**Moderator: Jill Darling**
**November 14, 2019**
**2:00 pm ET**

Coordinator: Thank you all for standing by. At this time, I'd like to inform all participants that your lines will be on a listen only mode until the question and answer session of today's call. Today's call is also being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the call over to Ms. Darling. Ma'am, you may begin.

Jill Darling: Great. Thank you (Kristy). Good morning and good afternoon everyone. Welcome to today's Rural Health Open Door Forum. I'm Jill Darling in the CMS Office of Communications. Before we dive into today's agenda, I have one brief announcement. This Open Door Forum is open to everyone but if you are a member of the press you may listen in. But please refrain from asking questions during the Q&A portion of the call.

If you have any inquiries, please contact CMS at Press@CMS.HHS.gov. I will hand the call over to our co-chair, Carol Blackford.

Carol Blackford: Thank you. Good afternoon everyone. We have a very robust agenda this afternoon where we will be addressing a number of our recently released Medicare payment rules. We are going to start off the hour with our hospital outpatient prospective payment system final rule. Dave Rice is going to lead off that part of our conversation this afternoon.

David Rice: Thanks Carol. The calendar year 2020 OPPS Final Rule with Comment Period displayed on November 1, 2019. This final rule contains a number of policies that further advance the agency's commitment to strengthening Medicare, rethinking rural health, unleashing innovation, reducing provider

burden and strengthening program integrity. The deadline for submitting comments on topics open for comment in the final rule is December 2, 2019. Those comments will be addressed in the calendar year 2021 final rule.

We are highlighting a few policies in the rule today that would be of particular interest to rural providers and we will cover a broader range of topics on next week's Hospital Open Door Forum call. Subject matter experts are available to answer your questions about only the topics discussed during today's presentation. We appreciate your understanding. With that, I will pass it off to (Josh McFeeters).

(Josh McFeeters): Thank you Dave. We're going to talk about the changes in the level of supervision of outpatient therapeutic services in hospitals and critical access hospitals. Effective for calendar year 2020, CMS finalized a change to the generally applicable minimum required level of supervision for hospital outpatient therapeutic services furnished by all hospitals and CAHs from direct supervision to general supervision.

General supervision means that the procedure is furnished under the physician's overall direction and control but that the physician's presence is not required during the performance of the procedure. This change ensures a standard minimum level of supervision for each hospital outpatient therapeutic service furnished incident to a physician's service. As stated in the final rule, with comment period, this change does not preclude a hospital from requiring a higher level of supervision for certain services as it deems appropriate.

With that I'm going to turn it over to my colleague, (Lela Strong-Holloway), to discuss the inpatient only list.

(Lela Strong-Holloway): Thanks (Josh). I'll be discussing changes to the inpatient only list for calendar year 2020. For our calendar year 2020 we finalized changes to the inpatient only list, including the removal of total hip arthroplasty, six spinal surgical procedures and five anesthesia services from the inpatient only list, making these procedures eligible to be paid by Medicare in the hospital outpatient setting, in addition to the hospital inpatient setting. A list of specific procedures can be found in the CY 2020 OPPS final rule with comment period.

I'll also be talking about changes to the medical review of procedures removed from the inpatient only list. For calendar year 2020 and subsequent years, CMS is finalizing a policy to exempt procedures removed from the inpatient only list from certain medical review activities within the two calendar years following their removal from the list. Specifically, procedures that have been removed from the inpatient only list will not be eligible for referral to recovery audit contractors or RACs, for noncompliance with the two midnight rule within the two calendar years following their removal from the inpatient only list.

During the two-year exemption period procedures removed from the inpatient only list will not be considered by the beneficiary's family centered quality care - care quality improvement organizations or BFCCQIOs, in determining whether a provider exhibits persistent noncompliance with the two midnight rule for purposes of referral to the RAC. Nor will these procedures be reviewed by RACs for patient status.

BFCCQIOs will however, have the opportunity to review such claims in order to provide education for practitioners and providers regarding compliance with the two midnight rule. But claims identified as noncompliant will not be

denied with respect to site of service under Medicare Part A. Now I'll turn it back over to Jill.

Jill Darling: Great. Thanks (Lela). Next, we have the calendar year 2020 physician fee schedule rule. And to start off we have Julie Adams.

Julie Adams: Thank you. Hi. This is Julie Adams from Division of Practitioner Services. The calendar year 2020 Medicare physician fee schedule final rule went on display on November 1, 2019 and will publish on November 15, 2019. The final rule updates payment policies, payment rates and other provisions for services furnished under the Medicare physician fee schedule on or after January 1, 2020.

Evaluation and management services - consistent with our goal to reduce burden, we are aligning our E/M coding with changes adapted by the American Medical Association current procedural terminology editorial panel for outpatient E/M visits. The CPT coding changes - retain five levels of coding for established patients; reduce the number of levels to four for office/outpatient E/M visits for new patients and revise the code definition. The CPT code changes also revise the times and medical decision making process for all of the codes and requires performance of history and exam only if medically appropriate.

The CPT code changes also allow clinicians to choose the E/M visit level based on either medical decision or time. We are adopting the AMA Specialty Society Relative Value Scale Update Committee (RUC) recommend values for the office/outpatient E/M visit codes for calendar year 2021 and the new add-on CPT codes for prolonged service time. The AMA RUC-recommended values will increase payments for office/outpatient E/M visits. The RUC recommendations reflect a robust survey approach by the AMA,

including surveying more than 50 specialty types, and demonstrating that office/outpatient E/M visits are generally more complex and require additional resources for most clinicians.

We are also strengthening the Medicare specific payment for office/outpatient E/M visits for primary care and nonprocedural specialty care that we finalized in the CY 2019 PFS final rule. We have simplified this payment by using a single add-on code describing the work associated with visits that are part of ongoing, comprehensive primary care and/or visits that are part of ongoing care related to a patient's single, serious, or complex chronic condition. This will be implemented in calendar year 2021.

We are not adopting changes to the global surgery codes as we continue to evaluate data. Thank you. Now I'm going to hand it back to Jill.

Jill Darling: Thank you Julie. Next we have (Liane Grayson) who will talk about care management.

(Liane Grayson): Thank you Jill. We have three updates to chronic care management services for calendar year 2020. First, we are finalizing our proposal to increase payment for transitional care management. Transitional care management is a care management service provided to beneficiaries after discharge from an inpatient stay or certain outpatient stays. Second, we are creating a Medicare specific code for additional time spent beyond the initial 20 minutes of a noncomplex chronic care management service, which is a service provided to beneficiaries with multiple chronic conditions over a calendar month.

We also refined several aspects of chronic care management care planning. Third, we are creating new coding of principal care management services

which are services for patients with only a single serious and high risk chronic condition. Back to you Jill.

Jill Darling: Thank you (Liane). And next we have Lindsay Baldwin, who will talk about the opioid treatment program.

Lindsey Baldwin: Great. Thanks Jill. So I'll go over two policies in the CY 2020 physician fee schedule final rule related to treatment for opioid use disorder or OUD. One is the new Medicare Part B benefit for opioid treatment programs or OTPs, and the other is a bundled payment made under the PFS for OUD treatment in the office setting. We note that most OTPs tend to be located in more urban areas so we wanted to make sure we created a similar set of services that could be furnished more broadly in an office setting.

So starting off first with OTPs, Section 2005 of the Support Act established a new Medicare Part B benefit for OUD treatment services including medications for medication assisted treatment or MAT, furnished by OTPs. We finalized the definition of OUD treatment services which include FDA approved opioid agonist and antagonist treatment medications which include methadone, buprenorphine and naltrexone; the dispensing and administering of such medications, if applicable; substance use counseling; individual and group therapy; toxicology testing which includes both presumptive and definitive testing; and take activities and periodic assessments.

We also finalized allowing counseling and therapy services described in the bundled payments, to be furnished via two-way interactive audio/video communication technology as clinically appropriate. We finalized bundled payment rates for OTPs based on the medication administered for episodes of care for a period of one week in duration based on a drug and a non-drug component, stratified into several codes to account for differences in

beneficiaries' clinical needs including add-on codes for intake activities, periodic assessments and take home doses of medication.

For the full listing of the payment rates, see table 15 of the PFS final rule. Rates for the non-drug component will be adjusted by geographic locality and will also be updated on an annual basis. We also finalized zero beneficiary copayment for OTP services in 2020. We did make several changes from the proposed rule to the final rule. For the drug component of the OTP bundle we finalized a payment of ASP plus 0% when available. For methadone we will use (Tricare) pricing when ASP is not reported.

For oral buprenorphine we're finalizing using NADAC pricing when ASP is not reported. For the non-drug component of the OTP bundle, we're finalizing a higher payment rate than what was included in the proposed rule. This higher payment rate will better align with Medicare payment amounts for similar services in other settings and with many Medicaid rates instead of cross walking payments to the rates paid by Tricare as proposed. In addition to the items and services specified by the statute for CMS to include in the bundle, CMS is also finalizing additional payments for intake and periodic assessment activities which OTP is required to provide under SAMHSA regulations.

We're also finalizing add-on payments for additional counseling and therapy services and for take home supplies of methadone and oral buprenorphine. CMS did not finalize the proposed partial episodes policy. CMS has thus updated the threshold for billing the weekly episode to the delivery of at least one service in the bundle which could be from either the drug or non-drug component. So that was OTP. And next I'll go over the bundled payments under the PFS for opioid use disorder.

So CMS is finalizing the creation of new coding and payment for a monthly bundle of services for the treatment of OUD that includes overall management, care coordination, individual and group psychotherapy, substance abuse counseling and an add-on code for additional therapy - I'm sorry, for additional counseling.

This will create an avenue for clinicians to bill for a group of services in the office setting, similar to the services being paid for under the new OTP benefit for opioid treatment programs. CMS will consider coding and payment amounts that recognize different levels of patient need and different types of practice arrangements for future rulemaking, including the use of MAT in the emergency department setting.

These codes were also added to the Medicare telehealth list for CY 2020. I would also just highlight that as of July 1, 2019 Section 2001 of the Support Act expanded the use of Medicare telehealth for services by waiving the geographic requirements and also allowing the beneficiary's home as a permissible originating site for services furnished for the purpose of treating a substance use disorder or a co-occurring mental health disorder.

And with that, I'll pass it back to Jill.

Jill Darling: Thank you Lindsay. And last we have Marissa Petto who will go over the ambulance certification statement changes.

Marissa Petto: Thanks Jill. This is Marissa Petto from the Center for Program Integrity. I just want to talk briefly about the two updates we made to ambulance certification statements as part of the calendar year 2020 physician fee schedule final rule. The two main changes that we made were one, to clarify the certification statement requirement for non-emergency repetitive

ambulance services and two, to add additional staff to the list of individuals who can sign a non-physician certification statement.

So in general, Medicare covers non-emergency scheduled repetitive ambulance services is a certification statement as obtained before the date of service. But of note, the presence of a certification statement does not alone convey that the transport itself is medically necessary. So we made changes to correct what really we interpreted as confusion surrounding the need for a separate or discreet form for a certification statement. We made clear that you don't need a separate certification statement or a form, or a specific form, if you already have that same information in another form or another format.

There's no specific required form or format for the certification statement. If you already have something that's conveying the same exact information that can double as a certification statement. You don't need to create another redundant certification statement. The second main change is that we are adding LPNs, social workers and case managers to the list of non-physician practitioners that can sign the certification statement when the physician is unavailable.

So we wanted to include those three types of staff in addition to those already on the list which include physicians' assistants, nurse practitioners, clinical nurse specialists, registered nurses and discharge planners. With that I'll turn it back over to Jill. Thanks so much.

Jill Darling: Thanks Marissa and thank you to all of our speakers today. (Kristy), please open the lines for Q&A.

Coordinator: Thank you. At this time if you would like to ask a question please press star followed by 1. Please ensure that your mute is off and please state your name

when prompted. Again, please press star 1 on your touchtone phone. Our first question comes from (Jim Miller). Sir, your line is open.

(Jim Miller): Yes. Good afternoon. Thank you for the information regarding the CCM program. The updates are helpful and I'll be following up on what you talked about. The question I have is I know Congress this summer, was looking at possible legislation to eliminate the coinsurance on the CCM program which has been kind of a barrier or a hindrance to participation in the CCM program. Do you have any update or any policy updates regarding this possible elimination of the copay?

Carol Blackford: Hi. This is Carol Blackford. Thank you for the question Jim. Unfortunately, we are not able to provide any updates on actions or issues that Congress may be considering. This is certainly an issue and concern that I know others have brought up during previous Open Door Forums. So it's certainly an issue that we're aware of. But we do not have any updates in terms of Congressional action that we're able to share with you at this time.

(Jim Miller): Okay. Thank you very much. I appreciate it.

Coordinator: Thank you. Our next question comes from (Tina) of Grand River Health. Your line is open.

(Tina): The question that I had, I just wanted to verify, you had talked about the ambulance services and the additional signers for the verification statement. Can you tell me who those three are again? I have case managers, LPNs and who else?

Marissa Petto: LPNs, social workers and case managers.

(Tina): Perfect. Thank you.

Marissa Petto: No problem.

Coordinator: Thank you. Our next question comes from (Susan Morgan). Your line is open.

(Susan Morgan): Is - when I'm listening about the CCM things will principal care management codes and add-ons codes be used in rural health clinics?

(Corinne Axelrod): Hi. This is (Corinne Axelrod). We did not propose that principal care management codes would be added to GO511, which is the general care management code for RHCs and FQHCs. But I do want to note that there was - we had a little editing error in the final rule, so thank you for bringing this up, just so that we can clarify that principal care management is not part of the codes that are available under GO511, the general care management code.

(Susan Morgan): Thank you.

Coordinator: Thank you. Again if you would like to ask a question please press star 1. Please make sure that your phone is unmuted and state your name clearly when prompted. Our next question comes from (Rebecca Halder). Ma'am, your line is open.

(Rebecca Halder): Yes. I just need you to repeat what you were saying about when the physician is not available to sign it was - who was the nurse practitioners can sign?

Marissa Petto: Yes. Already in regulation are a list of non-physicians that can sign the certification statement. They are physician assistants, nurse practitioners, clinical nurse specialists, registered nurses, and discharge planners. We

received feedback to add others to that list so we added LPNs, social workers and case managers to the regulation this year.

(Rebecca Halder): And that was regarding ambulance?

Marissa Petto: Yes, a n ambulance certification statement for non-emergency ambulance services.

(Rebecca Halder): I've got you. Okay. Thank you.

Marissa Petto: Yes. No problem.

Coordinator: Thank you. Our next question comes from (Todd Gibson). Sir, your line is open.

(Dale Gibson): Yes. My name is (Dale Gibson) and my question was about E/M coding. There was talk in there about physicians being able to (definate) an E/M code by time. Do doctors now need to document start and stop times for their time that they're spending with patients?

Carol Blackford: (Dale), this is Carol Blackford. If you could send that email to our Open Door Forum mailbox - I think Julie dropped off the call. he email is RuralHealthODF@CMS.HHS.gov. And we can get an answer to your question.

(Dale Gibson): Thank you.

Coordinator: Thank you. At this time, I'm showing no further questions. Again, if you would like to ask a question please press star 1. We do have a question from (Jeremy Levin). Sir, your line is open.

(Jeremy Levin): Thank you. Just based upon the caveat that you gave right at the beginning I assume on the open door hospital forum you'll discuss CMS's continued decisions moving towards transparency, cost transparency and potentially publishing fee negotiated charges at the next hospital open door?

Carol Blackford: This is Carol Blackford. And we will have a fuller discussion of the items in the OPPS final rule at our next hospital Open Door Forum call. If you have a specific request for any particular agenda items to be covered I believe we have an Open Door Forum email box for the hospital Open Door Forum. But if you want to go ahead and send it to the rural health ODF email box, I can make sure that it gets to the right folks so they can be ready for that issue.

Man: Thank you.

Carol Blackford: You're welcome.

Coordinator: Thank you. Our next question comes from (Amanda Bruce). Ma'am, your line is open.

(Amanda Bruce): Yes, thank you. My question is just a repeat of the rural health email please.

Carol Blackford: Sure. It's RuralHealthODF for Open Door Forum, at CMS dot HHS dot gov.

(Amanda Bruce): Thank you.

Carol Blackford: You're welcome.

Coordinator: Thank you. We do have one more question from (Laura Amberley). Ma'am, your line is open.

(Laura Amberley): Thank you. I was wondering if you could repeat what you said about the initiating site for telemedicine. Thank you.

Lindsey Baldwin: Hi. This is Lindsey. I think I might be the only one on the call that spoke to telehealth today. I was mentioning that the three codes that describe a bundled episode of care for the treatment of opioid use disorder under the PFS, which are codes G2086 through G2088 that we added those to the Medicare telehealth list for CY 2020. And I also noted Section 2001 of the Support Act which took effect as of July 1, 2019.

It waived the geographic requirements and also allowed the beneficiary's home as a permissible originating site, specifically just for services that are furnished for the purpose of treating a substance use disorder or a co-occurring mental health disorder. Does that answer your question?

(Laura Amberley): It does. Thank you.

Lindsey Baldwin: Great.

Coordinator: Thank you. Our next question comes from (Sarah Soyson). Your line is open.

(Sarah Soyson): Hi. My question is about the price transparency rule and again, what I've read is a final version will be posted in a forthcoming final rule. If that is the case would you have a special call to discuss those details?

Carol Blackford: We have not made a decision about whether or not we'll be having a special call on price transparency issues. But we will certainly take that as a suggestion to do so.

(Sarah Soyson): Thank you so much.

Coordinator: Thank you. At this time, I'm showing no further questions.

Carol Blackford: All right. Thank you everyone for the time this afternoon. This is Carol Blackford, the co-chair of the Rural Health Open Door Forum call. And on behalf of John Hammarlund, my fellow co-chair and myself, we want to thank you for your participation this afternoon. We hope that you found this information to be helpful. As always, if you have any suggestions for future agenda items, please send those to the Rural Health Open Door Forum email box. And again that's RuralHealthODF@CMS.HHS.gov. Thank you for your time this afternoon.

Coordinator: Thank you. This does conclude today's conference. You may disconnect at this time.

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