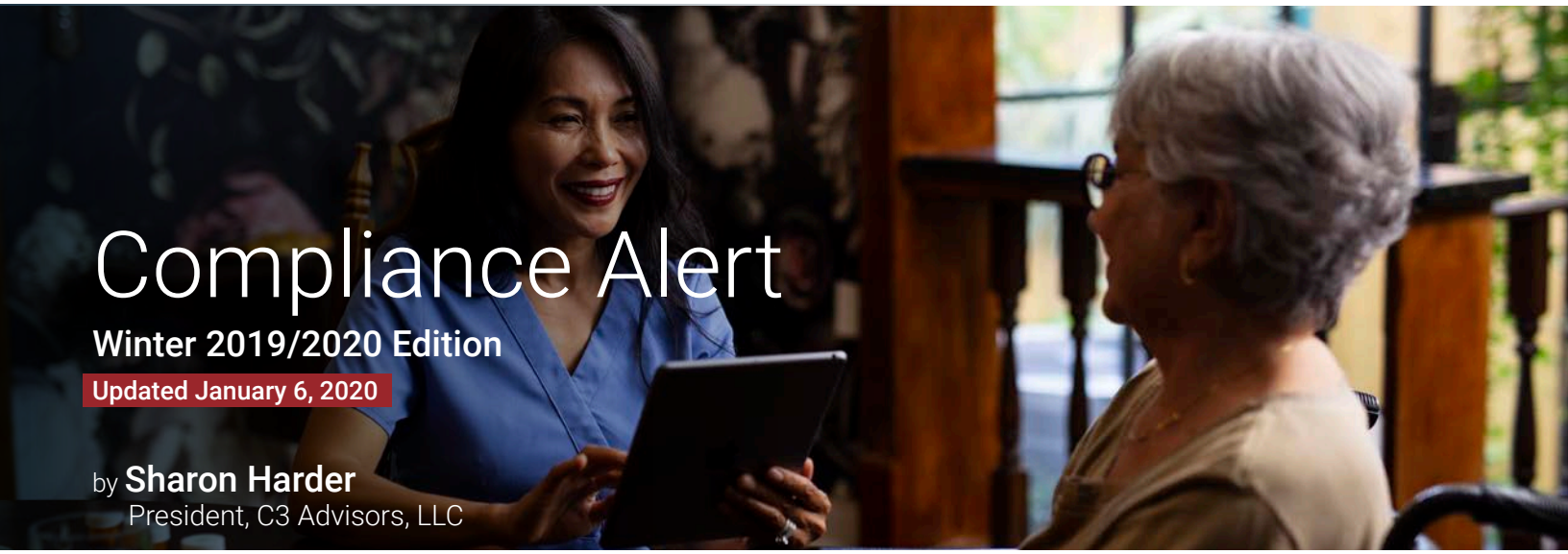

Compliance Alert

Winter 2019/2020 Edition

Updated January 6, 2020

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Highlights

It's that time of year again as the final rulemaking extravaganza from CMS becomes reality for next year.

As predicted, new discharge planning rules were finalized by CMS for implementation as of the end of November. The Review Choice Demonstration continues its march with Ohio coming on board at the end of September with Texas to be slated next. The home health final rule confirmed the latest on PDGM beginning in 2020 and the hospice final rule gave hospices a one-year reprieve for the expansion of EOB language aimed at the unrelated treatment addendum that was floated in the proposed rule. We'll talk about all of these topics and more in this release.

There is a new version of Appendix Q to the State Operations Manual with new guidance on Immediate Jeopardy that will be of interest to both home health and hospice teams. This is the first revision to the guidance around findings of immediate jeopardy since 2004. We cover the highlights of the changes in this alert.

Breaking news!

After the initial publication of this compliance alert, the Centers for Medicare and Medicaid Services (CMS) issued new guidance for home health agencies about the **Review Choice Demonstration**. This updated edition of the compliance alert explores the new guidance on page 3. New content is in red text for easy identification.

HOME HEALTH

The Review Choice Demonstration (RCD)

The Review Choice Demonstration (RCD) is now active in Illinois and Ohio. In fact, now that the project has been active in Illinois for six months, many Illinois agencies now have the option of selecting their subsequent review options if, as of November 30, 2019, an affirmation rate of 90% was achieved and as long as more than ten claims were submitted for review. Ohio agencies with at least a 90% affirmation rate for their first six months of the project will be able to select their subsequent review options as of April 1, 2020.

Review Choice has been rescheduled for the other three states with the next phase of the rollout planned for Texas on March 2, 2020. Both Florida and North Carolina are expected to begin under RCD on or about May 4th; however, CMS has indicated that it will monitor the transition to PDGM and assess the need for date changes if necessary.

Agencies that submit their claims to Palmetto GBA must have their review selections in place by at least two weeks in advance of the start of the project in their states in order to avoid the default option which is full post-payment review.

Texas, Florida, and North Carolina agencies will be able to select from three review choices. The initial choices are:

- **Choice 1** – 100% pre-claim review. All episodes are submitted for review and either affirmed for payment or non-affirmed based on a deficiency in the record submission. Deficiencies can be cured, and requests can be resubmitted an unlimited number of times. Non-affirmations cannot be the subject of an appeal.
- **Choice 2** – 100% post-payment review. All episodes are paid and then examined afterward. Payments are recouped for non-affirmed episodes.
- **Choice 3** – 25% payment reduction applicable to all episodes and limited follow-up review.

Agencies that fail to make a timely selection will be assigned Choice 2 with automatic post-payment reviews. Agencies that select Choice 3 at the outset will not have the option of selecting a subsequent review option after the first six months as the affirmation rate threshold of 90% will be inapplicable. Thus, agencies that select Choice 3 will stay there for the five-year duration of the demonstration.

Texas, Florida, and North Carolina agencies will be able to select from three review choices.

After six months, additional options become available for agencies with a 90% approval rate for more than 10 episodes:

- **Choice 1** - Continue with pre-claim review.
- **Choice 4** – Selective post-payment review which will apply to a random sampling of claims chosen for review every six months. Selecting this option requires that the provider remain in this class for the remainder of the demonstration project.
- **Choice 5** – Spot check reviews of 5% of claims. Providers can remain in this group for as long as they continue to demonstrate compliance with Medicare guidelines.

Once again, for agencies that make no selection, an assignment will be made in favor of Choice 4 for selective post-payment review for the duration of the demonstration.

What Agencies in RCD States Should Know

CMS has made it clear that, beginning in 2020, it will make the transition under PDGM for the variable LUPA thresholds based on the assigned case-mix. LUPAs will continue to be exempt from RCD.

Updated information!

Just before the 2019 winter holidays, CMS posted an update to Chapter 6 of the Review Choice Demonstration Operational Guide indicating that agencies in RCD States will need to submit a pre-claim request for each PDGM 30-day payment period. While the update was not included in a new version of the FAQs, the information does appear in Chapter 6 of the updated Operational Guide.

For episodes that begin on and after January 1, 2020 – for agencies in Illinois and Ohio – a pre-claim review request must be submitted for each PDGM payment period. Of course, this will extend agencies in Texas, Florida, and North Carolina as those states come into the project. Agencies will be able to select the multiple billing period option to request provisional affirmation of two or more billing periods at the same time. Once the pre-claim tasks are completed for the initial payment period, agencies will be able to establish start and end dates and requested HCPCS for subsequent period(s). If the Plan of Care (POC) changes for the second/subsequent period, it will also be necessary to upload the revised POC. Separate unique tracking numbers (UTNs) will be issued for each 30-day period. If documentation is submitted separately for each 30-day period, all of the required documentation will need to be uploaded each time.

New info!

For episodes that begin on and after January 1, 2020 – for agencies in Illinois and Ohio – a pre-claim review request must be submitted for each PDGM payment period.

What Agencies in Texas, Florida, and North Carolina Should Do

Agencies in the three states that are coming up for inclusion in 2020 need to first carefully consider their initial options under the demonstration and make sure that their choices are registered through the Palmetto e-Services portal. More information can be found beginning on page 9 of the RCD

FAQs at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Choice-Demonstration/Downloads/RCD-FAQs.pdf.

The updated Review Choice Demonstration Operational Guide is also available for download at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Choice-Demonstration/Review-Choice-Demonstration-for-Home-Health-Services

PDGM Compliance Issues

The Patient Driven Groupings Model will take effect on January 1, 2020 and as that happens the compliance focus for all home health providers must be expanded to include the elements of PDGM that will contribute to medical review and audit results.

What Home Health Agencies Should Know

In short, anything that drives a portion of the payment for services, no matter how small, is fair game in medical review. And, in 2020, the list of review topics will expand to cover PDGM elements that are agency controlled and that influence payment. The four areas that we predict will receive the most scrutiny as PDGM gains momentum are:

- **Admission Sources** – Institutional payment periods
- **Clinical Groups** – Primary diagnosis selection
- **Functional Impairment Levels** – OASIS accuracy and consistency
- **Comorbidities** – Secondary diagnoses selection

In addition to 2020 services and compliance focus, CMS has steadfastly indicated that it will be issuing ADRs for pre-2020 services provided by agencies that have a material shift in care delivery after PDGM is implemented. The primary focus of this will be, we believe, drastic reductions in therapy services as the therapy payment thresholds evaporate at the end of 2019.

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What Home Health Agencies Should Do

If the agency does not have a formal compliance program and work plan, now is the time to do that work as this was a Condition of Participation for all Medicare providers including HHAs as of 2010. The OIG guidance from 1998 continues to be the industry standard and it can be found at https://oig.hhs.gov/authorities/docs/cpghome.pdf

In the meantime, for agencies with operational compliance programs and periodic audit work plans, consideration should be given to developing review protocols directed at the following issues:

PDGM Focus: Institutional Payment Periods – Policy Statements and Medical Record Documentation

The inclusion of Occurrence Code 61 (hospital) or 62 (post-acute care) on the home health final claim will establish the fact that an agency is seeking credit for an Institutional Admission Source related to the payment period covered by the claim. The agency should establish a policy for when and how these two Occurrence Codes should be used and the documentation that is required to substantiate the claim for payment.

It is important to note that CMS has made it clear that each of the three MACs will be obligated to conduct a claim search for an underlying and qualified inpatient claim related to every home health final claim. If evidence of Medicare-covered inpatient service in a hospital or qualified post-acute facility is found, the home health claim will be coded and paid with credit for the Institutional Admission Source. Alternatively, if either of the two applicable Occurrence Codes is used and an inpatient hospital or post-acute claim is not found, the home health agency will still receive the payment based on the Institutional Admission Source for the period covered by the claim. In the absence of both the Occurrence Code and an underlying inpatient claim, the home health claim will be paid as a Community Admission Source.

The challenge with using Occurrence Code 61 is that it is not always abundantly clear that prior hospital stays are true inpatient stays.

The challenge with using Occurrence Code 61 is that it is not always abundantly clear that prior hospital stays are true inpatient stays. Observation stays or any other facility services paid under Part B will not qualify for the Institutional Admission Source case-mix rates. It is not always clear from Discharge Summaries whether Medicare patients in the institution for short periods of time were actually billed under Part A or Part B.

Adding to the complexity of the question is the fact that CMS has now reclassified some hospital procedures that are often the sources for home health referrals, removing them from the Inpatient Only List (IPO). Home health agency teams will need to be very aware of the reclassifications and referral source handling of procedures that could be billed under either Part A or Part B to ensure correct claim coding with respect to the use of Occurrence Code 61 designating an eligible hospital inpatient stay prior to the SOC.

More specifically, in 2019 CMS removed total knee arthroplasty from the IPO. And, as noted in MLN Matters SE 19002, this allows hospitals to bill for TKA procedures as either inpatient or outpatient services. It also allows short-stay TKA cases to be reviewed for compliance with the two-midnight rule although CMS notes specifically that its action does not mean that all TKAs must be performed on an outpatient basis nor that inpatient claims for TKAs are going to be targeted for review. Further, on November 1, 2019 CMS finalized the 2020 Hospital Outpatient PPS and Ambulatory Surgical Center Final Rule which removes total hip arthroplasty and six spinal surgical procedures from the IPO. Thus, these procedures are now also eligible for payment as outpatient services. What all of this means for home health agencies accepting orthopedic patients is that careful examination of the hospital stay will be warranted before claiming the patient as an Institutional Admission.

Although certainly rarer, there will also be patients coming to home health from extended nursing home stays that are not considered inpatient stays at the time of the patient's discharge. For example, a patient that has exhausted his/her Part A benefits but stays in a SNF with other payment arrangements and outpatient therapy would not be considered an inpatient referral to home health. And, under the PDGM rules, this patient would be a Community Admission.

With the foregoing in mind, agencies should establish a clear policy for when and how Occurrence Codes 61 and 62 are used. In every instance where the claim is coded for Institutional Admission credit with one of these two codes, the agency should have clear documentation in the record of the underlying, attributed inpatient stay to defend its coding choice. In the event of medical review, we are certain that the documentation will be required, especially if the underlying claim was either not a Medicare claim or not, for some reason, submitted and/or paid by Medicare. It is likely that agencies that demonstrate high levels of home health claims for which the related institutional stay cannot be determined in the MAC's claim review will find themselves with ADRs at some point. For this reason, documentation in the record will be an absolute necessity to defend the home health agency's actions with respect to coding included on the claim.

The assignment of the Clinical Group for classification of payment periods is dependent on a single element of the record, the primary diagnosis code.

PDGM Focus: Diagnostic Coding and the Clinical Group Assignment

The assignment of the Clinical Group for classification of payment periods is dependent on a single element of the record, the primary diagnosis code. There are two aspects of compliance that will find their roots in the primary diagnosis.

First, the origin of the diagnosis must be documented and traceable to a physician-assigned diagnosis within documentation that is acquired for the record as of the Start of Care. Without the origin of the primary diagnosis code documented for the patient's medical record, the diagnosis, at best, is a guess that cannot be defended in review. Coding conventions, as noted in the 2020 official coding guidelines are very clear:

> *"Code assignment is based on the documentation by patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis). There are a few exceptions . . . . based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI, a nurse often documents the pressure ulcer stages, and an emergency medical technician often documents the coma scale). However, the associated diagnosis (such as overweight, obesity, acute stroke, or pressure ulcer) must be documented by the patient's provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient's attending provider should be queried for clarification."*

In 2020 OASIS accuracy with respect to the M elements found between M1800 and M1860 will take on added significance.

Thus, for every assignment of the primary home health diagnosis code, the agency should acquire, for the patient's medical record, the underlying documentation of the patient's active diagnoses to supplement the assessing clinician's determination of the focus of care that drives the primary diagnosis assignment. This same documentation must also support any primary diagnoses that are assigned for recertifications.

Second, a key consideration for review of the Plan of Care, both in Review Choice and as a component of medical review, is the relationship between the primary diagnosis and the interventions in the Plan of Care. There must be a meaningful relationship between the two and that relationship must be borne out by the clinical documentation in the record.

PDGM Focus: Functional Impairment Levels

OASIS accuracy has long been a challenge for many providers, but in 2020 OASIS accuracy with respect to the M elements found between M1800 and M1860 will take on added significance. And, once again, the level of impairment that is identified in the applicable OASIS being used to calculate the payment must be in sync with the rest of the record. Many agencies experience two areas where gaps between the OASIS and the documentation in the record become apparent.

The first occurs when there are multiple disciplines involved in care and only one of them has assessed the patient for purposes of the OASIS. Most often, that is the RN who has performed the comprehensive assessment without, necessarily, the benefit of insight from therapy providers who may also be providing evaluations. When there is a disconnect between what the RN "sees" versus what the therapist determines upon his/her assessment of the patient, there is room for error. Thus, agencies will be well served to promote interdisciplinary collaboration within the five day assessment window whenever multiple disciplines are called for in a referral.

Second, there is the gap that is created between initial and succeeding episodes where the assessing clinician documents findings that are significantly different from the preceding assessment without evidence in the record as to how or why the improvement – or decline – occurred.

Agency quality teams will want to work toward consistency in OASIS responses that drive payment and to document reasons for any departures from one assessment period to the next as a means of remaining compliant and free from potential allegations of functional deficit "upcoding."

PDGM Focus: Comorbidities

As with the primary diagnosis, certain comorbid diagnoses or combinations of codes will drive payment additions. Thus, the need for accuracy in coding extends from the primary diagnosis to all coded secondary diagnoses which must be active, relevant to the care that the agency has planned for the patient and confirmed by the patient's historical record that is maintained by the agency.

As with the primary diagnosis, all comorbid diagnoses must have their origins in physician or hospital documentation at a minimum. Queries should always be used by the agency to identify conflicts or ambiguities in coding that would have an effect on payment.

PDGM Focus: Partial Episode Adjustments (PEPs) Under PDGM

We have devoted a significant amount of time to analyzing when and how PEPs might work under PDGM. On November 8th CMS issued additional manual instructions through MLN Matters CR 11527 which addresses two issues related to PDGM – the first of which is inpatient stays that span the end of a 30-day payment period.

In previous advice, we suggested that, for patients who are transferred toward the end of a payment period, the agency may want to consider a transfer with discharge if the patient is not expected to return by day 30 of the period because, in order to claim the Institutional Admission for a Late Payment Period, the patient must have returned to the agency's care within 14 days of the start of the period (as opposed to after the period begins). This would enable a readmission and new SOC when the patient is discharged from his/her inpatient stay and would also reset the Admission Source to Institutional.

In the latest guidance from CMS we learn that "for services after January 1, 2020, discharge is not required if the beneficiary has an inpatient stay that spans the end of the first 30-day period of care in a certification period." The HHA would submit the RAP and claim for the period following the discharge as if the second 30-day period were contiguous using a From Date of day 31 even though it falls during the inpatient stay with the initial, second period visit date that occurs after the hospital discharge. Medicare systems will allow the home health claim to overlap [with] the inpatient claim for dates on which there are no HH visits. Thus, CMS has confirmed that agencies have the latitude to either discharge the patient or perform a Resumption of Care that will simply extend the treatment into the second 30-day period of the episode in question.

PDGM Focus: PDGM Periods with No Visits – How to Report the Service Dates on the RAP

The same MLN Matters CR 11527 addresses PDGM Payment Periods for which there are no reportable visits. Here is what the article says:

"On RAPs for initial periods of care, the HHA reports on the 0023 revenue code line the date of the first covered visit provided during the episode/period. For subsequent periods of care, the HHA reports on the 0023 revenue code the date of the first visit provided during the episode/period, regardless of whether the visit was covered or non-covered.

The one exception to reporting a visit date on the 0023 revenue code of the RAP is when no visits are expected during a 30-day period of care. For instance, if the beneficiary's plan of care requires that the beneficiary is seen every six weeks and there is a recertification, the beneficiary might receive no

visits in the first 30-day period following the recertification. In this case, the HHA should submit a RAP for all 30-day periods, but only submit claims for 30-day periods in which visits were delivered.

If no visits are expected during an upcoming 30-day period, the HHA should submit the RAP with the first day of the period of care as the service date on the 0023 line. The RAP for a period with no visit will ensure the HHA remains recorded on Medicare's Common Working File (CWF) system as the primary HHA for the beneficiary and will ensure that HH consolidated billing is enforced. If no visits are provided, the RAP will later be auto-cancelled to recover the payment."

Discharge Planning for Hospitals

What Home Health Agencies Should Know

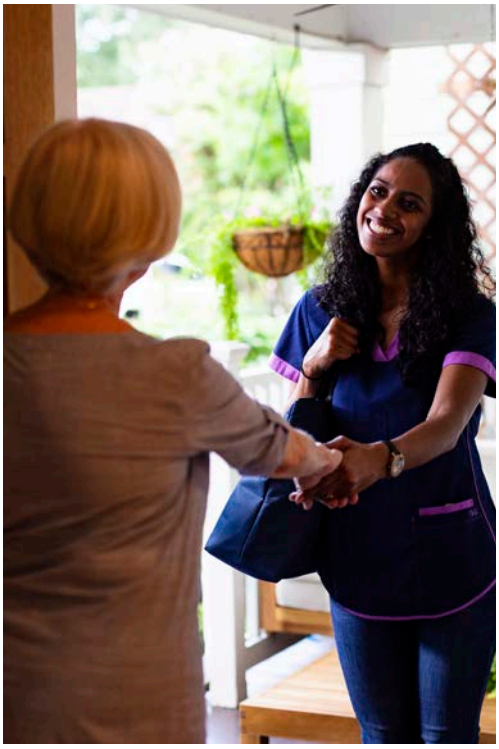
Discharge planning rules for hospitals were last updated in 2004; however, the rules have been changed again with a rewrite of the regulations at 42 CFR §482.43. Following is a summary of the requirements that now pertain to hospitals.

Each hospital must have an effective discharge planning process that focuses on the patient's goals and treatment preferences in place.

Each hospital must have an effective discharge planning process that focuses on the patient's goals and treatment preferences in place. The process must extend to and include the patient and his/her caregivers or support person(s) as active participants in the planning process.

The hospital discharge planning process must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge if an adequate discharge plan is not in place. In addition, if the hospital has not identified a patient as being at risk for adverse consequences, the hospital must still provide a discharge planning evaluation of the patient upon receiving a request from the patient, the patient's representative or the patient's physician. There are **eight standards** that apply to the process:

1. The discharge planning evaluation must be timely to ensure that discharge arrangements are made before discharge and without delaying the patient's hospital discharge.
2. The discharge planning process must include an evaluation of the patient's likely need for post-hospital services including hospice, extended care, home health, and non-healthcare services available from community-based care providers. The process must also include an examination of the availability of services and patient access to the services that might be needed.
3. The discharge planning evaluation must be included as a part of the patient's medical record and the results of the evaluation must be discussed with the patient and/or representative.



4. At the request of the patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient.
5. The discharge plan must be developed by or under the supervision of qualified personnel including an RN, social worker or other qualified staff.
6. The discharge planning process must establish a plan for regular re-evaluation of the patient's condition to identify changes that could require modification of the initial discharge plan and the plan must be updated, as necessary, to reflect such changes.
7. The process must be reassessed by the hospital on a regular basis with periodic review of sample plans and readmission statistics to ensure that plans being developed by the hospital are responsive to patient needs.
8. The hospital must provide assistance to patients, their families and representatives in selection of post-acute care providers by using and sharing data about quality measures and resource use. The hospital must ensure that the data is relevant and applicable to the patient's goals of care and treatment preferences.

Agencies should request that they be included as potential discharge destinations by the hospitals in their service area.

As the hospital discharges the patient it must also provide all necessary medical information that pertains to the patient's course of hospital care, post-discharge goals and treatment preferences to the appropriate post-acute providers, suppliers, facilities, agencies and other outpatient service providers and practitioners responsible for follow-up or ancillary care.

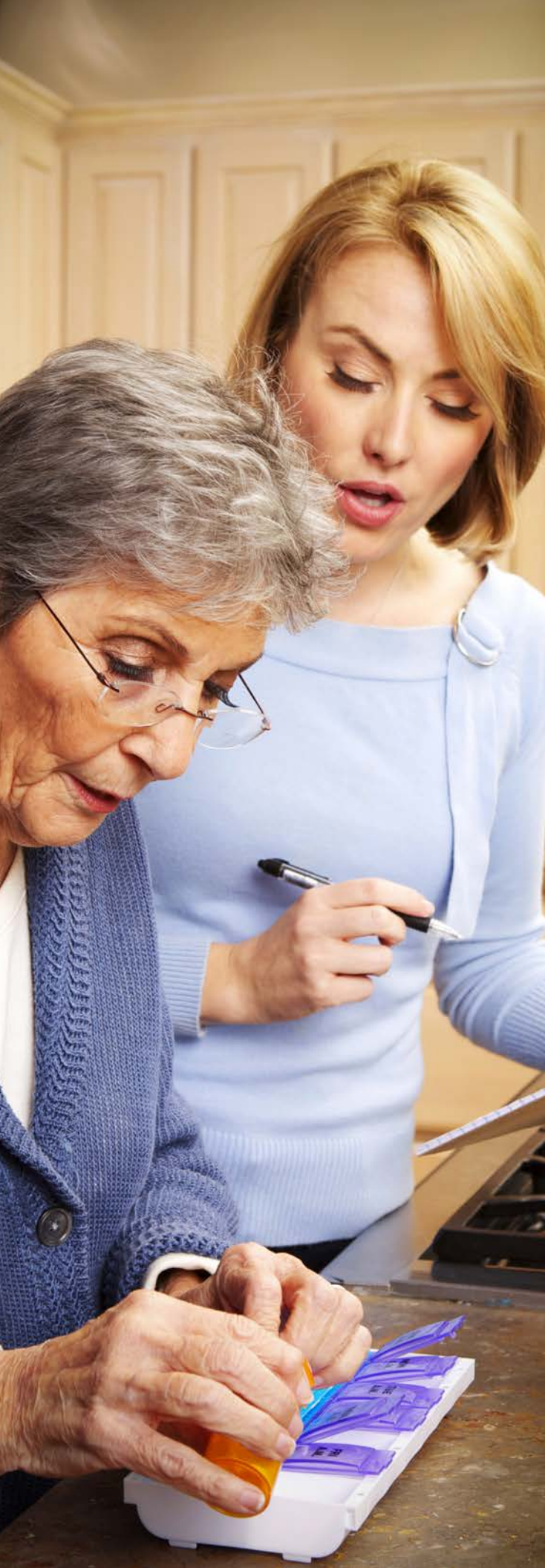
When post-acute care services are called for, the hospital must include, as a part of the discharge plan, a list of home health agencies, SNFs, IRFs or LTCHs that are available to the patient, each of which must be Medicare certified and serving the geographic area in which the patient resides or, for PAC inpatient services, responsive to the patient's preference as to location of care. This only applies to patients for whom the specific services are called for in the plan. If the patient will be covered under a Medicare Advantage Plan, the hospital must make the patient aware of the need to verify coverage of post-acute services.

Under these rules, the hospital has an obligation to ensure freedom of choice among providers and suppliers and "must, when possible, respect the patient's or the patient's representative's goals of care, treatment preferences, as well as other preferences they express." The hospital is not permitted to specify or otherwise limit the qualified providers or suppliers that are available to the patient and the hospital must disclose any financial interest that it has in any provider included on the list it shares with the patient or his/her representatives.

Home health agencies that wish to be included on the hospital's listing of HHAs must request inclusion.

What Home Health Agencies Should Do

First, agencies should request that they be included as potential discharge destinations by the hospitals in their service area.



Second, along with the request, we suggest including data that speaks to both quality and resource use (including hospitalization and readmission rates). This data can include information about specialization for specific types of patients or conditions and can include information about how the agency compares to others in terms of SOC timeframes, average visits by discipline, special programs or technology advantages, readmission rates, patient acuity etc. The rule suggests that hospitals avail themselves of information from Home Health Compare, but there is no limit on that, and any information that your agency can provide and substantiate with facts should be considered to augment your request.

Remember that the regulations which are now in effect do not permit hospitals to limit the number of qualified providers that are available to their patients.

Discharge Planning Rules for Home Health Agencies

What Home Health Agencies Should Know

The new rules also create a Condition of Participation for HHAs – 42 CFR §484.58. The requirements for home health providers are as follows:

HHAs must develop and implement an effective discharge planning process. For patients who are transferred to another agency or who are discharged to another provider such as a SNF, IRF, or LTCH, the agency must assist patients and their caregivers in selecting a post-acute care provider by using and sharing data that includes but is not limited to quality measures and resource use. It will be the agency's responsibility to ensure that the data that is shared is relevant and applicable to the patient's goals of care and treatment preferences.

When a patient is being discharged to another provider the agency must send all "necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care and treatment preferences to the receiving provider. If additional requests for information are provided the agency must comply with those requests.

What Home Health Agencies Should Do

First, work to make sure that the agency has updated discharge planning policies in place that are reflective of this new rule. Train the case management team with respect to the new requirements and how the agency should be documenting its discharge plans and external communications around patient discharges.

Providers that do not have iQIES access by the deadline could be impacted by returned claims.

Consider, as well, including some brief information about the discharge planning process that is in place at the agency as a part of the admission disclosures for patients at the SOC since it is already a requirement that patients must be informed of discharge policies followed by the agency.

Third, consider weaving these requirements into policies and procedures that address the new quality reporting process measures for transferring patient health information, including current medications, allergies and other patient information to receiving facilities and/or the patients themselves at discharge. It will be a bit more work but, remember, this is an element of quality reporting that will ultimately benefit the agency.

Internet Quality Improvement and Evaluation System (iQIES)

MLN Matters SE 19025 was released on November 18, 2019 and addresses provider action that is needed by January 1, 2020 regarding obtaining access to iQIES. Providers that do not have iQIES access by the deadline could be impacted by returned claims due to lack of an assessment match in the system. CMS strongly suggested that access should have been put in place by December 23, 2019.

What Home Health Agencies Should Know

There are four basic steps to the registration process.

1. Register in the HARP system at https://harp.qualitynet.org/register/profile-info

   HARP uses Experian to remotely verify a user's identity by applying the data that a user provides, such as date of birth and social security number, to generate a list of personal questions for the user to answer to verify his or her identity.

   Some users who attempt their HARP registration may receive an error message stating that their email address already exists. This probably means that some level of identity proofing has been completed in the past and that the user already has an Enterprise Identity Management System (EIDM) account. If this is the case, the login to HARP should be done with the user's EIDM login information. If you don't remember your login information, you will need to contact the Quality Net Help Desk at qnetsupport@hcqis.org, or call (866) 288-8912.

2. After the HARP registration (or EIDM login), users will be directed to set up two-factor authentication, which requires an extra layer of security. EIDM users will then need to login to HARP a second time to ensure access to iQIES to establish their role (see Step 3).

3. iQIES roles can be established by logging in to iQIES at https://iqies.cms.gov using the HARP User ID and password (or EIDM login information for EIDM users). The account will be verified using two-factor authentication

and once that is done the user will then select, "Submit." Note: For a better user experience, CMS recommends using Chrome or Firefox to access iQIES.

4. Select "Request User Role" on the *Welcome to iQIES* page. User roles are defined as:

   - **Assessment submitter:** The person who uploads and submits patient assessments and also generates reports.
   - **Provider administrator:** The person who creates and manages patient profiles and submits, modifies and inactivates assessments. Can generate views and reports, but cannot upload assessments.
   - **Provider assessment viewer:** Limited to finding and viewing patient profiles and assessments. Can generate reports. Cannot upload assessments.
   - **Provider security official:** Approves or rejects user access for organizations in HARP. Uploads, creates, manages, and submits patient assessments; creates and manages patient profiles and generates reports.

Note that there are four steps to request an iQIES role:

1. Select the "User Category"
2. Select a "User Role." Note: If the organization has not yet selected and registered a Security Official, roles cannot be requested. CMS requests that agencies establish at least two provider security officials who will be responsible for approving users
3. Select the Organization(s). Requests for the Vendor or Provider categories include the requirement to add one or more CMS Certification Numbers (CCNs). This enables access to those providers. As CCNs are entered, those providers are added to the list of permission requests. An error message will be displayed on the screen if an invalid CCN is entered.
4. Once all the required data is provided, select, "Submit Request." A "Role Request Submitted" message will display on the My Profile page.

The suggested deadline after which timely access for January 1, 2020 submissions cannot be guaranteed by CMS was December 23, 2019.

What Home Health Agencies Should Do

The suggested deadline after which timely access for January 1, 2020 submissions cannot be guaranteed by CMS was December 23, 2019. Agencies should make sure that all users have generated logins and roles to ensure access to the system in time for 2020 submissions under PDGM.

Home Health Therapy Maintenance Services

As a part of the 2020 Final Rule, CMS finalized the permissibility of therapy assistants providing maintenance services as of January 1st.

What Home Health Agencies Should Know

In the 2020 Final Rule, CMS stated that therapy assistants should be able to provide services under a home health maintenance program established by a licensed therapist if the assistant is acting within the scope of state licensure laws. The therapist would still be responsible for the initial assessment, the plan of care, the development of the maintenance program and reassessments every 30 days in addition to supervising the assistant's activities. This will bring home health into alignment with the applicable rules for other care settings such as SNFs.

CMS did not define new HCPCS Codes for therapy assistants relative to provision of maintenance therapy services even though the Final Rule does solicit input as to whether maintenance services should be differentiated from other types of restorative therapy.

There are two G-Codes currently used in home health for therapy assistants: G0157 for PT Assistants and G0158 for OT Assistants. There is no code for an SLP Assistant, currently.

What Home Health Agencies Should Do

Research the state law and regulatory requirements that govern the practice of physical and occupational therapy to ensure that assistants are able, under state rules, to engage in the provision of maintenance services.

The 2020 Proposed Hospice Rule contained a proposal to modify the hospice Election of Benefits. CMS postponed implementation of the requirement until October 1, 2020.

HOSPICE

Addendum to Election of Benefits Statements

In addition to some rate changes and rebasing which came as a surprise to many hospice providers, the 2020 Proposed Hospice Rule contained a proposal to modify the hospice Election of Benefits to include an addendum entitled "Patient Notification of Hospice Non-Covered Items, Services and Drugs." The proposal was for this set of rules to become effective on October 1, 2019; however, CMS postponed implementation of the requirement until October 1, 2020.

What Hospices Should Know

There is certain information that will be required on the EOB as of October 1, 2020 including the following:

- Information about the holistic and comprehensive nature of hospice benefits under Medicare.
- A statement that, although rare, there could be items, drugs or services that would not be covered under the hospice benefit because of a determination that the items or services are unrelated to the terminal illness that is the basis for hospice coverage.
- Information about beneficiary cost-sharing for hospice services.
- Notification concerning the beneficiary's right to request an addendum to the EOB that includes information and the hospice's rationale for why certain items, drugs or services are unrelated to the patient's terminal condition.

When there is an addendum to the EOB, certain information must be included:

- Identification of the hospice by name.
- Identification of the beneficiary by name with his/her medical record number.
- Identification of the beneficiary's terminal illness and any related conditions.
- A list of all current diagnoses or conditions present upon the patient's admission or upon the last update of the Plan of Care and the associated items, drugs or services that will not be covered because they are determined to be unrelated to the patient's terminal illness.
- A written explanation of the clinical rationale for the decision in clear language that the beneficiary can understand.
- Clinical references to accepted practice, policy or other coverage guidelines.
- Information concerning the purpose of the addendum and the patient's right to immediate advocacy.
- The name and signature of the beneficiary or his/her representative and the signature date along with a statement that by signing the addendum the beneficiary is not necessarily agreeing with the hospice's determination of coverage.

When addendums are requested as care begins, the hospice must complete the addendum within five days of the EOB date or within 72 hours if the request comes later at a time when the beneficiary is already covered under the hospice benefit.

What Hospices Should Do

Even though the implementation date has been moved off, it would be unwise to postpone thinking and acting to implement these changes by October 1st. Hospice teams should consider the following in the coming months:

- The degree to which non-covered care relates to the hospice and its patients. For example, determining the percentage and types of patients affected by non-coverage of services, drugs or other items.
- Determining the conditions and general situations where non-coverage would apply and the clinical rationale for each. Determination of whether the hospice's policy position is aligned with CMS guidance given that CMS believes that exceptions to coverage would be "rare."
- The policy and procedural updates that will be required as of October 2020 along with staff education concerning the requirement and the hospice's plans for implementation next year.

about the author

Sharon S. Harder has over three decades of executive management experience in the healthcare industry. She has served in financial and operational leadership roles in a variety of healthcare organizations ranging from a major healthcare professional association to large post-acute health careproviders. As President of C3 Advisors, LLC Sharon engages with clients to develop and implement the strategic vision required to improve their profitability and competitive position in the rapidly transforming healthcare marketplace.

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