Demystifying Hospice Virtual Care in the COVID-19 Emergency: Virtual IDTs, Virtual Visits and Face to Face Visits for Recertification

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Brought to NHPCO members by:

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Agenda

- **Where we are today**
- **Virtual IDT**
- **Virtual Visits**
- **Telehealth for FTF visits**

- **How does one conduct a virtual IDT**
  - Who needs to be “present”?
  - Is specific technology required?
  - What needs to be documented?
- **Can we satisfy the COPS with virtual visits?**
  - Do virtual visits count?
  - Are there discipline specific rules?
  - What if a facility/family won’t let us in?
- **Can we use telehealth to render FTF certification/recertification visits and/or medically necessary physician services?**
  - FTF for cert/recert
  - Billable telehealth visits
  - How do we report these on the claim form (UB04)?

CMS Stated Goals and Focus

1) To ensure that local hospitals and health systems have the capacity to handle a potential surge of COVID-19 patients

2) Remove barriers for physicians, nurses, and other clinicians to be readily hired so the healthcare system can rapidly expand its workforce;

3) Increase access to telehealth in Medicare to ensure patients have access to physicians and other clinicians while keeping patients safe at home;

4) Put Patients Over Paperwork to give temporary relief from many paperwork, reporting and audit requirements so providers, and States can focus on providing needed care to Medicare and Medicaid beneficiaries affected by COVID-19.

The Pandemic is Not:

- A regulatory vacation
- A waiver of excellent, individualized care
- An opportunity to bend a lot of rules because scrutiny is relaxed
- A pathway to less expensive operations because you can use fewer resources when regs are loosened

1135 Blanket Waivers for Hospice

- Published March 30th, Effective March 1st, 2020
- Relaxes COP compliance
- Only effective through end of the emergency period

- CMS granted these on a national basis for all hospices, in all states, for all Medicare patients
  - The letters to many states who requested Medicare 1135 waivers received letters that mirror these national waivers

Source: COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers

HIPAA Flexibilities

- Regarding telehealth visits the OCR published guidance relaxing strict guidelines re: security (**emphasis added**)
  - "Effective immediately, the Office of Civil Rights (OCR) will exercise its enforcement discretion and **will not** impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers **in connection with the good faith provision of telehealth** during the COVID-19 nationwide public health emergency"
  - A covered health care provider can use any nonpublic facing remote communication product that is available to communicate with patients
  - Applications **allowed**: Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype However, public facing communication should not be used in the provision of telehealth.
  - Applications **not allowed**: Facebook Live, Twitch, TikTok, and similar video communication applications that allow public interfacing.

Coding COVID-19

- Announced in MLN Matters, April 3, 2020
- As of April 1st, a specific ICD-10 code has been established for patients with COVID-19: U07.1
  - This “U” chapter is entitled “Reserved for future use”
  - To be used as primary if known positive
  - List additional effects of infection, such as pneumonia after U07.1, such as “other viral pneumonia- J12.89”
- Do **not** use U07.1 if only “suspected”
  - Use the symptom codes

Relief for Hospice Quality Reporting 3/23/20

- CMS announced relief from quality reporting timeframes
- Extension for quality reporting of HIS and CAHPS
- No penalty for delayed submissions during emergency
  - HIS exception through June 30th, 2020
  - Hospice CAHPS exception through September 30th, 2020

Source: CMS Announces Relief for Clinicians, Providers, Hospitals and Facilities Participating in Quality Reporting Programs in Response to COVID-19

Virtual IDT

Virtual IDT

The Hospice Regulations do not say that the IDT must meet in person!

418.56(d)

The hospice IDT must review, revise and document the individualized plan as frequently as the patient's condition requires, but no less than every 15 days

418.204 “Special Coverage Requirements”

- **CMS encourages hospices to implement telehealth for the team’s visits to reduce exposure and risk**
  - **“Use of technology in furnishing services during a Public Health Emergency**. When a patient is receiving routine home care, during a Public Health Emergency as defined in § 400.200 of this chapter, hospices may provide services via a telecommunications system if it is feasible and appropriate to do so to ensure that Medicare patients can continue receiving services that are reasonable and necessary for the palliation and management of a patients’ terminal illness and related conditions. The use of such technology in furnishing services must be included on the plan of care, meet the requirements at § 418.56, and must be tied to the patient specific needs as identified in the comprehensive assessment and the plan of care must include a description of how the use of such technology will help to achieve the goals outlined on the plan of care.”

Source: CMS 1744-IFC: Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency Interim Final Rule with Comment

CMS Example

- A terminally ill 85-year-old male with heart failure has been receiving hospice services and recently developed a fever, sore throat and cough. The patient has been diagnosed with suspected COVID-19 and his hospice plan of care now includes medications for symptom management. He is mildly short of breath but does not require supportive oxygen therapy. The patient's wife is concerned about potential for worsening cardiac and respiratory symptoms as a result of the patient's risk for increased complications due to COVID-19.

  The hospice plan of care has been updated to include remote patient monitoring with a telecommunications system to assess the patient's daily weight and oxygen saturation levels. The plan of care identifies the **measurable goal** that the patient will maintain an oxygen level above 92 percent and the patient will not gain more than 2 pounds in a 24-hour period. The plan of care identifies interventions if either of these goals are not met. **The remote patient monitoring allows for more expedited modifications** to the plan of care in response to the patient's changing needs.

Non-Core Services and Volunteers

- Waive Non-Core Services: CMS is waiving the requirement for hospices to provide certain non-core hospice services during the national emergency, including the requirements at 42 CFR §418.72 for physical therapy, occupational therapy, and speech-language pathology.
- Volunteers: CMS is waiving the requirement at §418.78(e) that hospices are required to use volunteers (including at least 5% of patient care hours). It is anticipated that hospice volunteer availability and use will be reduced related to COVID-19 surge and potential quarantine.

How Are You Applying These Flexibilities?

- At IDT, review care and determine the need to alter the POC to include telehealth and/or remote monitoring
  - Patients who are refusing visits at this time, or the facility in which they live is refusing access to patients
  - Patients whose symptoms are controlled and some or all of their currently planned visits may be feasibly completed remotely
    - Update the plan to distinguish in-person visits and remote encounters in POC
    - Update goals to include goals for the remote encounters
- Identify where you will document these remote encounters so they are not identified on the claim

Options

- Tele-meeting conducted in the usual format
- Each member of the team makes their revisions to the plan of care independently, in collaborating with key members. The entire revised plan is reviewed on a “Zoom” meeting, after which members sign off on the changes
  - Recommend a very proactive IDT
    - Ensuring we are prepared for the next 2 weeks vs recapping the last 2 weeks
    - “Lean” on your supportive care staff who are used to making calls to patients/families
  - Leverage “found” windshield time to work with families on legacy initiatives
- Mini-team meetings on each patient with the core team members involved— virtual or in person

Virtual Visits

Virtual Visits and the COPS

CMS has communicated that:

- Flexibilities are already included in the COPs
- The hospice COPs don't specify how or how often a visit must be made
- Hospices are required to provide services that meet the needs of the patient based on the plan of care that is person-centered and individualized
- Hospices must address issues on a case by case basis and **document** how the hospice is meeting the goals of care safely

Interim Final Rule (emphasis added)

§ 418.204 Special coverage requirements.

- (d) *Use of technology in furnishing services during a Public Health Emergency*. When a patient is receiving routine home care, during a Public Health Emergency as defined in § 400.200 of this chapter, hospices may provide services via a telecommunications system **if it is feasible and appropriate to do so** to ensure that Medicare patients can continue receiving services that are reasonable and necessary for the palliation and management of a patients' terminal illness and related conditions. The use of such technology in furnishing services must be included on the plan of care, meet the requirements at § 418.56, and must be tied to the patient-specific needs as identified in the comprehensive assessment and the plan of care must include a description of how the use of such technology will help to achieve the goals outlined on the plan of care.

Source: CMS 1744-IFC: Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency Interim Final Rule with Comment

Additional Flexibilities

- Initial Assessment CAN be rendered via **Telehealth** – CMS clarified on 4/7/20 Open Door Forum
  - The telehealth assessment MUST:
    - Meet the patients needs; AND
    - Must be contain enough of an assessment to create a meaningful, patient specific POC
- Comprehensive Assessment Timeframes
  - The timeframes for updating the assessment may be extended from 15 to 21 days (§418.54)
  - Best case scenario- the hospice RN can see the patient at least every 21 days to do a full comprehensive assessment
  - If not? In this emergency- again- do the best you can.
- Supervisory Visits May be Remote
  - CMS is waiving the requirement for in-person/on-site supervision of hospice aides (42 CFR §418.76(h)
  - Supervision should be done remotely by phone and/or video
  - Document how supervision occurred and ensure the components of the supervisory visit standard are still answered

Documenting a Virtual Visit

- Visit documentation should accurately reflect the service rendered
- RHC visits can be done as telephone only or through telehealth technology
  - Must be represented in the POC
- Do NOT report Telephone only or Telehealth visits on the claim
  - Unfortunately at this time no way to report visits for SIA
- What about telephone (audio only) calls?
  - Only traditional SW calls can/should be reported on the claim

Documentation is Key

- Plans of Care should indicate the “shift” to virtual visits
  - Opportunity to demonstrate you truly provide unique care plans
  - Visit counts/strings should be adjusted
    - By discipline
    - Based on barriers to access/staff
  - The plan of care MUST still be followed
    - So create a plan of care that can be followed!
  - Televisits must be tied to the patient-specific needs as identified in the comprehensive assessment and the plan of care must include a description of how the use of such technology will help to achieve the goals outlined on the plan of care.

Case #1 - Not enough nurses

- Your hospice is located in an area with a very high number of Covid-19 cases. 4 out of your 10 nurses have tested positive, but most are asymptomatic. How do you meet each patient and family's needs?
  - Or you have no more protective equipment left for the hospice staff

Options

- Have the infected nurses do telehealth visits on all patients, and deploy the healthy nurses to any patients with in-person care needs
- Contract for nurses
- Increase non-nursing visits within their scope of practice if there is a clinical need
- Increase physician tele-visits to help families feel more assured
- Adjust frequencies and document the reasons for variance from the regulations

Document! Document! Document!

- Necessary variance from regulations and your policy and procedure must be well-reasoned and systematically executed.
- If visit frequencies are reduced because of the pandemic, change those frequencies in the plan of care.
- If the plan of care changes in practice, change it in the medical record as well.

Documentation

- Telehealth visit for this patient to protect patient and caregivers from illness, due to global pandemic, national state of emergency, and shortage of uninfected nurses. I spoke with this patient and his wife via telehealth. Inspection of wound and information from family shows that there has been a decrease in redness on the heels, pain maintained at 2/10 with current regimen.....no in-person visit required at this time, will check in via telehealth in 48 hours, family has instructions for crisis contact 24/7.

Documentation

- Telehealth visit for this patient to protect patient and caregivers from illness, due to global pandemic, national state of emergency, and shortage of uninfected nurses. I spoke with this patient and his wife via Facetime since family has no computer. Patient is no longer responsive, grimacing evident via video feed. Patient unable to swallow pain medicine. Dispatched RN, Selma Jenkins, scheduled to arrive at the home at 2pm to instruct in sublingual administration of XXXXXXX.

Case #2 Unable to reach healthcare proxy…

- That out of town healthcare proxy is sheltering at home without a fax machine or e mail. Kinkos is closed. You need a consent, an election statement and other forms signed.

Options

- Check the living will for a back-up or follow the state hierarchy to find a more local person
- If they have e mail, send them the form in word format, have them type their name in, and e mail it back to you with a message that the typed name serves as their signature in this time of emergency. Save the e mail.
- If no computer, record a conversation in which the proxy gives approval for each form verbally

Sample Language

- Healthcare proxy is hospitalized with Covid-19. Per the State of Ohio healthcare proxy statute, we have obtained election of hospice benefit and consents from the patient's daughter verbally and via e mail after sending and explaining the forms…document the whole process; copies of e mails, description of process etc.

Case #3 The SNF/ALF/Family won't let anyone in…

- Fears of contamination and misinformation have caused the owner of an ALF to ban all hospice employees from their facility. You have no access to the patient.

Options

- Listen to and validate the fears, and provide facts that support the importance of visits, and safety precautions you can work with to help them feel more safe
- While helping them understand the importance of visits, continue to work with the family by telephone and telehealth, send supplies, medication and so on
- Offer to provide the facility a tablet
  - Ask for cooperation in rendering telehealth visits
- Document barriers to accessing the patient and steps to resolve them

Sample Language

- Due to the Covid-19 pandemic and fragile condition of patient, this visit was conducted telephonically to reduce risk of infection for the patient and caregivers…add your visit note
- In an effort to contain the spread of the covid 19 virus, the owners of this ALF are refusing access to the patient. I have had discussions with them to educate them on precautions we are taking and the necessity of nursing visits. Currently coordinating care via telephone and video conferencing with the patient and the RN at the facility. Maintaining supply, medication and DME delivery…add your visit note

Sample Language

- This face-to-face encounter was completed without the benefit of an in-person visit due to the deployment of the nurse practitioner with the Army Reserves to manage the pandemic… Add information here on the evidence that supports recertification, and the source

Telehealth

Telehealth: What's Changed?

- Allows health care providers to bill for patient care delivered by telehealth during the coronavirus health emergency regardless of the patient's location.
  - Expansion and revisions end when the PHE ends
- HHS has waived and modified certain telehealth requirements once the President declared a National Emergency
  - Waives the originating site requirement for telehealth services provided to Medicare beneficiaries.
  - Allows telehealth services to be provided to Medicare fee-for-service beneficiaries by phone if the phone allows for audio-video interaction between the health care provider and the beneficiary.
  - If the "…telephone has audio and video capabilities that are used for two-way, real-time interactive communication." Sec. 102(a)(1)(B)

Source: MEDICARE TELEMEDICINE HEALTH CARE PROVIDER FACT SHEET

CMS on Telehealth & “Phones”(emphasis added)

Clarifying Telehealth Technology Requirements

- *Our regulation at § 410.78(a)(3) states that telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications systems for purposes of Medicare telehealth services. As we interpret it, this regulation does not apply to mobile computing devices that include audio and video real-time interactive capabilities, even though such devices are now referred to colloquially as “phones” since they can also be used for audio-only telecommunications. In light of the PHE for the COVID-19 pandemic, we believe it is important to avoid the potential perception that this language might prohibit use of any device that could otherwise meet the interactive requirements for Medicare telehealth, especially given that leveraging use of such readily available technology may be of critical importance.*
- *Therefore, we are revising § 410.78(a)(3) to add an exception to this language on an interim basis for the duration of the PHE for the COVID-19 pandemic. We are adding the following language at § 410.78(a)(3)(i): “Exception. **For the duration of the public health emergency as defined in § 400.200 of this chapter, Interactive telecommunications system means multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner**.”*

- Source: CMS 1744-IFC: Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency Interim Final Rule with Comment

Hospice FTF Flexibilities

- Amending the regulations at § 418.22(a)(4) on an interim basis to allow the use of telecommunications technology by the hospice physician or NP for the face-to-face visit when such visit is solely for the purpose of recertifying a patient for hospice services during the PHE for the COVID-19 pandemic.
- If FTF is only for administrative need for certification, this is not billable (no change here!)

Source: CMS 1744-IFC: Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency Interim Final Rule with Comment

Updated 418.22- Certification of Terminal Illness

- During a Public Health Emergency, as defined in § 400.200 of this chapter, if the face-to-face encounter conducted by a hospice physician or hospice nurse practitioner is for the sole purpose of hospice recertification, **such encounter may occur via a telecommunications technology** and is considered an administrative expense. Telecommunications technology means the use of interactive multimedia communications equipment that **includes, at a minimum, the use of audio and video equipment permitting two-way, real-time interactive communication** between the patient and the distant site hospice physician or hospice nurse practitioner.

Source: CMS 1744-IFC: Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency Interim Final Rule with Comment

FTF – Cert/ReCert Visits

- Allows face-to-face encounters for recertification for hospice care to be completed by NP or physician using telehealth **during the emergency period**
- Documentation is key
  - Reference the emergency/barrier to complete in-person

Types of Billable Virtual “Tele” Visits

Medically Necessary Services include:

- **Telephone** evaluation and management service**:**
  - 99441: 5-10 minutes
  - 99442: 11-20 minutes
  - 99443: 21 - 30 minutes

- **Telehealth** –provided by an eligible provider using an interactive 2-way real-time audio and video. **Requires modifier -95**

CMS Clarity on Audio Only

April 7, 2020 CMS Letter to Providers (emphasis added):

- "Please note: In a case where two-way audio and video technology required to furnish a Medicare telehealth service might not be available, there are circumstances where prolonged, audio-only communication between the practitioner and the patient could be clinically appropriate yet not fully replace a face-to-face visit. For the duration of the PHE for the COVID-19 pandemic, Medicare will make separate payment for audio-only visits described by CPT codes 98966-98968 and CPT codes 99441-99443 as outlined on page 125 in the Interim Final Rule with Comment."

Source: April 7, 2020 Dear Clinician Letter

Telehealth Considerations

State Rules & Regs

- Who is allowed to provide telehealth/telemedicine
- Scope of practice
- Consent issues
- HIPAA enforcement discretion v. your state's privacy rules

Telehealth: New Approved Codes

To enable services to continue while lowering exposure risk, clinicians can now provide the following additional services by telehealth:

- **Initial hospital care**
  - CPT codes 99221-99223
- **Initial nursing facility visits**
  - CPT codes 99304-99306
- **Domiciliary, Rest Home, or Custodial Care services**,
  - CPT codes 99327- 99328 (New-pt)/99334-99337 (Established-pt)
- **Home Visits**
  - CPT codes 99341- 99345 (New-pt)/99347- 99350 (Established-pt)

Medically Necessary Billable Visits

- For either new or established patient E/M visits
  - The only exam components that can be rendered (counted) are those that don't take physical touch.
    - The clinician **cannot** auscultate the lungs or palpate a liver/spleen
    - (S)he **can** do an exam based on observational findings, e.g., scleral icterus, oral thrush, the appearance of distress, mood/affect and/or orientation.
    - **If you are not able to conduct a physical exam at all**, then you cannot bill a new patient E&M visit code unless you qualify to use time (> 50% of the time in C/CC).
  - T**he level of service depends on the documentation, just like a normal visit.**
  - **Modifier 95 on telehealth E/M visit codes**

Key Takeaways

- Virtual/telehealth services are allowed
  - When appropriate – how will you define?
  - Update POC
- Facing impediments to in-person care?
  - Document, document, document
  - Be creative
- Billable “physician services”
  - Know the difference between an E-visit and telehealth
  - All other physician visit rules apply

Resources

- CDC: https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html
- CMS: https://www.cms.gov/newsroom/press-releases/cms-issues-clear-actionable-guidance-providers-about-covid-19-virus
- NHPCO, for everyone: nhpco.org/coronavirus
- 1135 Waiver-at-a-Glance: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/1135-Waivers-At-A-Glance.pdf
- Office of Civil Rights: https://www.hhs.gov/sites/default/files/notification-enforcement-discretion-hipaa.pdf