Centers for Medicare & Medicaid Services
Open Door Forum: Physicians, Nurses and Allied Health Professionals
Moderator: Jill Darling
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Coordinator: Welcome and thank you for standing by. At this time all participants are on a listen-only mode until the question and answer session of today's conference. At that time, to ask a question press star 1 on your phone and record your name at the prompt.

Today's call is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the call over to Jill Darling. Thank you. You may begin.

Jill Darling: Great. Thank you Alysa. Good morning and good afternoon everyone and welcome back to our Physicians, Nurses, and Allied Health Professionals Open Door Forum. We're really looking forward to hearing from you regarding today's agenda.

As Alysa said, I'm Jill Darling in the CMS Office of Communications. And before we get into today's agenda, I have one brief announcement. This Open-Door Forum is open to everyone. But if you are a member of the press you may listen in. But please refrain from asking questions during the Q&A portion of the call. If you do have any inquiries, please contact CMS at press@cms.hhs.gov. I will also give an email out in case you're unable to ask a question during the Q&A portion or if you would just like to email us. Its partnership@cms.hhs.gov. That's partnership P-A-R-T-N-E-R-S-H-I-P at cms dot hhs dot gov.

And I will now hand the call off to our co-chair Marge Watchorn.

Marge Watchorn: Thank you, Jill. And thank you so much, everybody, for taking time out of your days to come and listen to some of the things that have been keeping us busy over the past several months. And as Jill mentioned really welcome back. It's been certainly a while since we've convened the group.

And I'm sure you all are aware that with the activities regarding COVID have kept us busy. But I think I would be remise if I didn't say that we are aware of all of the work that you all are doing on the ground and in your practices. And just want to say thank you so much for all the work you're doing and all the care you're providing to our beneficiaries.

Even though we haven't had one of these Open-Door Forums for a little while, I think across the agency we've certainly tried to offer many different ways for folks like you to interact with subject matter experts. And we hope that you have availed yourselves of those opportunities during the COVID-19 public health emergency. You know we've certainly been busy during the PHE.

You may be aware we've been engaged in a number of activities including interim final rulemaking. We've exercised various waiver authorities all in an effort to offer an array of flexibilities to practitioners so you can provide care to your patients in the best and safest possible way during this pandemic.

And in fact, some of the proposals that you're going to hear about today on the call are in fact where we are proposing to make some of those temporary flexibilities permanent. So really, we want to help you understand today at a high-level what some of those proposals are.

But it's really important that we also use this rulemaking experience. I'm sorry. This rulemaking process to hear about your experiences. How have these flexibilities affected you all working, you know, on the ground day in and day out with your patients and in your practices? What's been working for you in these policies? What hasn't been working for you? Maybe what did we miss?

So, you know, certainly, we want to hear from you today. But in order to make sure that we can address your concerns in our formal rulemaking process, just want to remind you. Please be sure to submit public comments on the Physician Fee Schedule proposed rule which you can find in the Federal Register. Comments are due by October 5th of this year.

And again those comments need to be submitted formally through one of the modalities that's listed in the PFS proposed rule. So again we look forward to hearing from you and hearing your comments. So we have a number of speakers who are assembled virtually for you today. And hope you find this information that we share helpful.

So without further ado, I will hand it off to my colleague Patrick Sartini.

Patrick Sartini: Hi. Thank you, Marge. I'll be talking about telehealth and other services involving communication technology. So 1834(m) of the Social Security Act specifies the circumstances under which Medicare may pay for telehealth. Medicare telehealth services are services which are ordinarily furnished in person and are typically subject to geographic site of service, practitioner, and technological restrictions. In response to the public health emergency for the COVID-19 pandemic, CMS was able to waive a number of these restrictions

as well as to adopt regulatory changes to expand access to Medicare telehealth broadly.

Outside of the PHE, the statutory restrictions would require an act of Congress to modify the following. However, is a summary of the regulatory flexibilities CMS is proposing to adopt on a permanent basis.

So for CY 2021, we are proposing to add a number of services to the Medicare Telehealth List. These include lower level established patient home and/or domiciliary visits and assessment and care planning for patients with cognitive impairment, group psychotherapy, and two add on codes associated with our previously finalized office outpatient E&M policies.

In addition, we're proposing to create a third temporary category for criteria for adding services to the list of Medicare telehealth services. This new category we refer to as Category 3 describes services added to the Medicare Telehealth List during the PHE that will remain on the list throughout the calendar year in which the PHE ends.

This will also give the community time to consider whether these services should be delivered permanently through telehealth outside of the PHE. Services we are proposing to add to this Category 3 list include lower-level emergency department visits, higher-level established patient home and domiciliary visits, certain psychological testing services as well as nursing facility discharge data management.

We are soliciting comments on services added to the Medicare Telehealth List during the PHE for COVID-19 that CMS is not proposing to add to the Medicare Telehealth List permanently or proposing to add temporarily on a

Category 3 basis.

In response to stakeholders who have stated that once every 30-day frequency limitation for subsequent nursing facility visits furnished via Medicare telehealth provides unnecessary burden and limits access to care for Medicare beneficiaries in the setting we are proposing to revise this frequency limitation from one visit every 30 days to one visit every 3 days. We are also seeking comment on whether it would enhance patient access to care if we were to remove frequency limits altogether and how best to ensure that patients would continue to receive necessary in-person care.

For our communications technology-based services we are clarifying that licensed clinical social workers, clinical psychologists physical and occupational therapists, and speech-language pathologists can perform, rather can furnish this debrief online assessment and management services as well as virtual check-ins and remote evaluation services.

For the duration of the PHE, we also established separate payment for audio-only telephone evaluation and management services. While we are not proposing to continue to recognize these codes for payment under the PFS in the absence of the PHE, the need for audio-only interactions could remain as beneficiaries continue to try to avoid sources of potential infection. We are seeking comment on whether CMS should develop coding and payment for a service similar to the virtual check-in but for a longer unit of time.

For the duration of the PHE, we also adopted an interim final policy revising the definition of direct supervision to include virtual presence of the supervising physician or practitioner using interactive audio-video, real-time communications technology. We're proposing to continue this policy up

through the year in which the PHE ends or December 31, 2021, whichever is later.

We're seeking information from commenters on whether there should be any guardrails in effect as we finalize this policy through December 31, 2021, or the end of the PHE or whether we should consider adopting this policy on a permanent basis and what risks this policy might introduce to beneficiaries if they receive care from practitioners under remote supervision.

Finally, in recent years, CMS has finalized payment for seven remote physiologic monitoring or RPM codes. In response to stakeholder questions about RPMs, we are clarifying this proposed rule, our payment policies related to the RPM services described by CPT Codes 99453, 99454, 99091, 99457, and 99458.

In addition, we are proposing as permanent policy two clarifications to RPM services that we finalized in response to the PHE for the COVID-19 pandemic. These are number one; we are proposing as permanent policy to allow auxiliary personnel to furnish certain remote monitoring services under a physician's supervision. Auxiliary personnel may include contracted employees.

Secondly, we are clarifying that the medical device supplied to a patient as part of a remote monitoring service must be a medical device as defined by Section 201(h) of the Federal Food, Drug, and Cosmetic Act and that the device must be reliable and valid and that the data must be electronically collected and transmitted rather than self-reported.

So with that, I would now like to turn it over to Christiane LaBonte.

Christiane LaBonte: Thanks, Patrick. Good afternoon or good morning. This is Christiane LaBonte. And I'll be discussing our proposals in the office visit E&M space and provisions related to teaching physicians and residents.

Starting with office visit related policies, just to quickly review what we did last year. As we finalized in the Calendar Year 2020 Physician Fee Schedule's final rule, in 2021 we will largely be aligning our office and outpatient E&M visit coding and documentation policies with changes laid out by the CPT Editorial Panel for office visits beginning January 1st.

This includes the code redefinitions that rely on time or medical decision-making for selecting visit levels with performance and history and exam as medically appropriate, deletion of the level 1 new patient code, and a new prolonged services code specific to office visits. We are also adopting revised medical decision-making guidelines adopted by the CPT Editorial Panel.

Additional information about the AMA CPT changes are available on the AMA web site.

For the CY 2021 proposed rule related to the office visit code, we're proposing two minor refinements given how much we covered last year along with a set of revaluations for certain code families. So I'll start with the two minor refinements.

So the first, we're proposing a refinement to clarify the time to which prolonged office visits under CPT Code 99XXX can be reported. In the Calendar Year 2020 Final Rule, we stated that CPT Code 99XXX can be reported when the time exceeded the minimum time on a Level 5 visit by 15

minutes. And we are concerned about double-counting time.

So we're proposing that when time is used for level selection and the max time on a Level 5 visit is exceeded by 15 minutes then practitioners would report a CPT Code 99XXX.

For the second refinement, we're proposing to revise the times that we use for rate-setting purposes only. This is a technical detail that only applies to price setting and not how practitioners report time. In the Calendar Year 2020's final rule we used RUC recommendations on total time for rate-setting.

When the RUC surveyed specialty societies for the office visit code they surveyed pre-service, day of service, post-service, and averaged them. And they also surveyed total time and sometimes these numbers conflict. It's more consistent with our rate-setting methodology to use the sum of the component times rather than the RUC recommendations. So we're proposing to use some of the component times.

And again, this is a technical detail that applies to rate setting only. The times that practitioners would use for level selection are determined by the CPT Code descriptors and we direct you there.

Earlier I mentioned revaluations for certain code families. And just to quickly recap in the CY, Calendar Year 2020 rule cycle, we sought comment related to the code sets that include, rely upon, or are analogous to office visits and whether or how we might revalue those services. So for the Calendar Year 2021 proposed rule, we're making a number of proposals to increase the valuations for services when they include, rely upon, or are analogous to office visits that we previously finalized for 2021. These include seven

bundles or code families where we know the visit is being furnished or it's explicitly built-in. So what we're proposing to do is bumping up those valuations.

As I said, there are seven code families. And they're the following, end-stage renal disease, the monthly capitation payment. Those were valued using a building block methodology. And the E&M visits are largely being furnished. And we're seeking comment on the number of visits.

Maternity services. Those are similar to ESRD codes and we believe the visits are being furnished. So we're proposing to increase the values for those services.

Transitional care management services. Those are valued via a direct crosswalk. They always use a Level 4 or 5 visit so we're proposing a commensurate increase to the valuation of the TCM services.

Next cognitive impairment assessment and care planning and the initial preventive physical exam and initial and subsequent annual wellness visit. So that's the Welcome to Medicare and Annual Wellness visit and the cognitive impairment code. These codes and these families are similar to transitional care management where the office visit is always furnished and it was valued using a direct crosswalk.

The next code family are emergency department visits. Historically these were valued in relation to office visits. And we believe there would be a rank order anomaly had we not revalued them. So we're proposing new values.

And finally therapy evaluation and psychiatric diagnostic evaluations and

psychotherapy services. For these services practitioners can't report E&M visits under the law. And these services were similar enough. So we're proposing - similar enough to office visits. So we're proposing a commensurate increase to their evaluations.

And finally, we're soliciting public comment regarding how you might clarify the definition of HCPCS Code GPC1X. Just as a reminder that's an add on code that we finalized in the CY 2020 rulemaking cycle for office and outpatient visit complexity.

And our comment solicitation discusses whether we should refine our definition or our utilization assumptions for this code. And we provided some additional language and examples about how we intended this code to be used and we look forward to public comment on this and all these topics.

Switching topics to teaching physician and resident policies, for the duration of the COVID-19 public health emergency we implemented several policies on an interim basis through the interim final rule that Marge was mentioning at the top of the call. And we issued those rules on March 31st and May 1st. I'll summarize these policies in three major points.

So the first teaching physicians may use audio-video real-time communications technology to interact with residents through virtual means which meets the requirement and the law that the teaching physician renders sufficient personal and identifiable physician services to the patient to exercise full personal control over the management over the portion of the case for which a fee schedule payment is being sought.

And this provision permits the use of audio-video real-time communications

technology also applies when the teaching physician is involving a resident and furnishing services on the Medicare Telehealth List that Patrick was speaking about a little while ago.

The second major point I'd like to make is that teaching physicians who involve residents and providing, furnishing care at primary care centers can provide the necessary direction, management, and review for the resident services using the same audio-video real-time communications technology. Residents furnishing services at primary care centers may furnish an expanded set of services to beneficiaries including Levels 4 and 5 of an office visit for both new and established patients, care management services, and communication technology-based services.

And finally, we allowed PFS payment to the teaching physician for services furnished by residents via telehealth in the primary care exception for services that are also on the Medicare Telehealth List of Services.

And the third major point I'm going to make relates to resident moonlighting. For the duration of the public health emergency. Medicare considers the services of residents that are furnished outside the scope of their approved GME Programs and furnished to patients in the hospital in which they have their training program as separately billable physician services. For these policies that - for all of these policies that I've discussed we are considering whether they should be extended on a temporary basis or made permanent.

And in the proposed rule we're soliciting public comment on whether these three major policies that I discussed should continue once the public health emergency ends.

Now I'll turn it over to Sarah Leipnik.

Sarah Leipnik: Thanks, Christiane. I'm now going to discuss our proposal regarding professional scope of practice and related issues.

So first is the supervision of diagnostic tests by certain non-physician practitioners. We are proposing to make permanent our policy for the duration of the COVID-19 public health emergency that allows non-physician practitioners which are nurse practitioners, clinical nurse specialists, certified nurse midwives, and physician assistants to supervise diagnostic tests as allowed by state law and scope of practice. The non-physician practitioners would maintain any required statutory relationships with supervising or collaborating physicians.

Second is pharmacists providing services incident to physicians' services. We are reiterating our clarification that pharmacists can be auxiliary personnel under our 'incident to' regulations. As such pharmacists may provide services incident to the services and under the appropriate level of supervision, of the billing physician or non-physician practitioners, if payment for these services - if payment for the service is not made under the Medicare Part D benefits.

Therapy assistants furnishing maintenance therapy. We are proposing to make permanent our policy that we adopted for the duration of the COVID-19 PHE that allows a physical therapist and occupational therapist the discretion to delegate the performance of maintenance therapy services as clinically appropriate to a therapy assistant, either a physical therapy assistant or an occupational therapy assistant.

And lastly, with regard to medical record documentation, we are broadly

clarifying that therapy students and students of other disciplines working under a physician or practitioner who furnishes and bills directly for their professional services to the Medicare Program may document in the medical record so long as it is reviewed and verified, signed and dated by the billing physician, practitioner, or a therapist.

I am now going to discuss our proposal regarding valuation of services for vaccine administration, immunization services. In the CY 2021 Physician Fee Schedule proposed rule, we are proposing to establish new payment rates for immunization administration services described by CPT Codes 90460, 90461, 90471, 90472, 90473, and 90474, and HCPCS Code G0008, G0009, and G0010 that better reflect the relative resources involved in furnishing all of these services in consideration of payment stability for stakeholders, public health concerns, and the importance of these services for Medicare beneficiaries.

I am now going to turn the call over to Lindsey Baldwin to discuss Medicare coverage for opioid use disorder treatment services. Lindsey.

Lindsey Baldwin: Great. Thanks, Sarah. This is Lindsey Baldwin. And I'll go over the proposals for Medicare coverage of opioid use disorder treatment services furnished by Opioid Treatment Programs or OTPs. For CY 2021 we're proposing to create two new add on codes describing payment for OTPs when they furnish beneficiaries with a take-home supply of naloxone for opioid overdose reversal. We're proposing one add on code for nasal naloxone, another add on code for auto injector naloxone. And we're seeking comment on providing patients with injectable naloxone.

We have a discussion in the rule that we're exploring claims processing

flexibilities that would allow OTPs to bill on Institutional Claim Forms. We're also proposing to revise the regulation text in order to allow periodic assessments to be furnished via two-way interactive audio-video communication technology.

We're also providing clarification related to the date of service, use on claims for the weekly bundles, and add on codes. And lastly, we're seeking comment on whether we should consider stratification of the coding and payment to account for significant differences in resource costs among patients.

And with that, I will pass it off to JoAnna Baldwin to talk about appropriate use criteria.

JoAnna Baldwin: Great. Thank you, Lindsey. So today I have a brief but important update about the Appropriate Use Criteria Program.

And that is the program will continue its educational and operations testing period for an additional year. That is the primary announcement. Let me take a moment. I wanted to lead with that. But let me take a moment to quickly recap the program and to put that announcement into perspective.

So the Appropriate Use Criteria Program is a Medicare fee-for-service Part B Program. And it requires that when a practitioner orders advanced diagnostic imaging for a Medicare beneficiary, they must consult a qualified clinical decision support mechanism. The outcome of that consultation will be whether the service that is - whether the imaging service that is being ordered adheres, does not adhere, or is not applicable to the appropriate use criteria that was consulted.

That information, that consultation information would then be transmitted to the practitioner that furnishes the advanced diagnostic imaging service as well as the facility that is providing that advanced diagnostic imaging service. And the information about the consultation would be reported to Medicare on the Claim Form.

So I wanted to provide that quick recap to help put into perspective today's announcement. So the program for Calendar Year 2020 we are currently in the educational and operations testing period which is a no-penalty phase. There are no payment consequences during this year for the AUC Program. And this phase will continue through Calendar Year 2021.

I know a lot of our stakeholders are - were used to seeing this program discussed in the Physician Fee Schedule which is why I am joining today's call which is primarily about the Physician Fee Schedule proposed rule. But we were not in the rule this year. We were able to make this announcement on our web site. It is currently posted on our web site.

So I'll just take a second to steer our stakeholders and practitioners to that location so they can see the announcement. We are working to update our educational material so that everything aligns with this web site posting.

So just very briefly, we are on cms.gov/medicare and we are listed under the Quality Initiative and Patient Assessment Instruments is where we can be found. And you'll see the Appropriate Use Criteria Program is listed right there.

The next topic today is open payments. And I will turn it over to Kathleen Ott.

Kathleen Ott: Thank you so much. As she mentioned, my name is Kathleen Ott. And I work on compliance and communications for the Open Payments Program.

Some of you are probably already familiar with the program. But I wanted to go over some highlights of it very quickly as a refresher. Open Payments is a transparency program where on an annual basis drug and device companies report payments or other transfers of value made to physicians and teaching hospitals. That information is published once per year on our web site.

We successfully published 2919 data in June of this year and it's currently available for download. It's also available for review and dispute if you are a current physician covered recipient. Again that data was already published but you can still put the disputes into our system until the end of the calendar year. And the data if it's changed may be updated in feature refreshes.

I'd also like to mention our program's COVID-19 statement quickly which says that we are sensitive to the difficulties presented by the pandemic but we are bound to program guidelines by the statute. So we are not able to waive any of these requirements.

If you want any more information on our Program's COVID Response you can visit the Contact Us page of cms.gov/openpayments.

The main thing I'd like to highlight with our meeting today is that there were some changes made to the Open Payments Program in the Support Act that take effect with the 2021 data. First NPIs will now be published. And second, there are five new covered recipient types.

That means along with physicians and teaching hospitals new covered

recipient types will be physician's assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and anesthesiologist assistants, and certified nurse midwives. We're working on making these changes as clear as possible for these new covered recipients.

There is a new page on our web site that is targeted to these new types. And we will continually be updating it with new information as it's available. You can find that link under the Program Expansion box on the Open Payment site landing page.

We're asking specifically that physicians with the new covered recipient types in their offices or organizations let those individuals know that this change is coming and point them to our web site and the new page as a resource. Also if your office or organization has a consolidated review and dispute process it will now need to include those two covered recipient types.

Again please note that the data on these new covered recipient types will be collected from January 2021 and onward. The first review and dispute period for these new covered recipients will be in April and May of 2022.

Those are all the talking points that I had for this afternoon. But if you need more information, the web site again is cms.gov/openpayments.

Thank you for your attention. And I'll turn it back to Jill Darling.

Jill Darling: Thank you, Kathleen, and thank you to all of our speakers today. Alysa will you please open the lines for Q&A?

Coordinator: Thank you. We'll now begin the question and answer session. If you would

like to ask a question, please press star 1 on your touchtone phone. Make sure your phone is unmuted and record your name clearly when prompted. Your name will be required to introduce your question. If you need to withdraw your question you may press star 2. Again to ask a question, please press star 1 and record your name. It will take a moment for questions to come through. Please standby.

And our first question comes from Ed Gaines. Your line is open.

Ed Gaines: Thank you CMS for the opportunity for the Q&A and the Open-Door Forums. They're very, very helpful. Question regarding the COVID counseling codes. You announced that recently. I'm wondering. Those are time-based codes. Are you planning on issuing more guidance or are the MACs going to be issuing more guidance about documentation and coding as it relates to those COVID counseling codes?

Patrick Sartini: Thanks for that question.

Jill Darling: Go ahead, Pat.

Patrick Sartini: Thanks for the question. So we have put out I think a number of FAQs or documents about how use of the existing E&M coding could be used in those scenarios.

And the requirements are still the same. For example, if that encounter is more than 50% of that encounter is used for counseling then one would use time to account for what level of service is billed.

But the requirements truly haven't changed for that code set. So would

certainly point you to CPT Manual or other guidance out there that really discusses how those codes should be selected. And, of course, if all else fails, you can certainly reach out to your MAC to also ask a question.

Ed Gaines: Thank you.

Coordinator: Our next question comes from Christie May. Your line is open.

Christie May: Hi. I'm wondering if you can give me an idea if the proposed cuts take effect if, for example, where ortho we are looking at a negative 5% reduction. However, there is going to be some increases in the E&M Coding Systems.

And can you kind of advice how all of this is going to affect across the board since there's the increase in E&M but we're expecting a negative 5% reduction. Is that going to take place on surgeries, things such as that nature?

Woman: Sure. I can take that question. So in the Impact Table that you see in the Impact Section for the proposed rule, we illustrate how we expect what the impacts will look like for 2021 as a result of both the E&M revaluations and other valuations of other codes that we do on a regular basis. And those would be impacted again for 2021.

Our statute requires that when spending increases by more than $20 million on an annual basis and expected spending I mean our statute requires us to budget neutralize across the Fee Schedule so that that means that all codes are adjusted when the values of some codes go up and the values of other codes go down.

Christie May: Okay. And I thought the Fee Schedule the proposal pulled up, can you advise

what table that was again?

Woman: I don't have that. Let's see. It's going to be at the back of the rule in the DB Impacts pages.

Christie May: Okay.

Woman 1: One second. I'm scanning through it. Unfortunately, I didn't have that page right in front of me.

Christie May: I know. And it's a long one this year.

Woman: It's so long. Yes, just how it is.

Patrick Sartini: Yes. We could also...

((Crosstalk))

Patrick Sartini: We could also have her send in her information. And we can follow-up.

Woman: Yes, absolutely. Yes. Can send us an email at partnerships@cms.hhs.gov. And we'll provide you with correct page information.

Christie May: Okay. Thank you very much.

Woman: Sure.

Coordinator: The next question comes from Patrick. Your line is open.

Patrick: Yes. Thank you so much for doing these forums. We're in FQHC. And what we're looking for is if the pandemic expands is there a plan on increasing the payment for the amount of the services? Currently that we're only billing the G2 or (25) on the claim and it's not taking to affect that RHCs and FQHCs do a higher level of a visit including more complex patients and more comorbidities.

Emily: Hi. This is Emily. I am not sure that we have actually the right subject matter experts to speak to FQHC and RHC telehealth policy on the line. But if you could please submit that question to the mailbox, we can try to get it routed to the right area.

Patrick: All right. That's perfect. Thank you so much.

Coordinator: And again as a reminder. If you'd like to ask a question please press star 1 and record your name. The next question comes from Beverly. Your line is open. Beverly your line is open.

Beverly: I'm sorry. Can you hear me? Hello.

Jill Darling: Yes, we can. Go ahead. We can.

Beverly: Okay. I'm trying to get clarification on the teaching physician guidance. It sounded like what you said is that the exemption for the teaching physician that we currently have under the PHE is eligible based on the CPT Codes identified in the telemedicine list that was expanded because we were trying to determine if that exemption under the PHE is applicable in all places of service. So it sounds like it is going by the CPT Code level that is on the CMS list. Would that be correct?

Woman: Sure. So to clarify that, if you're in - so you would build the GC Modifier for any service that, in which you have a resident involved in furnishing a service with a teaching physician. And that's not restricted to a particular list of CPTs with the exception of surgical and interventional services where we're continuing to require the personal presence of the teaching physician.

For the primary care exception however under that provision that permits residents to furnish care to beneficiaries in certain primary care centers without the presence of a teaching physician. And under the ordinary time policy, residents can furnish certain levels of E&Ms. And we - for the public health emergency we've expanded that list to some other services and under - and in that case, teaching physicians would be billing the GE modifier along with the claim.

And under any of these scenarios residents or I should say that teaching physicians may involve residents in furnishing services that are on the - that are telehealth as well.

Beverly: Okay. So can I just make sure that I understand? If the CPT level is on the covered list currently and that is an inpatient level that's where some of our biggest need is in our behavioral health services, then the teaching physician could provide oversight via telemedicine to the resident when the resident is providing the approved CPT Code on an inpatient basis. Correct.

Woman 1: Yes. Yes. You've got it.

Beverly: Great. Thank you.

Coordinator: Your next question comes from Diane. Your line is open.

Diane Przepiorski: Good morning good, afternoon to everyone. This is Diane Przepiorski with the California Orthopedic Association. Also, an orthopedic (agency).

The first question is could you please repeat the URL where we can find the announcement on the appropriate use criteria change this morning?

And then the second question is, we were also expecting a requirement for e-prescribing as of the first of the year for providers prescribing controlled substances. And we're wondering whether or not CMS is moving forward with that requirement in January.

Thank you.

JoAnna Baldwin: This is JoAnna. I can take the first question about the Appropriate Use Criteria Program announcement.

And I'll, you know, and I'll repeat. If you can't find the link please feel free to send an email to the resource box that's been mentioned. And we can certainly provide you with the link directly so you don't have trouble finding it.

But the web site is cms.gov/medicare. And from there you have to scroll pretty far down. But there's a subheading called Quality Initiatives and Patient Assessment Instruments. And it is in that list that you'll find appropriate use criteria.

Diane Przepiorski: Okay. Thank you. And what about the e-prescribing?

Marge Watchorn: This is Marge Watchorn. Thank you for that question. I don't think that we have the right experts on the call today who can address that question. So if you could please send an email to partnership@cms.hhs.gov. And we can get that routed to the correct individuals.

Diane Przepiorski: Okay. Thank you very much.

Coordinator: The next question comes from Lisa. Your line is open.

Lisa Stand: Hi. This is Lisa Stand with the American Nurses Association. And my question is about the open payments' expansion.

And thank you for pointing out the new material on the web site. My question though is whether there is going to be any further rulemaking to implement the Support Act expansion, for instance, adding the practitioner role to the CFR regulations on open payments.

Thank you.

Kathleen Ott: Thanks for that question. At this time, I'm not aware of any additional rulemaking. I'm sure that's something that would be helpful. If you have any ideas, we would love to hear why that would be useful. So if you visit the Open Payment's Contact Us page, that would be great to hear.

But at this time I'm not aware of any additional rulemaking.

Lisa Stand: Thank you.

Coordinator: And I'm showing no questions in the queue at this time.

Jill Darling: And I'll hand the call back over to Marge for closing remarks.

Marge Watchorn: Thanks, Jill. And I just wanted to reiterate again. We do appreciate all of the work that you all are doing, you know, on the front lines. Most of us, you know, live and work in Baltimore.

And it's really important for us to hear from you in terms of what your experiences are and what your thoughts are on these policies. So definitely want to encourage you to read the rule. Consider how the proposals would affect your practices and submit your thoughts, any comments that you have.

And believe it or not, comments that are supportive of our policies are just as important for us to hear, you know. Are we on the right track? That sort of thing as well as areas that you feel our policies could be improved or revised in a way that would make more sense for you all.

So again thank you so much for taking the time to spend with us and to hear about some of the work we're doing. And thank you again for all the work you all do.

Gene Freund: And this is Gene Freund. I want to echo the importance of getting those comments in, both positive and negative comments because the people working on the rules cannot - basically can't act on things that weren't submitted by public comment.

And thanks again for all you do.

Marge Watchorn: Okay Jill, I think we'll turn it back to you to close it out.

Jill Darling: Again everyone, thank you. Again the email is partnership@cms.hhs.gov for any questions or comments. And we look forward to talking to you to - at our next Physicians Open Door Forum. Thanks, everyone. Have a great day.

Coordinator: That concludes today's conference. Thank you for participating. You may disconnect at this time.

End