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RHC Covid-19 Testing Funds: What You Need to Know

Nathan:

0:06
Hello, everyone. I want to welcome all of our participants. My name is Nathan Baugh, the Director of Government Affairs for the National Association of Rural Health Clinics, and the moderator for today's call, and also a bit of a speaker at the end on the telehealth issues. Today's main speaker is Bill Finerfrock, the Executive Director of the National Association of Rural Health Clinics. And, the top, the main topic, is the RHC Covid 19 testing funds, what you need to know.

0:39
You want to go next slide, real quick. This series is sponsored by HRSA Federal Office of Rural Health Policy, and it's done in conjunction with the National Association of Rural Health Clinics, or supported by a co-operative agreement. As you can see on your screen, through the Federal Office of Federal Office of Rural Health Policy, that allows us to bring you these calls free of charge. The purpose of the series is to provide RHC staff with Technical Assistance and RHC specific information. Today's call, the 93rd in the series, in 2004, during that time, there have been over 26,000 combined participants on the RHC National webinars.

1:22
As you know, there's no charge to participate in the call series. And we encourage you to refer others who might benefit from this information, to sign up and receive announcements regarding gates topics and speaker presentations at the RHI Hub website.

1:38
During the Q&A period, we will, we will pull up a chat box, And you can ask your questions at that time. We like to do it all at once. So, questions aren't coming in while the speakers are coming in. The future e-mail questions to bf@narhc.org, and put RHC question in the subject line. All questions and answers will be posted on the ORHP Conference Call series website, and the NARHCwebsite, which is narhc.org. OK, with that, I'm going to turn it over to the main speaker for today, which is Bill Finerfrock.

Bill:

2:17
Thanks, Nathan, and thanks, everybody, for taking the time to be here with us today. Our topic today is the Covid 19 testing. Last week, on May 20th, the Department of Health and Human Services released money to virtually every federally certified rural health clinics, the purpose of which was for covert testing or covert related activities. Each eligible receive, RHC should have received a deposit of roughly \$49,640 in your account. If you have a an ... EFT Billing Arrangement with with CMS, then your money was deposited. If you do not have a ...

3:07
EFT Arrangement, then you are going to receive that money via Check, which typically occurs 7 to 10 days after the mailing of that check. Now, that's an estimate. We're not sure exactly when those checks were put into the mail. But if you've gotten in ES or have you got to check for the provider relief payment in all likelihood, you're gonna get a check for this project as well. And whatever amount of time after those funds were deposited for most, when they were released, is what you can expect here.

3:43

So, I would say, you know, anywhere from 7 to 10 days, but, Kimberly, a little bit less could be a little bit more depending upon mail service in your area.

3:54

So, you know, why rural health clinics and why, now, what is this all about?

4:00

I think you've all read and are aware that as we enter this next phase of The Cove at 19 pandemics testing is critically important to trying to identify fully everyone who may be carrying the virus. or who had the virus. And may have potentially build-up antibodies.

4:24

And it will not only mean this money to provide information necessary to policymakers, but also help with the things in your community. You know, where do we have outbreaks? Where do we have so-called hotspots? This information can be also helpful in the event that we see a resurgence. So all the efforts that the government would like you, to undertake, is intended to feed into that process. So we can resume normal activities, whatever our new normal may be once we are past this pandemic. So in essence, the federal government wants your help to defeat this pandemic.

5:09

So why rural health clinics?

5:11

Well, I think generally the view is that you're a respected voice in your community members and people from your community. Look to you for answers and solutions to healthcare problems. And it's always been the case prior to this, whether it was a traditional flu outbreak, whether it was other medical problems, with something that may have been unique to your community. But you are the respected voice when it comes to health care, and people we suspect are turning to you, Asking about testing, where can I get testing? Can I get testing? What can I do? And so Congress and the administration are looking to rural health clinics to step up, be creative, and help stop the spread of coronavirus.

6:01

So this money was money that was specifically appropriated by the Congress as part of the Cares Act. And it was a \$225 million was specifically put there for rural health clinic for testing covert testing and testing related activities.

6:21

HHS adopted a policy when they were looking and said, All right, we've got \$225 million. How did we spend this?

6:28

And they decided to make equal payments to every RHC, regardless of size now. This meant that smaller RHCS are defined as revenue or staff would receive a larger payment as a percentage of clinic revenue than a larger clinic and I think this was intentional. I think the general sense was that some of the larger clinics, particularly clinics that are linked to hospitals, had access to more information about testing and could collaborate with colleagues in their system. Whereas the smaller RHCS, particularly the independent RHCS were much more isolated, in many cases, would find it more difficult to get information. If there had been some efforts to try and LinkedIn, to size or payments a number of patients, given the while, \$225 million, is a lot of money.

7:23

When you're looking to spread that out, over about 4500 rural health clinics, you really, you know, you're going to have amounts on the lower end of that distribution that would be so small as to really not be able to do

anything. So the decision was it would simply take the 225 divided by the number of RHCS and give each REC the same amount of money, that \$49,640. So who is eligible? Who is a rural health clinic? And for purposes of this initiative, all rural health clinics that have a C at CMS certification number, what's referred to as your CCN number.

8:05

And are listed in either the CMS provider of services file updated as of March 2020, or the CMS survey and certifications Quality Certification, that oversight report list before May seventh of 2020. So each one, there's a cutoff date. Now, that means that there may be some our agencies who got their CCN. But if we're not on those lists by either one of those lists, by the date, their March of 2020 there, That was when it was last updated for the Provider Service File, or May seventh the update there. But if you are on either of those and you have a CCN then, you can expect that. You will get your share of this distribution.

8:58

Most are going to receive it electronically through an electronic banking account information. If you don't, you'll get it. By check in, as I said, generally that will arrive within 7 to 10 days.

9:11

In some cases, since the payments were made by the tax ID number, it may take time for your larger parent entity to distribute the funds across the individual RHC sites.

9:24

So, in other words, what that means is if you're part of a health system, you're a provider based RHC where you operate as a distinct part of that parent entity. The money went to the parent organization. because that is whose tax ID is on file with the government.

9:44

So, if that money went to the parent entity, it's incumbent upon them to make sure that that flows down to the RHCS. And so if you're part of that and you haven't seen that money or haven't heard about it, you might want to make an inquiry backup your corporate food chain to say, hey, it's our understanding. This money came in for rural health clinics for testing and testing related activity. We'd like to know what the plans are for how you intend to use that money.

10:11

Also, there is a small subset of RHCS for which there's a problem of matching the name of the rural health clinic with the tax ID number.

10:22

And we are working with the federal Office of Rural Health Policy to try and identify, reach out to those clinics and find out and get the proper information verified.

10:33

So it's a small number of clinics who are on the list of clinics who are eligible. But when they went to load in the information into the system, the tax ID number didn't properly match up. And so they were unable to make that transfer of monies.

10:51

Hopefully, as quickly as possible, we can get that cleared up when we get all the necessary information. So, first, you know, electronic funds deposited then left the checks. But then we have this, like, I said, small group of people, We're going to try and work down through that list to identify the name and the proper Tax ID number. So, one of the questions obviously, that people have been asking from the outset is, you know, What can I do with this money?

11:21

And folks really have a lot of latitude in how you can spend the money as long as it does on some kind of covert testing or covert testing related activity. It's here that we really want to encourage people to think creatively about how you might use this money. It's not something that, you know, you had to have done. It could be prospective. There is no time limit on when you have to spend this money by. So if you get people together, and you say, You know, Let's do something in the month of June. Let's do something in the month of July. This money is there for that purpose. So, you know, think about how you want to use that money. Not necessarily how you might have used that money. Now, understand that you could be subject to an audit at a later date. In which time, you would be asked to provide a report on how you spent the money.

12:19

So, you do want to keep very good records of how you ended up spending this money. In terms of, you know, we engaged, in testing, we bought tests, we used personnel, by P P E associated with testing, we'll go through some examples, but, you know, keep an accounting of how you spend some money uncovered related how much you spent. So, if you are asked, you can document, Here's what we got, here's how we spent.

12:47

So, you got the money, now, what?

12:51

Within 45 days of receipt of that money?

12:56

Regardless of how you get it, whether it's by, I'm sorry, if it's by a C H or within 60 days, if you get it as a payment from the issuance, you should complete the attestation process. This you may be familiar with many of you, because you had to do this with regards to the provider relief funds.

13:17

You will want to sign the attestation form, agreeing to the terms and conditions attached to the receipt of these monies. Not returning the payment or attesting to the receipt within the timeframe will be viewed as acceptance of the terms and conditions. So, let's say you just don't do anything, and you forget or, it's, you know, It's 50 days. You got some money from a CH 50 days and you go, Oh, my gosh. I forgot to test. Well, at that point, the government is going to say you took the money, you accepted the money. We are going to assume that because you took it, didn't return it within 45 days that you're accepting it and that you are agreeing to the terms and conditions. If you have not done so already on, the screen is the link to, the terms and conditions for the world testing money. I would encourage you to go and review that.

14:14

It's very similar to some of the other attestation forms you may have completed. There are some unique parts to this that are different from the others, but a lot of it is going to be very familiar to you, but I would encourage you to go and review that so you are familiar, so you can go and test.

14:34

In general, I mean, it's very long. I just here, really quickly, at the very beginning, you're going to be asked to hereby attest to the following terms and conditions. You're going to have to provide your, your 10 your tax ID number associated with that, who is receiving it, that that is an authorized person from your organization to make that an attestation and just understand that it's not exhaustive and you agree to comply with any other applicable statutes and regulations. And you're going to be asked to certify that as a rural health clinic that you provide testing or incurred testing related expenses. So, you know, that you have expenses, or you will have expenses that you can incur to use this money.

15:22

You're not currently terminated from participation in the Medicare or precluded from receiving a payment through Medicare. You're not currently excluded from participation in Medicare and Medicaid and other Federal health care programs, and you do not currently have privileges revoked. So, basically your standard, I'm in good standing with the Medicare program.

15:44

Again, there's a time limit on the attestation. But there is no time limit on how quickly you need to spend the money.

15:52

If you've already been doing testing or testing related activities for which no payment was received from another source, then moneys could be applied to those expenses retro actively, but you need to document those things that occurred particularly didn't occurred retroactively.

16:11

If you don't start testing until August. You know, maybe you want to, you know, do something for your local school system.

16:17

They're getting ready to thing about re-opening and they want to test the teachers, they want to test students, know, and you're not going to spend it until August. That's fine. Now, as I said, there's no time limits. Again, now you want to document, here's what we did, here's how much money was allocated. Here's how much we spent for this activity. So, you know, I can't emphasize enough that you want to document what you spent, what you spend it for, how much of that \$49,000. So, you have it if you are asked to provide that information.

16:51

So, you want to review the document, you've reviewed it, and now you're ready to sign the attestation.

16:57

Here's the link to the portal that you will want to go to, to sign the attestation and begin this process.

17:04

Yes, I've tried it, but I can't complete it because I don't bill Medicare.

17:10

And so, what should you do if you run into that same problem, we recommend that you call the provider support line at (866) 569-3522. So, there are rural health clinics, pediatric, Rawls Connect. For example. There's some obstetric gynecological RHCS that typically would not be billing Medicare because of the nature of the patient population that they see. But yet, they want to be an RHC potentially for Medicaid reimbursement for those two specialties.

17:43

So, because you don't enroll in Medicare programs, you may not have that or you didn't receive any money from the previous distribution centers. You'll see why that becomes relevant.

17:57

You want to call this number. We are aware, HHS is aware that there are providers who cannot enroll or cannot attest, because they did not receive any distributions. But I want to emphasize, it's very important that while we are working on this, at a federal level, to try and figure out what the options are, it's important that if you're in this category to call, tell them about the problem so that they can create a ticket, it can create an internal tracking within the distribution system to know that these problems are occurring, and the magnitude of the problem. So, please, if you, if you try to attest and you go to the website, you can complete the process. Call this number and explain to them the situation.

18:46

So, you go to enter the system, you click the link.

18:50

This is the first page that you're going to come to and I want to draw your attention down to where it says eligibility.

18:58

As a reminder, you must sign the attestation, 40 days racy age 60 days for a check.

19:04

Then, it comes to the question: are you a billing age that received Medicare fee for service payments from the Centers for Medicare and Medicaid Services in 20 19, so, you have an option of Yes or no. If you answer Yes, then this is the page that you're going to go to and you're going to be asked for this information. In particular, the Tax ID number, either your EIN, or your Social Security number, whichever is the most appropriate one, connected to the billing entity, and then you can do multiple TINs to do it, to do the verification, and you have to have all nine, and then you would continue and go through the process.

19:46

But, again, going back, So what, what happens if you say no to that question? Are you a billing entity that receive Medicare fee for service payments from the Centers for Medicare and Medicaid Services, and you say No.

19:58

So, you've answered no to the eligibility, this is what's going to happen.

20:02

We're sorry You are currently not eligible.

20:05

Only building entities that receive Medicare payments in 20 19 are eligible. If you believe this is an error, please visit or call, and again, here's that number. We would like you to call.

20:18

So if you go through and use you, did not get Medicare payments, so you cannot attest, particularly if you are wanting to turn the money back. Technically, if you don't test, as I said, and you don't do anything automatically at 45 days or 60 days, assumption would be that you've tested and agreed to accept. But, if you want to return that money in particular, it's imperative that you go through this process. Again, here's that number.

Nathan:

20:49

Hey, Bill.

20:50

Yeah, in this context, can you clarify what Medicare Fee for service payments?

Bill:

20:58

All and that's actually very, very often Medicare Fee for Service RHC has got, Why don't get fee for service? I get cost based reimbursement and under the Medicare statute, technically, that's not correct. Even cost based reimbursement is for purposes of this program. And others considered fieser fee, for fee, for service. You don't get paid off of the fee schedule.

21:24

But you do technically get paid fee for through the fee for service mechanism of Medicare. So, where you see that? Please don't presume that that doesn't apply to you. You are, even as rural health clinics, paid by Medicare under the fee for service system. You just get cost based reimbursement or per visit payments. So, would still apply.

21:47

Thank you.

21:49

So what are some permissible expenses? We have a little bit more detail as we go further. But, you know, we show some here planning for implementation of a ... testing program. So you bring people together. Maybe you organize a community meeting. You reach out to employers, You reach out to the faith based community. You reach out to the education community, And you say, Let's get together. Let's talk about how we might want to approach testing in our community. You know, the local EMS service, if you have one.

22:24

And so, you know, you need to get some space, and you have to pay for that. Or you have to pay your staff time to to go and attend that meeting. Those are expenses that you can attribute to and apply this money for those expenses building for or construction of a temporary structures. You may have seen in the news. Some places are putting up Drive-thru tense, where people can drive up the different stations. Somebody gets their information. Somebody explain to them how to administer, puts a nasal pharyngeal swab into their nose. Then they have a collection station in the patient moves on. And you want to do that under a tented environment to create some privacy and protection.

23:15

You can do that. Well, the purpose of that purchase of that tenting would be an appropriate use, leasing a property, or retrofitting a facility has necessary to support testing. Maybe you have space, but you need to, you know, make a doorway, handicap accessible, or you want to improve the ventilation in the room. Or you need to do just some other things to be able to take some space and convert it into supporting ... testing. The money can be used for that kind of an update in renovating, but, again, it can't be just, oh, we're renovating to renovate. We are doing this in order to facilitate Covid 19 testing.

23:59

You can use it for supplies, if you want to do testing, You can, you know, get test kits. If you wanted to go that route or the materials you need to get the swabs, you need to get reagents and chemicals. You're gonna need to do training of your staff on, on proper testing collection procedures. You're gonna want to report the data to HHS or those testing activities. You may have to hire someone to do data entry PPE for your employees who are going to do the testing, so that they, because you don't know when someone drives up. Are they a positive or a negative. I was recently talking to someone who engaged in testing for a rural health clinic, they didn't think they had any Cove. In their community.

24:45

They tested 110, or so, people, and they identified 14 people who tested positive, none of whom had any symptoms. So, they were under the false impression that there was no ... in their community when, in fact, there were a fair number of cases in that community. So, under that presumption, you want to make sure that your staff are properly protected, because they don't know who's driving up in the car, they don't know what their status is, and, and you don't want to encourage or promote the spread of the virus.

25:19

So, what can't you spend the money on? Well, one thing you couldn't spend it on is, you can't go out and buy a boat.

25:26

I, and you can't call it ... testing, and say, Yeah, this is, I paid for this for covert testing, that would not qualify as spending money on covid testing, even if you named your boat covid testing.

25:41

You can't go out and establish a college fund for your newly renamed daughter coven. That would not constitute covid related activity. It might make your child happy, but the government would not be happy, and that would not qualify as covert related activity.

26:01

Now, one of the So, you use some common sense. I mean, I think that, you know, we can all figure out what is covered and what is not covered related. Doesn't mean that, you know, it, it can't have multiple purposes. If you're, you know, refitting, Are we doing renovations for a room? It doesn't mean that you have to, you know, deconstruct the room after you're done the testing. It may have more permanent value, but if you're doing it for the purposes of the covert testing, same thing, now you may want to lease a tent or you may want to buy it, tend to do this. If you buy the 10, doesn't mean you have to re return it. Ah, you plot it for its intended purpose. And, you know, it's allowed to to continue to own it. Now, the.

26:47

The one of the questions that has come up is, if I'm in an organization, we have independent RHCS that are part of a multiple RHC group. We have obviously provider based RHC sees that are attached to a parent hospital.

27:05

Because the money's were distributed on a per RHC basis.

27:11

Does that mean that they have to be exclusively pay expense on an individual rural health clinic, or could you pull those resources into some type of a group activity? And HHS has said that it is permissible to pull those monies together based on an organization's number of eligible sites into a group activity.

27:38

So, the billing tax ID are receiving the payments and operates, more than one site, has the discretion to distribute the payment amongst their RHC sites. So, if you have five RHCS, two of which are more centrally located for your population, you may want to do testing at two of the five sites, instead of all of those sites, that type of thing. So you know, you don't have to, if you have five RIT's, you don't have to spend 40, 900, 648, each one. If you are going to consolidate, you still have to demonstrate how that money was used to justify the payments. But you can consolidate into subsets of your RHC sites. You don't have to technically spend it at each individual site.

28:33

How does this differ? Now, we've had this question from folks about the rural distribution of the funding. So, this is \$225 million specifically for rural health clinic testing, and it is not to be confused with the money that was the rural distribution from a couple of weeks ago, which was for lost revenue or unintended or unexpected expenses related to covert. This is money that is specifically for the covert testing. In addition, there were, there was a slightly different list that was used for this initiative, then was used for the provider relief funding. So, they were able to use a more up to date list for this distribution, whereas the the covert 19, the Provider relief money's, the list was a little bit older. So, there were RHCS that may be getting this money.

29:30

Who didn't necessarily get money from that Provider Relief Fund, but they are for very different purposes. This money is specifically for covert testing or related activities, the other monies were for lost revenue or for unexpected expenses Related to covert. You cannot use this money to pay for the same activity, so if you are going to attribute the provider relief money for certain things, you can't turn around and say, Oh, I'm also going

to use that money. The money for the same thing. Now, it may be that the provider relief money, it's covering some salary, and it's not enough and you want to supplement that, because you want some of that staff to be engaged in covert testing. But again, it has to be specific to covert testing or related activities.

30:20

Again, we want you to think creatively, but act responsibly.

30:24

Think about how you might be able to use this money to really help your community. There's a significant concern we've seen in different areas of the country. Hotspots in rural communities. Particularly around nursing homes, and or large facilities, such as a meatpacking or Meat processing plant.

30:45

Look at your community. How might this money be best utilized to try and prevent those things from happening to identify your potential? Hot spots? Again, are their schools or their faith based organizations or their employers in your community that you might want to partner with to say, You know, We'll do a matching program with an employer. You put up, you know, \$5000 for employee testing, and we'll match it, or whatever amount you think is going to be necessary. So you can think creatively about how you might maximize the value of this money to work with others. So you can do even more or with your local school system, that they put up money, and you put up money to help cover testing in your schools.

31:28

But, you know, don't, don't think small, think creatively, and how this can be best utilized to try and help your communities, your patients, your staff, to ensure that they don't get get sick, That, you know, we keep the kogod virus at bay. And we don't have this second search.

31:48

I would also suggest that you think about, again, down the road, remember, this is not, there's not a time limit on how quickly you have to spend this money.

31:59

You may want to think about the possibility that if there is a vaccine that becomes available later in the year, do you want to hold some of this money in reserve to help? do vaccine distribution? If that becomes available with some type of additional education down the road. So, you know, don't think that I have to spend this in the next 30, 60, 90 days. There may be things that you think, well, this would be really a good use of this money, but it's not going to occur until the fall, we're going to reserve some of this money for an activity down down the road. But, again, think of it, how can you help your community?

32:37

Data collection? I did want to say that there will be some data collection that the government is going to want to us. The National Association, as you'll see shortly, has been engaged through an expansion of our co-operative agreement with the Federal Office of Rural Health Policy to do additional education, information, gathering, et cetera. And one of the things that that we will be reaching out is to try and get more information about. now, these will be probably in some form of a survey document, or a questionnaire that we will ask you to complete and send back, most likely online. So that we can begin to have some baseline data on how much testing is occurring, the types of testing that are occurring, et cetera.

33:26

But again, with the idea that this is not going to be an onerous amount of data collection or information gathering, but trying to establish some baseline information that we think going down the road will be helpful in this effort as well.

33:42

Where can I go to get more information about ... testing. So the Centers for Disease Control has put some information up. And here's a link to that guidelines for clinical specimens.

33:56

But I also want you to know that, as part of this initiative, we're working with the Centers for Disease Control to do a webinar with them, hopefully, within the next week, to seven, to nine days, 7 to 10 days, with representatives, subject matter experts from the CDC, from FEMA, from other areas, to help you understand, what some of your options are, where you might go to get testing supplies. What might you need? How do you get in the queue? And who can you potentially go to at your state level for more information? So, we're hoping to have some information out on that very shortly, unfortunately. We couldn't get that locked in by today's webinar, but we're hoping to have that information to you soon. At this point, we're gonna, we're gonna stop, and we're gonna open it up to questions related to cope with 19, testing, and testing related activities.

34:54

I'd like to welcome Kerri Cornejo and Sarah Young, who are with the Federal Office of Rural Health Policy, who've been invited to participate in this question and answer portion of the webinar, carrion, Sarah, I've been heavily involved in developing the Kogod Testing Initiative for the Federal Office of Rural Health Policy. And so, at this point, we're going to take questions, Nathan, if you want to, read the questions, and then we'll form them out.

35:26

Now, in anticipation of, this one of the things that we did, ask them to put together, and figuring that you were going to probably want this in writing. Some more, examples, we want to share some with you. Again, though, I want to emphasize that. these are just examples. Often, I see folks to say. Can you give me some examples. And you say. Yeah. Sure. You can. Do you know you give them one. Or two things. Then the next thing you know, they said. Well, that was the only thing you said, I could do. No, these are intended to stimulate thinking, stimulate some ideas on your part, but these are examples, you know, you can use it for efforts to maintain or increase your capacity personnel, to support ... testing, related clinical or operational needs. And that may be hiring or contracting someone to come in on a, on a temporary basis to help with that.

36:21

Developing your plans, as I've mentioned before, distribution, obtaining and distributing tests within your service area. Maybe nobody can get to testing, but you could use this money to go out and purchase. test, give them to your patients, you know, and then send them in, but now you would have money to do that.

36:42

Purchase, the equipment, and supplies, as I've mentioned. A drive up, or walk up, testing laboratory services. Maybe you're a critical access hospitals. You want to be able to do some of the testing yourself. You know this. This money can be used to help you do that with your, with your rural health clinics, community, and patient education, doing outreach assessment of symptoms delivering test results. And appropriate follow up now, here, I want to make it clear: you cannot use the money to pay for things that you are going to get reimbursed for. So, although the actual test collection is not reimbursable by Medicare, for example, it might be by commercial insurer. If it is, then you can't use that money to pay for collection if the commercial insurer is going to pay for it.

37:35

But you can't use it for you. Maybe you're doing a visit that's related, and as a consequence of that visit, you say, I think you need to get a test. Again. That visit is reimbursed by Medicare, and by most commercial insurers, if not all. So you can't use it. So you do have to be a little bit careful here about the the line of distinction between is this activity going to be reimbursed. Which case I can't use this money for that purpose? It's not going to be reimbursed. Then I can use it for that purpose. And then some more examples

here. Again, really training outreach. Reporting, information PPE. I mentioned some health information. Maybe you want to upgrade your, your ability to track, and, and this internally, and that will require an upgrade.

38:26

If you have an electronic health records to allow you to capture the relevant information, this could be used to help pay for that upgrade. Again, minor alteration and renovation projects, or purchase or lease, mobile vans and equipment. So those are some questions at this point. Nathan. Are we getting questions from the audience? We can open up.

Nathan:

38:52

We have a lot. Yes. We have lots of questions. So we will try to get through as many as we can and about 15 to 20 minutes. And then our friends over at HRSA have to get off. and at the end of this webinar, for those who are interested, we'll switch over to some telehealth information.

39:11

And then we'll take to some of the questions that we might not have gotten to this session.

39:22

So with that, I'm going to the first question, which is from Robert Stevens, who asks that the terms and conditions state, that building, or construction of temporary structures is an allowable use of funds. How about installing a new parking area with a dedicated clinic, and transfer Coburn patients, that would be permanent. Would the temporary structure clause preclude the use of funds for a permanent parking lot construction project?

39:54

Bill, I don't know if you want to take that, or if that would be considered a minor alteration or renovation?

40:02

Carrie, you also can weigh in.

Bill:

40:06

I mean, I will give you my opinion, that if it's a permanent building, and it's a parking lot.

40:14

Construction. I don't know that that certainly the construction of a new building is not a minor alteration or renovation, so I don't think it would fall there. I'm not sure what the covid related, if you do the parking lot, The covid related part of that would be, But, I think that would, in my mind, would be questionable.

40:34

Kerri?

Nathan:

It's a dedicated clinic entrance.

Bill:

40:39

Oh, entrance.

40:41

Yeah. So, so, the clinic is they're just putting a door in?

40:46

Yeah. Presumably. Section of the market because you may want to segregate your covid patients from or suspected covid patients from your regular waiting room, for example, then I would think putting a door and would constitute a minor alteration or renovation.

Nathan:

41:07

I'm not sure about the parking lot part. Kerri go ahead.

Kerri:

41:12

We can certainly follow up with you on that. But just going back to the terms and conditions, there's a piece about the building or construction of temporary structures. But then there's also the piece on retrofitting property. So those are additional things in addition to the temporary structures, but to get you a firm answer, we can certainly take it back to our folks and get their opinion on it, especially from a legal perspective.

Bill:

41:38

And, Kerri, would those be posted up in an FAQ document?

Kerri:

41:43

I can follow up with you on that as another thing we'll have to, you know, think about, depending on the questions that will have to follow up on,

Bill:

OK. All right.

Nathan:

41:54

So the next two questions. Yes. Next two questions are actually the same. And they are, does antibody testing count for the purposes of this funding?

Kerri:

42:06

And that's something that we had anticipated. We heard from NASA and really, if you go into the terms and conditions as going to be your main guiding document and they provide some definition of what's considered a test. Of course, they don't provide a list, you know. But that might be something we could look into that certainly. But you can see here, and if it's been approved by the FDA, then that's something that qualifies. And also, if the developer has requested more intensely request an emergency, use authorization from the FDA. And the FDA has an information available about that on their website. And that's another item we can follow up with you on as well.

Nathan:

42:56

Bill, anything to add?

Bill:

No, I think that that was it. I mean, the only that the, you know, the FDA, the number of tests, because we were looking at this, and who's approved, I mean, it's very, very extensive. It's almost too much. It's almost overwhelming. But, you know, I think, again, with the CDC, in particular next week, we may also be able to go into that was a little more detail.

Nathan:

43:22

OK, so, hopefully, we can get some better clarification on antibody testing going forward, but review the terms and conditions for the exact definition. Alright, next question Is From April Settles, who asks, or who says that testing is completed at our hospital? Not the RIT is, can the funds be used by the hospital?

43:42

That is the same tax ID.

43:47

Well, I think I presume here if I could add, just for April's question. I'm presuming that the that potentially the I'm not sure if she's talking about the specimen collection or the laboratory component of the testing is performed at the hospitals.

44:04

But go ahead Kerri.

Kerri:

The term, I'm sorry, the FAQs that we have that are also available on the Federal Office of Rural Health Policy website does say specify that the payment would be distributed among RESP site.

44:21

But that's, again, another nuance, we wanna make sure that we collect your questions and, you know, make sure that we are giving, you know, looking into things and giving proper guidance when somebody's new on issues. And that's certainly another item we can follow up on as well. But also the FAQs on our site will just point out that that is a useful resource as well.

Bill:

44:45

The other, I mean, I would add to that, I think you, if you're, if you're contemplating putting money at, let's say, the critical access hospital or a hospital that has the rural health clinics in the rural health clinics, money was intended. And you want to use some of that. I think you want to be able to show how that money spent at a hospital correlated to know the RHC. And, in particular, the patients, you know, where are you increase your capacity, so that the RHC was able to collect 150 specimens. And as a result of some of that money being spent at the hospital, you were able to increase your testing. Capacity turnaround results for that RHC much more quickly or whatever you want to show that.

45:37

There is a direct correlation, I think, between something that you did at a, at a hospital level and to the rural health clinic that was the intended recipient of those monies.

Nathan:

45:50

Right, And, correct.

45:51

You can correct me if I'm wrong, but hospitals, urban hospitals that own rural health clinics received money from this testing fund. And the intent here is certainly for, is to improve testing capabilities in rural areas.

46:11

So if you, if your parent entity is in an urban area, and all the money is being spent there, I think that's maybe where you're not going to want to do that. And you're gonna want to make sure that this is something done in a rural setting, right. At the hospital is right next to the rural health clinic, it might be a little bit of a judgement call, or a different scenario.

Bill:

46:34

Yes. You're right. And the, there was no, unlike to provide a relief funds, where if the parent hospital was in an urban area, the rural health clinics did not receive payment In this instance. The work, the location of the parent hospitals did not preclude the rural health clinic from receiving funds. But I think you're absolutely right. That you're going to really need to show that that money didn't stay at that urban hospital. And then it was used to the benefit of the rural health clinic and the patients they're serving.

Nathan:

47:11

Alright, next question is, I believe, should be a slam dunk, easy question. Crystal. Can we buy testing equipment slash machines with this money?

Kerri:

47:26

Question and answer is yes. I would add the caveat which Bill mentioned, if it's reimbursable from another source, then funds can't go to. That doesn't mean. It could be reimbursable for one instance and not the other, so there's nuance there. But overall, the answer to that question is yes.

Nathan:

47:48

OK, thank you, Kerri. I have the next question again. This might be too specific for us to answer here, but Cammie Cohen's D asks, can we use this for IGG antibody testing? I would have to. We would think we would have to research exactly this test.

48:07

Does anyone does anyone know off the top of their head if IGG antibodies is endorsed by the FDA?

Bill:

48:18

I thought it was IGEs, antibody testing that IGG but I could be wrong.

48:25

It is, I believe that it is one of the serology tests that is being used for, for that testing.

48:34

But I think the larger question is, is it only for virology testing to determine individuals who have the disease or don't have the virus versus the serology, which is the antibody to see if the individual had it and presumably has recovered? And that gets into the nuanced interpretation of what constitutes testing. It's it's something that is being debated at the state level. Some states are reporting both virology and serology as part of their testing data. Others are just doing the virology. But my understanding is that it is a legitimate test for the, for identifying if the individual has the antibodies, but I don't know if would carry was gonna get clarified. Is testing the broadly both Virology and serology or just the virology.

Kerri:

49:29

And we will get, you know, we will look into this further and get you some more detailed information.

49:34

But, so far, you know what, the terms and conditions say is it related to diagnosis? I could just know thinking about an issue where maybe you have the virus but now you're having some after effects.

49:48

And so perhaps the antibodies has been related to the diagnosis, but we will get you a firm answer on that to get some information on that. We don't have any FAQs right now related specifically to antibody testing. I'd also just add, with regards to lab, that all state and federal regulations about what lab you can do and how would also apply.

Nathan:

50:14

And I'll just also point out that hopefully, by the time we do the CDC webinar, we'll have a little bit further clarification. Some of the clinical questions about tests versus that tests, et cetera, will be better suited in that in that webinar. We're going to try to knock out as many questions as we can, and then we will switch over to the telehealth component. Next. Question is from Amy Johnson, Could we implement a program for all non symptomatic testing so I'll throw in on this such as, you know, testing temperature.

50:59

Something like that chart an employer site,

Kerri:

If it's related to the purpose of diagnosing covid then I don't see why not then. Yes, you should be able to include that as covert testing and then also related expenses.

Nathan:

51:19

All right, great. Thank you, Amy. Next question is from Missy.

Bill:

Just real quickly, I want to interject, because I see some numbers are going down a little bit. At the end of today's presentation. there is a question we will ask you to fill out relative to the kinds of information you would find most useful from the CDC presentation. So, if you, if you're interested in hearing from the CDC, if you could take a moment and just let us know what the areas are, We've already gone over some areas we'd like them to touch on, but we wanted to make sure you might have some things for CDC that we're not thinking

of. And if you could take a minute or two, and just complete that. So, we make sure that we get folks from CDC to cover the kind of things that you're interested in. We could do that. So, thank you, sorry about that.

Nathan:

52:12

All right, thanks to our next question, is from Missy Beasley, could we send the money on a patient self-registration?

Kerri:

52:20

Oh, sorry, Nathan, I didn't hear that.

Nathan:

52:24

Could we spend the money on a patient self-registration system?

Kerri:

52:31

Know, there's a lot of leeway in what related expenses mean, and if it's related to the testing and maybe it's part of your planning, how you plan to implement the testing process in your clinic then that if it's reasonably related to the covert testing done yet.

Nathan:

52:51

If you look for a contact list, contact lists, registration, just something like that, sorry.

Bill:

I was just gonna say no. If you look on the screen, the third bullet from the bottom, Health Information, Technology and Digital Tools, Technology to Support Patient Engagement, Remote Monitoring, Case Management, Health Information Exchange, and Enhanced Recording. So, you know, you see is the technology is the upgrade that you're looking at. The recording going to feed into that ability. Again, you need to be able to make some reasonable rational connection to what it is that you want to use the money for for covert related activities. Again, doesn't mean it if you keep it has value beyond.

53:41

Covid. It's something it's going to be an improvement, but you need to be able to make the case. This is, you know, that there is a covid component today, to the software, you're buying the upgrades that you're doing.

Nathan:

53:55

Thank you, Bill. Next question is from today's High, Lisa. Do you have examples of effective expense tracking tools that you can RIT's can use or adapt? Bill, I can take this, or you can take it.

Bill:

54:11

You can go ahead.

Nathan:

54:14

We don't have them in this webinar, but I know that several people are developing tools that will help you keep track, track of expenses related to the covid, find the Provider Relief Fund to General Allocation Funds. And we do plan, and this is a slide that we do have later. We will plan, at some point in the future, as having a Webinar on cost reporting in the era of Covid 19, with all the different allocations. Cost reporting questions are, are numerous. And so I'm sure we're going to have cost report focused Webinar in the future.

54:59

Go over this in more Detail. Alright. Next question Is from Brooklyn Dowell.

55:06

Can any of this money be used to pay the physicians base salary and not productivity bonuses?

55:13

So there a distinction between the type of Salary it can be used for.

Kerri:

55:21

We don't provide that level of detail, though it is a good question. Of course, if it's reimbursable, so as part of their salary, would be able to be reimbursed for the Medicare private insurance, then you couldn't count that portion. But, you know, related expenses, there's a piece that says items and services furnished to an individual during a healthcare provider office visit.

55:49

We thought, you know, again, that's another one that we would want to look into, but we don't provide that level of detail, and if it's reasonable, that it fits within testing or related expenses within the terms and conditions, That would be your guide.

Bill:

56:06

Yeah. But also, keep in mind that, you know, did you get a paycheck protection loan? Did you get any of the grant money for the Provider Relief Fund? Did you get a Medicare advanced payment, all of which were monies that could be used for the compensation of a of a provider? And so, you know, if you've gotten those monies, I think it's going to be harder than usual to justify why this money from covert was necessary.

56:39

I would think that you would need to have some kind of a specific the doctor, the PA, the nurse practitioner or left to run a coven. Or oversee covert collection site and that was time that was not spent in the RHC for which compensation might be warranted, but you're gonna, you're gonna. I think you're going to need really specific data. Collection and reporting information order to justify that.

Kerri:

57:11

You make a great point there. You would have to, you know, you want to specifically attribute funds under this directly.

57:21

Know, it would have to do some sort of testing.

57:24

You think of like a swab or possibly an antibody testing confirming their information, but, uh, yeah, Definitely, you want to be detailed.

Nathan:

57:37

And broke, I would just add, that, presuming that the provider relief funds for lost revenue, that money is probably much more easy to use, or salary, position, base salary, just, as a general rule of thumb. Alright, so we're coming up on three, Kerri. I know. You have to go to go right after three. Or you want to keep taking questions. We have plenty.

Kerri:

I have some additional time though. I would also add, you know, if you have further questions, we can provide our contact information. We're happy to help field questions. And then also you know, Nathan, if you want to send any questions our way that we weren't able to answer on the call.

Nathan:

58:22

Well, yes. I was going to mention Kerri we have this, we have all the questions that are being asked, of which we will definitely not get to all of them. So we can send this document for to you. So you can see the full suite of questions asked today. And in my own form future guidance that you put out. So folks that didn't get your question answered it was not in vain.

58:48

You asking, We will have a record of your question, it will help inform our future guidance. And that's OK, Kerri.

Kerri:

58:56

Yes, definitely. And if you want to send questions to Bill or Nathan, we're working together, as I mentioned, on the co-operative agreement. That's also a great way to get in touch with us and consolidate e-mails, especially when we start seeing trends in certain areas and then Bill and Nathan could help us put out the technical assistance guidance on that.

Nathan:

59:18

Yeah. Sorry, I didn't mean to put that on HRSA. We are a resource as well. Alright, let's just talk about a few more, and then we're going to switch over to telehealth.

59:29

This is a, this is a really interesting question from Ellen Schonburg. Thoughts, if another provider from our community, once their patient tested for covid, We do not currently test patients that are not patients of our RHC.

59:52

one, would they be Yeah, go ahead.

Kerri:

59:55

Oh, no, you can go ahead, and Nathan with your follow up.

Nathan:

59:58

I think that there's, there's certainly permitted to test a new patient that they don't have an established contact with, so this is absolutely permissible. If they do want to start testing patients, they do not have to be only established patients.

Kerri:

1:00:19

Yeah, that was what I was going to say.

1:00:20

And, of course, it, you know, you have other, you know, policies in your clinic or other, you know, if you want to feel for, it does something different, but there's nothing in the terms and conditions that say you can't test a new patient.

Bill:

1:00:33

Yeah, and there was a, I was talking with some folks last week, they were telling me about two independent rural health clinics that are in the same area, and they collaborated with one another to host testing.

1:00:48

They, they set it up at a mutually convenient third party location. I don't know if it was like a school parking lot or, you know, someplace or shopping center. And they, they pool their funds in order to allow for one Drive up testing for folks from, from both clinics. They provided some resources and stuff. So, you know, I thought that was a great example of folks who are not even normally connected.

1:01:16

Who, you know, but said on this, we're going to collaborate. I would think that same kind of thing, which, you know, if it's an RHC in a non or H C, where you can do that same type of collaborative effort.

Nathan:

1:01:31

All right. So, there's one more question I want to get to on the, on the list here, which is actually a segue into Telehealth. But before we do that, I actually had a question that I wanted to before. And maybe we have an answer, maybe we don't. Can a rural health clinic use the funds, use the rural health clinic testing funds, to essentially outsource the testing work to, let's say, a fee for service provider?

1:01:59

Could you contract with another entity that may be already doing testing and sort support their efforts and sort of funnel it to them?

1:02:10

Is that would that be permissible?

Kerri:

1:02:13

That's another way to look into, because, you know, when you do look at the FAQ, that talks about the funding being at the site. Now, of course, if you have multiple sites at the same 10, you might pull it at one site the site. So, I want to look into issues of contracting a little more closely. As we said before, you want to make sure it's happening in a rural community.

1:02:40

The other things that you, one farm out components. But maybe at the RHC, you would have the testing center right there.

1:02:50

I would want to be careful about that, because our FAQs, to say it would have to be somebody at the site.

Nathan:

OK. All right. Fair enough, OK. Last question. And then we're going to switch over to telehealth. And this is a bit of a segue into that. And it's from Mark Holden men is telemedicine and improving technology for telemedicine, a reasonable use of this money.

Kerri:

1:03:14

That's again, it has to be connected back to your testing plan. So, you have to be doing the testing, which would be the diagnostic testing, and then somehow of telehealth was related to that as it related expense. Like maybe you are doing intake. If somebody would be qualified for testing by your policies, for example, I can see that as being a related expense, but it still has to tie back to that testing.

Bill:

1:03:44

I think, if I can add, I think it has to be credible.

1:03:48

I don't think you look at your mission statement, and you just take everything that's in your mission statement currently, and then pull some things out of there and go as it relates to covid testing, as it relates to covid testing. So, you're really not doing anything different than what you were doing before. You simply taken a document, and you've added covid testing to the document, and therefore, sought to justify the spent expenditure of money.

1:04:16

I Analogize and several years ago, when there was money available for primary care providers. There was a question of what constitutes a primary care provider. And it's one of those things, we're kind of in our mind, we know what is a primary care provider but then trying to define it or put it on paper. And I remember meeting with somebody who is working on the definition and they said they, they just got done a meeting with the ... Group who are trying to convince them that ... with primary care providers. And you know, again, the point is you don't just can't just turn around and say we're doing this for covid and assume that that means it's OK. That really does have to be some purpose, some intent part of a plan, that Kerri mentioned as to, How does this play into or feed into covid testing or testing related activities?

1:05:10

Yeah.

1:05:13

All right, well, thank you very much, Bill and Kerri, you're welcome to stay on, but we're going to move to the next little segment here, which is going to be Telehealth.

1:05:23

And then, again, we'll do a Q and A and Bill, do you want to just go hard stop 3 30 to Understand?

Bill:

Yeah, that would be that would help.

1:05:33

I think so.

Nathan:

OK, so, we're gonna do some telehealth, and then we'll do Q&A on Telehealth and or anything else until 3:30, Cate, if you could take down the questions just for now. They are big on my screen.

1:05:50

All right.

1:05:52

So, I'm just going to talk hopefully briefly about the telehealth update.

1:05:58

And we don't have time to get into the history of how far the telehealth policy has calmed in the last couple of months. It's obviously changed dramatically.

1:06:11

In the last major update to the RHC, tell, our policy was April 30th. And then, it was released an updated MLN matters as C 20016, which are guiding document for telehealth visits.

1:06:29

In this document and April 30th update rural health clinics, it was made explicit, explicitly clear that wrong to use ...

1:06:40

code T 2025 immediately with modifier C G, for all telehealth distance site visit claims.

1:06:51

Previously, for about 10 days, we were supposed to use the most appropriate hex code, such as and 992149, 2, and three, et cetera.

1:07:02

And then we would put modifiers on that claim. That was the policy for about 10 days, and then it was switched, as of this April 30th update to everybody, needs to report G2025 now.

1:07:18

In July, July first, you will no longer put modifier CG on the claim. I'll get into a little bit more about what happens in July and Effect.

1:07:29

The other major, major update that was made on April 30th is that now RIT's can use Textbooks code G2025, our Telehealth Visit Code to bill for audio only telehealth visits.

1:07:46

Previously, audio only services, or sort of orange into our G0071 service, which only pays \$24.76.

1:07:58

On April 30th, there was a major update, not only for us, but on the physician fee schedule side, In terms of the number of codes that are fee schedule peers can bill for via telehealth.

1:08:12

And CMS clarified that a significant number of their telehealth codes and CPT codes can yield audio only. So, when CMS made that change, they had to, of course, extend that to rural health clinics. So, now we can use G 2025 to bill for audio only telehealth visits. And as long as it's one of the visits or CPT codes on that CMS list, but I billing for the next slide.

1:08:48

And it says, there's a column in there that says, this service can be performed audio only. You can do this audio. Could you go back real quick. I'm not ready yet.

1:09:03

So the payment for G2025 is going to be \$92.03.

1:09:10

But until June 30th, rural health clinics are actually going to receive their normal all inclusive rate.

1:09:18

So, again, you're putting CG on the claim until June 30th, and you should receive your normal all inclusive rate.

1:09:27

But the payment will be \$92.03 eventually, they will be a recoupment period or an additional payment, made in July for each G2025 service performance.

1:09:45

And they will, they will, even it out, or measure it up at the end, in July, to make sure that you, you will get paid \$92.03. So, if you get paid more than that, as you're all inclusive rate, there'll be a recruitment period to bring you back down to \$92.03 for each telehealth as it provided. If you are an independent RHC in your cap is below that, which it is, then you'll get an additional payment in July to bring you up to \$92.03 for each. Telehealth visit provided. The exact details of how the recruitment is going to work is still to be determined.

1:10:28

We don't know if it's going to.

1:10:30

They will allow clinics that owe money back to Medicare, for example, to make a lump sum payment Or if they would just take it out of Medicare claims and reimbursement until such time that you are made all the details are still to be determined.

1:10:49

Next slide.

1:10:54

Couple of other updates. Initially, when the after April 30th and the G2025 policy was announced. A lot of folks started building right away and got rejection.

1:11:09

It's my understanding that pretty much all the MACs are now processing G20255, where the CG modifier properly.

1:11:20

It didn't happen overnight. But I think we got to a place malware. It's pretty good. If there are some macs that have rejected all your claims and you're absolutely building it. Right, please let us now. We need to get CMS involved, but it's my understanding that it's, it is working now properly.

1:11:37

With the caveat that I've had, some people just anecdotally tell me that, for whatever reason, their processes works smoother if they also append the modifier 95, which is a completely optional thing that RIT's can't do.

1:11:54

As I mentioned, CMS significantly expanded the codes that providers can bill via telehealth on April 30th. That's the Excel sheet that you can download at the link below.

1:12:07

And again, as I mentioned, a number of those services, CPT codes, can be billed with audio only.

1:12:16

But for rural health clinics, since we combine this entire set of CPT codes into one code, G2025, some of this distinctions there are a little bit less relevant because it's everything is a G2025 service for us.

1:12:39

Next slide.

1:12:45

Um, this is a chart that I hope is helpful. It's been updated quite a bit since all of these telehealth changes came in.

1:12:54

I want folks to still make sure that they are very specific when they're talking about different types of telehealth services, OK? There's the virtual check ins or virtual care communications. These are very, these are remote, evaluations of a picture, by the physician or clinician that are only five minutes.

1:13:19

You bill, for these with G0071. The payment is \$24.76 We bill on the UB-O4

1:13:27

No modifier necessary and we use the most appropriate Revenue Code 052X. Now again, this was the policy before the Telehealth visit. It's still the policy. We still can bill

1:13:40

G0071s, also billable under G0071 is something called the Digital E Visit.

1:13:49

This is at least five minutes of going back and forth with the patient over a patient portal, OK, So if the clinician is spending time answering questions with the patient, and they spend more than five minutes over the course of seven days, that's now, that's still a G0071 line, and you can again, bill for that.

1:14:12

Telehealth visits, as I just explained, our now G2025 And there was this confusion for awhile that the audio only ...

1:14:23

E &M visits were billable on the fee schedule, and these are the CPT codes for them are 99441 through 443 for us.

1:14:31

And initially, we had to shoehorn these into G0071 and call them essentially virtual care communications and audio only E & Ms, but now a much greater expanded definition of telehealth visits. And what can be done audio, only you can now build for these G2025 services. And you're going to want to build them as G2025 services and ..., because, of course, the payment is better as at \$92.03. So, that is a very quick update on Telehealth bill. You can go to the next slide.

1:15:16

Do you want to take this one, Bill?

Bill:

1:15:18

I'm sure that, you know, we've we've referenced here. So the National Association of Rural Health Clinics has an existing co-operative agreement arrangement with the Federal Office of Rural Health Policy.

1:15:28

That's what allows us to bring the webinars that we referenced at the outset, that has been expanded to give us the opportunity to do even more, not only webinars, but different educational outreach initiatives. We're going to be looking to try and work with states on this as part of this process, and more will come in the next couple of months as we start to roll this out. But, we're very excited about the opportunity to work with rural health clinics, to work with the Federal Office of Rural Health Policy, to expand the kind of education that we can bring to you. The kind of information we can sponsor, that we can host to try and help you work through the, the requirements for testing.

1:16:13

Testing related activities and the kinds of things you can think about and, and bringing you kind of examples of what some other RHCS are doing. Bring together some, some of your peers, some of your colleagues, to talk about how they went about doing it so that, the opportunities there, for potentially, you to try and replicate your communities.

1:16:37

So, along those lines, I mentioned that we're going to have a webinar with CDC, Hopefully, in the next 7 to 10 days. We're also planning on one on cost reporting. How does all of this play into your cost report? Both the Provider Relief Funds, the telehealth things that Nathan is talked about, and we've recorded on before, those have cost report implications, this new money for covert testing, what are the cost report, implications there? And then, as I mentioned, ideas on collaborating with your community to re-open safely, and then data reporting. We're also looking to have some additional webinars on some of the billing issues related to these activities, so stay tuned, a lot of education information coming your way over the next several months.

1:17:34

And then, finally, you know, I've mentioned, So, what do we need? What do you need in the way of education? What do you need in the way of resources? How can any RHC best be of help to you? We will be putting out a survey shortly asking these questions. Please take a few minutes to let us know exactly what it is you need. We will ask you identifier you provider based, or independent, or the needs different. Are they similar? Those will be through a separate survey. I did mention At the end of this week, we will get a survey questions specific to the CDC presentation we're organizing. And then I'd like to thank Kerri Cornejo and Sarah Young with Federal Office of Rural Health Policy, for just for participating, and then, as I mentioned, have been heavily involved with this.

1:18:27

So, we already, Bill Yeah, I don't know how they showed up again, but for those of you who are certified, rural health clinic professionals, here's the code for that ... code, RGW647.

Nathan:

1:18:46

Then these are going to leave it at that screen.

1:18:49

Yeah, let's take some questions, but I'll leave it at the code screen, OK.

1:18:56

All right, so we've got 10 minutes for questions and I'm willing to bet that one of the feedbacks will get an hour and a half is too long. But we have a lot of information, so we apologize for that. So we're just trying to get that information out. We'll try to be more succinct in the future. But let's go ahead and open up the questions. I'm gonna go ahead and skip to questions that are coming in right now. So folks.

1:19:24

Know, Cate stopped it, but Cate, if you could put it up again.

1:19:33

I see, OK. Are you there?

1:19:36

Yep.

1:19:36

I open it up for them, OK. So the questions are opening it up.

1:19:42

Would like I mentioned before we're obviously we can't get through all these questions. But they're actually a great record of the things that folks are asking and we will look at them after and certainly help inform what FORHP and NARHC puts out terms of further help on this. I'm not seeing any questions flow in on telehealth.

1:20:07

I presume folks have them because my e-mail box has been for Kim asked, can we get to telehealth slides? Yes, the entire slides or will be available on multitude of places first ... dot org. Second, you can download it. If you look on handout, goto Webinar, you can download it there, also be posted on our RHI Hub or the multitude of places.

1:20:38

Of visits being considered encounters in the future.

1:20:44

So I believe Terry, what you're asking is that you would like to telehealth visit to be considered an encounter and count towards your all inclusive rate. That. Is a possibility there, is we are working to change, that. I can't talk too much about the legislation, that we're working on this call, because we're not allowed to advocate on this call. But there is a possibility that the statute could be changed, especially long term, to count the telehealth visits, as encounters. But, as of right now, they are not considered encounters.

1:21:27

Deborah de Los Santos asks, should a pediatric RHC bill with the Key 0071 code?

1:21:35

Um, those codes that I went over, debora, are for Medicare.

1:21:41

So, the Medicaid billing and coding, I'm not entirely sure. It would depend potentially on the state that you're in, whether the state is covering telehealth and what their roles are. So I can't answer that, unfortunately, but I presume that the state is not going to do it the exact same way as Medicare it.

1:22:05

Dixie asks, what is the recommendation outdoing annual wellness exams by Telehealth, since they will not be tracked for the common working file?

1:22:17

C F W?

1:22:18

I'm sorry, CWF.

1:22:22

This is a great question. Dixie, it's one we have posed to CMS. They've told us that they are working on a solution for this.

1:22:31

But it's a great question because the code that you are billing is G2025, not the Annual Wellness exam code.

1:22:39

And, therefore, There's no record in the common working file that you've done an annual wellness exam. And you need that for, among other things, your quality metrics, etcetera. So, it's an amazing question. We've asked it to CMS.

1:22:58

We do not have an answer yet, but they have indicated they are working on that.

1:23:05

Thank you for the question. Next question is from Sherry. Sophie?

1:23:10

Do we have to go back and rebill All encounters under G2025 if we build the other codes.

1:23:20

Another amazing question.

1:23:24

I don't have an explicit answer. I think potentially some of the consultants may have some hands-on experience with MACs where rebilling is what they would recommend.

1:23:36

I haven't seen anything in our policy that says that you need to do that. I think that going back and if you could rebill it as G2025 it would probably be a good idea.

1:23:52

It might be MAC dependent.

1:23:53

And I might ask, other folks have more expertise in billing for that 10 day period.

1:24:01

What the best practices for those claims that were built under that, that policy that was only in place for 10 days?

1:24:10

Stephanie asks, Does G2025 only apply to facility?

1:24:17

I'm not entirely sure what You mean by that question. Bill, do you have any context on that?

Bill:

1:24:26

Can you repeat the question again? I can't see them.

Nathan:

Stephanie asked, Does the G2025 only apply to the facility?

1:24:36

That sounds like a physician fee schedule, billing question, where you would have a professional C and a facility fee.

Bill:

1:24:44

Yeah, This is for a rural health clinic visit. So it'd be the same, it's an all inclusive rate. It's just at a different rate than you would normally be receiving for all inclusive rate.

Nathan:

1:24:55

Sorry, Stephanie Eastern, if you send me an e-mail, if you want to elaborate on that. Next question is from Enjoy Crown. We've got four minutes.

1:25:05

Had a CMS said anything about the annual wellness visit, Sorry, yes, I just answered that one. They are working on it. We know that that's an issue. Julie Christenson asks, if we have already sent Telehealth visits with another repeat question. I would, I think that really sending them again, where G2025 is, the recommendation I would go with by again. I would potentially ask our form, or ask some consultants about their experience with those claims that were billed and Natalie April range what the best method to get those paid is.

1:25:45

Jeanette Oberlin asks, I might have missed it. Any word on reporting to preventive services that are reported at G2025? How would they be updated on a common file? Again, this, in my opinion, is one of the issues with combining 200 plus codes into one code.

1:26:07

We can differentiate between preventive services and normal services, We can differentiate between any of those different services provided. So it's one of the issues that CMS is aware of, and potentially we will have a solution. And I do believe it goes beyond just the annual wellness visits, the other things that would be considered preventive, and, therefore, not have cost sharing obligations for the Medicare beneficiaries. So, there are, there are other ones that are in that category. So, we're hoping to have solutions on that soon.

1:26:45

Do one more, and then we'll close it down. Sounds good.

1:26:49

Sure.

1:26:52

Has it been decided the best way to rebill for previously paid G0071 claims, should we submit adjusted claim or a new Claim again, Shauna is a great question. Very valid question.

1:27:07

I do not know the answer.

1:27:09

I think the best way, it's not, it's certainly not a policy.

1:27:17

I think folks that have experience rebilling those G0071 ones probably can answer that question a lot better than I So I would suggest asking that on the forums.

1:27:30

Just, for example, those G0071 services that were the audio only visits that you shoehorned into G0071.

1:27:41

Well, now, they can be paid \$92 at the G2025.

1:27:46

So, how do you resubmit or rebill those? What's the best way to do that? I think we would have to go on sort of anecdotal evidence or other people are experiencing to tell you that the best way, probably to rebill. But I'm sure that there's, it might vary by MAC, etcetera. So, with that, thank you all for your questions.

1:28:10

We'll go ahead and go to, there's Bill's contact information.

1:28:15

And then there's my contact information, the phone numbers, the same for both of us.

1:28:21

And I'm going to go ahead and do the closing remarks.

1:28:25

We'd like to thank everyone for joining our call today, especially Kerri Cornejo and Sarah Young. Please encourage others who may be interested to register for this series. We welcome you to e-mail us your thoughts and suggestions for future topics. Either, you can e-mail me or Bill and just be sure to put an RHC TA topic in the e-mail subject line. Again, I'm going to repeat it just verbally, one last time.

1:28:53

The ...

1:28:55

CRHCP course CEU code for today is our RGU 6 4 7, are RGW 6 4 7.

1:29:03

Be on the lookout for the next schedule, excuse me, when we will schedule the next webinar with the CDC and a very short period of time. So please be on the lookout. We're going to send an e-mail out to all of those who have registered on the call series. Thank you all for your participation, and that concludes today's call.

Bill:

1:29:26

Thanks, everybody.