

Centers for Medicare and Medicaid Services  
Rural Health  
Open Door Forum  
Moderator: Jill Darling  
November 15, 2018  
3:30 p.m. ET

Operator: Good afternoon. My name is (Julie) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services, Rural Health Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key.

Thank you, Dr. Jill Darling, you may begin your conference.

Jill Darling: Thanks, (Julie). Good morning, and good afternoon, everyone. I'm Jill Darling in the CMS Office of Communications and welcome to today's Rural Health Open Door Forum.

Before we get into today's agenda, I have one brief announcement. This Open Door Forum is not intended for the press and the remarks are not considered on the record. 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](mailto:press@cms.hhs.gov).

And I would like to hand the call off to our Co-Chair, John Hammarlund.

John Hammarlund: Thanks very much, Jill. Hello, everyone. Welcome to our Rural Health Open Door Forum Call and Happy Rural Health Day. This is John

Hammarlund, the CMS, Regional Administrator in Seattle and Co-Chair of the CMS Rural Health Council.

Carol Blackford and I are delighted to have all of you with us today as we have a rich agenda of important information to share with you.

But this call is even more special because our CMS administrator, Seema Verma, has joined us today. It would be my pleasure to introduce her.

Miss Verma was nominated by President Trump in November 2016 and confirmed by the Senate in March of 2017, a nationally recognized leader in health policy and operational design. She has guided healthcare policy in the public and private sectors, notably working with states to build flexibility into their Medicaid programs to help them meet the diverse needs of their unique populations.

She served as Vice President of Planning for the Health and Hospital Corporation of Marion County, Indiana. And most recently, before joining CMS, was President and CEO of SVC, Inc.

As a CMS administrator, Miss Verma oversees a \$1 trillion budget and administers health care programs for more than 130 million Americans every day. I will tell you on a personal level that I and others have greatly appreciated the leadership and vision she has brought to CMS, with respect to improving health care and health in rural America.

Administrative Verma, we're honored to have you on our call today, and I will now turn it over to you.

Seema Verma: Well, thank you, John, and Happy Rural Health Day to everyone.

So as you know, this past May, CMS released the agency's first rural health strategy. And it was intended to provide a proactive approach on health care issues to ensure that nearly one – that the nearly one in five individuals who live in rural America have access to high-quality, affordable health care.

And I'm particularly excited by this because for the very first time, CMS is organizing and focusing our efforts to apply a rural lens to the vision and the work of the agency.

And to give you a flavor of what that means, when the staff (reached) me on any policy issue that we're considering, I always ask them to say, "What is the rule impact?" And that's something that we do across the board with all of our policy development processes.

So every time we consider policy, we are thinking about the impact on rural communities. And in a few minutes, you're going to hear more about how we've applied this lens to some of our recent work.

And as you listen to the presentations from CMS staff today about some of our recently published payment regulations, you'll learn about the work that we've done to reduce administrative burden and provide greater flexibility for providers.

You'll hear about our plans to pay for virtual check-ins, which is intended to alleviate transportation obstacles, and we help improve access to care for patients. You hear about the changes we're making to documentation requirements to give you more time for patients and help you spend less time doing paperwork.

And these initiatives are just the start. We're not done working on improving the health and access for rural America. Well, maybe if you review the agency's first rural health strategy document this past May, we're intensifying our focus on rural health to work towards transformational change to create a sustainable rural health system for the long term.

And I can tell you that we're going to have a very specific focus on this directly from the administrator's office, from my office, where we can coordinate across Medicaid and Medicare and the exchanges in leveraging the entire agencies research resources to focus on rural health.

We're going to be holding additional listening sessions and gathering input in the coming weeks. And the idea here is to have our team work with folks that are on the front lines to find ideas and things that we can do at CMS to improve care in rural communities. We're interested in, potentially, creating new demonstrations that we can work in partnership with rural communities.

The other thing that we're planning on addressing is the wage index. Last year, we put out an RFI to look at the wage index and the Medicare program. And that's something that our team is actively working on.

So thank you for the very work – the very important work that you do for our beneficiaries. And we know that we have a lot to learn – a lot to learn from you, as you all are on the front line, so we appreciate your dedication to rural America. And I thank you for joining us today.

John Hammarlund: Thank you very much, again, Administrator Verma, for joining us today.

And with that, we will hand it back to Jill to begin our agenda. Thank you.

Jill Darling: Great. Great. Thanks, John.

First, we have some provisions under the (provision) fee schedule final rule. So I will hand the call off to Emily Yoder.

Ann Marshall: Thanks, Jill. This is...

Emily Yoder: Hi, I'm really – I'm going to hand it – hand it off to Ann Marshall.

Ann Marshall: Thanks, Emily. Yes, hi. This is Ann Marshall in the Division of Practitioner Services. We're the division out at the South – at the staff level, the physician fee schedule payment rule every year.

And my colleague, Emily and I, are going to review the provisions that were – we finalize this year regarding documentation, cutting a payment for evaluation and management visits.

This is an area where we have been working hard especially in the past year or two to update and sort of bring Medicare rules and the rules around E&M, generally, more into line with current medical practice and to reduce administrative burden and to reduce time that practitioner spend documenting these visits where it is – where it may be unnecessary or redundant.

And so we put forth a proposal this year that addressed – that proposed a lot of changes around both documentation and coding and payment after getting feedback from stakeholders extensively over the last year. And the policies that we finalized, we finalized some of what we proposed. But we also made a lot of changes because of comments that we heard.

And so the policies that we finalized are kind of divided in two parts. Starting in we're implementing several documentation changes that will provide some more immediate burden relief. And these will not impact coding and payment in next – starting next year.

And in 2020, practitioner should continue to use either the 1995 or 1997 E&M documentation guidelines as they currently are, in order to document these visits. But CMS has made some provisions that expand current policy for history and exam where certain data that is all ready present in the medical record will not need to be redocumented as it currently is, but instead can be more simply reviewed and updated and signed off on by the billing practitioner.

Starting January 1st of 2019, we have also eliminated the requirement to document the medical necessity of a home visit, instead of an office visits. So that provision is also an immediate change that was broadly supported that we are finalizing as proposed.

We are making some more substantial changes to documentation of E&M office and outpatient visits that we finalized, that will start into two – 2021 to allow some time for implementation and systems preparation, and, potentially, some continued dialogue with stakeholders around these issues.

But in the meantime, the changes that we finalized on the documentation side for level two through five office outpatient visits, starting in 2021, we will allow a choice to document using either the current framework or current medical decision-making rules or time.

When time is used to document, practitioners will simply have to document the medical necessity of the visit and that the billing practitioner personally spend the required amount of time face to face with the beneficiary. But we will not be requiring more detailed support in those cases.

When current framework or medical decision making is used for level two through four physician fee schedule, payment of office visits, we'll require only the supporting documentation associated with a level two visit. And this policy is enabled by a corollary policy that Emily is going to review shortly. But we are assigning a single payment rate to level two through four office outpatient visits.

And so combining payment for those visits into one, we felt – enabled us to apply a minimum documentation standard where only the information required for level two, which is just very basic information would be required for purposes of payment and practitioners would then be freed up to, perhaps, document any additional information they may need for clinical or legal or other purposes. But it would not be – we would not require more as a condition of payment under the physician fee schedule.

And this would help eliminate some of the aspects of documentation within each level of visit that we've been hearing from stakeholders are the most sort of clinically outdated and unnecessarily burdensome.

Rules for level one visit – visits will not change, and I'm going to turn it over to Emily now to talk a little bit more about the coding and payment changes that will be coming in 2021, along with these documentation changes

Emily Yoder: Thank you, Ann. So as Ann said, as a supplement to our 2021 changes to documentation, we finalized some coding and payment changes that will go into effect in C.Y. 2021 as well.

So we finalized a new single payment rate for in an office outpatient visits levels two through four, and we also finalize the main – maintenance of a separate payment rate for the level five visit to account for – that needs a particularly complex patients.

We also finalized implementation of two add-on codes describing the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care, reportable with the E&M office outpatient level two through four visits.

These new services are not restricted by physicians' specialty, and the use of these codes, generally, would not impose new per visit documentation requirements.

We're also finalizing adoption of a new extended visit add-on code for use with E&M office outpatient level two through four visits to account for additional resources required would practitioners need to spend extended time with the patient.

The aspects of our proposal that we are not finalizing, we are not finalizing reduced payment when E&M office outpatient (produced) – or furnished on the same day as procedures.

We are not (finalizing) separate coding and payment for pediatric E&M visits or the standardization of the allocation of practice expense are reused across the office outpatient E&M business.

As Ann said we very much look forward to continued work with the stakeholder community, including the AMA CPT Workgroup on E&M to refine these policies.

And now I will hand it off to my colleague, Lindsey Baldwin, who will be discussing communications, technology-based services and Medicare telehealth.

Lindsey Baldwin: Great. Thanks, Emily. This year, we made two significant proposals to pay for our communication technology-based services. This was a high priority for the agency and a significant step toward increasing accessibility for patients and modernizing Medicare payment for virtual services.

These services are not considered Medicare telehealth and are therefore not subject to the statutory restrictions that applied to those services. We received a lot of support from commenters.

And therefore, we finalized separate payment for both the brief communication technology based service or virtual check-in and remote evaluation of recorded video and or images submitted by an established patient.

We also finalized separate payment for inter professional consultations between practitioners and for chronic care, remote physiologic monitoring.

We received comments about who could build for these services, the frequency with which they could be build, the kinds of technology that were included and the rules surrounding beneficiary consent.

We address these concerns in the final rule are also happy to take questions on them during this call.

Under Medicare telehealth, we're finalizing the addition of two codes describing prolonged preventive services to the Medicare telehealth list. We're also finalizing implementation of the telehealth provisions in the Bipartisan Budget Act of 2018, which expands access to home dialysis therapy and expands of telehealth for individuals with stroke.

Additionally, through an interim final rule with comment period, we are implementing a provision from the Support for Patients and Communities Act that removes the originating site geographic requirements and as the home as a permissible originating site for telehealth services, furnished for the purposes of treatment of a substance use disorder or a co-occurring mental health disorder on or after July 1st 2019.

This provision has a 60-day comment period just end on December 31st. And with that, I will pass it off to (Susan Genesco) in the Division of Ambulatory Services.

(Susan Janeczko): Hi. I'm (Susan Janeczko) and I have three updates for you today on – related to RHCs.

First up is the 2019 payment for RHCs. The RHC payment limit per visit for calendar year 2019 is \$84.70, effective January 1st, 2019 through December 31st, 2019.

The calendar year 2019 RHC payment limit reflects a 1.5 percent increase above the calendar year 2018 payment limit of \$83.45 cents. Next up payment for care management services.

So let's start with the punch line effective January 1st, 2019, the payment rate for HCPCS code G0511 General Care Management Services is set at the average of the national non-facility PFS payment rates for CPT codes 99490, 994-87, 99484 and 99491.

A little bit of background. The payment amount for HCPCS code G0511 is currently set at the average of the three national non facility PFS payment rates for the CCM and general BHI codes and is updated annually, based on the PFS amounts.

The three codes are CPT 99490, 20 minutes or more of CCM services; CPT 99487, 60 minutes or more of complex CCM services; and CPT 99484, 20 minutes or more of BHI services.

For practitioners billing under the PFS, we propose for calendar year 2019, a new CPT code corresponding to 30 minutes or more of CCM furnished by physician or other qualified healthcare professional, similar to CPT codes 99490 and 99487. RHCs and FQHCs, we propose to add this code as a general care management service and to include it in the calculation of HCPCS code G0511.

So we propose now finalized that starting on January 1st, 2019, RHCs and FQHCs will be paid for HCPCS code G0511, based on the average of the national non facility PFS payment rates for four CPT codes, including CPT code 99491 instead of three.

Finally new virtual communication services. The takeaway here is in the 2019 PFS final rule, we finalized a policy that effective January 1st 2019 RHCs and FQHCs will receive payment for virtual communication services when at least five minutes of communication technology based or remote evaluation services are furnished by an RHC or FQHC practitioner to a patient who has had an RHC and FQHC billable visit within the previous year, and both of the following requirements are met.

The medical discussion or remote evaluation is for a condition not related to an RHC or FQHC service provided within the previous seven days, and the medical discussion or remote evaluation does not lead to an RHC or FQHC visit within the next 24 hours or at the soonest available appointment.

When communication-technology based services are furnished, in association with an RHC or FQHC billable visit, the cost of these services are included in the RHC or the FQHC PPS and are not separately billable.

However, if there RHC or FQHC billable visit, these costs are not paid as part of an RHC AIR or FQHC PPS payment.

Particularly in rural areas where transportation is limited and distances maybe far, we believe the use of communication technology-based services may help some patients to determine if they need to schedule a visit at the RHC or FQHC.

We therefore proposed and have now finalized that effective January 1st, 2019 RHC and FQHCs receive an additional payment for the cost of communication technology-based services or remote evaluation services that are not all ready captured in the RHC AIR or the FQHC PPS) payment when the requirements for these services are met.

Now to receive payment for virtual communication services, RHCs and FQHCs must admit an RHC or FQHC claim, with HCPCS code G0071 for virtual communication services, either alone or with other payable services.

Payment for G0071 instead of the average of the national non-facility PFS payment rates for HCPCS code G2012 communication technology-based services and HCPCS G2010 for remote evaluation services.

Coinsurance deductible, do applied to RHC claims and coinsurance applies to FQHC claims. Also RHC and FQHC face-to-face requirements are, of course, waived when these services are furnished to an RHC or FQHC patient.

Please see the information we have posted on our CMS RHC website for more details. And we hope to have a FAQs document posted soon.

But if you have questions in the meantime, you can reach us at our mailbox [FQHC-PPS@cms.hhs.gov](mailto:FQHC-PPS@cms.hhs.gov).

Thank you. I believe (Patrick) is up next.

(Patrick): Thank you. We finalize two revisions – the physician supervision requirements to specify that diagnostic tests when performed in part by radiologists, assistants, or R.A.s may be furnished under at most direct level of physician supervision, rather than under a more stringent personal level of physicians’ supervision, to the extent permitted by state law and state scope of practice regulations.

These changes in response to stakeholder comments that the current requirement of personal supervision that applies to some diagnostic tests is overly restrictive when the test is performed by an R.A. and does not allow for radiologist to make full use of IRAs, and, therefore, reducing the required level of supervision will improve efficiency of care.

We also finalized the removal of potentially duplicative requirements for notations and medical records that may have previously been include – and

included in the medical records by residents or other members of the medical team for E&M visits when furnished by teaching physicians.

So now I will hand off to Heather Grimsley.

Heather Grimsley: Thanks, (Patrick). The PFS final rule included this subset of changes to the Medicare Shared Savings Program that will propose in the August 2018 proposed rule, the Medicare program, Medicare Shared Savings Program Accountable Care Organizations Pathways to Success.

We finalized five policies in that PFS. We finalized the voluntary six-month extension for existing ACOs whose participation agreements expire on December 31st of 2018 and the methodology for determining financial and quality performance for the six-month performance year from January 1st of 2019 through June 30th of 2019.

We also finalized a reduction in the Shared Savings Program core quality measure (set) by eight measures and an order to promote interoperability among ACO providers and suppliers have added a new certified EHR technology threshold criterion to determine ACO's eligibility for program participation and will retire the current Shared Savings Program quality measure on the percentage of eligible clinicians using (start).

This results in a core quality measure set of 23 measures for ACO's report starting in performance year 2019. We finalized refinements to the voluntary alignment process, as authorized under the Bipartisan Budget Act of 2018 to allow beneficiaries who voluntarily align to a nurse practitioner, physician, assistant, certified nurse specialist or a physician with a specialty not using assignment to be prospectively assigned to an ACO that the clinician they align with is participating in an ACO.

We also continued our continuing policies to provide relief for ACOs and their clinicians impacted by extreme and uncontrollable circumstances in 2018 in subsequent years. And, finally, we finalized revisions to the definition of primary care services that are used in beneficiary assignment to incorporate advanced care planning codes, administration of health risk, assessment

service codes and codes for annual depression screening, alcohol misuse screening and alcohol misuse counseling.

If you have any additional questions on the Shared Savings Program policies, you can e-mail [ACO@cms.hhs.gov](mailto:ACO@cms.hhs.gov). Thank you.

Jill Darling: Thank you, Heather. Next, we're going to be going into the Outpatient Prospective Payment System final rule, and up next we have Bill Lehrman.

Bill Lehrman: Thank you. This is Bill Lehrman from the Division of Consumer Assessment and Plan Performance of CMS to make the announcement about the HCAHPS survey, which a lot of hospitals have will be using.

Beginning with October 1st, 2019 discharges, the three communication about pain items on the HCAHPS survey will be removed. We – CMS made this policy through the Outpatient Prospective Payment System rule, which is now on display.

So beginning on October 1st, 2019, the HCAHPS survey will have 29 items, rather than 32. The three removed items will deal with communication about pain. CMS is making this change in order to be in compliance with the recently passed Support Act.

The current survey, which has 32 items will be in effect through – for discharges through September 30th, 2019. So the new items – the pain items will be removed beginning with October 1st, 2019 discharges.

We will be providing the new surveys on our HCAHPS online website in early 2019. And we will cover this topic in our HCAHPS training, which also occur in early 2019.

More information about the removal of the communication (my pin) items from the HCAHPS survey can be found on our HCAHPS online website, which is [hcahpsonline.org](http://hcahpsonline.org). Thank you.

Jill Darling: Thank you, Bill. And next we have Steven Johnson.

Steven Johnson: Thanks, Jill. Section 603 of the Bipartisan Budget Act reduced Medicare payment for certain off-campus hospital departments, by eliminating eligibility or payment under the OPPS effective January 1st, 2017.

Services furnished in certain types of locations, such as dedicated emergency departments were exempt from the reduced payments under the Statutory Provision.

For C.Y. 2019, we proposed that as an excepted off-campus provider-based department furnished items and services from a clinical family of services that it did not furnish and subsequently bill for that service during a baseline period.

Generally, those that begin billing for hospital outpatient services after November 2nd, 2015, services from the new clinical family services will not be covered outpatient department services, instead services in the new clinical family services will be paid under the physician fee schedule.

However, after consideration of the public comments we received, we are not finalizing this proposal at this time. We do intend to monitor expansion of services in-off campus physician-based departments. And, if appropriate, may proposed to adopt a limitation on the expansion of excepted services in future rulemaking.

Similarly, CMS has been concerned that there has been an unnecessary increase in the volume of clinic visits, furnished in off-campus provider-based departments. We believe that payments incentives in the form of higher payment amounts under the outpatient prospective payment system, may have driven services from the physician's office to off-campus provider base department.

To address this concern, we have finalized a proposal to pay for clinic visits furnished in an off-campus physician-based department, thus otherwise paid under the OPPS that is an accepted physician-based department at a physician fee schedule equivalent rate, paying for clinic visits furnished and excepted

off-campus to provider-based departments at the physician fee schedule equivalent rate removed as payment incentive.

We believe that this change will allow for greater physician and beneficiary choice in the site of service selection, and will control unnecessary increases in volume for this cover outpatient department service.

We are phasing in this policy over two years to allow it to balance the immediate need to address the unnecessary increases and the volume of clinic visits, with the concerns that providers should have time to adjust to these payment changes.

This policy is projected to result in an estimated combined savings of \$380 million and lower co-payments for beneficiaries and savings for the Medicare program and taxpayers for 2019.

For an individual Medicare beneficiary, current Medicare payment for the clinic visit is approximately \$116 with \$23 being the average co-pay.

Our policy to adjust payment to the physician fee schedule equivalent rate will bring the payment rate down to \$81 and the co-payment to \$16, thus saving beneficiaries and averages \$7 per visit in C.Y. 2019.

For details on these two policies and other policies, we encourage everyone to read the CY 2019 OPSS final rule. I will now turn it back to Jill Darling.

Jill Darling: Great. Thank you, Steven, and thank you to all of our speakers today, as well as our CMS Administrator Seema Verma.

(Julie), will you please open the lines for Q&A please?

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please press star then one on your telephone keypad. If you would like to withdraw your question, please press the pound key.

Please limit your questions to one question and one follow-up to allow other participants time for questions. If you require any further follow up, you may press star one again to rejoin the queue.

Your first question comes from Cristie Knudsen. Cristie Your line is open.

Cristie Knudsen: Hi, this is Cristie Knudsen of Audubon County Hospital in Iowa. And I've got a question on the new E&M rules in the released rule. Do those documentation requirements or rules, will those apply to documentation done in a rural health clinic?

Ann Marshall: Hi, this is Ann Marshall. Is there anyone on the line from RHC payment system who can answer that? I don't – I don't believe that was proposed. I think that what was proposed was only for physician fee schedule payment but someone on staff and up – in other payment system should probably confirm that.

Cristie Knudsen: I'd – it'll create confusion if the (AIR) asked to document one way for that one place for someone that's not an RHC and then if they come and work in the RHC, they follow a different set of documentation rules.

Ann Marshall: Right. In fact it's...

Corinne Axelrod: This is Corinne. Hi (inaudible)...

Ann Marshall: Hi, Corinne. I'm sorry. I was just saying that the...

Corinne Axelrod: Oh, hi this...

Ann Marshall: OPPS really has the same questions, yes.

Corinne Axelrod: Yes, this is Corinne Axelrod. And we did not address that because the RHCs are not paid based on the level of coding, but we, generally, try to keep everything as similar as possible to the requirements under the fee schedule.

So we will certainly look at that. And maybe that's something we can add to our FAQs at some point, but we, generally, don't have any guidance for RHCs regarding the documentation requirements.

Cristie Knudsen: The reason I'm asking is we're required to report a level on the RHC claims, even though we roll everything up to one charge line, but we're required to report that detailed down below. So if that...

Corinne Axelrod: Right. You're...

Cristie Knudsen... detail will be changing...

Corinne Axelrod: Yes, you're required to do accurate coding, but we'll look at that and try to address that, perhaps, on either in a FAQ or on another ODS call.

Cristie Knudsen: OK.

Corinne Axelrod: Thank you.

Cristie Knudsen: My next question on the new rules is it talked about obtaining information from labs, and you've changed the – you clarified where you're asking for lab information. And you define to the saying that you were going to expect information from hospitals that reported claims with the one for X type of bill for non-patient encounters, lab work and critical access hospitals. Do some of that do a fair amount of that? Will we be expected to be reporting to that?

Ann Marshall: This is an Ann, I think that this question is not about the E&M documentation, I think it's about a different lab provision. Is there someone on the line who has expertise in that provision?

Cristie Knudsen: It's under the clinical laboratory fee schedule in – that was in the rule.

Corinne Axelrod: This is regarding the 14X issue that was in the final rule, and I'm not sure if Sarah Shirey-Losso was on the – is available but I would have to go back and check if that applies to critical access hospitals.

I assume it does but what – if you wouldn't mind sending us an e-mail, we'd be happy to get back to you on that.

Cristie Knudsen: And where should I mail – e-mail that to?

Corinne Axelrod: You can e-mail it to me Corinne C-O-R-I-N-N-E dot Axelrod A-X-E-L-R-O-D @cms.hhs.gov.

Cristie Knudsen: OK. Thank you very much.

Corinne Axelrod: Thank you.

Operator: Your next question comes from Sheila Goethel with Rural Wisconsin Health Cooperative. Sheila, your line is open.

Sheila Goethel: Hi, thanks for taking my call. My question is somewhat similar to the previous question regarding the E&M changes effective one – January 1st, 18 2019, namely the new and establish office out-patient E&M visits where the entire history can be recorded by the ancillary staff. The practitioner can just sign it, indicate the information was reviewed and verified.

When a critical access hospital – the urgent care (encounter is bill), critical access hospitals typically use those office and visit E&Ms because the G0463 is not applicable to non-PPS hospitals.

So can you confirm if these 2019 documentation changes will be applicable to the CAH's urgent care encounters?

Ann Marshall: Hi, this is Ann. Thanks for the question.

What we finalized is for purposes of payment of physician claims, so professional services. And my understanding is that some CAHs use a method where they report their physician claims on the same claim as the claim for the facility part of payment.

Sheila Goethel: Right.

Ann Marshall: And in those cases, it would apply to the – on the physician side of the house, as far as whether it applies for payment to a CAH or more – moreover, any you know, outpatient hospital claim, I think we would have to discuss with the hospital payment staff.

Sheila Goethel: But is it applicable to CAH method to billing then?

Ann Marshall: It's applicable for the physician for payment of physicians' underpayment under payment under the physician fee schedule.

Sheila Goethel: OK. That answers my question. Thank you.

Ann Marshall: OK, sure.

Operator: Again, if you would like to ask a question, please press star one on your telephone keypad.

Your next question comes from Cristie Knudsen with Audubon County Memorial Hospitals. Go ahead.

Cristie Knudsen: Hello. Me again. I got another question on the physician fee schedule rule. And it has to do with the appropriate use criteria – the last – towards the back of a – the bill.

But it's my understanding that that does not apply to critical access or rural health clinic providers. However, our radiology exams are read by an external radiology group that are paid under the physician fee schedule.

So in order for them to receive full payment, I would assume that they would need the appropriate use information to put on their claim, which (hat) – would have to be received at the time of the service if I understand the rules correctly. Is that correct?

Carol Blackford: Hi, Cristie. This is Carol Blackford. I don't believe we have any of the experts on the appropriate use criteria that can make the call today.

So could you e-mail your question to me [carol.blackford@cms.hhs.gov](mailto:carol.blackford@cms.hhs.gov) and we will get that to the appropriate people in our Centers for Clinical Standards and Quality.

Cristie Knudsen: OK, thank you very much.

Carol Blackford: Thank you.

Operator: Your next question comes from (Theresa Clerk), with Sullivan County Memorial. (Theresa), your line is open.

Operator: (Theresa), your line is open. You may be on mute.

(Theresa Clerk): Oh, I'm sorry. With the installation of the April 2018 system released, our E.R. visits are not getting paid. I did call Medicare and I talked to them and they send us to the MLN Matters to – as information but can you help us figure out where we need to go so we can get our claims paid?

Carol Blackford: Sure. (Theresa), this is Carol Blackboard. Can you tell me where you're located at again?

(Theresa Clerk): We are of – critical access hospital in Missouri.

Carol Blackford: And I'm going to pause to see if we have any of our regional rural health coordinators on the line that could reach out to you directly to get help in getting your claims paid.

(Theresa Clerk): OK. Thank you.

Michelle Wineinger: Yes, Carol. This is – Carol, this is Michelle Wineinger, and I'm the Rural Health Coordinator for region seven.

Just feel free to send me an e-mail and with your contact information I'll reach out to you. My e-mail is Michelle M-I-C-H-E-L-L-E dot Wineinger W-I-N-E-I-N-G-E-R @cms.hhs.gov.

(Theresa Clerk): OK. The last name is W-I-N-E-I-N-G-E-R?

Michelle Wineinger: Correct.

(Theresa Clerk): All right, Michelle. Thank you.

Operator: We have no further questions at this time.

Carol Blackford: OK, well, this is Carol Blackford. I just wanted to take a moment to kind of thank everyone for their participation in the – in the call today and thank all of our CMS presenters, both in Baltimore and our rural health coordinators in the regions for all of their participation today and their help with the questions.

And I'm going to continue, as I do, on every call to encourage you to send your agenda items to me. We want these calls to be helpful and productive for you. And we're always looking for feedback on potential agenda topics. And my e-mail address is [carol.blackford@cms.hhs.gov](mailto:carol.blackford@cms.hhs.gov).

We also have a rural health open door forum e-mail box that's available as well. And that is [ruralhealthodf@cms.hhs.gov](mailto:ruralhealthodf@cms.hhs.gov).

So on behalf of John and myself, I want to thank you for participating today. And I think that concludes our call. I'll turn it back over to Jill.

Jill Darling: Yes. Thank you, Carol. Thanks, everyone, for joining today's home health – I'm sorry – today's Rural Health Open Door Forum. So we will talk to you next year. So enjoy your day. Thank you.

Operator: Thank you for participating in today's Rural Health Open Door Forum Conference Call.

This call will be available for replay beginning (on) November 16th 2018. The conference I.D. number for the replay is (488)-9757. Again, that's 3488-9757. The number to dial for the replay is 855-859-2056. Again, that's 855-859-2056.

This concludes today's conference call. You may now disconnect.

END