Rural Rounds Summary

JULY 15, 2026

About Us

Rural Rounds was started as a way to connect rural health leaders across the nation in order to tackle the real-world issues facing rural healthcare today. You no longer have to feel isolated and you don't have to fight your battles alone!

We know that leading a clinic in Rural America brings it own challenges and it can often feel very isolating. So, every Wednesday from 9am to 10am CST, rural health leaders from across the United States come together virtually to discuss hot topics or challenges that are facing their clinics and organizations. This is a safe zone for leaders to ask questions, share ideas, and learn from their peers.

Summary of Today's Rural Rounds

Thank you to those who brought important topics to today's discussion. Below is a summary of what we discussed.

Proposed 2027 Physician Fee Schedule Final Rule- Diabetes Self Management Training & Nutrition Therapy

- CMS recently released the proposed 2027 Physician Fee Schedule Final Rule and within it they are proposing to allow RHCS to be paid at the All-Inclusive Rate (AIR) for Diabetes Self Management (DSMT) and Medical Nutrition Therapy (MNT) services.
- These services may be furnished by providers other than RHC practitioners (such as registered dietitians) but they must be under the direct supervision of an RHC practitioner (MD, DO, NP, PA).
- If DSMT or MNT services are furnished the same day as another qualified visit RHCs would only receive one AIR payment.
- This is a proposed rule and has not been finalized. RHCs should NOT begin to implement these services until the rule if finalized and not until after the effective date. More information is to come if finalized.

Follow Up Visit Workflow (Process for ensuring follow up visits are scheduled before the patient leaves)

- Attendee Response
  - Providers finish and sign off on note before patient leaves

    - The patients stop at front desk as they leave and the receptionist reviews the note
    - Receptionist will schedule patient for follow up visits, labs, etc. based on the orders in the note. They will also print work excuses.
    - If patient does not wish to schedule at that time the receptionist will put in a reminder (recall) so that the patient can be contacted later to schedule
    - Receptionists also check to make sure the patient is scheduled for other past requested follow up visits. Rule every patient should be scheduled for a follow up in the future.
- Attendee Response
    - Yellow colored paper slips are available in all rooms for the providers to utilize, where they write down any follow up orders. They have patient name, provider name and options for follow up (3 months, 6 months, 1 year), AWV, H&P to circle, along with labs or other testing patient may need.
    - The patient stops at the front desk and give the receptionist the yellow slip and they schedule the visit/s accordingly
    - The yellow slips go back to the nursing staff to follow up and ensure all visits have been scheduled. They will put in any future orders for labs, etc.

Triage Nurse (Who has and any job description to share?)

- Attendee Response
    - Has a brand new job description for Triage Nurse. Will send to Cassie and it will be sent out to attendees.
- Consultant Response
    - Make sure you are implementing protocols, approved by your providers, for triage nurses use.
    - There are books that can be purchased with protocols, but make sure your providers sign off on the protocols they approve.
- Attendee Response
    - Utilize a Clear Triage online system that nurses can input symptoms and gives you a stop light report.
    - You can actually text the patients with instructions
    - Attendee will send information to Cassie and will share it out with attendees.

Medication Refills (Do nurses enter refills or do the providers?)

- Attendee Response
    - Nurses handle all refills except for Controlled Substances
- Attendee Response
    - Triage nurse handles all refills with other nurses work the pool when needed.
    - Working with providers to get refills entered during the patients 3/6/9 month/yearly appointments to help limit the number of refill requests they are getting.
    - Also have patient contact the pharmacy first before calling office, as often there are refills available
- Consultant Response
    - Make sure to check your state regulations on delegation to ensure there are no limitations on who can enter medication orders

Care Management (Does anyone have protocols for implementing Remote Patient Monitoring and handling results?)

- Attendee Response
    - Utilize an outside company for RPM devices and Chronic Care Management (CCM).
    - Up to provider enroll and do the care plan with the patient.

    - Does have an onsite CCM coordinator that sets the patient up on device
    - Have offsite Patient Health Advocates that work with onsite staff and do the direct calls with the patients.
    - Has an onsite Transitional Care Management (TCM) coordinator
- Consultant Response
    - Several companies are available to outsource your RPM, CCM, etc. Make sure you do your research and vet the companies. Make sure they understand Rural Health.
    - Reach out to any of the consultants if you have questions on any particular companies
- Attendee Response
    - No longer doing CCM, but has moved to Advanced Primary Care Management (APCM).
    - Consultant Response- Similar to APCM, but little different from CCM. If need more information, we can schedule time for more information on these different models.
- Attendee Response
    - For Blood Pressure protocols they recommend having the providers sign off on any.
    - Recommend separating the alerts between non-STAT and STAT
    - Avoid alert fatigue with patients, so not contacting the patient with every reading.
        - Example, for the non-STAT alerts, greater than 140/90 and there are three (3) consecutive readings over the 140/90 range than that triggers outreach to the patient
- Attendee Response
    - Has CCM files that they are happy to share.
    - Protocols need approved
    - Suggest using AI to get a start and then take to providers for tweaking and approvals

Payers (Medicare Advantage) That Recognize Your RHC Designation and The Guidelines

- Attendee Response
    - Re-negotiated new contracts with all Medicare Advantage payers to get them to pay the AIR
    - Send rate letters to them annually or when rate changes
- Consultant Response
    - When a contract is in place, the contract trumps and they do not have to pay your AIR if the contract speaks differently (Example, Fee-for-service contract, will pay you FFS rates and not your AIR).
    - Pay close attention to contracts. Some insurance the effective date of the rate change does not back date to January 1, so may have different effect dates of rate changes.
    - If you <u>do not</u> have a contract with a Med Advantage payer then the MA should pay you your AIR. You often will have to send them your rate letter with each claim.

Rural Health Transformation Program (RHTP)

- Consultant Response
    - RHTP is state specific. There were no specific state questions asked.
    - Encourage you to stay on top of in your state. NARHC is putting out updates in their newsletter.
    - If have questions, please reach out to any the consultants to help guide you

Insurance Medical Record Requests (How do you handle or respond to them?)

- Consultant Response
    - Clinics get blanket requests to send a range of dates of records to insurance companies
    - Many of these requests are not HIPAA compliant. Make sure you properly vet them.
    - They should only be requesting information on claims they have adjudicated. If requesting more than that may require additional written permission from the patient.

- You do not have to respond to these requests. There is a letter template you can send back to the insurances. A sample letter will be sent out or reach out to a consultant for a sample letter.
- Many of the Medicare Advantage plans are requesting in order to review past medical records in order to increase the patients RAF Score in order to receive more money from Medicare

Staff Retention (Trouble getting new receptionists and Medical Assistants)

- Attendee Response
  - Giving sign on bonuses for nursing staff
  - Give after working 6 months.
- Attendee Response
  - Seen good success with paying 100% of their insurance premium and purchase a Gap Insurance so zero out of pocket for staff
- Attendee Response
  - Enroll current receptionist staff in an MA program and pay for it
  - Was able to use a discount through state rural health association
  - Helps make the staff well rounded by working the front and the clinical side
- Attendee Response
  - Work on the culture within the clinic
  - 90% of those they have hired were referred by someone internally
  - Also offer bonus to staff who refer new employees
- Attendee Response
  - Also focus on culture
  - Administrator started to pay attention to pain points for each department/person
  - Communication was biggest problem with no streamlined communication
  - Defined who staff went to based on what the situation
  - With improved communication staff seem happier
- Attendee Response
  - Offered staff to work four 10-hour days per week vs five 8-hour days
  - Has been a big draw to new employees

Understanding Part A Remits (Negative EOBs)

- Consultant Response
  - Negative remits happen because of patient Part B deductibles (We receive remits from the Part A MAC, but the patient is utilizing their Part B benefits in an RHC)
  - Every January, Medicare Part B deductibles start over
  - Often, depending on the clinics internal fee schedule, patients may meet their deductible at their first or second visit to the RHC at the beginning of the year.
  - The deductible is applied based on the allowable charges (which are the total charges on the RHC claim). Example, total charges are $350 and the deductible is $300. They will meet the deductible at that visit.
  - Medicare processes as follows:
    - $300 applied to the deductible
    - Remaining balance of $50.00 is what the 20% coinsurance is calculated on.
    - Patient responsible for the $300 deductible and $10 for the coinsurance. Patient is responsible for paying this.
    - Medicare then will take applied deductible amount and subtract the AIR and the remaining balance will result in a negative payment to the clinic.
  - Often in January and February, when everyone being seen is starting deductible over you will receive a “negative” remit because there was no positive payments made to take away from.

Once majority of patients start to meet the deductible and you have positive payments, Medicare will offset with the negative payments due to Medicare.
    - In the end the balance to the patient should be the deductible and coinsurance amount on the EOB.
    - Will add more information to next Rural Rounds rounds.
    - For more information on how to post these remits reach out to one of the consultants, as each system may handle differently.

Medicare Annual Wellness Visits (Can you do via telehealth and how to bill if done with an Acute visit?)

- Consultant Response
    - You can do AWV via telehealth. Through 9/30/2026 you can bill these will the G2025 and CS modifier and you will receive a separate telehealth rate of $97.35 (2026). Some MACs are not processing these claims correctly because they do not recognize the CS modifier. Often they are applying a coinsurance inappropriately.
    - Starting 10/1/026, you will begin billing telehealth visits to Medicare with one of the approved telehealth CPT codes and this includes AWV. Bill with the actual CPT, use 93 or 95 modifier, and NO CG modifier (not receiving AIR). You will no longer use the CS modifier for AWV done via telehealth.
- Consultant Response
    - You can do an AWV and an acute visit the same day, BUT you will not get an AIR for each service.
    - You would bill the AWV along with your acute visits (example 99213), and apply the CG modifier to the acute visit. Make patient aware they will be responsible for a portion of the visit because the acute issues addressed.
    - You would receive 80% of your AIR for the acute visit, plus 20% of the billed charges for the acute visit and the AWV will be written off.
    - Even though not getting paid separately for the AWV it is still important to report, as this is a benefit to the patient with limitations on frequency.

Topic Suggestions

If you would like to suggest a topic for upcoming Rural Round sessions, please visit www.empowerruralhs.com/ruralrounds to submit your topic. Submissions should be submitted each week by Tuesday at 3:00pm CST to be added to discussion for that week.

Invitation to Rural Rounds

If you know of someone who would benefit from attending Rural Rounds, please direct them to sign up at www.empowerruralhs.com/ruralrounds and click on “Get Your Spot at the Table.” Attendees must now complete a Zoom registration request in order to receive the recurring Zoom invite. You only have to complete this registration once.

Recording of Past Rural Rounds

Rural Rounds, starting 7/15/2026 will be recorded for those unable to attend. To access the recordings please visit www.empowerruralhs.com/ruralrounds. The videos will be posted within 24 hours after the session. A summary of the session will be emailed to all invitees, as well.

Contact

If you need further information on any topics discussed today or need further assistance, please email info@empowerruralhs.com

If you would like speak with any consultants participating in Rural Rounds, please contact them directly. No one participating in Rural Rounds will be directly solicited to purchase services. If you have any concerns, please email info@empowerruralhs.com to discuss.