Questions and Answers from Rural Health Open Door Forum- November 14, 2019

1. 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?
    a. 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.
2. 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?
    a. LPNs, social workers and case managers.
3. When I'm listening about the CCM things will principal care management codes and add-ons codes be used in rural health clinics?
    a. 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.
4. 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?
    a. 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.
5. 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?
    a. Your inquiry regarding the documentation required to bill for E/M services was sent to our team from a medical review perspective. From a medical review perspective, we would defer to any specific instruction published in regulation, in addition to those instructions disseminated from the American Medical Association in relation to CPT coding. We are not presently aware of any specific instruction related to the new E/M codes and start/stop times. That said, the Medicare Administrative Contractor (MAC) or other review contractor would need to identify sufficient information to substantiate the code billed. You may wish to reach out to your MAC with specific examples/questions to further guide your facility's practice.

6. 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?
    a. 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.

7. I was wondering if you could repeat what you said about the initiating site for telemedicine.
    a. 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.
8. 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?
    a. 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.