognized provider for the RHC. The physician, the PA, the nurse practitioner, clinical nurse specialist, others who are recognized in the RHC setting for medically necessary service.

Under Chronic Care Management the expectation is that these services are going to typically be provided by individuals other than the physician, the PA,

the nurse practitioner, etcetera. Because of that there was no mechanism under traditional RHC payment methodologies for recognizing these as RHC services.

What CMS is now doing is saying that even though there will not be a face-to-face encounter with a physician, the PA, or the NP, they are going to pay for these services, albeit at an alternate rate.

The National Association of Rural Health Clinics worked very closely with CMS on this. We responded to a number of suggestions. We made some of our own suggestions as to ideas and things of how thy might do this. We want to thank CMS for being responsive and working with us to come up with a payment methodology that we think will work for Rural Health Clinics.

These are some of the chronic conditions that CMS would recognize as chronic conditions that a patient would have that would be eligible for payment under the Chronic Care Management benefit.

Individuals - this is not exclusive. These are just simply examples of the types of typical chronic conditions that may exist for Medicare beneficiaries that would be covered under this new benefit.

So shortly after this new benefit was announced for the fee-for-service providers, CMS did reach out to NARHC and indicated to us that they were willing and interested in providing this type of coverage for Rural Health Clinics. And they wanted to work with us in a way that allowed these services to be covered and that were administratively feasible and simple for the RHC staff and the clinics. And so going back to last year, we began working with them on this.

In early December CMS asked us to review a variety of payment options and indicate possible pluses and minuses for each approach, and also which approach might work best for Rural Health Clinics and their patients.

The examples of some of the things that they had under consideration was that the RHC would be a modifier code on a billable visit for Chronic Care Management eligible patients. That would occur each month and that would trigger an add-on payment CCM related services.

The value of that would be actuarially comparable. We didn't, you know, that would have to be determined later.

Another option that we suggested was that simply making a CCM visit a billable RHC encounter, even when performed by the nurse or other qualified individuals, it would be billable as a Rural Health Clinic. And we proposed paying that at the Rural Health Clinic rate as with any other visit. And then if it was delivered in conjunction with another otherwise billable encounter, the clinic would only get one billable visit.

The other option was excluding CCM as an RHC service, similar to a hospital visit. Right now essentially allowing you to bill it on the 1500, and have the RHC bill it using the traditional Part B, requiring you however to carve out those costs - the cost of the personnel, the time that they spent working on the CCM benefits.

Another option under consideration was having the RHC capture all the costs and report these separately on the cost report. This would be similar to how you do flu and pneumonia right now, and getting reimbursed separately for your costs there.

And then finally, the other final idea under discussion was to consider a per beneficiary monthly payment which would be almost in the form of like a capitated payment if you will. You would receive a lump sum quarterly payment after providing documentation for the services.

So out of all this, what is CMS proposing? CMS proposed that RHCs, beginning January 1 of 2016 will be able to bill for CCM service furnished by or -- and this is the key -- incident to -- a physician, nurse practitioner, physician assistant, or certified nurse midwife for an RHC patient once per month. And then only one CCM payment per beneficiary per month can be made.

So the incident to, this is what will allow these services to be provided by the non-physician, non-PA, non-NP, non-midwife personnel; deliver these services and then the THC will be able to bill for these to Medicare as a Rural Health Clinic.

For CMS purposes, to make - is proposing to make a separate payment for these services. So this would be separate from your Rural Health Clinic billable visit and it would be - so it would be separate from your all-inclusive rate.

The proposed payment for the services is going to be based on the physician fee schedule payment for the appropriate CPT code. In this case it's 99490. The code would be billed as a standalone service or with other payable services on the RHC claim.

So if you had a patient, you can bill as I noted earlier, once per month for the service for qualifying patients. You can do it either as a standalone bill submitted for these services or you can put it on in conjunction with another

billable visit for non-chronic care related visit but, you would receive payment for both.

And the payment, just by way of comparison, the patient for CPT code 99490 for 2015 under the fee schedule was $42.91 per beneficiary per month.

So we don't know what the actual payment will be, but just for reference purposes, it was $42.91 per beneficiary per month this past year. We anticipate as being in that general vicinity for 2016.

So as I said before, the face-to-face for the recognized RHC professional is waived. It will not be a requirement for the CCM portion of the payment to have the direct involvement of the physician, the PA, the NP, or the CNM.

Coinsurance and deductibles would apply as applicable, to your RHC claim. So there is a copay, the same 20%. So if you took that $42.91 as an example, Medicare's beneficiary copay would be 20% of that so roughly, you know, $9 if you're rounding up, would be what you would collect. You know, $45 and $46 is what you're going to collect - I'm sorry, around $9 is what you're going to collect from the beneficiary. The remainder will be paid by Medicare.

Now CMS has indicated that once they finalize this -- we're assuming that it will be and I'll talk about that in a minute -- that they will issue instructions; more specific billing instructions for that at a later date.

We would anticipate that those would be released sometime in mid to late November. Again, with this benefit becoming available for billing as of January 1 of 2016.

It's important to note that there are specific requirements that you will have to meet in order to be able to get paid for these services. The requirement for

getting paid for Chronic Care Management services will be no different for Rural Health Clinics than they are for any other provider who is seeking payment for Chronic Care Management services.

So all of the requirements I'm going to go through here are requirements that are already applicable to those providers who are seeking payment for Chronic Care Management services under the fee schedule.

First, the requirement for payment for CCM services provided by RHC are the same. So beginning 2016 you would have to provide a minimum of 20 minutes of qualifying CCM services during a calendar month to patients with multiple -- two or more -- chronic conditions that are expected to last at least 12 months or until the death of the patient. And that place the patient at significant risk of death, acute exacerbation, decompensation, or functional decline. So, all those criteria have to be met to determine basic eligibility.

A minimum of CCM services, very important to understand, the patient must have two or more chronic conditions that are expected to last at least 12 months until the death and that place a patient at significant risk. So that is the first test of what patients will qualify.

For purposes of the 20 minute minimum requirement, you count the time of only one practitioner auxiliary staff. So for example, let's say the nurse or the medical assistant is working under the supervision of the physician in the RHC and they're meeting jointly with the patient for 15 minutes. That is not 15 minutes for the nurse and 15 minutes for the physician, that's only 15 minutes. You don't get to double up on your time, as you're calculating your time for meeting the 20 minute minimum requirement.

And you will want to document in the patient record, the time that is spent either by the nurse, medical assistant, physician, PA. It doesn't include the

physician, PA and NP from being involved in this care and providing these services. But it gives you the flexibility to allow this 20 minute amount of time to be provided by someone other than one of those principle providers.

So you can count overlapping intervals as when two or more are meeting about a patient. Only conversations that fall under the scope of CCM services would be included towards the time requirements. And again, these are areas where CMS is going to provide us with some additional documentation and additional information as this process moves forward.

Some other things that are required in order to be able to bill for CCM. Beneficiary should be informed about the availability of CCM services from the RHC, and the beneficiary must provide his or her written agreement to have the services provided, including electronic communication of the patient (unintelligible) as part of care coordination.

So what this means, only one provider can be paid for delivering the CCM services. And it will be up to the patient to - the eligible patient to determine who they want to provide those services.

So if they're not currently having anybody provide CCM and you're going to now do this, you'll want a written statement from the patient saying this is a benefit that is available and I hereby assign to, you know, the name of your clinic or the health professionals in the clinic who are going to provide the CCM services.

What this does is it prevents Medicare from paying twice. That another provider doesn't turn around and say, well I'm providing that service for this patient.

The patient is going to have to assign one. And only one will be eligible. One provider is eligible to receive the payment for CCM services.

You're going to need to discuss with the patient what this is. What are these CCM services? What are you going to be doing? How is this different from other things that you may be doing for that patient? How are they going to access the system if they have question, if they have issues, if there are problems that they're having, who should they contact?

What phone numbers? What's the best method of contracting the practice when there are issues or questions or problems? And how will the patient's information be shared among others?

In many cases some of these patients may be under the care of a specialist who is specifically involved with one of their chronic conditions. There may be multiple specialists who are involved in the care of the patient. How are you going to communicate with each of those specialists? What other physicians are involved in the care of this patient?

Also you're going to have to inform the patient that another provider cannot furnish or bill. As I said, only one is eligible to bill, so you're going to want to talk to your patients to make sure that they have not previously provided this assignment of CCM to someone else.

And if they have and they want to switch that over to you in your Rural Health Clinic as their primary care provider for the Chronic Care Management, they can do that. They will need to provide written termination to the provider with whom they had previously said they could do that. And again, provide the written permission for you to serve as their CCM practitioner.

And again, the applicability of the deductible and the coinsurance applies even when CCM services are not delivered face-to-face. So there is no waiver of the copay or the deductible with regard to these services.

CCM proposes that all of the following scope of service requirements must be met to bill for the CCM services. And again, these are the same requirements that any other provider will have to adhere to in order to be able to bill for CCM.

Continuity of care with a designated RHC or FQHC practitioner with whom the patient is able to get successive, routine appointments who is going to be the provider of record for the ongoing care of this patient.

Care management for chronic conditions including systematic assessment of the patient's medical, functional and psychosocial needs, system based approaches to ensure timely receipt of all recommended preventive care services. How are you going to document this? How are you going to make sure that the patient is getting those services and what kind of mechanisms will you have in place for notifying a patient if they are not obtaining the services that are necessary in order to comply with this?

What type of Medicare medication reconciliation process do you have in place with review with those patients of adherence? And what are the potential interactions and oversight of patient's self-management of medication?

You know one of the things that the chronic care - this is not just hey, how do we get, you know, an extra $40 per month per patient to the Rural Health Clinic or to other providers?

What this is trying to encourage is, communication with the patient in an environment and in a situation where it is not an acute episodic event that's

bringing the patient into contact with the practice, but instead encouraging you and your practice to engage in an ongoing communication to stay in touch with your patient.

Again, not necessarily through you. It could be your nurse, your medical assistant; other appropriate individual within your clinic who is maintaining ongoing communication with the patient. Talking to them about it with the goal that if we are able to do a better job of engaging these patients on this type of a front-end operation, we can help to keep patients out of the emergency room, out of the hospital, intervene earlier where we can target and identify that a particular condition is deteriorating and that we need to have some kind of an intervention.

Hopefully it can occur then at a clinical level rather than having to have a more acute encounter as I said, at an ER or at a hospital.

You have to develop a patient centered plan of care document that you are going to create. Your practitioners who are furnishing it, they are going to do it in consultation with the patient.

Other caregivers - you may have patients who are very frail who have a caregiver; someone who is taking responsibility for this individual's care. It could be a family member, it could be a neighbor; it could be someone else. They want you to engage that person as part of this process as well, particularly in cases where you're dealing with a patient who may be frail, have cognitive deficiencies that make this challenging. Who is the caregiver and making them aware of this?

And also communicating with other key players. What other providers; what other practitioners are involved in the treating of this patient and establishing a communications tool with them.

This is where it's going to get a little bit more complicated for some of the RHC's. You know this is going to rely - you're really going to want to look at your ability to have an electronic health record if you don't already have one.

Creation of an electronic care plan that would be available 24 hours a day, seven days a week to all practitioners within the RHC who are furnished CCM services and whose time counts toward the time requirements for billing CCM codes.

So you're going to want to have electronic availability for your - you know if it's a physician, your PA, your NP, your nurse, your medical assistant; who would need access to this information that if at two o'clock in the morning there's a phone call that someone is having an acute episodic event, you have access to - you know the person who's on call or someone else who's being called in that practice has access to that information 24 hours a day, seven days a week. And it must also be available to other practitioners and providers as appropriate who may be furnishing care to the beneficiary.

Again, this is to foster communication so that a physician who is handling one aspect of the patient's care from a specialty perspective has the ability to understand what perhaps another physician may be doing. Did they change a medication that's having a contrary reaction to something else that's going on?

But you know giving everyone access to this information in a timely fashion so you can figure out what's going on so you can appropriately address the patient's urgent chronic care needs.

The RHC has to be able to facilitate communication of relevant patient information through this electronic exchange, and it has to be a summary of

care. You don’t have to give them access to the entire record, but a summary of care.

Many of your electronic records or health records will have that functionality, and that is one of the things that tends to be inoperable is the summary of care, even though the full medical record may not be fully accessible.

There is no specific electronic solution or format required here, so you do have some flexibility. And again, I think we’ll be seeing more guidance from CMS on this, going down the road.

Communication to and from home and community based providers regarding the clinical needs must be documented. So if there’s a home health involved; if there’s hospice involved, you know, what is - what’s going on here?

Secure messaging. This is again one of the other areas where it’s going to be a bit challenging via Internet or other asynchronous, non-face-to-face consultation method for a patient and caregiver to communicate with the provider regarding the patient’s care in addition to the use of the telephone.

You may want a default. There’s no requirement that the patients have to use this secure communication. They can always use the telephone and most of your patients are probably not going to have access. You simply have to provide them with that functionality.

But in reality the assumption is that most patients are simply going to call and use the phone to communicate when there are issues that occur. So the key in this is that they’re available but they’re not required to use them.

Certified health IT must be used for the recording of demographic information, health related problems, medication, medication allergies,

clinical summary record, and other scope of services. These are some of the basic functionality requirements of a certified EHR system.

Again, hopefully most of you have that. If not, you would want to think about getting this. And keep in mind that there are still Medicaid EHR incentive payments that are available to you as Rural Health Clinics if you can meet the threshold test of eligibility as a Rural Health Clinic.

There's roughly $60,000 per provider within your RHC that's available. If you don't already have a certified EHR, this may be the impetus for you to go and get one. You're still eligible if you can get it for the Medicaid EHR incentive payments. And now it can be used as part of adhering and meeting the CCM. So now there's a mechanism through which you're going to be able to generate some additional revenue which may help pay for some of those systems that in the past you didn't think you could afford.

Again, you must use a technology certified for the addition of certification criteria of acceptable EHR. Whatever the certification standards are as of December 31 of the year preceding each CCM payment year.

So you don't have to have the most up-to-date certification of your EHR, you can have - you can be a year behind in terms of your certification.

Next Nathan is going to talk to you about the CPT code mandate that CMS wants to implement.

Nathan Baugh: Hey everyone. Beginning on January 1 of 2016, all RHC claims must include the appropriate CPT code or HCPCS code as Bill likes to say. This is in addition to the currently required revenue code. It's important to note that there is no changes in payment.

And CMS is assuming that because RHC's should already be capturing this data for things like preventive services, that CMS does not consider this to be a new burdensome requirement.

If that's not the case, please reach out to us. But our initial communications with the Rural Health community have - seemed to back that up.

And the next thing I have for everyone is the PQRS reporting exemption, those of you that are on the Listserv, may have seen some emails back and forth on this.

CMS had sought to clarify that Rural Health Clinic eligible professionals are not subject to PQRS payment adjustment, even when they're performing non-RHC services.

However there - CMS has some operational issues in the way they are applying this PQRS exemption. And therefore it's not being appropriately applied and administered to all Rural Health Clinics.

So I don't want to get into the details of that now. Just know that we are working with CMS to get this fixed, and we're going to keep everyone updated through the Listserv and when we have a solution.

And that's really all I have. I'm going to toss it back to Bill.

Bill Finerfrock: Okay. The - a couple of the things we just wanted to - they're not Rural Health Clinic specific, but to give you a heads up, you may want to ask your local ambulance service, there are some proposed standards for ambulance that CMS is seeking to adopt in terms of the qualifications of the personnel who are in the ambulance.

That would be a requirement for payment for ambulance services that there be two individuals, one of whom is at least BLS approved, and the other meets whatever the minimum state requirements are for being in an ambulance as part of that process.

So you may want to check with your state or check with your local ambulance. If you need a copy of the proposed requirements, send us an email; send it to me at info@narhc.org, and we can send you the proposed requirements that CMS has put forward here.

In terms of the timing of all this, the standards of the proposed changes I should say, are out for public comment. So everyone - NARHC, you as individuals, you know, anybody within your community; anyone is now eligible or able to comment on the proposed changes.

NARHC will be commenting on these on behalf of the Association and the Association's membership. And the deadline for submitting comments is September 8.

If you think everything here is great, we encourage you to comment to CMS on that and let them know. If you have questions you can certainly submit those to CMS as part of the comment period. You can also reach out to us again, if you have any questions, if there's some confusion, send us an email at infor@narhc.org and we will try and get an answer.

I will tell you that in many cases as I've said before, you know, we require additional information from CMS prior to being able to answer some of these questions. We just won't know.

We believe that this policy will be adopted. That the CCM policy and the CPT proposed policy - mandatory reporting of CPT codes will be adopted as part

of the physician fee schedule final rule that typically is released by CMS in early November.

So we will be looking sometime in early November to see the formal policy announcement from CMS with regard to not just these policies, but a number of other policies that don't affect RHCs.

And so it will be some time after early November when CMS will release the additional guidance that we made reference to earlier, to the RHC community.

On your screen is the Web site - www.regulations.gov. And CMS really welcomes your comments. And you can go there and you can electronically submit your comments.

As I said, NARHC will be submitting comments on behalf of the Association and its members in support of this proposed policy. This has been our read. If you feel that this is a bad policy, if you feel that there are problems with it, let us know and we can certainly, you know, look at your comments, look at your concerns; see if we can incorporate those into comments that we submit or help to assuage concerns that you may have.

We don't see anything in this policy that gives us pause. As I said, some of these standards and requirements for CCM are going to be difficult for RHCs to meet. We understand that. But as I said earlier, they're not asking Rural Health Clinics to do anything differently than what they are asking of other providers who also obtain payment for these services.

And so, had the standards been stricter or more stringent or things of that nature that would be one thing. But the fact that, you know, they are not asking RHCs to do any more or any less than what they're asking of other providers for these services, we felt that it would - you know, we couldn't ask

them to have a lower bar if you will, for Rural Health Clinics to get paid for this.

Similar on the CPT codes that Nathan talked about, we feel that in the long run this will really help us to have a better understanding of what is actually occurring in the RHC during a Rural Health Clinic encounter.

Right now we have the diagnoses code, we have the revenue code so we know why the patient came in. We know where the services were provided, but we really don't have a handle on what is actually occurring during that encounter.

As many of you know, we've been trying to get an increase in the Rural Health Clinic cap for many years. And while we have a lot of cost data now, what we don't have is an ability to do a crosswalk to be able to look and see what actual services are being provided in an RHC, what those services would be valued at, at a CPT level, and then make a crosswalk to see how that relates to the RHC payments that the clinic is receiving, particularly those clinics that are subject to the cap.

So we think that from a quality standpoint this will enhance the ability for us to move into a system where we can link some quality incentives to the Rural Health Clinic payment, and it can provide us with documentation and information that will be valuable in justifying, we believe, an increase in the RHC rates because of that ability to crosswalk and demonstrate that, you know, RHCs that are subject to the cap are being grossly underpaid for the services that they're providing.

Nathan Baugh: So it looks like we have a lot of questions. So do you want to start at the very top chronologically and kind of start working our way down?

Bill Finerfrock: Sure. These are folks who've entered into the Chat box. So we'll try and work through those and then operator, after we get through we can open it up for some questions from the phone line and then just kind of go back and forth.

So the first question comes from (Marie). Does the patient need to have a provider available after hours? Or to rephrase, does the provider have to have access for patient after hours?

Essentially the patient has to be able to reach the practice 24 hours a day or someone. So if you have an on-call service that can then contact the provider if the need outside the RHC hours, that has to be available to them.

So you would have to have way in which the patient can reach you. Or conversely, if the patient shows up in the ER, and it's noted that the individual has a chronic care and you're part of a Chronic Care Management because you've notified your local ER that this patient is there, that they can contact you.

So you will have to have an ability to be contacted. It doesn't necessarily mean that you have to go if the patient is at the ER, but they do have to contact you as the provider. And then they can make a determination of whether or not it's necessary for them to actively engage or determine what is in the best interest of the patient.

Nathan Baugh: And it looks like the next couple of questions are whether or not the documentation will be available after. And we just went over that.

All right, so the next question is from (Marla). She wants to know whether or not RHC providers will also be exempt from PQRS payment penalties for services outside the RHC such as hospitals?

(Marla), I understand this is where the confusion lies. Currently the mechanism CMS is using to determine whether the PQRS penalty should apply is the employer identifier number or the tax ID number.

So essentially, independent Rural Health Clinics are not going to be subject to PQRS penalties because they're using their own tax ID number and CMS recognizes that.

The problem is -- and this is what we're going to work with CMS -- is that provider based clinics, because typically they're using the tax ID number of the parent entity, CMS has no way of, you know, noting that these are in fact, non-RHC services provided by RHC providers. And so then they are applying the PQRS standards.

So this is what we're trying to work on with CMS to make sure that there's not a double tankard. And so it's unsure how we're going to fix this problem, but we're going to provide formal comments. And I'm going to - Bill and I are going to keep everyone up-to-date on that.

It looks like (Vince) had the same question. And we'll scroll down.

Bill Finerfrock: Well operator, why don't you go ahead and provide the instructions for people who want to ask questions over the phone.

Coordinator: Thank you. Participants on the phone if you'd like to ask a question, please press star 1 and record your name. If you wish to withdraw your request, please press star 2. Once again if you would like to ask a question, please press star 1 and record your name. One moment for incoming questions.

Bill Finerfrock: While we're waiting for questions, (Shannon) asked, will billing the CPT code on the claim, are they still just wanting one line for the CPT code and the 521 revenue code, or are they wanting each item listed with the 521 revenue code?

Our understanding is that they want each code. So if you provide multiple services during the face-to-face encounter which would involve multiple CPT codes, they want to know all of the services that you provided during that particular encounter.

Operator, do we have any calls?

Coordinator: We sure do. We have two questions in queue. The first one comes from (Kristina). (Kristina), your line is now open.

(Bill): Go ahead (Kristina).

(Kristina): Hi. Please answer my questions. It's going to be about the CPT code. What if, I was going to say, we have a joint injection and an office visit the same time and we enter two lines with a 0521 Revenue Code, a 99213 and 0521 Rev Code and a 20610.

(Bill): Correct.

(Kristina): Okay.

(Bill): All right?

(Kristina): Thank you.

(Bill): Next question on the phone.

Coordinator: Our next question comes from (Tim Miller). You may begin.

(Tim Miller): Yes, thank you for the call today (Joe). And I do have actually two questions; one on the CCM.

What type of safeguards will be in the Medicare system to avoid delinquent provider that actually does the service, and their payments may be held up by someone who inadvertently built the service (sic)?

(Bill): If the - so let's say you have a patient and the patient obviously has their Medicare number -- their Social Security number. And so a claim comes in for that patient for a CCM, and then a week later a second claim for CCM comes in for that same patient. That claim is going to be - the second claim is going to be rejected.

And at that point, what I assume would happen, is the rejected provider would try, you know, and understand why their claim was rejected and then try and find out from the patient to say, "Gee, you know, Mrs. Jones, I thought I was providing your CCM but my claim got rejected. Have you indicated to some other provider that you are - they are able to bill for CCM services?"

If she says no, then I think the appropriate next step would be to contact the contractor, the (Mac), and indicate that, you know, you've spoken with the patient, the patient has asserted that your practice is the only one they've approved for CCM, and then they can go back and see who was the other provider who billed for it and then, you know, kind of unravel it from that point.

But Medicare will only pay one provider, one payment per month. And that second payment/claim comes in that month, then that claim is going to be rejected.

(Tim Miller): Okay and the other question I have is regarding the new requirement on HCPCS Coding starting January 1.

(Bill): Mm-hm.

(Tim Miller): Was this run by the National Uniform Building Committee of which CMS is a part of or was this a unilateral decision by CMS?

I tried the Indiana State Uniform Billing, and to my knowledge this has not been discussed by any entity that's involved in UB billing.

(Bill): I don't know the answer to that question. We can certainly, you know, ask folks at CMS whether this was something.

What would be the reason they would have to run this by the Uniform Billing?

(Tim Miller): Because that's the governing body that basically overlooks and oversees the UB billing used by all payers and all providers, and that includes commercial, Medicaid agencies.

(Bill): Right.

(Tim Miller): It's the governing body for the use of that particular billing document.

(Bill): I understand but I mean there is a place on there for (Unintelligible) and it's up to each individual/every payer to decide what boxes they want filled in, what information they there.

I'm not trying to engage in a debate, but it why CMS, if they have a piece of information that's already an acceptable piece of information on the UB would

have to get someone else's permission to say that this is something we want clinics to report.

And as I noted -- as (Nathan) noted -- they already require that you do this for the preventative services where the deductible is waived or the co-pay is waved so that Medicare knows to pay 100% of the payment; there's no 20% beneficiary co-pay. And RHCs are collecting this data and reporting it to the beneficiary in terms of the calculation of the co-pay on the visit.

So - you know, but if you want to have some more conversation, I would be more than happy to better understand what the concerns would be and we can try and find out if CMS did talk to anybody in the Uniform -- the NUC -- about this.

(Tim Miller): Yes, I would appreciate that because there are some implications to come in beyond this. It probably needs to be talked about offline.

(Bill): Okay, great. Thanks.

Nathan Baugh: Okay, and it looks like the next question online was from (Amy). That was same as (Shannon).

And the question after that is from (Cheryl). She asks, "What documentation is required to support the CPT Codes?"

(Bill): There shouldn't be any different documentation required to support the CPT Code when provided by an RHC than any other provider for whatever the CPT - whatever the documentation and the medical record that's required for the CPT would be the same.

I mean you're doing these services presumably for your non-RET patients using CPT Code Billing for those and having to meet those documentations. So there's nothing different; it's just reporting something that you previously have not had to report. But the documentation should be the same; your medical records shouldn't require any additional documentation at the CPT level for the reporting of these CPT codes.

Nathan Baugh: All right, so the next question is from (Jerry). He asks, "Will the Webster's Dictionary definition be used to define successive or will CMS define this for us?" I'm assuming he's talking about chronic care management here.

(Bill): You have to...

Nathan Baugh: Successive appointment requirement in chronic care management.

(Bill): You know, I'd have to go back and look (Jerry). I don't know that - my guess is that they're not going to provide a definition of successive, but - and maybe that word is not being used properly.

You know, but again, if you want to send me an email offline, we can try and figure out what it specifically is that could cause the problem and what it is that CMS is trying to say there and whether or not we need some clarification of terminology.

Operator, do we have any questions over the phone?

Coordinator: Our next question comes from (Julie). Your line is now open.

(Bill): Okay.

(Julie): Hi. So I think to the last - maybe what the last caller was asking, we would be expected to show then in the patient's chart like duration of phone calls with the patient and/or specialist in helping manage their chronic conditions if perhaps there was an audit to support this minimum 20 minute timeframe.

(Bill): Correct, correct.

(Julie): Yes, that's something we're just not used to doing. And then...

(Bill): Yes and this is a whole new area for CMS and for providers. I mean typically, you know, you're being paid for episodic care where as this is more documenting communication, conversations, particularly for individuals other than the physician. And so, yes, you're going to be doing documentation of things that in the past you probably haven't had to document.

Nathan Baugh: And this is already a benefit for non-rural health clinics. And in the early returns physicians have been using Excel sheets to keep track of how much time they're spending with each client. So there's no program or anything out there right now; it's simply an Excel sheet. So...

(Bill): Okay?

(Julie): Thank you.

(Bill): Thanks. Did you have anything more (Julie)? Okay.

(Julie): Does that time include reviewing results?

(Bill): You mean individually or reviewing them with the patient?

(Julie): Individually.

(Bill): Well yes, it should include that. Again, these are some things we may need to get clarification on, but it's essentially that you're spending at least 20 minutes a month directly related to that patient's care.

So if you've got results coming back, again, documenting that I spent, you know, ten minutes reviewing results or five minutes reviewing results, documenting that in the chart so that you achieve that minimum of 20 minutes per patient.

(Julie): Thank you.

(Bill): Mm-hm.

Nathan Baugh: All right, so the next question online is from (Glen) who's worried that he wants us to answer if we think requiring CPT level details will lead to implementation of PPS payment methodology similar to how FQACs are paid.

(Bill): We don't know. That's something that Congress is going to have to determine.

We have had some conversations about how do we move RHCs to newer payment methodologies. Is PPS a viable option, is some kind of an enhanced cost-based reimbursement with incentive? You know, we've had a number of conversations on this notion of quality and linking quality to payment.

It certainly could facilitate the adoption of a PPS because it would give you a better ability to completely understand what exactly is concerning in the RHC space which would then allow you to do a more accurate crosswalk.

The problem with PPS is when it was in the early stages of being discussed with regard to the FQACs, and we were involved in some of the discussions, where that they wanted to base it on what the RHC was being reimbursed by Medicare at that time. And for those RHCs that were tapped, it was going to be based on the RHC tap which was unacceptable to the association because it would have locked folks into an artificially low reimbursement level.

What CPT did, we can now have a more accurate financial accounting of what actually is occurring, what the value is of the services. So based on that it would allow us to create a more accurate PPS if that is a decision and a direction that folks want to go.

But, you know, the concept is not alien but we're nowhere near that at this point as best I can tell.

Nathan Baugh: All right, for the next question online is from (Jerry). He asks, "RHCs are set up by one MPI at the entity. How will CMS determine who is the provider for the monthly CCM payment?

(Bill): The patient will identify who the provider is and they will linked - that MPI, when you enroll in Medicare, you are enrolling with the RHC through your RAC enrollment and identifying the RHC as part of that enrollment process. But the payment will go to the RHC, not to the individual practitioner who's been identified as the CCM provider.

Do we have any questions on the phone Operator?

Coordinator: As a reminder, if you'd like to ask a question, please press star 1 and record your name.

We have one additional question in queue. It comes from (Cheryl). You may begin.

(Bill): Okay.

(Cheryl): Hello?

(Bill): Hi (Cheryl).

(Cheryl): Hi. My question is - I'm the one that asked about what documentation was needed to support the CPT. And what I'm meaning is that like when a patient comes in, sees a provider, nurse practitioner/doctor or whatever, we have to have our chief complain (sic) (HBI) review systems exam, diagnosis and all of that.

What is expected to be documented in the chart to support this - for us to bill this CPT?

(Bill): Are you talking about specifically the CCM CPT?

(Cheryl): Yes.

(Bill): Oh I'm sorry. I thought your question was referring to the reporting of the CPT for as part of this process.

Okay, I guess I can't answer the question off the top. I mean this is when - I said earlier that CCM (sic) will provide addition billing guidance after the role is finalized. That (unintelligible) be there.

The only thing I can say is the standard, the CCM services are currently billable through the fee-for-service side of Medicare, and the CPT code is out

there. I would just say go and look and see what the documentation requirements are for billing for at CPT under fee-for-service and it would be the same documentation requirement.

(Cheryl): Okay, thank you.

(Bill): Yes.

Nathan Baugh: Okay so the next question online is from (Phyllis) who wants to know if an RN can provide this service in a facility setting with an order from the provider. She's talking about CCM.

(Bill): Well there are a couple of things in there that are giving me a little bit of pause for confusion.

But essentially an RN and the assumption is that in many instances, an RN who works in the RHC -- and that's where I'm a little bit confused by the question because provide the service in the facility with an order from the provider, I'm assuming by facility you mean in the rural health clinic.

So if the RN is an RN who is employed by the RAC, so it is a cost that is being born by the RHC, that the nurse does the 20 minute -- minimum 20 minute -- of time per month per CCM eligible beneficiary, does the documentation fulfill the other requirements, yes; the nurse can do that.

There is, as I said, no requirement that the physician other than the established or PA entity, the initial establishment of the care plan and providing the appropriate supervision -- incident to supervision of the nurse -- these are services that the assumption is are being provided by a nurse, a medical assistant or some other qualified individual.

Nathan Baugh: All right, it looks like there was some audio issues, but I think most people are okay.

(Mary) wants to know if we can provide our answers - questions previously asked. I'm not...

(Bill): As I said at the outset, the call is being recorded. A transcript of the call as well as a recording of the call will be available. We will send out an announcement on the NRHC list serve where you get the announcements about the calls letting you know that the transcript and the audio, the written transcript and the audio are available. And you can go in and you will see all the questions that are asked, the answers that are provided will be in that transcript.

Nathan Baugh: All right, so the next question online is will the requirement for after-hours call apply if the Care Management is provided in person?

(Bill): I honestly don't understand that question. I mean after hours is that the basic purpose there is if the patient has some type of an acute episodic event that requires them to be able to get in contact with the provider who is their principal provider for the chronic care management -- whoever has been identified -- or another individual within the practice who is an alternate that the patient can do that.

And so that requirement, I'm not sure why being available in person would eliminate the need for after-hours care. So maybe I'm not understanding the question. But based what I've got in front of me, that's the best I can do.

Nathan Baugh: Okay so the next question is from (Christian) who asks, "Do we need to continue with the costly timely (PQS) activities in order to try to meet the requirement, or should we hold until further notice.

So (Christian), I assume that you're in a provider-based roll health clinic. I don't know how fast CMS is going to fix this problem.

(Bill): Yes, I mean we can't - I mean we would be at a difficult spot to tell you not to continue to do it, as (Nathan) said, without knowing how quickly we're going to get this all resolved. So I think you're going to probably just have to keep doing what you've been doing in terms of trying to collect and report.

But what is clear is that the only thing that it could potentially apply towards are the non-RHC services, and predominately these are going to be the visit to a hospital where the provider has left the RHC, has gone to the hospital and is billing on the 1500. Anything that you bill on a rural health clinic claim absolutely is not subject to PQRS.

So the only thing that would apply to are those claims that you're providing on a 1500, and based upon what CMS has identified is, and then only if it's using an EIN other than the rural health clinic EIN. If you're using the rural health clinic's EIN and billing on a 1500, it should automatically be flagged as exempt from the negative payment adjustment.

What we're trying to get clarified is those other services where you're not using the (RAT) specific EIN, so when it's a provider-based RHC and the EIN is of the parent hospital, and Medicare does not know that this is a rural health clinic, a health professional is providing the service, it would appear that those may be subject and trying to figure out a way to exempt them as well.

But that's the best that we can do right now.

Nathan Baugh: So you want to go to a phone question?

(Bill): Sure. Do you have any on the phone Operator?

Coordinator: The next question comes from (Ralph). You may begin.

(Ralph): Yes, I'd like to ask if anybody there has had any experience with clinics -- non-rural health clinics -- who have been charging and using the CCM procedure. Are they getting any pushback from the beneficiaries receiving a bill for $30 for this CCM, and they're saying, "Why am I getting another bill?" You know what I mean?

(Bill): No, other than the amount, I think I know what you mean. The amount should be a lot less than $30 that they're getting from the practice if it's 20% co-pay.

(Ralph): Or whatever it is after their deductible. I'm just wondering if anybody is getting any pushback from the patients saying, "Why am I getting another bill?"

(Bill): I don't know the answer to that question. I think it's a great question and we can try and reach out to some other organizations.

I would say that if you go back through the slides, one of the things that is part of this process is that at the outset there's an expectation that the practice/provider is sitting down and communicating with the patient, explaining the CCM, explaining what all will be done, what they're doing, why they're doing it.

And as part of that I would expect that you would explain how the payment for that is going to occur and that the payment - patient will be responsible for the 20% co-pay. And that if you explain that to them upfront, that doesn't mean that patients always listen or that patients always fully understand, and

that's why sometimes it's good to have a family member with them or a care giver with them.

But that this would all be explained at the front end of this process in order to minimize that type of feedback from the patient of, "Gee, why am I getting this?" to say - and you may even want to consider having that in the document that the patient signs when they choose you and attest for you to be their CCM provider that it's in there and that I understand that I will be responsible for the 20% co-pay and have them initial it or whatever.

But, you know, so that if there is a subsequent question, you at least have the ability to go back and say, "Well, you know, don't you remember when we met and here it is in our document, et cetera, et cetera, et cetera."

But I think it's a good suggestion. We can try and reach out to and in particular I think the American Academy of Family Physicians to see what kind of experience they've had and if they have any suggestions to the extent that they've identified this as an issue. Have they got any materials, any information, how to help educate or minimize the extent to which this might occur, and then we can share that with you as well.

(Ralph): Thank you (Bill). Great ideas.

(Bill): Thanks.

Nathan Baugh: Okay, so the next question online is from (Lori) who asked if we could provide the email address again to obtain the document specifying the ambulance personnel requirement.

(Bill): Sure. Just send an email to Info, I-N-F-O, at N-A-R-H-C Dot Org.

Nathan Baugh: Excellent. Okay next question is from (Christina) who asks, "Is adding (CPD) codes on multiple lines effective on January 1, 2016, or is this a final rule already or do we need to wait for final rule?

(Bill): So this is what's called a Proposed Rule. It's available for 60-day Public Comment Period which ends September 8. At that point, CMS goes back and reviews all comments that are submitted, and based on those will issue what's called a Final Rule in early November.

In the proposed rule, they indicate that they are proposing that this will be effective for services provided on or after January 1 of 2016. It is possible that based on the comments that they receive that they could delay that.

That was one of the things that we've talked about is, you know, is there going to be a need, for example, for practice management software program to be modified and what would be involved in that. Is that something that could occur in the timeframe that we have prior or will we need additional time to allow the technical operational part of this to occur?

At this point, we have not been made aware of any significant operational challenges that would require us to go back and ask for a delay. So at this point we would assume or expect that the policy will become effective on January 1 of 2016, but we won't know that definitively until after the issuance of the Final Rule in early November.

Nathan Baugh: All right, so the next question is from the North American Healthcare Management Services who asked, "With the changes to individual line billing, do the charge/price still get bundled into one line or will it all be itemized?"

(Bill): I don't believe that that's specifically addressed in the Proposed Rule, but I don't believe that they're asking for a breakout or an itemization of this from a

financial perspective. So you're still rolling everything up into a single AIR, but it's simply reporting at a CPT level what actually happened. They're more interested and want to know what happened.

You obviously, from an internal standpoint, will want to know the appropriate fee schedule amounts so you know how to calculate the beneficiary co-pay. But I don't believe there's anything that's requesting you to report that. If you roll it all up, what's your AIR and your CPT is for informational purposes only.

Nathan Baugh: Okay, the next question online is from (Bonnie) who asks, "Would they break down the payment for CPT or one payment, and we will need to figure out how to post and break down with contractual. This has always been a problem when billed CPT codes impact (unintelligible)."

(Bill): Remember, you're not billing this as a CPT. As I just said, you're reporting the CPT but it's not used for anything with respect to Medicare's billing or what you're submitting to Medicare as part of the claim.

You're still going to get paid on your all-inclusive rate basis. They simply want to know, have you report for informational purposes what's occurring at a CPT level.

So I don't think that - so nothing has changed from a billing perspective other than you will now be reporting information that previously was not reported but does not affect the payment that you're going to receive from Medicare.

Nathan BAugh: Do you want to do online or over the phone?

(Bill): Sure. Do we have any over the phone Operator?

Coordinator: This time there are no questions. As a reminder, if you'd like to ask a question, please press star 1.

(Bill): Okay, there's a question. Where can the presentation be obtained?

If you are on the NARHC list serve, either the RHC-TA or the NARHC news, a link was sent out to that. If you don't have that, send me an email at Info@NARHC.org and I will send you the link to where you can go and get the slides for download.

Nathan Baugh: All right, so the next question is from (Ky) who asks if he can begin sending CPT codes before January.

(Bill): I have no idea. I guess we have to ask CMS what would happen if a claim came in with CPT codes on it prior to the effective date. But I don't know.

Nathan Baugh: All right, the next comes from (Mandy) who asks, "What RAC providers providing CCM have to add CCM time to their time studies to carve out the CCM time from RHC expenses on a cost report?"

(Bill): No. The way that they are doing this would not require you to carve out any of those expenses. They've indicated that it would not have any impact on your AIR which suggests that there's no carve out that would be required.

So all of your costs are going to continue to be captured on your cost report and you're going to get paid for these services. But there should not be a requirement for any carve out.

Nathan Baugh: All right. The next question is from (Carrie) who asks, "Do the 20 minutes have to be at one time or can they be accumulative throughout the month?"

(Bill): They can be accumulative throughout the month. You don't have to have a sit down full 20 minutes at one time; it can be, you know, ten minutes here, five minutes there, ten minutes there, five minutes there. You've got your 20 minutes. You just have to have it documented and, you know, what was the purpose, what was it that you did and be able to demonstrate that you achieved that minimum of 20 minutes; it does not all have to be at one time.

Nathan Baugh: It looks like the next comment is from (Christian). (Christian), if you're still online and you want to discuss more, feel free to email me.

The next question is from (BDC) who asks, "In an independent RHC, can (unintelligible) in a nurses role provide the CCM service and bill for that service?"

(Bill): I'd have to go back - again, we're going to get billing instructions. They talk about a nurse or medical assistant are the two most commonly mentioned individuals or types of individuals. They talk about a qualified individual but I don't believe that there is an actual definition of who does or does not qualify as a qualified individual.

We can check on that and that sometime, again, it may come out in the billing guidance where CMS clarifies that. Or we can also check what they're allowing with respect to the current CCM benefit for fee-for-service providers to see if they've provided any specificity there.

But I don't know beyond the effective - you know, they do talk about a nurse or a medical assistant, what other types of individuals might be recognized.

Nathan Baugh: The next question is from (Belinda) who asks, "If you can count five minutes for the doctor's reviews of the last, five minutes the nurse calls the PT, five minutes for changing the medication, (unintelligible) five more minutes for

following up to see if the patient is taking the medication correctly and that would qualify for the 20 minutes?"

(Bill): Again, that's getting to a level of specificity we're not able to answer at this point. You know, again, CMS will issue some guidance.

I think, you know, the spirit, if you will, of this is that you are engaging the patient; you are, you know, you're working your communicating with the patient. The whole purpose here is to try and ensure that there is a level of communication and review of what's going on with the patients to ensure that all the necessary things are occurring that you want to do in order that the patient is complying with their medications, their labs are in order, their blood work is within the proper perimeters of whatever your expectation is for the particular chronic condition if that is appropriate, is all being properly managed.

So in terms of how you want to get down to the specificity of the time and what will or will not count, you know, that will have to be answered at a subsequent point.

But I think, you know, if you adhere to the general spirit and concept of what it is that we're trying to get at and the government is trying to get at here with regard to trying to do a better job of managing patients and not simply dealing with everything as an acute episodic event, will keep you well within where you need to be.

And just conceptually, this is part of a larger process of trying to, again, get away from simply a system where all payment is directly tied to acute episodic events when an individual get sick, has an occurrence, has an event, and begin to try and focus on how do we keep people healthier, how do we keep them out of the ER, how do we keep them out of the hospital. And one

of the ways to do that is to engage in meaningful dialogue, meaningful communication with the patient in a way that helps to improve the quality of their care and also helps to reduce costs in the long run.

Nathan Baugh: All right, so the next two questions are related.

(Bill): We're going to have to probably start winding this up too; we're well over our hour here that we normally allot. So I would just say we'll take all the questions we have posted now, but we're going to have to cut it off at this point.

Nathan Baugh: All right so the next two questions are related. They're asking that it appears that RHC will need to create a written agreement specific for CCM Services for its patients to sign. And then also, "Is there going to be a specific form the patients to sign that they understand this?"

(Bill): Yes, there will be a form that the patient has to sign. I don't believe that CMS has an approved CMS form, if you will, but we will reach out to some of the other organizations who've had a little bit more experience and see if we can make some sample documents available of what others have done in this area to get proper documentation and (unintelligible) from the patient with regard to identifying and choosing the provider who's going to be the delivery of the CCM services.

Nathan Baugh: The next question is, "Are we now going to have to report all CPT codes along with revenue code, or just report the CCM CPT code when seeing a CCM patient?"

(Bill): No. The CPT provision or proposal is separate from CCM. What CMS is asking and so, you know, a patient comes in now for a, you know, they think they have a broken arm. And so you're going to (unintelligible) reduction of

the fracture; you're going to do a casting. If you have an X-ray machine, you may have taken an X-ray in the office.

Right now you would do that all under a single revenue code and submit it to Medicare and you would get your all-inclusive rate, but there would be no identification on the claim form of what exactly you did.

What they're asking is that now on the UB form, you would identify by CPT Code what exactly you did for that patient in the course of their visit to your office. And so it's simply reporting at that CPT level what you did.

And so it's no different than what you would have done if you were in a fee-for-service world; the only difference is that now it's strictly for reporting purposes and it's not going to translate into what Medicare is going to pay you. But we will now begin accruing a database that will allow us to have a very clear picture of what is actually occurring in the RHCs in terms of the types of services that are being provided.

And again, that will help to better inform us of what the financial ramifications are and help to make the case of why rural health clinics should deserve a higher payment under the all-inclusive rate and also potentially facilitate the ability of an RHC to participate in some type of a quality improvement/quality initiative because typically is using CPT level data as the marker for demonstrating that you're adhering to appropriate treatment protocols, undertaking the correct course of treatment for a patient by diagnosis code.

So this will help to allow us to go in and say, you know, when RHCs have a patient with this diagnosis code, here are the services they're providing and being able to determine that yes, they're doing the right thing.

Nathan Baugh: All right, so (Lori) says that she already reports CPT Codes and that the claims process is just fine.

(Bill): Okay, so whatever asked before, we can start reporting CPT level claims now and not having to wait till January 1; it appears that you can do that and it would have no adverse effect on your Medicare claim.

Nathan Baugh: And finally (Lisa) asks, "What date of service do you use if the time is over the course of months?"

(Bill): Good question. And again, I think that's one of the things that will be put out in the guidance when the policy is finalized in early November. It's one of the things that will be on the billing guidance that Medicare will issue subsequent to the finalization of the policy.

That concludes our call for today. I want to thank everyone for participating. I think we had an excess of 350 people on the call today which is great participation; wonderful questions. And the number of cases, obviously, we still have more information that's going to have to come out from CMS as we move forward.

If you have questions or if you have concerns about these policies, as I said, please feel free to contact us at Info@NARHC.org. Make us aware of your concerns or whatever questions you may have, we will do our best to try and get answers.

We will be having another RHC call and webinar towards the end of the month. It's going to be Ask the Experts. We're going to pull together a group of RHC consultants, and it's essentially going to be an open mic opportunity where you can call in with your questions, post them up on the webinar format

here and, you know, we'll do that. We've done those in the past and they've been very popular.

I want to thank the Federal Office of Rural Health Policy for their support for this initiative. As you all know, this is made available to you free of charge through the Federal Office of Rural Health Policy supports it. They make this webinar available to you and we're very appreciative of their support along with the National Association of Rural Health Clinics.

Thank you all for participating and we will talk to you in a few more weeks. Thanks and have a great rest of the day.

Coordinator: Thank you for your participation. You may disconnect at this time. Speakers please stand by for the post-conference.

END