Centers for Medicare & Medicaid Services
Special Open Door Forum:
Home Health Electronic Clinical

Moderator: Jill Darling
April 22, 2014
3:00 p.m. ET

Operator: Good afternoon. My name is (Jamie) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare & Medicaid Services Home Health Electronic Clinical Template Special Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Jill Darling, you may begin your conference.

Jill Darling: Thank you, (Jamie), and thank you everyone for joining us today for this Special Open Door Forum. My name is Jill Darling in the CMS Office of Communication. We do apologize for the delay in starting. We wanted to try and get as many callers in as we could. So, this Special Open Door Forum is scheduled until 4 o'clock Eastern Time, so we will keep it to an hour.

So, right now, I'd like to pass the call on to Pamela Durbin.

Pamela Durbin: Thank you, Jill, and I want to thank everybody for joining CMS on the call today for the eClinical Template Home Health template.

Before I introduce the speaker and the key participants, I would like to direct you to the announcement, the Open Door Forum announcement for this call. The links to the website is provided for you. When you click on that link, it will bring you directly to our Home Health Electronic Clinical Template

website. And then I would like to direct you to the download section. I'm going to give everybody a minute to get there.

When you get to the download section, the first line, the suggested Electronic Clinical Template for Home Health, that is the agenda for today's call, which has additional information for you. The second line is the PowerPoint presentation that we will be going over during today's call. The third line is the actual template itself. The suggested Home Health Electronic Clinical Template Version 3.1; that is the template that we are discussing today.

So, without further ado, I would like to introduce to you, Dr. Mark Pilley. He is our speaker today and will be our presenter for the PowerPoint presentation. He is a Contract Medical Director, a CMD, for CMS Supplemental Medical Review Contractor.

Our special participants today, we have Hillary Loeffler, she's a Technical Advisor for the Centers for Medicare & Medicaid Services Home Health and Hospice Payment Group. And we will also have joining us later on in the call, Robert Dieterle, he is the Initiative Coordinator for CMS' Electronic Submission at Medical Documentation Initiative under the Office of the National Coordinator Standards and Interoperability Framework to define and develop national standards for interoperability.

So, without further ado, I will turn the call over to Dr. Pilley. Dr. Pilley?

Mark Pilley: I'm here. Thank you very much for that introduction, Pam. And I want to welcome everybody to the Open Door Forum. I understand we have over 450 people on this forum. That's tremendous.

We'll be talking today about the initiative under ONC's S&I Framework that the electronic submission of medical documentation at CMS has launched. And this is specific for home health face-to-face encounters.

Now, what I want to do first, I hope all of you pulled up the PowerPoint presentation because I'd go through it one slide at a time. So, what we'll be talking about today is basically this initiative and how it is being developed under the S&I Framework, and what are the kind of work groups we're

working with and how we are at this point in time wanting to move from the transition of paper to electronic structure data documents for electronic submission, a medical documentation on electronic determination of coverage.

Let's go to slide two, and this slide two tells you those people at CMS that are the leaders and the other volunteers or co-leaders, they're involved in this initiative. Pamela Durbin is the health insurance specialist. Dan Caldwell is another health insurance specialist with CMS who has been involved with esMD initiative at this phase since, in 2011. That new one is a chief medical information officer, and Bob Dieterle is our initiative coordinator. Some of you may have known me from the past life as I was involved with Home Health and Hospice under Jurisdiction 11.

Let's go to the next slide, number three. This is basically our agenda. We are in the opening remarks, we're going to talk about an introduction to the eClinical template concept itself where we'll talk about home health face-to-face encounter use case presentation and then we'll have some questions and the answers in closing remarks. Now, one of the things I wanted to just point out on the agenda is that we're not going to be directing specific time during this presentation to the eClinical template itself. But we are going to be talking about the development of this and what that means.

Let's go to the next slide, number four. Standards and interoperability, S&I Framework, under ONC. This is very robust, repeatable process that'll help to improve interoperability and the adoption of standards of health information technology in the exchange of information in the medical documentation. The S&I Framework will streamline the execution of the data segmentation initiative across the solution development life cycle which is the next slide, slide five.

This is our development life cycle. The S&I initiative phases are on the left-hand side. And you can see, there is a (step by) process of pre-discovery, discovery implementation, and in launching pilot projects and then evaluate on those pilot projects for effectiveness and lessons learned.

For the electronic determination coverage phase, which falls as one of the categories under the S&I, the esMD workgroup initiative here, we have a process for a charter. We use – we develop a use case, we live up for standards of harmonization and developing specific clinical elements that we can use to crosswalk to structured data such as in standard like HL7 and then we begin an implementation in guidance of piloting those initiatives.

Since we're in the use case, we'll concentrate on the details, the use case at this point in time, and this is where we create a use case for user stories. We define the actors of the roles and develop activities in sequence diagrams. We identify dataset elements which the clinical information that can be used to develop structured data and structured documents for transmission of those documents to the payer upon request. We identify risk issues for those risks and obstacles. And we have a sub workgroup effort that develops structured data requirements, templates for data capture, and the assistance support.

Let's move to the next slide. I think it's important to provide a brief overview of the background in terms – this is driven by improper payments in the need to achieve better accuracy in payments. Medicare receives about 4.8 million claims per day. In 2013, Medicare fee-for-service program was estimated to issue more than $36.0 billion of improper payments. That's about a 10.1 percent error rate. Medicaid program was found to have about $14.4 billions of improper payments in 2013.

At the current time, most of the reviews in audits are being done by humans, and the claims are, you know, the medical documentations are being reviewed by the medical reviewers and auditors and encoders, being reviewed by the contractors that do medical review under CMS, and that has listed on the slide to the Medicare administrative contractors, companies of error rate test, contractor payment error rate, measurement contractor, and the Medicare recovery auditors.

Next slide, please. This shows the improper payments for Part A services excluding (infant) patient hospital services for 2013, and this report came out in November 2013. As you can see at the top of the list is Home Health Services with a projected improper payments of $3.091 billion. That's 17.3

percent of this particular improper payment rate. Now, this is published by the CERT.

All right, let's go to the next slide. esMD background, the initiative before Phase 1 went into effect was what we traditionally knew as the paperwork, the paper trail, the USPS request for documentation in support of services that were built and sending of paper documentation to the review contractor for a review.

Phase 1 went into effect in September 2013, with the continuance of the paper request for documentation but with the capabilities and availability for providers to send documents electronically through the esMD gateway. Now, this wasn't a requirement. This was an option. And today, it's a growing option.

Phase 2, which we hope to see in the near future exactly when it's not known. But if I say near future, that could be one or two years. But that is the ability to send electronic medical documentation request and to receive electronic medical documentation in response to that request by the payer.

Next slide, which is slide nine, gives you a basic high level overview of that request. Providers would opt to request to receive electronic medical documentation request, the eMDR, and would receive those eMDRs from Medicare and then in response, send back to the medical documentation in electronic form.

The initiative for esMD is to move that through the phases of electronic forms that we currently get now which are used generally unstructured documents like PDF. We do receive some PDFs to the esMD that can't be searched in terms of word search, but we're really talking about moving this from an unstructured document to a structured document that could potentially not like containing text but contain codes of that link to a specific clinical information, functional impairments in the levels of abilities and structural impairments.

Next slide, next slide gives you basic overview of what we're looking at in terms of our challenges, scope, and what we hope in terms of outcomes. In terms of our challenges, enable the provider to capture the documentation to

benefit determination based on payer rules. That in this case is allowing the physician that has the information that supports the face-to-face encounter certificate to put together a document that meets good, provides good information for benefit coverage, secure exchange of the templates, decisions support and documentation between payers, providers, home health agencies and the beneficiary.

The scope is basically defining the use case, the user stories, the requirements supporting the standards-based architecture for the medical documentation; reuse of existing S&I initiative efforts were impossible, and creation of structured data captured templates and supporting exchanged standards; Home Health face-to-face encounter as a use case; the outcome is a successful pilot of templates and decision support to the EMR systems; information exchange standards over standards of secured transactions for the purpose of determining coverage; and this also includes the possibility of a digital signature that is scribed to the document to validate off the record. And that's the validation of the use case for face-to-face encounters.

Next slide, this is slide 11, this is the general workflow, and this is a busy slide but it points out that the patient that’s going to be at the top of the pinnacle of the workflow is the focus of coverage here, the focus of providing services. Physician and non-physician providers are involved. And as per the policy language, the physician must document the face-to-face encounter certificate. Non-physician providers are allowed but non physician providers that can complete the face-to-face encounter itself but the completion of a document that is anticipated and expected to be by the physician.

Of course, there is interchange between the home health agency. There is sometimes a need to involve other specialists like a physical therapist, occupational therapist, or even a physiatrist on occasions. And then there's exchange to that information across electronic gateway and through a health information handler potentially. Now, occupational therapist and physical therapist themselves are not allowed non-physician providers. But they do provide information that physicians can use to understand their patients' function limitations, capacities, and risk and tolerances.

Next slide. These are related S&I Framework initiatives that esMD interfaces with. First one is transitions in pair. And this defines the electronic communication and data elements necessary for clinical information exchange to support transfers of care between providers and between providers and patients. The relationship is standards for exchange for clinical information. And I believe it's this workgroup that has developed plan of care in a use of particular form for that, and that's a 485 form but that's not a sanction form per se but that's the counter form and that's fine. But that's been developed. So, this is going to kind of – this (initially) will dovetail on to transitions of care.

Provider directories, that's the next line down, next road down. To find the transition requirements for coordinated (sets) needed to support queries to provider directories to enable electronic health information exchange, the relationship, electronic influence for participants and Electronic Determination of Coverage, or what we call eDoC.

OK, the initiative of Structured Data Capture, SDC for short, external template driven capture of structured data within the electronic health record. Templates and workflow to capture payer required information. esMD author of record. This is the digital signature that is identity proofed at a medium level across the federal bridge issued by a certifying authorities or registered authorities and the relationship that at standards for digital signatures on transaction and documents. If this could be implemented there's a potential we can reduce some of our payment error rate by as much as 20 to 30 percent and also speed up turnaround times for medical review and audit.

Direct is a transport system basically or transport way. And it's so simple, secure, scalable standards way for participants to send authenticated, encrypted health information. Relationship utilizes direct as a transport mechanism between providers, payers, and suppliers, and it can interface with the esMD gateway.

Next slide, which is slide 13, this gives you overall workgroup structure for the esMD workgroups. As you can see, at the top, is what we outlined previously in terms of chartered use case harmonization in pilots. And down

below, on our sub workgroups, we have other use case stories that we process now (power mobility) devices (inaudible) prosthetics.

Our third initiative is home health. The structured data is to determine documentation requirements, evaluate appropriate clinical elements. But we don't want to leave elements out if the physician may want to use in terms of representing the patients presentation in a clinical or medical documentation, and to define clinical vocabularies.

The documentation templates, these are the defined template requirements that define template workflow and define EHR data capture. Transport systems are just that. That's how you send the bundled documentation electronically. ASC X12 275, 270, 277 through direct and connect into the esMD gateway.

Next slide is simply – that's slide number 14, that's simply we're going to enter into a phase we talked more specifically about the home health face-to-face encounter esMD initiative.

Next slide is slide 15. That talks basically about – what this represents is basically what the physician can use in terms of billing for their services. OK, because the physician is really where the face-to-face eClinical templates being directed to. We won't dwell on this. I mean it just shows there's a number of different ways that a face-to-face encounter can be accomplished by the physician. And as we mentioned previously, non physician providers in those – that are allowed are PAs, licensers, practitioners, clinical nurse specialists, and midwives.

The next slide, slide 16, face-to-face encounter documentation in terms of meeting requirements, it's a brief narrative which describes how the eClinical findings of the encounter support patients home bound status and (need for) skilled services. It's a physician certification that is required. It's required to be created by the physician and what is invited in terms of any documentation request by the payer for review as any other medical documentation that supports national coverage determination, local (coverage) determination requirements but also supports the need for homebound skilled services. (By

now), we get the encounters by the usual manner of mail, fax, or through the esMD gateway.

Next slide. This is simply the graphic depiction of the four jurisdictions under which home health and services are being adjudicated by the Medicare MACs. I won't dwell on that slide. All of you in home health know who those particular administrative contractors are. And in terms – it's prepayment/post payment this time. There has not been any discussion to my knowledge of prior authorization at this time.

Let's go to the next slide which is slide 19. This is just a general flow process. I mean we developed this to try to get a handle on how the use case can be developed, OK? Now, on the top, you see the home health face-to-face encounter that's performed by the physician or non physician provider. But on the left, you can see the entry point could be a number of different clinical setting from hospitalization, hand off from the hospitalists to the community physician transitions from the hospital to a skilled nursing care facility and then to home health, or it could be a situation where you have a change in clinical status and the patient being at home and they request to have some home health services and that's requested by the treating physician. It could be people leaving contact home health agencies and say, "I need some assistance." And the home health agency can call their treating physician and that could be initiated at that point.

Then once the face-to-face encounter has been completed, the physician makes the documentation, develops the certifications and signs at a day fit. And those exam findings are in some clinical documentation. (Jointly speaking), it can be in the face-to-face encounter but we commonly see at this point in time a face-to-face encounter certificate that has essentially a narrative describing why the patient is homebound, what's the skilled care need that they have and provide some diagnoses.

So, in itself, it's really not a clinical documentation per se as much as an account or a certification meeting requirements. Well, some are prior to that document being composed is a clinical history and presentation for that patient that is documented in many, many different ways in settings.

But once the certification is signed and dated, then it's communicated to the home health agency, who has developed a plan of care or is developing a plan of care which then has to be signed by a qualifying – certifying, recertifying physician. And actively, the physician that completes the face-to-face encounter certificate also.

Let's go to the next slide and that's slide number 20. What we did here is we involved license to clinical medical professionals because many times occupational therapist, physical therapist, speech language pathologists are involved in that patients' recovery, (inaudible). But as we said earlier, PT, OT evaluation does not meet the face-to-face requirement, and they're not allowed non-physician providers per se but the information that is provided by those specialists are very important to incorporate into a face-to-face encounter document if so deemed by the physician completing that document.

Next slide is slide 21. Slide 21 is simply giving you a link to code of Federal Registry 424.22 which defines the requirements for home health services. And that serves as the basis for our user story.

The next slide, slide 22, is it provides you with coverage and documentation requirements under CMS. And here, we've got the benefit coverage manual and a link to that and a transmittal that talks about further clarifications in guidance on physicians and non physician providers in performing the home health face-to-face encounter in physician certification.

The next slide which is slide number 23. We have the links to all of the CMS Home Health MACs, Medicare Administrative Contractors.

Next slide, slide number 24, is some more resource information, clinical research information through MedLearn Matters published by CMS.

The next slide, which is slide number 25; this talks about the structured information for the eClinical template. This gives you some information that's available and including the eClinical template website and the eClinical template link that goes right to the face-to-face eClinical template documentation.

Next slide, slide number 26. This is a basic general overview outline of the components of the home health face-to-face eClinical template. It's a basic straightforward in history and physical really with the details (followed) on each categories. This gives a general outline of information – categories of information that we've identified that can be applicable in providing information needed for documentation in support of home health services.

Next slide is slide number 27. And this basically talks about the eClinical template process itself in terms of why we are doing this to identify individual clinical elements and to link them with structured data document potentially so they can be codified. And they could be also utilized in terms of developing clinical document architecture of CDA, which is a structured document that then can be wrapped up into a CCDA and sent electronically via health information handler who direct or connect to the esMD gateway.

Actually, the template will be considered consensus on best practices that it's also a desire to get sufficient enough information and comprehensive enough information that the physician can go into the electronic medical record in which this is housed and pull out the information that they need and the categories of information that described the patients' functional limitations and impairments and tolerance and risk.

The next slide is slide 28. This is representing the face-to-face encounter workflow using digitally signed records or documents. And it's the same as – pretty much the same as before, but instead of sending the document electronically, you have a digitally signed document. And we have a couple of pilot projects right now involving PMD where there are coordinates and efforts to do just that.

The next slide is slide number 29. This talks about our electronic and termination of coverage time line. We are here and really it has April 14th of where – we're a week past that at this point in time. And as you can see, what we included in here is basically what has transpired since the April of last year and that includes the Power Mobility Device user story, the lower limb prosthetic user story, and the development of the PMD eClinical template,

pilots, and now we're looking at the development of the lower limb prosthetic electronic clinical template pilots.

So, Home Health is the next phase of esMD, and we're anticipating that there'll be additional initiatives in the future yet to be announced.

The next slide is slide number 30. This is a call for public participation. And from where I understand right now with the number of people on this call, we're getting a lot of interest and that's good because we need good feedback and we need important information from the community. Payers, certainly Medicare and Medicaid commercial payers are certainly invited because we're developing this to be utilized not just by a Medicare fee for service processes but it can be adopted and utilized by other payers of Medicaid if so desired.

Providers provide organizations, suppliers, health information and handlers, you know, the electronic medical record vendors in association, health information exchanges, CAQH CORE and other expertise that they're interested in coverage determinations, developing structure documentation and decision support and potentially preauthorization in the future. And like I said, there's no initiative at this point in time in terms of home health services entering into the prior authorization demonstrations like PMD. And as I pointed out, PMD is still under the demonstration at this point in time.

Next slide is slide number 31. It's a summary. The eDoC workgroup identifies best practices for payer interaction with providers for determination of coverage, developing, delivering and using structured document templates to support coverage determination, addressing all the record requirements, secure electronic communication including payers, providers, suppliers and beneficiaries and creating implementation guides, what we call IGs, for payers and providers for all required eDoC processes and transactions.

I do want to say one thing at this point. The eClinical template itself is not a form that CMS is mandating or prescribing. It's developed to capture sufficient clinical information to be able to be utilized in electronic medical record system to develop a structured medical documentation for electronic determination coverage eventually. So, that serves a purpose of providing

what needs to be incorporated into electronic medical record for a physician that needs to pull out a wide scope of information because there are – there's a wide scope (of reasons) why people need home health services. So, it's not there as a mandate, it's there as a template to be used so we can identify electronic elements in developing, you know, the documentation itself, the documentation guides or EMR vendors.

Next slide is going to be slide 32, and we're going to talk about next steps real quick here. Every Wednesday, from 1:00 to 2:00 to two Eastern Time, we have a community meeting under the S&I Framework. We use the Wiki S&I Framework web link, and we are discussing the home health face-to-face encounter template for the – and the elements of that on an ongoing basis. When we get to a point, we have (raised some) – we have completed our development, we will put it out for review and consensus and voting by the community.

Next slide is slide number 33. And this is the links to the esMD initiative and the program and it gives you links once again to the electronic template program and the electronic template itself.

Next slide is slide 34. It gives you the contact information for the leads and co-leads for this initiative.

And we'll go to the next slide which is questions and answers.

Operator: As a reminder ladies and gentlemen, if you would like to ask a question, please press star then one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Please limit your questions to one question and one follow-up to allow other participants time for question. If you require any further follow-up, you may press star one again to rejoin the queue.

And your first question comes from Eileen Sullivan from Bayonne Medical Center. Your line is open.

Eileen Sullivan: Hi. I was wondering if my question has to pertain to this subject or can it pertain to the probe and educate audits or the two midnight rule. Am I – is

anyone there able to answer those questions first of all? Because we're getting – the American Case Management Association, case management directors are getting different direction from different MACs. So, we need CMS to address some of our questions directly.

Pamela Durbin: This is Pam. On this call, we do not have anybody to answer those questions, but I am happy to take that comment and recommend it possibly for a call. Could you please send your comment to the eclinicaltemplate@cms.hhs.gov and you can find that link on the agenda, on the webpage.

Eileen Sullivan: OK.

Pamela Durbin: So, again – and if you don't get your question in on this call, please e-mail the eclinicaltemplate@cms.hhs.gov . And this link is available on the agenda for you as well. That's posted to the website.

Eileen Sullivan: OK. So, no one there can address the physician co-signing and inpatient order prior to discharge?

Pamela Durbin: No, ma'am. Not on this call.

Eileen Sullivan: OK. Thank you.

Operator: Your next question comes from (Dale Gibson) with (Dale Gibson Incorporated). Your line is open.

(Dale Gibson): Yes. I'm in the same situation. I have some issues with some MACs not being able to process claims timely or correctly. Is there someone there going to address this issue with or are we just pertaining to a home health medical rep?

Pamela Durbin: Yes. For this call is specifically for the home health face-to-face requirements and the eClinical template. But you are welcome to send your question or your comment to the eClinical template web box or e-mail box at cms.hhs.gov.

(Dale Gibson): They haven't had a call in sometime (inaudible) specific, you know, specific calls. I mean do they plan to have another phone call, or are we just stuck out here in limbo?

Female: I do believe there'll be another call on the two midnight rule. I don't know when it is scheduled. We (currently) do not have the experts in the room right now to know when that next call will be. But as Pam said, if you want to send in your question or comments to the e-mail address that Pam gave, or I also believe the in-patient two midnight has its own e-mail address, e-mail box, that's just out there on the website. You can send in to either one of those and we will certainly take that. That'd be public and still requesting additional instruction from the two midnight perspective. And I – but I do know there are additional calls.

For this particular call, the expertise that we have online and in the room, it's really only related to this new initiative that home health face-to-face eClinical template.

(Dale Gibson): OK. Thank you.

Female: Thank you.

Operator: Your next question comes from …

(Brad Determan): Pam, this is (Brad Determan) now on the call.

Pamela Durbin: Thank you.

Operator: Your next question comes from (Susan Benedetti) from (Mountain Home Health). Your line is open.

(Susan Benedetti): Hello?

Pamela Durbin: Hello. This is Pam. What's your question?

(Susan Benedetti): I did not have a question but I just heard my name.

Pamela Durbin: All right. Do you have any comments for the home health face-to-face eClinical template?

(Susan Benedetti): You know, it just seems like it's getting more and more complicated, and doctors aren't very happy with it and home health agencies are getting docs because doctors aren't completing this to Medicaid or Medicare's requirements. And I think that if the doctors not completing it as they should be and the doctors ought to get dinged as well.

Pamela Durbin: Thank you for your comment.

Operator: Your next question comes from (Debra Vuwell) from (Legal Advocate). Your line is open.

(Debra Vuwell): I'm – this number SE1219 and this relates to the physician certification requirements number four, item number four, on that document. It states, if the patient needs or needed skill nursing services on an intermittent basis or physical therapy, speech-language pathology, or continues to need occupational therapy after the need for skilled nursing care of PT or speech-language pathology ceased. Where a patient's sole skilled service need is for skilled oversight of unskilled services, the physician must include a brief narrative describing the clinical justification of this need as part of the certification or recertification.

Here's our concern about the language in this particular item. This is not addressing and actually appears to be in conflict with the Olmstead Act. The Olmstead Act, for those who don't know what that is, it's an Americans with disabilities related item passed in 1999, which protects the inclusiveness of the patient in the community. In other words, it is the idea of Olmstead Act to federal law that the patient would be served best by the search with home health care needs in their home and it is more inclusive in the community as well as more financially agreeable to the community generally. It's definitely cheaper for a person to obtain needed services in the home.

The other aspect that is not addressed here is the consumer directed personal assistance program which is operated by many independent living centers through a variety of profits and non for profit companies throughout the

nation. And the consumer directed personal assistance program, what we find is that in many of the people who have the level of ability to be participating in that program do not necessarily need skilled nursing services but they do need help with daily living activities.

So the concern here is on to two parts. The part one is for the physician. If the physician says no, this person for example and it's consumer directed personal assistance program, does not need skilled nursing, are we putting patients at risk of being placed in an institutionalized setting rather than being unable to stay in their home which would be a direct violation of the Olmstead Act? And on the patient/enrollee side, the question is how can patients and enrollees protect their ability to stay in the community with language such as this, not defining for the physician ways to be congruous with the Olmstead Act as well congruous with the needs of CMS.

That's my question.

Pamela Durbin: Ma'am, you raised an interesting question and I would appreciate that if you would put that in an e-mail to me at the eclinicaltemplate@cms.hhs.gov .

(Debra Vuwell): Can you tell me who you are, please?

Pamela Durbin: Sure. This is Pamela Durbin.

(Debra Vuwell): Pamela Durbin, OK. And I have the e-mail address that was the general e-mail address, should I put your name in the subject line or how would you get it?

Pamela Durbin: I monitor the eClinical template mailbox.

(Debra Vuwell): OK.

Pamela Durbin: But you can also – so eclinicaltemplate@cms.hhs.gov

Hillary Loeffler: And then also, this is Hillary Loeffler.

(Debra Vuwell): OK.

Hillary Loeffler: The information that you are reading from and the MLN article SE1219 that outlines the skilled service requirements for eligibility for the home health benefit, those are requirements for the Social Security Act, those are not CMS requirements per se. They would only be changed by an act of Congress. So, what you're quoting is Social Security Act Congressional requirements for eligibility for the home health benefits.

(Debra Vuwell): Yes. I guess my concern is that the language isn't really specific enough to the Social Security aspect of the law predated the existence of the Olmstead Act or even the Americans with Disabilities Act. So, my concern is with this language, it could easily be misinterpreted by physician that, you know, certain people would not be eligible for home health care services which is they make this skilled nursing requirement. And so, this is what my concern is because the old (inaudible), you know, which is the father or mother whatever you want to call it, this doesn't really take into consideration the laws of (inaudible).

Pamela Durbin: Yes, ma'am. And you raised an interesting point and that's a valid point. Please again send those comments to us so we can address that offline. So we …

(Debra Vuwell): OK.

Pamela Durbin: Yes, thank you.

(Debra Vuwell): Thank you very much.

Female: And we just like to remind everyone that we do understand you may have many (questions) for CMS but the experts in the line and in the room today is really, can only really address issues and questions pertaining to the home health face-to-face eClinical template.

Operator: Your next question comes from (Kizzie Williams) from Little River Memorial Hospital Home Health, your line is open.

(Kizzie Williams): Hi. I joined the conference late and I heard the guy that was doing the presentation kept asking about, (was saying) going to the next slide, where do I go to print out the slides or can I print them out so that I can view them?

Pamela Durbin: Ma'am, do you need the link?

(Kizzie Williams): Yes. I need the link.

Pamela Durbin: Do you have the announcement for the Open Door Forum?

(Kizzie Williams): Yes.

Pamela Durbin: Click on the link in the announcement for the Open Door Forum.

(Kizzie Williams): What is the link?

Pamela Durbin: It's a long one but it says eClinical template home health. It's in the middle of the announcement, right. It says you can find the proposed document by going to http electronic clinical template home health. Do you see the link on the announcement?

(Kizzie Williams): No, ma'am. Someone else gave me the announcement. So I'm not sure if they gave me the right thing because I was looking through it, through the presentation and I couldn't put in several links on here and no one seems to be correct. Can you give it to me?

Pamela Durbin: I can give you a short one. It's http://go.cms.gov/homehealtheclinicaltemplate

(Kizzie Williams): And that would give me all the slides?

Pamela Durbin: Yes, ma'am. What that'll do is it will bring you to the webpage, the home health eClinical template webpage and you'll notice in the middle of the page that there is a box that says Download and the PowerPoint presentation is the second line in the download section.

(Kizzie Williams): Second line in the download section.

Pamela Durbin: Yes.

(Kizzie Williams): Thank you.

Pamela Durbin: You're welcome. Or you can also e-mail the eClinical template mailbox and I can mail you the slides if you can't …

(Kizzie Williams): That's eclinicaltemplate.gov, correct?

Pamela Durbin: At cms.hhs.gov.

(Kizzie Williams): OK. All right. Thank you.

Pamela Durbin: You're welcome.

Operator: Your next question comes from (Jane Demas) from Washington Region Medical Center Home Health. Your line is open.

(Jane Demas): Thank you. This is directly related to the face-to-face issue that we're facing each and everyday in looking at the suggested electronic clinical template elements. This is extremely task-intensive and way more than a narrative. We are having difficulties already getting the doctors to vary from just saying that the tax and effort to leave home as a reason, as a rationale for homebound status. We have tried to educate them, we've tried to give them examples, we've used the ML learning information to share with the doctors, and they still do not comply with what we need on our face-to-face.

So, you know, I think home health agencies are needing some help. We are losing millions of dollars, not collectively. Individually, we're losing tens of thousands of dollars on a face-to-face document that, you know, we didn't have good – really good direction about and now we're having difficulty with the physician. So, is there anyway to make this process less laborious?

Female: I do think that, yes, we are trying in the creation of this eClinical template to make the process easier for all that are in practice. Now, we currently, the face-to-face requirement is a statutory requirement. And so, CMS is trying to implement and import that as best we can. And one of the ways, we have heard from the public, that it is very laborious and very hard to meet all the requirements. And so, one thought is if this creation of eClinical template is it

would be endorsed and used by electronic health systems that it could actually make things easier long-term for the physicians and the home health agencies.

We finally do realize that home health agencies have issues gain as physicians to document correctly. So, we do hear that on the regular basis from all provider (inaudible), you know, rely on physician data. We are certainly always open to ideas about ways that we can educate physicians and we certainly do realize that it is (inaudible) that some health agencies (inaudible) but we are hoping that especially if that's in the right direction to making (inaudible).

(Jane Demas): Well, I noticed it's supposed to be held in one question but if you don't mind a quick follow-up. Is there some release in site for home health agencies during the interim of while this gets hashed out and that will, you know, will give us some release from losing dollars while we're trying to get to the physicians online to help us.

Mark Pilley: This is Mark Pilley, Dr. Pilley. I'm very familiar with home health services and transitions of care from prior clinical practice. I want to make some real important points here. We're not trying to transition you from one – this process from one paper document to another paper document.

I think that that's kind of a misunderstanding. This isn't being prescribed or mandated, this is a set of data elements that could be presented in representation of a patient's clinical condition and why they have the impairment they have that don't let them leave the house and why they need certain skilled services. It provides information that can then be filled into an electronic system, an EMR, electronic health record system, that's available for the physician to utilize in providing the information.

Now, what has happened in the industry is that the face-to-face encounter certificate has been instilled to one form, OK, and that's one form, OK? And it is – there's a narrative on there. It's not an in of itself but clinical document, OK? It is a narrative that is to provide a straightforward communication of why the patient is homebound and why they need skilled care need. It

satisfies the need for payment of services and 40, you know, 40 to 60 percent of the time.

Nevertheless, it's not sufficient, and 40 to 60 percent of the time depending on what time and what the reviewers are doing, what review and so on and so forth. And as you could see in terms of Part A services including inpatient it was 17.3 percent representing $3 billion which are projected. That's projected now in the improper payments.

What is being said here is that the face-to-face encounter certificate form is just that, it's a certificate. It's authorizing home health services. We're not seeing as a general rule all that other clinical information that goes to support that set of need. If it's concise enough and if it's specific enough on the form, that allows us payment and reimbursement. If it isn't, then it's like the other documentation that comes in the background is there. We're not seeing that. That doesn't get to be seen. And there is a Social Security Act 1833E that requires that there'd be supporting clinical documentation for services bill that are established those services as (reasonable) and necessarily paid for.

(Jane Demas): OK.

Mark Pilley: So, we're not really trying to complicate things. What we're trying to do, what we are doing is that we were trying, what we will do with this is transition to the next level of documentation from paper to electronics which you'll actually provide – and provide, you know, physicians are – they're transitioning too. Some will transition to get a little robust and I'm not talking medical documentation, some will not. And some will want to stick with paper and that's fine. There's lots of different mechanism sending documentation that's requested.

But what we're actually doing here – and we have to provide a set of data elements that is enlightened up in scope that the physician can go to that template and their EMR system and they can find the category of information, they need to house that information that specifically describes that patients' condition, their impairments, limitations, their tolerances, their risks, the need for skilled services.

Pamela Durbin: And Dr. Pilley, this is Pam and before I came to CMS, I was a documentation specialist. And to appreciate that, I was trying to get the physicians to just write acute in front of congestive heart failure. And that was very challenging, so I could appreciate trying to get the face-to-face documentation.

So, perhaps this will help you as you approach your physicians. It is really only asking for the homebound status. They can't walk more than 150 feet. They had medication changes so they need a skilled nurse in the home. That's really the only components that we're asking for in the narrative.

And I believe in the continuum of patient care, the excellent care that they provide in the office and at the bedside needs to continue to the documentation. And the documentation in itself is required because as you said, home health agencies collectively are losing millions of dollars individually are losing tens of thousands of dollars. The last thing CMS wants is for our beneficiaries to be denied access to care. And we want the physicians and the home health agencies to be paid for the services that they provide our beneficiaries.

So that's why this documentation is important. And I would encourage you to go on the website. There is an MLN Matters Article Special Edition 1405. And in that MLN Matters article, there are examples of good and bad documentation specifically what CMS and its contractors are looking for the face-to-face (care) …

(Jane Demas): Yes. (Inaudible) they're submitting in our doctors. Unfortunately, we continue to keep trying to educate them. I do handle the recovery audit contractor request and, you know, that's just another one of the components of wanting to try to make sure we're all in the same page because sometimes they'll say things denied for payments that you question why and then they'll turn around and approve something else is just the same. So (inaudible) …

Pamela Durbin: And we're – yes ma'am and I'm also part of an initiative to work on standardizing reviews. And with that, I believe we have time for one more call – one more question on the call.

Operator: Your next question comes from (Greta Rasen) from Hope International Hospice. Your line is open.

(Greta Rasen): Hello?

Pamela Durbin: Hello. Yes, ma'am, what's your question?

(Greta Rasen): I joined the conference earlier. I'm from California. My question was is this conference also includes hospice or this is specifically from home health?

Pamela Durbin: Specifically for the home health face-to-face, yes, ma'am.

(Greta Rasen): I see. So, anyway, I was trying to get to the website as well but it keeps on giving me an error.

Pamela Durbin: Do you have the announcement? Do you have the announcement for the Open Door Forum?

(Greta Rasen): Yes, I have it in front of me.

Pamela Durbin: You know, what, you can Google it. It's available. Home health eClinical template CMS and it will come up for you. I apologize for the difficulty in the link.

(Crosstalk)

(Greta Rasen): OK. Thank you very much.

Female: … and we can send them (inaudible).

Pamela Durbin: Yes. Did you – please if you can't Google it, if you don't find it by Google or on the announcement, I can send you the link. Please e-mail the eClinical template mailbox, eclinicaltemplate@cms.hhs.gov.

(Greta Rasen): OK, I will. Thank you very much.

Pamela Durbin: Thank you.

Thank you everyone for joining today for the Special Open Door Forum. Have a wonderful day.

Operator: This concludes today's conference call. You may now disconnect.

END