Chronic Care Management Benefits, Workflow and Reimbursement
Tuesday, December 11, 2018
12:00pm – 1:00pm EST

Hello everyone, thank you for joining us with today's webinar. My name is Morgan Garguilo and I am the moderator for today. Our webinar is Chronic Care Management, Benefits, Workflow and Reimbursement. This webinar is in collaboration with the New England Rural Health Association.

I want to go over a few housekeeping items before we can. This call is being recorded for training purposes. I will give you information to access the recording after the webinar.

This call is on mute for the presentation. If you have not downloaded the slides, I have the phone number and the link in the chat, so you can get those.

We will take questions at the end of the recent webinar, and I will provide you with information how to unmute your line at that time. We will take questions through chat as well. If you have a question, feel free to enter it into the chat. We will answer questions partway through.

At this time, I would like to introduce our speaker, Susan Whittaker, CPC, CPMA. She has more than 25 years' experience with healthcare, currently is the Senior Program Coordinator for the New England QIN-QIO where she supports medical providers, including those in underserved and rural areas, through Medicare's merit-based system through the quality payment program. Additionally, working closely with patients and family and The Patient and Family Advisory Council for the region and is a Diabetes Self-Management Program Leader. She is a certified personal professional coder, and a certified professional medical auditor, through the Academy of professional coders. With that said, I am now going to pass it over to Susan. She will get the presentation started.

Hello everyone, thank you so much for joining the webinar today on Chronic Care Management, Benefits, Workflow and Reimbursement. We will talk about Chronic Care Management and, the workflow, and reimbursement.

This is our disclaimer. The only thing I want to say about this, this presentation does include some coding, and billing information. That changes every year. It is important to look at the regulations every year, to see if there are changes. If so, the codes that we will talk about today are still valid for 2019. However, there is a new code and a new service for chronic care management that we will talk about that did not make it into the slide. I will give you that information so that you can review it. You can locate it in in your coding book.

Here is the agenda. We will talk about the overview, what is chronic care management services, the importance of Chronic Care Management (CCM), which is how I will refer to it throughout the webinar, the required elements of the documentation and the medical record, that manage chronic care management coating, resources and we will have plenty of time for questions.
Chronic Care Management - Overview: Chronic Care Management is a physician offered covered service. It focuses on patients with two or more chronic diseases. And because the patients are engaged in their own care plans it does support and inform activated patients. A proactive team is assigned to your chronically ill patients. This ties in beautifully with Patient Centered Medical Home Care management support modules. as we will see on the next slide.

The Patient Centered Medical Home Care management competencies. Its purpose is to identify patients who might benefit from chronic care management, and there is a couple of ways to do this. One way is to run some diagnosis reports, and choose those that need chronic care, such as diabetes, heart disease and kidney disease.

We are talking about the medical population ages 65 and older. Another really great way to identify patients for chronic care management is through performing annual well visits. At the end you can identify patients who would benefit from the service. The second is collaborating with the patient and caregivers to develop a documented plan of care including lifestyle goals and patient preferences. Again, this goes along beautifully with the reimbursable Medicare coverage service. This slide list the ways that patient benefit from CCM. They received team of healthcare professionals, within your practice. A focused personalized care plan, support between medical visits, and because they have a copy of the care plan, it increases self-management for their illnesses.

Chronic care management, simplifies care coordination and transitions for the medical practice, by creating a mechanism by which you can track and manage all non-face-to-face care in one location within the medical record. It makes it easier to see what has been going on with your patient in between visits. It supports patient and family adherence to care plans because they are a part of the care plan, they have helped to created. It also increases patient practice communication. Last but not least, the first bullet, billing for services that you already provide. We know this happens all the time, you are doing in between office visit care with patients, and this is one way to get paid for doing it.

According to CMS, an estimated 177 million Americans have one or more chronic health conditions. One in four adults have two or more chronic health conditions, such as, heart disease, cancer, Alzheimer's disease, kidney disease, stroke, and COPD. Most chronic diseases are caused by a short list of risk behaviors as listed by The Centers for Disease Control. The list of these short risk behaviors include tobacco use and exposure to secondhand smoke, poor nutrition including diets and low in fruits and vegetables, high in sodium and saturated fats, lack of physical activity and excessive alcohol use. These are wonderful things to know about, and to put mitigating strategies for these risk behaviors into your comprehensive care plan for your patient.

CMS.gov research statistical office has a wealth of information about chronic conditions. Every state has a report on this website, but I live and work in Maine and I thought I would pull the statistics for Maine. This is listing of chronic conditions for male and female, 65 years and older. You will notice on the left-hand column the females with 0 to 1 chronic conditions is 34.8%. And the males are just slightly higher at 38.1%. And the second, third and fourth columns list patients with two or more chronic conditions. You will notice as we get up to four and five chronic conditions, and six and above, the statistics are the same for males and females. This report tells you that patients that actually qualify for chronic care management, and for females, in Maine, with two or more chronic conditions, 65.3% qualify. So, 65.3% of your female population in Maine are likely to qualify for these services. 61.9% of the males. That is a lot of people that could benefit.

This is the chronic conditions chart book for Medicare. It lists the prevalence of chronic conditions along the scope among Part B beneficiaries, from 2015. You can see hypertension is the most prevalent disease at 55%. Followed by hyperlipidemia, arthritis, diabetes, heart disease and chronic kidney disease. Also, I want to point out that 17% of that population is known to have depression, which can be included in your management planning.

CMS listed chronic care conditions that you could consider, realizing that this includes these conditions but not limited to these conditions. Such as Alzheimer's, arthritis, asthma, atrial fibrillation, autism disorders, cancer, COPD, cardiovascular disease, depression, diabetes, hypertension and infectious diseases such as hepatitis and HIV. I would like you to consider substance abuse disorders as well. That will be something that everyone is grappling with on a large scale, and it would fit into this model.

CCM, chronic care management is important in rural areas as well. According to the American health ranking senior report for 2018. Seniors who live in rural areas experience health disparities across a wide range of behavioral and outcome measures. This report is wonderful, it lists, and it gives a health report by state. It will give your state ranking, successes and challenges, and a full section of disparities in rural health. I have chosen some of these disparities to highlight today. For example, rural seniors are more physically inactive. Physically inactive, according to report, is no activity or exercise other than a regular job. And 34.3% of rural seniors are inactive compared to about 30% of urban and suburban seniors. Fewer have very good or excellent health, fewer are vaccinated for flu, and more rural seniors report falling. The prevalence of falls among urban seniors is about 29.5%. For rural seniors it is 34 and 32.4% more rural seniors smoke.

That is the Chronic Care Management. Now we will talk about Operationalizing Chronic Care Management, Eligibility, Workflow, Documentation and Billing.

First, is Medicare's patient eligibility. The patient is eligible with part B Medicare or dual eligible Medicare and Medicaid patients. Also, some HMO plans and commercial plans cover chronic care management services. But, I am speaking mostly about how this works with the Medicare population. Patients need to have two or more chronic illnesses, the illnesses need to be expected to last at least 12 months, with risk of exacerbation, decompensation, functional decline or death. Patient consent is necessary to render the services. A lot of people ask me, why would a patient consent to receiving services that they perceive that they already have? But there is some rationale that you can let patients know, you will be allowed to bill for their services between office visits, which in the past you were unable to do so. This allows you to maintain the necessary staff to meet their needs between office visits and perhaps giving them some regular check-ins into the office.

I just want to say a word about Medicare's annual wellness visits. This is a wonderful opportunity to identify patients for chronic care management. There are three types of annual wellness visits. The initial preventive physical Exam (IPPE) (G0402) provided within the first year of Medicare eligibility. The Annual Wellness Visit, Initial (AWV) (G0438), provided within the second year of Medicare eligibility, and the Annual Wellness Visit, subsequent (AWV) (G0439). Those are the codes on the side. If you are within it will be G0468. This is an excellent time to check in with people, figuring out what they need for screening, creating a care plan, and recommend them for CCM.

Who can provide CCM services? This slide will be updated according to the 2019 regulations that have come out. CMS has decided to add a new CCM service, which will be chronic care management provided personally by physicians. That will be billed differently. I will explain the code momentarily. It is 99491. The strategy now is to have clinical staff to provide chronic care management within the office, and billing one-way. If your physicians care to do the CCM instead, they would bill under a different code. The two codes cannot be reported together. The strategy would be to choose who does the most chronic care within your office. Whether your care manages are nursing staff, you will choose to bill iy that way. To bill it that way. I will change the slide to see who can provide supervised by the physicians

and non-physician practitioners. Your billing for providers, will go under the physician and/or the billing providers. The CCM services rendered by your nurses, medical assistance, care managers.

How do you begin? Medicare used to require an initiating visit, but now they will allow you to start chronic care management with patient consent and the creation of a care plan, at any time for an established patient who has been seen within one year. However, if you have a new patient, or patients who have not been seen within one year. They would need an initiating visit. Again, this is a great time for the annual wellness check-up or an office visit, to get them signed up or enrolled in the program. Again, the patient consent may be verbal, but it must be documented in the medical record. A lot of practices choose to have a form, so they can go ahead and keep it in a certain place, so they can access it more easily.

I see there is a question that chat. I am going to go ahead and dress it now. Are the annual wellness visits actually a "physical"? I know when Medicare first started to talk about annual wellness visits, it was as a No-Touch visit. Which I thought it was relatively fortunate. There are certain elements of exams between annual well visit, vital signs, hearing screenings, and the other thing…it is an excellent time to give a Medicare woman her annual pelvic and breast exam, or a prostate exam for a male. Some elements can address all the needs of a physical exam. However, the important thing to note, if you provide a Medicare Part B patient with the old physical exam, that is not covered at all. They would receive that entire bill which is a real problem for patients. Again, with community health workers, if they are a part of the clinical staff within your office, I would have to say yes. Also, other practices have talked about having a life coach involved in CCM. Again, I think, this is where you want to make sure that the life coach is doing chronic care disease management, as opposed to health education for other purposes.

I am going to talk about the care plan. Here is the comprehensive care plan. You would need to have these elements. This is the documentation that would support your care plan. You want to list the problems, that is the chronic problems for which you are initiating this management. The prognosis, your measurable goals, symptom management, interventions, community services plan, things like if the patient is having trouble falling. Will they be with in balance or will they be with the diabetes management? Also, in general, it is best to establish a review date. The review date can be whatever the physician thinks. If this is someone who was fairly stable, it could be six months, or I think a year is a little long. It can be monthly if you have someone very ill, or it can be weekly. The patient does receive a copy of this care plan, and again this ties in beautifully with Patient Centered Medical Home Management Care components.

Talking more about the medical record documentation. The way this works, you would establish an account for the monthly CCM. In that account you would list flowsheet style, the actions of chronic care management. You must include a summary of actions. For example, the patient calls in and they are experiencing nausea from chemotherapy. They have medications ordered, and maybe the dosage is altered. In that case, you want to include a summary of that action, and the date, and who performed the action, and the time spent performing the action.
You want to check your electronic health record (EHR) for any CCM records that might be available. If you do not have templates, it is important that you list who performed the action, without signing and dropping the charge in the electronic health record. The charge usually gets signed off at the end of the month. You can list to perform the action, as you go along.

I am going to take a moment to look at the chat.

The question is “Is there any role for care coordinators?” I would say there is a role for care coordinators.

Answer: Definitely. Care coordination is a part of the CCM services.

Another Question is “There used to be a restriction on the types/versions of EHR that were needed to bill for CCM. Is that still in place, or can any EHR be used?”

Answer: I do not know of any restriction of types of Electronic health records that are needed to bill for CCM. I do know that it is required that a certified electronic health record be used. It does not say the year, but you must be able to maintain a current problem list, medication reconciliation and health history. As long as your electronic health record is able to do that, I think you would be able to support chronic care management services, just by that.

This updated patient history on the electronic health record, it ties in beautifully with patients that are Patient Centered Medical Home. Knowing and managing your patient those are exact components of a particular part of PCMH know as Chronic care management billing information. I will not go through this. We will take a few more versions of the chat that might have not been addressed already.

As I mentioned, you want to create and encounter each month for tracking the summary of action for CCM documentation. The CCM would be built at the end of each calendar month. If your patient moves, or deceased, you may bill before the end of the month. If the patient requests that CCM Services be discontinued, that would become effective at the end of that calendar month. You can continue to list your CCM services to the end of that month.

This is the **coding summary**.
The first code, G0506 is an add-on code, that is a physician code. It is added to the initiating visit or the office visit, at which the comprehensive assessment and plan was created, and the patient was started on CCM services. Because that is a Medicare G code that would not be used for FQHC claim. The billing is on the next slide.

The all payer code is the 99490, chronic care management services at least 20 minutes. However, when you hit 60 minutes, you are able to build for complex CCM management. That term does not mean that your patient is more complex, it means that the service you had to provide for that length of time That makes it just a higher billable service and in any and/or 90 minutes and beyond, you can add 99498 for an additional 30 minutes.

If you are in a FQHC claim, or billing for Aetna, you could use all these payer codes. You cannot use them for your Medicare patients.

The new code 99491, it is a physician code. I will read the description, new for 2019. CCM services provided personally by a physician or other qualified health care professional. At least 30 minutes of physician or qualified healthcare professional time per calendar month. The physician services, the 99491 are for 30 minutes or more.

This is the coding for the RHC/tran15. This is new for January 1, 2018. If you have not heard about these, this is a service that you may bill the setting, G0511. This is a general care management code and the

actual payment is set up to average the payment for the other codes that other physician offices can used to bill. The payment for that G0511 is 228 2018. The 2019 fee schedule Lookout tool has not been updated yet. I am not sure what it will be for 2019.

The following services may not be billed in conjunction with chronic care management services. Just to be clear about the new position code, 99491. You will not be able to bill the clinical staff chronic care management, and physician stent -- management at the same time. Which I think is unfortunate. Because I am sure that healthcare team, including the physicians and clinical staff, but that is the way to set up. The strategy for that would be to have the bulk of your services done by either the clinical staff or the physician, and bill accordingly.

CCM services may not be built in conjunction with transitional care management. Also, it may not be billed with home health supervision, G0181.

For some of you that may not know what that is, when the physician receives a care plan from the home health agency, it is usually a three or four-page document that they sign off on. They may have an electronic version at this point. By signing off on the care plan, the physician agrees to supervise that care plan with the home health aide agency. That is a billable service and the code for this supervision is G0182. It will not be billed for chronic care management patients and renal services. CCM is excluded because they have their own set of codes for reimbursement. Prolonged E&M services will not be billed in conjunction with CCM. Also, another provider care management cannot be billed in conjunction with it. That is why patient consent is important. Hopefully the patient will realize that they are having chronic care management services through their primary care office, or through their specialty office. The physicians hopefully will not bill at the same time. One thing to bear in mind, if these CCM services are outsourced, to someone, through their primary care physician they would be unable to bill them for themselves.

I am going to go over a few resources. CMS has a great website called connected care for chronic care management initiatives. I do not see that it has been updated for the 2019 coding. That should be done soon. They have a nice toolkit. They have a very nice support for FQHC claims. There is a document called Frequently Asked Questions which is helpful. And the Center for Disease Control - chronic disease information is always valuable.

I have gone through that relatively quickly. I will rely on you, Morgan Garguilo to read some of the questions that have not been asked yet.

Sure. I know you have read a couple. If I repeat them I apologize.

I know you answer the first one that came in, Are the annual wellness visits actually a "physical"?

After that, we have a question about “Would Community Health Workers be included as well?”
Yes. I did answer that, but I do not mind answering it again. As long they are working under a billing physician, if they are working within a community health center, and a part of the clinical staff, they would be included. My email addresses on the last slide that we will show people. If I misinterpret those questions, please feel free to shoot me an email and we can discuss that.
swhittaker@healthcentricadvisors.org

And then Jesse, “I am confused about the documentation of the care plan, which I understand is necessary to bill for CCM. Can you give us a template for the care plan? Do you have a template that we can share with the folks with a care plan?
I did go over the elements of the care plan. If you go to the CMS connected toolkit, I am sure there is information on the care plan on that one. I think I'm going to keep going. I am going to take a look at some of these questions.

Is there a role for care coordinators? Definitely, yes. They are a part of the staff and coordinating care with other providers and community resources which can be counted as a CCM action. They would be a part of the healthcare team.

We were told for Medicare purposes that we cannot bulk together in a WV with a follow-up. Do you know anything about this?
Actually, there are regulations that I have read for Medicare, I encourage you to do what is right for your patient. In other words, you would not schedule a follow-up visit and an annual visit at the same time. That is correct, you would not do that. If someone comes in for an annual well visit, they present with an acute issue, and they said their shoulder is hurting and they come up with sinusitis. And the provider goes ahead and does a service of E&M and addresses the problem, you can bill the AWV with the modifier with an office visit. I would not schedule a follow-up and AWV at the same time, so many of the elements of tran 12 would be a part of the follow-up anyway. Getting current history, and things like that.

There used to be a restriction on the types/versions of EHR that were needed to bill for CCM. Is that still in place, or can any EHR be used?
I think I answered that one. CCM does require that an updated problem list, medication list and history are on the electronic health record.

The next question, we do not have EHR. We are paper charts and document all calls and house calls. Will that be enough?
You do have a certified EHR. But I do not think it needs to be a 2015 version for those purposes. If you do not have an EHR on your paper chart, that is a very good question. I do not know the answer to the question. The regulations stipulate that you need to have the updated information on an EHR. Having no EHR is probably not sufficient. But again, I think I would like to ask that question to CMS before finalizing that for you. If you could email me, that would be great.

Will patients have a copayment or coinsurance for these services?
I believe they do. I cannot say for certain, I apologize for that. I believe they do. Which is one of the reasons that some of the patients were upset about that a little bit. I know coinsurance and deductibles can apply to chronic care management in rural health centers. And coinsurance only applies in the FQHC. I do believe there is a copayment for private practices. I need to confirm that.

We can batch the billing all onto one day? I was told by my biller that we would need to bill on the day the management was performed?
Yes, one month's worth of action gets bundled into one bill. And that would go out at the end of the month. At the end of every month, the last day of the month is when that is billable.

Is the time billed as the sum for the month?

Yes, it is. You take all actions performed and you find the codes that most appropriately reflect the amount of time that you spend. And you would bill those accordingly.

Does CCM apply for patients on Title 19 in nursing facilities on Medicaid stay?
That is a very good question. I do know that CCM is covered in long-term care facilities and in the nursing home setting for their primary care physicians, to bill. I do not know if that completely answers your question. But I do know it is payable in the nursing homes.

Are the timeframes for billing per interaction or can be consolidated across the whole month per billing professional?
The new code that has come out, then 94914 Physician chronic care management services. If you are in a practice billing under the same, I would include the time spent on chronic care management, and personally done by physicians. I would consolidate that for the group. Whenever billing provider handled between visit, and not a face-to-face action for the patient, that would be included and billed for that month. And the same goes for the clinical staff only. Whatever clinical staff contributed to the chronic care management encounter for the month, their time would all be consolidated across the month as well. Just be aware of the new coding that splits out chronic care management for clinical staff, versus physicians, and other billable providers.

Do you want to see if there are any phone questions? Or should I just keep going?
Yes, we can keep going. If you would like to ask a question over the phone, press pound six to unmute yourself. Susan you can keep reading and chat as people get themselves unmuted. We will check to see if there are any questions on the line. Okay, that sounds great.

The next question…Can you bill for a TCM code and a CCM on different days of the month? That would be no. If you perform transitional care management services for patients within a given month, you would not also bill chronic care management on that same month or during the same month.

The next question, do these require face-to-face for Medicare, or can they be completed over the phone? The idea behind chronic care management services is that they are non-face-to-face. In other words, these are the phone calls, emails through the portal, things like that. You are handling these for your patient between visits. I will say that Medicare also has rolled out a new virtual check and service for physicians for 2019. It is a G code. One is a virtual check in, the other is a patient could send data for the physician to review, and the physician could bill for that service as well. Just a heads up. If you happen to decide to bill some of those virtual check in codes by physicians, those services would not be included in your chronic care management actions and time. You could still build CCM for all the other actions. All the CCM actions that the physician takes during the course of the month.

The next question. To clarify, can you use the physician code 99491 on the same day as an AWV?
The answer is yes. If the 99491 was being billed on the last day of the month, for example, like November 30. And that happens to be the day that your patient came in for their annual wellness visit, yes, you can bill both services. Remember that 99491 is a monthly code. You will bill that at the end of each month.

It looks like Jesse has sent us a blurb from patient health information.
Structured Recording of Patient Health Information

● Record the patient's demographics, problems, medications, and medication allergies using certified

Electronic Health Record (EHR) technology. This means a version of certified EHR that is acceptable under the EHR Incentive Programs as of December 31st of the calendar year preceding each Medicare PFS payment year. For more information, this is from CMS website, (https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/) unclear on meaning. It does look like EHR is required for CCM. As we suspected.

The next question from Denise. We need to take a further look at that. And to see if they reference chronic care management services. If they are talking about the care plan documentation, it does look like the electronic healthcare record is required.

Jesse, I heard the copayment was waived. It is possible, again I am not sure about the copayment physician office. I know there is no copayment for the annual wellness visit. I thought there was for CCM. I am not sure. You need to take a look at it. As I said there is are some coinsurance and deductible responsibility if applicable.

Sorry for asking here, do not know if it is on a slide until I go through them.
I will switch to the next slide. That is my email address Swhittaker@healthcentricadvisors.org . Perhaps if you copy it into your email. You should be able to get through to me that way.

If we are a FQHC can we bill a 99491?
I honestly doubt that, although I do not know for certain. But I do see there is a Medicare G0511 code is probably the only CCM code that you are going to be able to use in the FQHC. I would look for some regulations going down the road on that. I know it is a brand-new code and they should be coming out with more guidance on that soon.

The next question from Erica. So if I have a TCM on 12/8/18 I cannot do a CCM until Feb correct? Due to you cannot start a CCM in the Middle of the month?
That is correct. I need to look at that to see that transitional care management and when it will be billed out. You simply would not bill it out in the same month with the CCM.

Can you speak about core needing ACL and CCM services coordinating? What do you mean by ACL services? I am not exactly sure what you are referring to?

Okay, thank you for sharing that other website (Another website with details on EHR: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagementServicesChanges2017.pdf)
on the EHR details.

The last question that I see:
Do we need to document what happened in the CCM time (what was specifically discussed) or do we just document the time required?
You need to include the summary of the action. That is the guidance from CCM. Creating a summary of the action. It is not to be a long, drawn-out documentation. But you do want to say the purpose of the action, what was discussed, if anything was changed. You want to make it meaningful, so that of someone goes in the week after, and they say they know the patient talked to one of the nurses last week, and what happened. You really want to have enough information, so you can follow-up with the patient in a meaningful way. It is not just all about tracking time, and getting billed for it, it is also about creating a one-stop shopping in between office visits, and the care. And you can use it to help your

patients navigate their illnesses between office visits. Yes, definitely include a summary of the care and what happened. Especially if you do a check in, you want to know how the patient is doing. Go ahead and document that out.

Can the clinical staff create the care plan or MUST the provider create the care plan?
The care plan used to be created by the provider.

We are discussing Medicare only, but does chronic care management apply to other healthcare insurance?
When I did check this out a few years ago, other insurances were covering CCM. Now I know that some of them offer CCM in-house, like some of the insurance companies offer that service to patients. By doing that, they may decide not to pay for it. The thing to do is to go to the website, or go to your representative, of that insurance, Anthem, Aetna or whomever. You can ask for their policy on CCM to see if it is billable by them.

Does the consent need to be in writing?
No. It could be a verbal consent given to the provider. It does need to be documented in the medical record. Again, just for ease of finding the consent, when needed, it might be a nice idea to have a form that they fill out. But it is not necessary according to the regulation. Maybe at the initiating visit or the annual visit it could be documented that the patient has given consent for CCM services.

Okay, are there any calls waiting? Hello, if you would like to ask a question over the phone, please press pound six. Does anyone have a question?

I am sorry to belabor the point about the EHR. I actually had this difficulty. I used it as a point-of-care. When I last tried to do this in 2017, starting to use CCM. I had the version of the EHR checked, to see if it is compatible with CCM. Specifically, my version is the 3.7.
I would be careful out there starting this. Because not all versions of your EHR or supported on this. I still have yet to hear the defendant liberally whether that has been waived at this point with the new versions of the chronic care management billing. Okay. On your EHR version, were you unable to keep a current problem list, and medication list, and a health history for the patient? Or was it more of a version type, rather than the functionality of your EHR?
My EHR does do that. It was a matter of my version from 2014. And this only apply to EHR's that have been certified after the date of chronic care management. That was years ago. That was my roadblock and I am not totally clear.

I appreciate your feedback, thank you very much. I was under the impression, that you can keep the data up to date, and that would be meeting the regulation Medicare. Perhaps I need to look into that a little further, to see if they require a certain version. Thank you.
Thank you.

I have a question. Can you provide us with the slideshow of this, or is there anything on your manual? I would like to share this with other employees.
Yes, okay, is that the updated slide deck with the 2019 coding, Morgan Garguilo?
Yes.
Okay, are you able to access the link? I put a link in the chat conversation, on the right side of your screen. You can click on it to access the slides from today's presentation. If not, we will send out an email tomorrow, and it will contain the link to the website where you can get the slides.

Perfect, thank you very much.
You're welcome.

Do we have any other questions? You can enter them in chat, or by phone by pressing pound six on your phone. Okay, do you want to add anything before I add the closing remarks?

I want to thank everyone for joining us today. I appreciate your calling in today. Have a great rest of your day, thank you.

If you can go down to slides for me, I will do the closing remarks. Thank you everyone for a great discussion. I have a few announcements. I want to remind everyone we are on social media. You can visit us on Facebook, LinkedIn and You Tube. After you close out of the webinar, the evaluation will pop up on your computer. Please fill it out as we greatly appreciate it. If you do not have time to do it right now, you will receive an email tomorrow with the link to the evaluation, as well as the link to our event page. As I mentioned, the PowerPoint is on the website. Within the next few business days we will add a recording of the webinar. You can find a link in the chat would like it. Thank you for attending everyone. Have a great rest of your day.
Thank you, Susan.
Thank you, Morgan.