



EDUCATIONAL RESOURCES



HOME HEALTH



HOSPICE

COVID-19 REGULATORY & FINANCIAL RELIEF MEASURES FOR HOME HEALTH AND HOSPICE:

What Do They Mean For Your Agency?



5 STAR CONSULTANTS
HEALTHCARE SPECIALISTS

ACCREDITATION COMMISSION *for* HEALTH CARE



EDUCATIONAL RESOURCES



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HOSPICE

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Please send all questions to customerservice@achcu.com

INTRODUCTION

- CMS announced the COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers on March 30, 2020.
- These 1135 waivers are retroactive to March 1, 2020 through the end of the Public Health Emergency (PHE).
- So, everyone has probably heard of these waivers, but the real question is...
 - What does this mean for my agency?
- We are going to answer that question by breaking down some of the crucial areas that impact Home Health and Hospice agencies.

1135 WAIVER – WHAT IS IT?

- Section 1135 of the Social Security Act authorizes the Secretary of the Department of Health and Human Services to waive or modify certain Medicare, Medicaid, CHIP, and HIPAA requirements. However, two prerequisites must be met before the Secretary may invoke the § 1135 waiver authority.
 1. The President must have declared an emergency or disaster under either the Stafford Act or the National Emergencies Act.
 2. The Secretary must have declared a Public Health Emergency under Section 319 of the Public Health Service Act.
- Then, with respect to the geographic area(s) and time periods provided for in those declarations, the Secretary may elect to authorize waivers/modifications of one or more of the requirements described in Section 1135(b).
- The implementation of such waivers or modifications is typically delegated to the Administrator of CMS who, in turn, determines whether and the extent to which sufficient grounds exist for waiving such requirements with respect to a particular provider/supplier, or to a group or class of providers, or to a geographic area.



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HOME HEALTH

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COP – INITIAL ASSESSMENT - 1135 WAIVER

■ Initial Assessment

- CMS is waiving the requirements to allow HHAs to perform Medicare-covered initial assessments and determine patients' homebound status remotely or by record review.
 - Allows patients to be cared for in the best environment for them while supporting infection control and reducing impact on acute care and long-term care facilities.
 - Allows for maximizing coverage by already scarce physician and advanced practice clinicians and allow those clinicians to focus on caring for patients with the greatest acuity.
- This means that an in-person visit is not required to complete the initial assessment.
- Whether done remotely, through record review, or in person, the initial assessment must still be completed within 48 hours.

COP – INITIAL ASSESSMENT - 1135 WAIVER

- CMS clarified that initial assessments performed remotely or by record review cannot be counted as a visit.
- Remote contact can be completed via phone call to the patient to discuss the patient's immediate care needs and homebound status.
- This may also be accomplished by review of the medical records you have received as part of the referral.
- Recommend that you do both a call to the patient and a review of medical records for the initial assessment.

COP- INITIAL ASSESSMENT

- The initial assessment itself has long been an area of uncertainty for many agencies, as the clinician often completes the initial assessment and the SOC comprehensive assessment during the same visit.
- However the initial assessment and comprehensive assessment are 2 separate conditions in the CoPs –
 - §484.55(a) Standard: Initial assessment visit.
 - §484.55(b) Standard: Completion of the comprehensive assessment.

COP - INITIAL ASSESSMENT

- The initial assessment is completed to determine the immediate care and support needs of the patient and determine eligibility including homebound status.
 - The immediate care and support needs are the items and services that will maintain the patient's health and safety until the HHA can complete the SOC Comprehensive assessment and establish a Plan of Care.
 - This can include things such as medications, mobility aids, skilled nursing treatments, fall risks, etc. Eligibility including homebound status is also determined at this time.

COP – OASIS - 1135 WAIVER

- OASIS Reporting
 - Extending the 5-day completion requirement for the comprehensive assessment to 30 days.
- CMS continues to require that patients still have an assessment to determine, and be able to appropriate, meet their care needs.
 - Recommend HHAs only extend completion of the comprehensive assessment for emergency staffing issues, PPE shortage, Patient refusals, etc.
 - Comprehensive assessment is crucial in developing an appropriate POC
 - Potential for clinician completing comprehensive assessment to be exposed/contract virus and be unable to complete documentation
 - OASIS accuracy can be impacted
 - OASIS required to determine HIPPS/Payment
 - Documentation must be completed prior to submitting claim for 30 day episode –Cash Flow

COP – OASIS - 1135 WAIVER

- OASIS submission
 - Waiving the 30-day OASIS submission requirement. Delayed submission is permitted during the PHE.
 - CMS has not indicated how long providers have to submit
 - *The OASIS must be transmitted prior to submitting the final claim for payment. (CMS, conference call April 14, 2020)*
 - CMS also stated that there will be no penalties from late submissions during the emergency period.
 - Recommend submitting within 30 day timeframe when able

COP – AIDE SUPERVISION

- Waive onsite visits for HHA Aide Supervision
 - CMS is waiving the requirements which require a nurse to conduct an onsite visit every two weeks.
 - This includes waiving the requirements for a nurse or other professional to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan, as this may not be physically possible for a period of time.
 - Virtual supervision is encouraged during the period of the waiver.
 - Can be telehealth/telephone.
 - If performed remotely, this is not a billable service.

HOMEBOUND – 1135 WAIVER

- COVID-19 infected persons are considered homebound.
- Suspected COVID-19 persons who are quarantined are considered homebound.
- If the patient has a condition that makes them more susceptible to contract COVID-19, they are considered homebound.
 - Medically contraindicated to leave the home/ documentation of compromised condition by physician.
 - Homebound status documentation at admission and ongoing should include conditions that support medical contraindication as functional status may not support homebound status.

FACE TO FACE ENCOUNTERS - 1135 WAIVER

- F2F Can be via telehealth
 - This applies to all patients, not just those affected by COVID-19.
 - Must be 2 way audio/visual
 - Skype, Facetime, Zoom, etc.
 - Not subject to HIPAA enforcement
 - Does not have to be patient's phone; if patient does not have phone/ smartphone, then nurse can use own phone to facilitate.
 - Document details of date of F2F, what the focus is on and include on POC as you do today.
 - Document that you are facilitating F2F at patient and physician request.
 - Visit can be billed by the physician, but HHAs CANNOT bill for this.

TELEHEALTH - 1135 WAIVER

- CMS allows HHAs to provide all necessary telehealth during emergency period.
 - Technology can be used to minimize the risk of exposure to clinicians, patients, and the public during an outbreak of an infectious disease, such as the PHE for the COVID-19 pandemic.
- CMS acknowledges that the use of telehealth technology may result in changes to the frequency or types of in-persons visits outlined on existing or new plans of care.
- Telehealth must be ordered by physician and on the Plan of Care.
- 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.

TELEHEALTH - 1135 WAIVER

- The inclusion of technology on the POC must be tied to the patient-specific needs identified in the comp assessment & the measurable outcomes that the HHA anticipates will occur as a result of implementing the POC.
- **Example:**
 - Physician orders an in-person skilled nursing visit once a week to assess the patient and to monitor for worsening symptoms and a video consultation twice a week between the skilled nurse and the patient for medication management, teaching and assessment, as well as to obtain oxygen saturation readings that the patient relays to the nurse during the consult.
 - The POC could specify that the goal of the video consultation is to increase patient adherence with medication regimen and oxygen use with no worsening respiratory symptoms.

TELEHEALTH

- Review POCs for all patients to determine which visits contain direct care tasks that are essential.
 - Wound care, Medication administration IV/injection, etc.
- Consider telehealth/remote encounter for visits that do not necessarily need to be “in-person”.
 - Teaching, some observation/assessment, therapy following up on home exercise program, etc.
- POC must be updated to include which visits are to be done in person and which can be done via telehealth/remotely.
 - Telehealth/remote cannot take the place of ordered visits
 - Must do in-person visits as ordered by physician!

TELEHEALTH

- LUPA thresholds are based on in-person visits, not telehealth/remote visits.
- Telehealth/remote visits do not affect payment amount.
 - No separate payment- NOT BILLABLE for HHAs
- Telehealth/remote visits must be documented.
- HIPAA – 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 PHE.
 - Waiver for this will end when the PHE has been declared ended

NON-PHYSICIAN PRACTITIONER (NPP) CERTIFICATION AUTHORITY - 1135 WAIVER

- Permits patient to be under care of an NPP to the extent permitted under state law
 - NPP defined as:
 - NP - Nurse Practitioner, PA - Physician's Assistant, CNS - Clinical Nurse Specialist
- Permitted to:
 - Order home health services
 - Establish and review POC
 - Certify and recertify eligibility

NON-PHYSICIAN PRACTITIONER (NPP) CERTIFICATION AUTHORITY - 1135 WAIVER

- Need to check scope of practice/state licensure for your state – many states mirror CoPs – state will also need to waive requirement
- Will continue after the pandemic ends
 - CARES Act makes this permanent, however CMS needs to implement. There will be additional guidance and regulations.
 - CMS utilizing discretionary authority not to enforce rules.

OT – ALLOWED TO COMPLETE INITIAL AND COMPREHENSIVE ASSESSMENTS

- Allow occupational therapists (OTs) to perform initial and comprehensive assessment for all patients.
- 42 C.F.R. 484.55(a)(2) and 484.55(b)(3). CMS is waiving the requirement that OTs may only perform the initial and comprehensive assessment if occupational therapy is the service that establishes eligibility for the patient to be receiving home health care.
- This temporary blanket modification allows OTs to perform the initial and comprehensive assessment for all patients receiving therapy services as part of the Plan of Care, to the extent permitted under state law, regardless of whether occupational therapy is the service that establishes eligibility.
- The existing regulations at § 484.55(a) and (b)(2) would continue to apply that OTs and other therapists would not be permitted to perform assessments in nursing only cases.

OT – ALLOWED TO COMPLETE INITIAL AND COMPREHENSIVE ASSESSMENTS

- CMS continues to expect HHAs to match the appropriate discipline that performs the assessment to the needs of the patient to the greatest extent possible.
- Therapists must act within their state scope of practice laws when performing initial and comprehensive assessments, and access a registered nurse or other professional to complete sections of the assessment that are beyond their scope of practice.
- Expanding the category of therapists who may perform initial and comprehensive assessments to include OTs provides HHAs with additional flexibility that may decrease patient wait times for the initiation of home health services.

Hospital Discharge Plan Items that May Impact HHAs

- April 13, 2020 - Hospital Discharge Plan Items May Impact HHAs: What is Waived and What is Kept:
- CMS is maintaining the discharge planning requirements that ensure a patient is discharged to an appropriate setting with the necessary medical information and goals of care.
- CMS is waiving:
 - Including a list of HHAs available to the patient;
 - Informing the patient or the patient's representative of their freedom to choose among participating Medicare providers; and,
 - Identifying in the discharge plan if the hospital has a disclosable financial interest in the HHA selected.

RAPS & SEQUESTRATION

- **RAPs**
- MACs were instructed to delay the autocancel of RAPs.
 - This is meant to ensure no further hardship to cashflow during the emergency when the end of episode claims may be late.
 - CMS will not take back the 20% provided at RAP, until the end of episode claim is submitted for the full amount.
- **Sequestration**
- The 2% sequestration reduction we have had for both Home Health and Hospice Medicare claims will be lifted beginning May 1st- December 31st.

SUSPENSION OF CLAIMS AUDITS

- Suspend TPE and ADR requests
 - MACs, RACs, SMRCs
- For ADRs that have been requested, claims will process and be paid
- No new ADR requests
- Reviews for fraud will be conducted

SUSPENSION OF REVIEW CHOICE DEMONSTRATION

- Temporary pause for IL, OH, TX.
- On hold for NC and FL
 - New dates will be established after the PHE
- Claims submitted prior to 3/29 will process as usual.
- Claims submitted after 3/29 to the end of the PHE will not be subject to review choice.
- Any pre claim review requests already submitted will be reviewed and, if affirmed, will not be subject to additional review.

SUSPENSION OF REVIEW CHOICE DEMONSTRATION

- HHA can choose to continue prepayment review.
- After the PHE, claims that were paid without Unique Tracking Number (UTN) will be reviewed.
 - May want to consider continuing prepayment review rather than risk a full audit after PHE ends.
- HHAs can submit claims without a review and UTN during pause and will not be subject to 25% reduction.
- HHAs with other choices (pre or post payment) will not receive ADRs and ADR in process will be released for payment.

QUALITY REPORTING – HOME HEALTH

- CMS is granting an exception to the Quality Reporting Program (QRP) reporting requirements for HHAs.
- 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 the post-acute care (PAC) quality reporting 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)

HOME HEALTH VALUE-BASED PURCHASING

- 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.
- <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Reconsideration-and-Exception-and-Extension>



EDUCATIONAL RESOURCES

HOSPICE

VOLUNTEER USE

- CMS is waiving the requirement 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.

COMPREHENSIVE ASSESSMENTS

- CMS is waiving certain requirements related to updating comprehensive assessments of patients.
 - This waiver applies to timeframes for updates to the comprehensive assessment (§418.54(d)).
 - Hospices must continue to complete the required assessments and updates, however, the timeframes for updating the assessment may be extended from 15 to 21 days.
 - The review of the Plan of Care must still occur every 15 days or as the patient's condition requires.
 - There were no changes to the hospice initial assessment. This assessment still must be completed by the RN in 2 days.

HOSPICE AIDE SUPERVISION

- CMS is waiving the requirements at 42 CFR 418.76(h), which require a nurse to conduct an onsite visit every two weeks.
- This would include waiving the requirements for a nurse or other professional to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan, as this may not be physically possible for a period of time.

HOSPICE AIDE COMPETENCY

- **Hospice aide competency testing allow use of pseudo patients.**
- 42 C.F.R. 418.76(c)(1). CMS is temporarily modifying the requirement in § 418.76(c)(1) that a hospice aide must be evaluated by observing an aide's performance of certain tasks with a patient.
- This modification allows hospices to utilize pseudo patients such as a person trained to participate in a role-play situation or a computer-based mannequin device, instead of actual patients, in the competency testing of hospice aides for those tasks that must be observed being performed on a patient.
- This increases the speed of performing competency testing and allows new aides to begin serving patients more quickly without affecting patient health and safety during the public health emergency (PHE).

HOSPICE AIDE 12 – HOUR ANNUAL IN-SERVICE TRAINING

- 12-hour annual in-service training requirement for hospice aides.
- 42 C.F.R. 418.76(d). CMS is waiving the requirement that hospices must assure that each hospice aide receives 12 hours of in-service training in a 12-month period.
- This allows aides and the registered nurses (RNs) who teach in-service training to spend more time delivering direct patient care.

NON – CORE SERVICES WAIVER

- CMS is waiving the requirement for hospices to provide certain non-core hospice services during the national emergency:
 - Physical therapy
 - Occupational therapy
 - Speech-language pathology

HOSPICE FACE TO FACE ENCOUNTER

- The interim final rule allows a hospice physician or hospice nurse practitioner (NP) to conduct the encounter using telecommunication technology if the visit is solely for the purpose of fulfilling the recertification requirement.
 - Telecommunications technology means the use of multimedia communications equipment that includes, at a minimum, audio and video permitting two-way, real time interactive communications.
 - Administrative requirement, not reimbursable
 - HIPAA concerns waived allowing use of Skype, etc.

TELECOMMUNICATIONS DURING PHE

- CMS will allow hospices to provide services to Routine Home Care (RHC) patients using telecommunication systems
 - Must be feasible and appropriate to ensure patients can continue to receive services and that the services are reasonable and necessary for the palliation and management of a patient's terminal illness and related conditions.
 - Technology use must be:
 - Included on Plan of Care
 - Tied to patient-specific needs as identified in the comprehensive assessment

TELECOMMUNICATIONS DURING PHE *(CONT)*

- 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
 - Measurable outcomes
- No payment for telecommunication visits
 - Only in-person visits may be submitted on claims (except for social worker calls)
- Can report telecommunications technologies on cost reports

TELEHEALTH 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.

TELEHEALTH FOR PHYSICIAN MEDICAL SERVICES

- During the PHE, CMS is taking additional steps to permit use of telehealth to deliver hospice medical services.
- Allow use of a patient's home and other locations as an "originating site".
- Eliminated requirement that only allowed telehealth services to be delivered in rural areas.
- Allows for use of telephones ONLY IF they have two-way audio-video capabilities that are used for two-way, real-time interactive communication.
- For the period of the emergency, HIPAA requirements have also been waived.

TELEHEALTH FOR PHYSICIAN MEDICAL SERVICES

- Medical services provided by a hospice physician or hospice-employed NP may be provided via telehealth and billed by the hospice provided the physician or NP is the hospice patient's designated attending physician.
 - CMS does not believe that direct patient care for Medicare hospice patients will typically be furnished via telehealth, we note that nothing in statute or regulation precludes a hospice designated attending physician from furnishing services via telehealth in accordance with section 1834(m) of the Act.

MEDICAL REVIEW

- Suspended
 - TPE - Targeted probe and educate
 - Post-payment reviews conducted by
 - MACs
 - SMRC
 - RAC
 - Medical reviews may be conducted during or after PHE if indication of fraud

QUALITY REPORTING - HOSPICE

- CMS is granting an exemption to the Hospice Quality Reporting Program (QRP) reporting requirements. Medicare-certified Hospices are exempt from the reporting of data on measures, Hospice Item Set (HIS) data and Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, required under Hospice QRP for calendar years (CYs) 2019 and 2020 for the following quarters.
- 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)
- <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Extensions-and-Exemption-Requests>



EDUCATIONAL RESOURCES



HOME HEALTH



HOSPICE

HOME HEALTH & HOSPICE

ACCELERATED AND ADVANCED PAYMENT PROGRAM

- CMS will accelerate/advance payment to all provider types.
- Provider can request up to 3 months of anticipated revenue.
- Requests submitted to MACs
 - Processing Time – within 7 calendar days
- After 120 days, CMS will offset claims payments against amounts owed for accelerated/advance payments.

ACCELERATED AND ADVANCED PAYMENT PROGRAM

- Full repayment will be required within 210 days – MACs will issue demand letters for remaining amounts.
 - Unpaid amount, remaining after 30 days from issuance of demand letter, is subject to interest
 - Use caution when requesting amount
 - Need to make realistic projections
- Providers under medical review are ineligible.
 - This does not include RCD

ACCELERATED AND ADVANCED PAYMENT PROGRAM

- MLN Connects April 9, 2020
- “The Centers for Medicare & Medicaid Services (CMS) has delivered nearly \$34 billion in the past week to the health care providers on the frontlines battling the 2019 Novel Coronavirus (COVID-19). The funds have been provided through the expansion of the Accelerated and Advance Payment Program to ensure providers and suppliers have the resources needed to combat the pandemic.”

CARES ACT PROVIDER RELIEF FUND

- Release of Emergency Funding Under the CARES Act
 - HHS to Begin Immediate Delivery of Initial \$30 Billion of CARES Act Provider Relief Funding
 - Recognizing the importance of delivering funds in a fast and transparent manner, \$30 billion is being distributed immediately – with payments arriving via direct deposit beginning April 10, 2020 – to eligible providers throughout the American healthcare system.
 - These are payments, not loans, to healthcare providers,
 - and will not need to be repaid.



CARES ACT PROVIDER RELIEF FUND

- Who is eligible for initial \$30 billion
 - All facilities and providers that received Medicare fee-for-service (FFS) reimbursements in 2019 are eligible for this initial rapid distribution.
 - As a condition to receiving these funds, providers must agree not to seek collection of out-of-pocket payments from a COVID-19 patient that are greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider.
 - This quick dispersal of funds will provide relief to both providers in areas heavily impacted by the COVID-19 pandemic and those providers who are struggling to keep their doors open due to healthy patients delaying care and cancelled elective services.

CARES ACT PROVIDER RELIEF FUND

- How are payment distributions determined
 - Providers will be distributed a portion of the initial \$30 billion based on their share of total Medicare FFS reimbursements in 2019. Total FFS payments were approximately \$484 billion in 2019.
 - A provider can estimate their payment by dividing their 2019 Medicare FFS (not including Medicare Advantage) payments they received by \$484,000,000,000, and multiply that ratio by \$30,000,000,000. Providers can obtain their 2019 Medicare FFS billings from their organization's revenue management system.
 - Ex: HHA with \$1,000,000 Revenue from Medicare Traditional patients would receive \$61,983.47.

CARES ACT PROVIDER RELIEF FUND

- What to do if you are an eligible provider
 - HHS has partnered with UnitedHealth Group (UHG) to provide rapid payment to providers eligible for the distribution of the initial \$30 billion in funds.
 - Providers will be paid via Automated Clearing House account information on file with UHG or the Centers for Medicare & Medicaid Services (CMS).
- Is this different than the CMS Accelerated and Advance Payment Program?
 - Yes.
 - The CMS Accelerated and Advance Payment Program has delivered billions of dollars to healthcare providers to help ensure providers and suppliers have the resources needed to combat the pandemic.
 - The CMS accelerated and advance payments are a loan that providers must pay back.
- For additional details see the full article:
- <https://www.hhs.gov/provider-relief/index.html>

NAHC - ADDITIONAL RELIEF REQUESTS

- For 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

NAHC - ADDITIONAL RELIEF REQUESTS

- Suspension of HHVBP Demo
- Streamline Aide competency to direct patient care only
- Waive 12-hour annual in-service training requirement for Aides – Home Health
- Abbreviated Comprehensive Assessment
- 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



EDUCATIONAL RESOURCES

CODING GUIDELINES

ICD-10 CODING GUIDELINES 4/1/2020 – 9/30/2020

NEW CODE- U07.1 -COVID 19

- Code only a confirmed diagnosis of COVID-19 as documented by the provider, documentation of a positive COVID-19 test result, or a presumptive positive COVID-19 test result.
- Provider's documentation that the individual has COVID-19 is sufficient.
- Presumptive positive COVID-19 test results should be coded as confirmed.
 - A presumptive positive test result means an individual has tested positive for the virus at a local or state level, but it has not yet been confirmed by the Centers for Disease Control and Prevention (CDC).
 - CDC confirmation of local and state tests for COVID-19 is no longer required.
- If provider documents "suspected," "possible," "probable," or "inconclusive" COVID-19, do not assign code U07.1.
 - Assign a code(s) explaining the reason for encounter (such as fever) or Z20.828, Contact with and (suspected) exposure to other viral communicable diseases.

ICD-10 CODING GUIDELINES 4/1/2020- 9/30/2020

NEW CODE- U07.1 -COVID 19

- Sequencing of codes
 - When COVID-19 meets the definition of principal diagnosis, code U07.1, COVID-19, should be sequenced first, followed by the appropriate codes for associated manifestations, except in the case of obstetrics patients as indicated in Section I.C.15.s. for COVID-19 in pregnancy, childbirth, and the puerperium.
 - For a COVID-19 infection that progresses to sepsis, see Section I.C.1.d. Sepsis, Severe Sepsis, and Septic Shock
 - See Section I.C.15.s. for COVID-19 in pregnancy, childbirth, and the puerperium

ICD-10 CODING GUIDELINES

APRIL 1, 2020 THROUGH SEPT 30, 2020

- Acute respiratory illness due to COVID-19
 - Pneumonia
 - For a pneumonia case confirmed as due to COVID-19, assign codes U07.1, COVID-19, and J12.89, Other viral pneumonia.
 - Acute bronchitis
 - For a patient with acute bronchitis confirmed as due to COVID-19, assign codes U07.1, and J20.8, Acute bronchitis due to other specified organisms.
 - Bronchitis not otherwise specified (NOS) due to COVID-19 should be coded using code U07.1 and J40, Bronchitis, not specified as acute or chronic.
 - Lower respiratory infection
 - If the COVID-19 is documented as being associated with a lower respiratory infection, not otherwise specified (NOS), or an acute respiratory infection, NOS, codes U07.1 and J22, Unspecified acute lower respiratory infection, should be assigned.
 - If the COVID-19 is documented as being associated with a respiratory infection, NOS, codes U07.1 and J98.8, Other specified respiratory disorders, should be assigned.
 - Acute respiratory distress syndrome
 - For acute respiratory distress syndrome (ARDS) due to COVID-19, assign codes U07.1, and J80, Acute respiratory distress syndrome.

ICD-10 CODING GUIDELINES 4/1/2020 – 9/30/2020

NEW CODE- U07.1 -COVID 19

- Exposure to COVID-19
 - For cases where there is a concern about a possible exposure to COVID-19, but this is ruled out after evaluation, assign code Z03.818, Encounter for observation for suspected exposure to other biological agents ruled out.
 - For cases where there is an actual exposure to someone who is confirmed or suspected (not ruled out) to have COVID-19, and the exposed individual either tests negative or the test results are unknown, assign code Z20.828, Contact with and (suspected) exposure to other viral communicable diseases.
- Screening for COVID-19
 - For asymptomatic individuals who are being screened for COVID-19 and have no known exposure to the virus, and the test results are either unknown or negative, assign code Z11.59, Encounter for screening for other viral diseases.

ICD-10 CODING GUIDELINES 4/1/2020 – 9/30/2020

NEW CODE- U07.1 -COVID 19

- Signs and Symptoms
 - For patients presenting with any signs/symptoms associated with COVID-19 (such as fever, etc.) but a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms such as:
 - R05 Cough
 - R06.02 Shortness of breath
 - R50.9 Fever, unspecified
 - If a patient with signs/symptoms associated with COVID-19 also has an actual or suspected contact with or exposure to someone who has COVID-19, assign Z20.828, Contact with and (suspected) exposure to other viral communicable diseases, as an additional code
- Asymptomatic individuals who test positive for COVID-19
 - For asymptomatic individuals who test positive for COVID-19, assign code U07.1, COVID-19. Although the individual is asymptomatic, the individual has tested positive and is considered to have the COVID-19 infection.

ICD-10 CODING GUIDELINES 4/1/2020 – 9/30/2020

NEW CODE- U07.1 -COVID 19

- COVID-19 infection in pregnancy, childbirth, and the puerperium
 - During pregnancy, childbirth or the puerperium, a patient admitted (or presenting for a health care encounter) because of COVID-19 should receive a principal diagnosis code of O98.5-, Other viral diseases complicating pregnancy, childbirth and the puerperium, followed by code U07.1, COVID-19, and the appropriate codes for associated manifestation(s). Codes from Chapter 15 always take sequencing priority.

ICD – 10 DIAGNOSIS CODING

- U07.1 will be in the MMTA – Respiratory Clinical Grouping for PDGM and will be in a Low Comorbidity group
 - Grouper was updated April 6, any RAPs and Final claims prior to that would not allow this diagnosis
- U07.1 will not be accepted for dates prior to April 1, 2020.
- Do not use U07.2- Cannot be used in USA.
- Check with your EMR as U07.1 will need to be added to calculate the correct HIPPS code and allow use of code on a claim.

CONCLUSION

- The COVID-19 Pandemic is unlike anything we have experienced before in our lifetime.
- We will get through this together...

CMS RELIEF INFORMATION WEBSITES

- <https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers>
- <https://www.cms.gov/newsroom/press-releases/trump-administration-makes-sweeping-regulatory-changes-help-us-healthcare-system-address-covid-19>
- <https://www.cms.gov/files/document/provider-burden-relief-faqs.pdf>
- <https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf>
- <https://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf>
- <https://www.cms.gov/files/document/covid-home-health-agencies.pdf>
- <https://www.cms.gov/files/document/covid-hospices.pdf>



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HOSPICE

QUESTIONS?

Please send all questions to customerservice@achcu.com



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THANK YOU

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