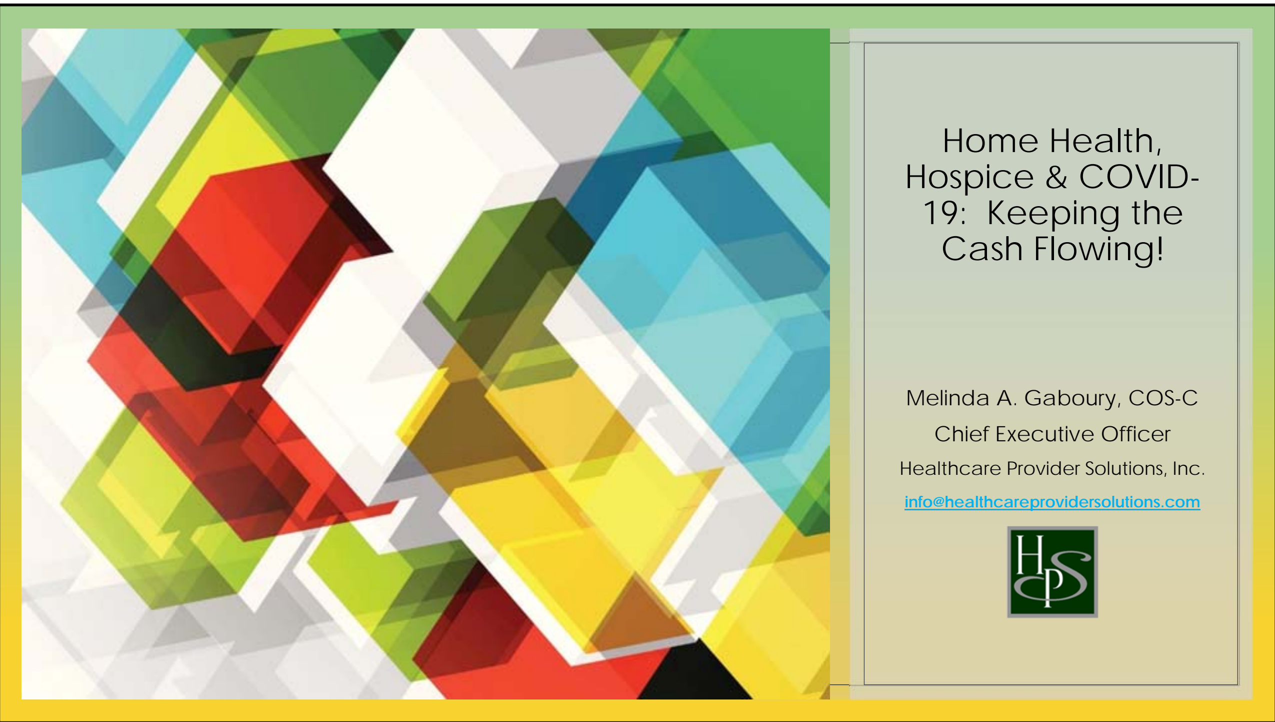

1

1135 Waivers Retro to 03/01/2020

- **Home Health**
  - Request for Anticipated Payment (RAP) – CMS is allowing the MACs to extend the auto-cancellation date of RAPs during emergencies.
  - OASIS Reporting – The 5-day requirement for completion has now been extended to 30 days.
  - OASIS Transmission – The 30-day submission requirement has been waived.
  - The initial assessment can be done via telehealth to establish homebound status, patient agreement to receive home health, etc. This can be carried out in the 48-hour window and meet the requirements. This does not include the comprehensive assessment of the patient, which continues to require an in-person visit.
  - Home Health Aide Supervision – the requirement to have an in-person aide supervisory visit is waived during the PHE – telehealth is recommended, but not required.

2

1135 Waivers Retro to 03/01/2020

- **Hospice -**
  - Volunteer Services – the requirement for the use of volunteers is waived during this PHE.
  - Non-Core Services – non-core hospice services are waived during this PHE such as physical, speech & occupational therapies
  - Comprehensive Assessment – The comprehensive assessment in hospice is still required to be an in-person visit but the timeframe for updating the comprehensive assessment has been extended from 15 to 21 days. Plan of Care must still be updated every 15 days.
  - Hospice Aide Supervision – the requirement to have an in-person aide supervisory visit is waived during the PHE – telehealth is recommended, but not required.

3

Quality Reporting Program (QRP)

- In accordance with 42 C.F.R. 412.560(c), 412.634(c), 413.360(c), 484.245(c), providers are excepted from the reporting of data on measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, and standardized patient assessment data required under these programs for calendar years (CYs) 2019 and 2020 for the following quarters specific to each program:
- **HHAs–Home Health QRP**
  - October 1, 2019–December 31, 2019 (Q4 2019)
  - January 1, 2020–March 31, 2020 (Q1 2020)
  - April 1, 2020–June 30, 2020 (Q2 2020)
- The OASIS must be completed as it pertains to payment – Start of Care, Follow-Up(Recertification), Other Follow-Up (significant change in condition), Resumption of Care (ROC) – Billing still requires that the OASIS used to calculate HIPPS code be transmitted and accepted prior to billing.

4

Quality Reporting Program (QRP)

- For the Home Health Value-Based Purchasing (HHVBP) Model, CMS is waiving enforcement of the following reporting requirements under the Model:
  - April 2020 new measures submission period (data collection period October 1, 2019 – March 31, 2020)
  - July 2020 new measures submission period (data collection period April 1, 2020 – June 30, 2020)
- The exceptions to the HH QRP and HH CAHPS reporting requirements will impact the calculation of performance measures under the HHVBP Model. CMS will address this issue with HHVBP Model participants at a later date.

5

Quality Reporting Program (QRP)

- In accordance with 42 C.F.R. 412.560(c), 412.634(c), 413.360(c), 484.245(c), providers are excepted from the reporting of data on measures, For HIS, the quarters are based on submission of HIS admission or discharge assessments. For CAHPS, the quarters are based on patient deaths in 2019 and 2020.
- **Hospice QRP**
  - October 1, 2019–December 31, 2019 (Q4 2019)
  - January 1, 2020–March 31, 2020 (Q1 2020)
  - April 1, 2020–June 30, 2020 (Q2 2020)

6

Telehealth

- **Home Health** – telehealth visits allowed to meet the **Face to Face (F2F)** requirement for all patients (not just COVID-19 related patients)
  - This visit can be billed by the physician, but NOT by the home health agency
  - There must be a two-way audio & video capacity
  - Home health agency can coordinate and can be in the home as this visit takes place, but again home health CANNOT bill for this.
  - Home health can conduct an initial assessment via telehealth to confirm the patient's eligibility, willingness to allow home health into the home and establish homebound status (to a degree). NOT BILLABLE BY HOME HEALTH! This is also NOT the comprehensive assessment/Start of Care OASIS visit – this MUST BE DONE IN PERSON.
  - Agencies have already discovered that doing the initial assessment via telehealth and then being in person for the SOC and assisting with F2F, with the physician, they are ensuring that the F2F encounter includes the needed elements for documentation. If patient has a facility encounter or an in-person physician encounter this would NOT be necessary.

7

Telehealth

- **Home Health** – telehealth visits for ongoing care.
  - Home health visits are allowed via telehealth. The following criteria for those visits must be met:
    - The telehealth visits MUST be included in the plan of care/orders, as telehealth visits, for the patients care in order to be provided
    - The telehealth visits CANNOT replace ordered in-person visits
    - There ARE NO BILLING codes for this service as this NOT A BILLABLE service.
    - These telehealth visits DO NOT count toward the LUPA thresholds.
  - HIPAA compliance -Covered health care providers will not be subject to penalties for violations of the HIPAA Privacy, Security, and Breach Notification Rules that occur in the good faith provision of telehealth during the COVID-19 nationwide public health emergency. **This Notification does not affect the application of the HIPAA Rules to other areas of health care outside of telehealth during the emergency.**
  - Waiver for this will end when the Public Health Emergency (PHE) has been declared ENDED.

8

Telehealth

- **Hospice –**
  - Telehealth visits allowed to meet the **Face to Face (F2F)** requirement for all patients (not just COVID-19 related patients)
  - This visit would be conducted by allowed physician or NP (PA not currently allowed)
  - There must be a two-way audio & video capacity
  - Can conduct Routine Home Care (RHC) under telehealth (does not have to have video), but must be a part of the plan of care and not jeopardize patient care.
  - Hospice is paid per diem and therefore there is no additional reimbursement for these visits and they are NOT reported on the claim.
  - Hospices are encouraged to do as much telehealth as is appropriate for the patient.

9

Homebound Status & Sequester

Patients who are suspected or confirmed to have COVID-19 along with other Medicare beneficiaries of advanced age may not physically meet the homebound standard even though they are instructed to self-isolate in their home. **However**, CDC and other guidance firmly states that these individuals should self-isolate and not venture into the open community as they are at high risk. As such, it is **"medically contra-indicated"** that they leave their homes. That is an existing standard for homebound status.

- 2% sequestration is being halted May 1 – December 1, 2020
  - Not yet determined whether this will be based on dates of service or payment dates.

10

NPPs to Certify Home Health Patients

Home Health

- Under the current statute only a physician (MD, DO or DPM) may certify patients for Medicare for home health services and sign orders for home health.
  - **Due to PHE, Congress passed legislation to permit NP, PA, and CNS (NPPs) to certify and order home health (*as permitted under state scope of practice*)**.
  - CMS accelerated implementation through non-enforcement policy issuance.
  - This is effective 03/01/2020….any patients that were on home health service as of 03/01/2020, the home health agency would need to get orders from the already covering physician to allow the NP, PA or CNS to sign any remaining orders.
  - With new Starts of Care or Recertifications during this PHE the NPP would be allowed to be the certifying practitioner with all oversite of the home health patient and NO physician is needed to co-sign the NPP orders.

11

Medical Review Halted

- **Targeted Probe and Educate (TPE)** - Home Health and Hospice
- TPE has been halted until further notice:
  - Any claims that have NOT had the chart sent in for review will be released for claims processing.
  - If you have had charts pulled for review but have not yet sent the chart in for review, DON'T!
  - If the Medicare MAC has already logged receipt of the chart for review, they will review that chart and return response as has already been occurring in TPE. NO OTHER charts will be pulled for review until further notice.

- Fraud Investigations do not cease!

12

Medical Review Halted

- **Review Choice Demonstration (RCD)** – Home Health
  - RCD is currently active in Ohio, Illinois & Texas and was set to begin in Florida and North Carolina on May 4.
  - RCD implementation in Florida and North Carolina HAS BEEN DELAYED until further notice.
  - Ohio, Illinois & Texas – if you are currently in the Pre-Claim Review (PCR) option of RCD it is being made optional for you to pause RCD/PCR if you would like to do so during the pandemic…..THE CATCH: as of April 5, 2020 Palmetto GBA is still stating that any agency that chooses to pause PCR during this time will have 100% ADR reviews on all claims that are submitted and paid during this time without a Unique Tracking Number (UTN).
  - There are ongoing discussions about this being changed so as not to subject agencies to this 100% ADR.

13

COVID-19 Diagnosis Coding for Home Health & Hospice

- There has been a code officially approved to be used in ICD-10-CM for COVID-19 for the USA and that is U07.1.
- This diagnosis code went into effect April 1, 2020 and can be used as the primary diagnosis of the patient in home health and hospice. This code is NOT in effect prior to April 1 and would not be accepted for dates of service prior to that.
- DO NOT USE U07.2 - - THIS IS NOT A CODE IN ICD-10-CM AND CANNOT BE USED IN THE USA.

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COVID-19 Diagnosis Coding for Home Health & Hospice

- **Home Health** – please note that this code is being implemented into the MMTA – Respiratory Clinical Grouping in PDGM and in a Low CoMorbidity category. Grouper should be updated April 6. Any RAPs & Finals prior to that would not allow this diagnosis as primary.
- EMRs will have to update this code in their acceptable primary list in order for the correct HIPPS code to calculate and the EMR to allow a claim with this code primary.
- **Hospice** – This can be used as the terminal/primary diagnosis for a hospice patient. Again, only April 1 and later admissions or recerts

15

Advanced/Accelerated Payments

CMS is making available Advanced Accelerated Payments to all provider types

- Providers can request up to 3 months of anticipated revenue
- Could receive as quickly as 7 days following request received by MAC
- After 120 days, CMS will offset claims payments against amounts owing for accelerated and advance payments
  - Full repayment required within 210 days
  - Providers under medical review ineligible (RCD does not count)
  - MAC handles all requests
- Be very cautious about amount that is requested…100% withhold begins on day 121 from disbursement of the funds to your agency. Need to make realistic projections.

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Cost Report Due Date Extension

CMS has instructed that the Medicare Cost Report (Home Health and Hospice) will have extended due dates due to this PHE. The following are the new due dates:

FYE	Initial Due Date	New Due Date
10/31/2019	3/31/2020	6/30/2020
11/30/2019	4/30/2020	6/30/2020
12/31/2019	6/1/2020	7/31/2020

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What Has Been Requested?

Home Health – the following items have been **requested, but not approved as of 04/05/2020**

- Face-to-Face be telephonic communication (no video)
- NPPs certifying & ordering home health be made permanent by CMS as soon as possible
- Venipunctures again be allowed during PHE
- Restore RAP payments to 60/40 - - 50/50 split
- Suspension of the 4.36% Behavioral Adjustment
- Allowing symptom code as primary for Person Under Investigation (PUI) that has been exposed to COVID-19
- Requirement for signed physician orders prior to billing final claims
- More flexibility in intermittent skilled nursing requirement
- Suspension of RCD completely with no 100% ADR after PHE
- Broad-scale settlements of appeals

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What Has Been Requested?

Home Health – the following items have been **requested, but not approved as of 04/05/2020**

- Suspension of HHVBP Demo
- Streamline Aide competency to direct patient care only
- Waive 12-hour annual inservices training requirement for Aides
- Abbreviated Comprehensive Assessment
- Permit therapy to conduct initial visit & comprehensive assessment even when nursing is ordered
- Allow telehealth OASIS recertification assessment for continued skilled need patients that are refusing in-person visits
- Waive written information requirement to be delivered to the patient
- Waive one direct discipline rule
- Relief from restriction under CLIA to permit home health to collect, transport, conduct & report COVID-19 test results
- Delay OASIS-E beyond 01/01/2021

19

What Has Been Requested?

Hospice – the following items have been **requested, but not approved as of 04/05/2020**

- Face-to-Face be telephonic communication (no video)
- Allow PAs to conduct hospice Face-to-Face
- Allow PAs & NPs to certify the terminal condition
- Expand telehealth allowance to not only RHC, but also GIP & Respite
- Allow subcontracting for core services
- Allow additional flexibility in the completion time for comprehensive assessment and updates to plan of care
- Allow for flexibilities related to GIP, CHC & Respite.
- Allow pseudo patients in Aide competencies
- Waive 12-hour annual in-services training requirement for Aides
- Allow flexibility with the 5-day window NOE & NOTR filing
- Allow verbal election of the Hospice Benefit
- Relief from restriction under CLIA to permit hospice to collect, transport, conduct & report COVID-19 test results

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Orders Management

Order management

- Receipt of physician signed & dated F2F & home health certifications, orders, & F2F encounter notes

- Timely signed orders will be critical to cash flow
- Order management must be treated with urgency, as if it were a new thing and we are forced to make it happen
- Assign someone the specific task in their job description and ensure that timelines established for follow-up and resending of orders is followed.
- Use the tools you have to the fullest – MOST EMRs have a physician order tracking mechanism that many don't realized exists

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Orders Management

- Not all physicians are the same…understand what each requires in order to get orders back timely.
- Know who is responsible in each office and hold them accountable
- Example timeline:
  - Day 7 ⇨ resend orders
  - Day 12 ⇨ call to physician office
  - Day 15 ⇨ escalate to clinical or manager
  - Day 20 ⇨ liaison visit to office

23

Request for Anticipated Payment (RAP)

- RAPs do NOT require OASIS to be transmitted before you file the RAP
- RAPs do NOT require a 5-day timely filing in 2020.
- RAPs ARE paid at 20% regardless of the HIPPS code accuracy
- RAPs do NOT require Occurrence Code 50
- RAPs do NOT contain 18-digit Treatment Auth Code
- RAPs ARE required to be in Paid Status before Final Claims will process and pay
- RAPs ARE required to have a HIPPS code that matches the HIPPS code on the Final Claim.

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Final Claims – Billing Requirements

Some data required on a PPS Final claims will be tweaked for PDGM:

- 18-digit Treatment Authorization Code/OASIS Matching Key will **NO Longer exist** under PDGM
- **Occurrence Code 50** will be entered on the Final claims with the Occurrence Date equal to the date the assessment is completed from M0090 of the OASIS that your system used to create the HIPPS (RTP Reason code 37253)
- **Occurrence Codes 61 & 62** will be utilized on 1st (initial) 30-day payment period Finals to signify that the patient is an Institutional patient status – 61 can by used on 2nd 30-day payment periods:
  - **Occurrence Code 61** – with the date of the ACUTE HOSPITAL discharge date that was within 14 days prior to the HHA start date
  - **Occurrence Code 62** – with the date of the SNF, IRF, LTCH or IPF discharge date that was within 14 days prior to the HHA start date

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Final Claims

- Finals DO require OASIS to be transmitted before you file the Final to be processed for payment
- Finals DO require pricing by MAC Grouper to calculate the HIPPS code and payment.
- Finals DO require Occurrence Code 50 with corresponding MOO90 date from the OASIS that was used in the creation of the HIPPS code
- Finals do NOT contain 18-digit Treatment Auth Code
- Finals ARE required to have a HIPPS code that matches the HIPPS code on the RAP.
- Finals ARE required to have Occurrence Code 61 or 62 if Institutional Credit is warranted for the payment period in order to ensure appropriate payment calculation

26

LUPA Thresholds

Variable thresholds based on Case Mix Grouping – Updated in Proposed Rule July 2019

- Different level for each of the 432 Case Mix Groupings – ranges between 2 - 6 visits.
- Based on 30-day payment periods – NOT 60-day episodes
- Utilize 10th percentile value of visits for each threshold
- LUPA reimbursement is per visit (as prior PPS)

- LUPA add-on
  - Applies only to SOC 30-day payment periods with total visits at or below LUPA visit threshold

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Case Mix Weights - LUPA

1FC11	Behavioral Health – High	Early - Community	0	4	1.1798
1FC21	Behavioral Health – High	Early - Community	1	4	1.2305
1FC31	Behavioral Health – High	Early - Community	2	4	1.3271
2FC11	Behavioral Health – High	Early - Institutional	0	4	1.3599
2FC21	Behavioral Health – High	Early - Institutional	1	4	1.4106
2FC31	Behavioral Health – High	Early - Institutional	2	4	1.5072
3FC11	Behavioral Health – High	Late - Community	0	2	0.7737
3FC21	Behavioral Health – High	Late - Community	1	2	0.8244
3FC31	Behavioral Health – High	Late - Community	2	3	0.9211
4FC11	Behavioral Health – High	Late - Institutional	0	3	1.2212
4FC21	Behavioral Health - High	Late - Institutional	1	3	1.2719
4FC31	Behavioral Health - High	Late - Institutional	2	3	1.3685
1FA11	Behavioral Health - Low	Early - Community	0	3	0.9284
1FA21	Behavioral Health - Low	Early - Community	1	4	0.9791
1FA31	Behavioral Health - Low	Early - Community	2	3	1.0757

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LUPA Example: Patient admitted to home health on 02/01/20 – no previous home health episodes. Patient discharged from Acute Hospital on 01/31/20. Patient has a primary diagnosis of Diabetes E11.9 and no comorbidities that group, medium Functional score.

HIPPS CODE: 1st 30-days: 2IB11

- Timing – Early
- Admission Source – Institutional
- Clinical Grouping –MMTA-Endocrine
- Functional – Medium
- Comorbidity - NONE
- Case-Mix Weight – 1.4513
- LUPA THRESHOLD - - 5

HIPPS CODE: 2nd 30-days: 3IB11

- Timing – Late
- Admission Source – Community
- Clinical Grouping – MMTA-Endocrine
- Functional – Medium
- Comorbidity - NONE
- Case-Mix Weight – 0.8651
- LUPA THRESHOLD - - 3

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Cash Flow

Current PPS Episode – SOC - $4,000

- Final billed around Day 75 and by day 90 - $1,600
- By Day 90 total of $4,000

PDGM 30-day Payment Periods - $1,800 each

- **RAP billed around Day 10 - $360**
- RAP for 2nd 30-day Day 35 - $360
- Final billed around Day 45 and by day 60 - $1,440
- Final billed around Day 75 and by day 90 - $1,440

30

OASIS/Claim Matching MBI

- Biggest issue is the MBI on the OASIS doesn't match the claim.
- If the MBI is changed/updated after the original OASIS is submitted they have to do an OASIS correction to the SOC or Recert OASIS.
- Use the eligibility verification rather than the referral information as the accurate source of information as to the patient's demographic information.
- If you receive a warning on validation reports with a message indicating the MBI submitted is different than the last time an OASIS record was submitted they need to go to their MAC's MBI look up tool and make sure the one they used on their record is correct.

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Hospice Billing

- Biggest concern is revocations and readmissions
- Need to please expedite the paperwork with ANY and ALL revocations and discharges so that the Notice of Termination/Revocation can happen timely and the subsequent NOE (with you or another admitting hospice) is NOT late.

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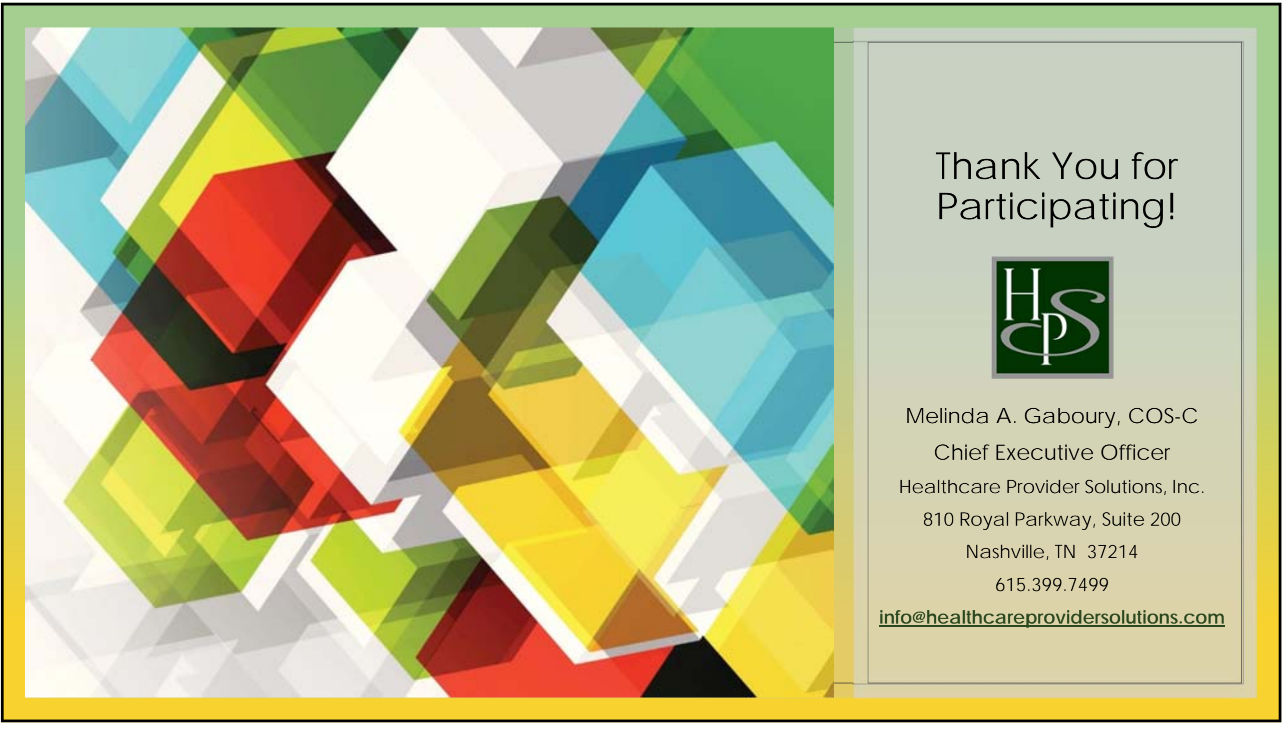

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