

The next CMS Home Health Hospice & DME/Quality Open Door Forum scheduled for:

Date: Wednesday, December 1, 2010;  
Start Time: 2:00 PM Eastern Time (ET);  
Please dial-in at least 15 minutes before call start time.

Conference Leaders: Michael Bussacca, & William McQueeney.

**\*\*This Agenda is Subject to Change\*\***

I. Opening Remarks

Chair- Lori Anderson

Co Chair – Nancy O'Connor

Moderator- William McQueeney (OEABS)

II. Announcements & Updates

1. OASIS Update,
2. HH Caps
3. Face –to-Face Encounters for certification/recertification -- clarifications,
4. Coverage of therapy services in the home health setting – clarifications.

III. Open Q&A

**\*\*Next ODF: Wednesday, January 19, 2011\*\***

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Open Door Participation Instructions:  
This call will be Conference Call Only.

To participate by phone:

Dial: 1-800-837-1935 & Reference Conference ID: 24747689

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Encore: 1-800-642-1687; Conference ID# 24747689.

Encore is an audio recording of this call that can be accessed by dialing 1-800-642-1687 and entering the Conference ID. This recording will be accessible beginning Tuesday, December Monday 6, 2010 and expires after 3 business days.

For ODF schedule updates, E-Mailing List registration and Frequently Asked Questions, visit our website at <http://www.cms.gov/OpenDoorForums/>.

Thank you.

Audio File -

[http://media.cms.hhs.gov/audio/120110\\_Home\\_HealthHospiceDME\\_Open\\_Door\\_Forum.mp3](http://media.cms.hhs.gov/audio/120110_Home_HealthHospiceDME_Open_Door_Forum.mp3)

## **Centers for Medicare & Medicaid Services**

**Moderator: Bill McQueeney**  
**December 1, 2010**  
**2:00 p.m. ET**

Operator: Good afternoon. My name is Matthew and I'll be your conference operator today. At this time I'd like to welcome everyone to the Home Health, Hospice and DME 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 key pad.

If you would like to withdraw your question, press the pound key. Thank you. The Forum leader is Bill McQueeney. You may begin your conference.

Bill McQueeney: Thank you Matthew. Hello everyone and welcome to our Home Health, Hospice, and DME Open Door Forum call.

I have a couple of housekeeping things to go through before we begin.

One is we're in our 10th year of Open Door Forums and we want to start every one of these by soliciting input from all of you as to how we can make the Open Door Forums better, how we can make it meet your needs more.

We're particularly interested in people who have suggestions about our format, how we archive the material that we send out, and we're also interest in people who have an opinion about whether they could participate in the conference if we had live streaming audio as opposed to the current

conference call approach. If we did that then everyone could hear us on their browser and then those few that had questions could call into an 800 number.

So, if you have thoughts about that or concerns about that, please send an e-mail to [odf@cms.hhs.gov](mailto:odf@cms.hhs.gov). And we'll be glad to get back to you about that. One other thing that all the open door Forum leaders have been asked to go over at the beginning of it really relates to a recent regulation. I'm just going to read this verbatim because that's how they gave it to me.

“The Accountable Care Act has changed the law so that all claims for services furnished on or after January 1, 2010 must be filed within one calendar year after the date of service.

All claims for services furnished before January 1, 2010 must be filed on or before December 31, 2010. The Accountable Care Act gave the Secretary the authority to create exceptions to the one year timely filing period. We created three new exceptions to the timely filing rules in addition to the already established exception for administrative error. We'll be updating our [Internet Only Manuals](#) in the weeks to come.

And the manual will reflect what we said in the regulations and add some additional details about the exceptions to the timely filing rule.”

So, just wanted to make sure everybody was aware of that.

Now I want to welcome all of you, as I say, to the call. I want to welcome our roomful of experts here in CMS central office and our regional office experts who are also on the line. And I'm going to turn the call over to our chair person, Lori Anderson, the Director of the Division of Home Health, Hospice and HCPCS (Healthcare Common Procedure Coding System).

Lori?

Lori Anderson: Thank you Bill. Good morning and afternoon everyone. The bulk of today's call will focus on some questions that we have been receiving associated with the recent publication of our home health calendar year 2011 final rule. But

first we have an OASIS (the CMS Outcome and Assessment Information Set) update that Robin Dowell from our Office of Clinical Standards and Quality will give us.

Robin Dowell: Thank you Lori. I just have two items for the group.

Number one is that there are now available on YouTube the complete set of four OASIS C training videos. The topics are the [PBQI \(Process Based Quality Improvement\) Process](#) [32 minutes], and then three separate videos on specific process items and how to accurately answer them including [Accurately Responding to Process Items: Intervention Synopsis \(M2400\)](#) [30 minutes], [Accurately Responding to Process Items: Plan of Care Synopsis \(M2250\)](#) [15 minutes], and [Accurately Responding to Process Items: Fall Risk Assessment \(M1910\)](#) [12 minutes].

It's a total of about an hour and a half of training video and the best way to locate those on YouTube is to search OASIS C process items. Just go on the [www.youtube.com](http://www.youtube.com) and search OASIS C process items and all four of those videos will be near the top of the list. The addresses are also available on the CMS Web site on a [Home Health Quality Initiative](#) page under [Educational Resources](#) and under [Spotlight](#). You can get the actual detailed YouTube addresses.

The second item is that our OASIS C Guidance Manual Annual Revision is in process. This update incorporates the existing errata plus multiple (approximately 77) other clarifications that were derived primarily from the OASIS Q&A. And this manual will replace the existing current version of the OASIS C Guidance Manual as a download on the OASIS user manual page at the Home Health Quality Initiatives page again.

So we hope that that revision will be complete by the end of this month.

Thank you.

Lori Anderson: OK, thanks Robin. Our next agenda item, Lori Teichman will give us an update on the Home Health CAHPS®. Thanks Lori.

Lori Teichman: Thank you Lori.

I just wanted to mention that as recently announced in the 2011 final rule the Centers for Medicare, Medicaid Services has extended the dead line for applying for an exemption from participating in the Home Healthcare CAHPS® or HH CAHPS® survey (Consumer Assessment of Healthcare Providers and Systems) for the calendar year 2012 annual payment update. The original date was June 16, 2010 and we extended it to January 21, 2011.

Medicare certified home health agencies that serve 59 or fewer unduplicated patients between April 1, 2009 and March 31, 2010 who meet survey eligibility criteria may be request an exemption from participating in the home health CAHPS® survey for calendar year 2012. All such agencies will be required to count the number of patients that served during that 12 month period and to report this count to CMS on an online form that is on our Web site and the Web site is <https://homehealthcahps.org/> and that is the official government Web site of the Home Health CAHPS® survey.

And this is the Web site that contains all the information about the home healthcare CAHPS® survey and is the most reliable source about home health CAHPS®. You may see home health CAHPS® on other sites but this is the official site. And for additional information if you would like to speak with somebody personally you could call our Home Health CAHPS® survey coordination team on a toll free line [1-866-354-0985](tel:1-866-354-0985) or you may e-mail a team member at ([hhcahtx@rti.org](mailto:hhcahtx@rti.org)). RTI is the government contractor that is working on Home Health CAHPS® with CMS.

Thank you so much.

Lori Anderson: Thanks Lori. Now with that I'm going to turn it over to Randy Thronset who is the Deputy Director of the Division of Home Health, Hospice, and HCPCS, who has a list of questions and answers that he would like to discuss on this call. Most of these we have answered in detail in our home health final rule. But we've received these questions from the industry and we'd like to answer them on this call as well.

Randy Thronset: Thanks Lori. Like Lori just said, the type of questions we've been getting you know we feel as though you know we do address a number of them in the rule but being as there have been a number of them coming in on some certain specific areas, we thought we'd try to add a little more clarification or at least repeat what we said in the rule to emphasize what our policies are.

There is one hospice face to face question that has come in which is basically asking the question of how hospices are to handle the face to face when a subsequent hospice is involved. When a patient is in their third or later benefit period is admitted to a new hospice, the receiving hospice must have that face to face encounter as part of the recertification process. The requirement for a face to face in the third benefit period isn't specific to whether there's a single hospice or multiple hospices.

So when we have a new hospice come on the scene they are required to have that face to face encounter as part of that recert. Since this is a new admission for that hospice whether the patient is coming from another provider type or from the home or transferring, we understand that the receiving hospice may not have up to 30 calendar days prior to the start of that benefit period to have the face to face encounter.

However, the statute requires that the visit occur prior to that 180th day recertification and subsequent recertification. And consequently we do not have the ability to waive the statutory requirement. Since the benefit period does not change with the transfer if the patients transfer to the new hospice, the receiving hospice does not have to have a face to face encounter for that current period if it can verify that that previous hospice has provided the visit.

And according to our COPs (Conditions of Participation) the sending hospice must forward to the receiving hospice the patient's clinical record which includes the certification and recertification of terminal illness if requested. The clinical record can be used to verify whether or not that sending hospice had provided that face to face encounter. We also received some questions with regards to the home health face to face.

A number of the questions revolved around the liability of when the certification face to face encounter requirement didn't occur within the defined time frame. So the question really is, if the now required face to face encounter between the beneficiary and the certifying physician or the non physician practitioner does not take place within the defined time frame, can an HHA hold a properly notified beneficiary liable for any home health services that might have been provided for the issuance of an HHABN (Home Health Advance Beneficiary Notice of Noncoverage) or otherwise.

Now as we discussed in the final rule the HHABN is not approved to transfer liability to the beneficiary when technical requirements for payment such as the face to face are not met. Now there are circumstances in which a beneficiary could be held liable for payment to the HHA. For instance after, if after being properly notified by the HHA, a beneficiary, that a beneficiary must receive all of their home health services from that HHA.

And that if the beneficiary then chooses to receive such services outside of those provided by the HHA the beneficiary may be held liable and the beneficiary still chooses to get – if the beneficiary chose to get services from the other provider. However beneficiaries cannot be held liable when payment or certification requirements are not met.

For example, when a beneficiary cannot be held liable for payment for services received during a home health episode of care, when a physician does not sign the plan of care, or certification. Similarly the face to face encounter is part of the certification and is a requirement for payment and thus the responsibility of the HHA. A beneficiary cannot be held liable for payment for home health services received when the HHA does not meet the certification and payment requirements of ensuring that a face to face encounter occurred for that beneficiary.

Technical requirements for payment and requirements for certification are responsibility of the HHA and not the beneficiary. Now we understand the concerns of the industry surrounding exceptional circumstance that may result in minor timing delays and will consider those sort of concerns as we develop our contractor reform instructions.

There was another question with regards to the face to face and it had to deal with the documentation. Folks are asking if the documentation of the face to face if it were to travel as an addendum and not part of the certification form itself, if it can travel separately from the certification. And the answer to that is no. As we described in our rule, the documentation of the face to face is part of the certification, whether it's part of the form or as an addendum and thus they must travel together and can't be dealt with separately.

There also appears to be some confusion as to whether or not a hospital physician and I'll use that term real loosely. We're talking about a physician in an institutional sort of setting. When hospital physician who is the beneficiary's attending physician while the bene is in the hospital can be the author of the documentation of the face to face. When it is the community physician who will ultimately sign the plan of care and be responsible for the bene while receiving the home health services.

Again, as we discussed in the final rule, the hospital physician is allowed to initiate the order for services and certify the patient's home health eligibility. As such, because the documentation of the face to face is part of that certification, it would be appropriate for the hospital physician to document that they had the face to face encounter with the beneficiary and how the clinical findings of that encounter support home health eligibility and initiate that plan of care.

The community physician designated on that discharge plan would then assume responsibility for the beneficiary and sign the home health plan of care.

Another issue that came up, there appears to be some questions surrounding what is required in the documentation of the face to face and whether, what I'll call lead in phrases or fill in the blank sort of language can be used. Again this is an issue that we did discuss in the final rule and the answer to that question is no.

We expect the physician to draft the documentation language. As we said in the final rule, we believe that if we were to allow the home health agency to craft some standard language for the physician is simply signing below that canned language or filling in the blank that we wouldn't be achieving the level of physician involvement that was intended with this provision of the law.

There were a couple of other smaller items that were asked. One was what was the meaning of the phrase "at some point", in the sentence of the rule that said the community physician designated on the discharge plan would assume the responsibility for the patient "at some point" after acute discharge updating orders and signing the plan of care.

The key point here is that to be eligible for the Medicare home health benefit, the beneficiary must be under the care of a physician. Now we didn't want to be too prescriptive when we talked about this handing off of a beneficiary between the hospital physician and a community physician. The bottom line is that there must be a clear hand off between the physician and it has to be reflected in the discharge plan and thus that patient is continually under the care of one of those physicians.

There were just a couple of questions about telehealth and whether how telehealth was to be used for the face to face. I'll just say up front telehealth was not approved for the hospice face to face provision. It was part of the provision for home health face to face and it said that a face to face encounter including through the use of telehealth, but that is subject to the requirements in section 1834 M of the act, which really outlines that it has to occur on one of those originating sites that's described in 1834.

There were a few questions with regards to the reporting of the nursing and therapy visits. The question being, there's often more than one reason for a nursing or therapy visit. How does the nurse or therapist and ultimately the home health agency determine what the appropriate visit code should be? Can more than one visit code be billed for such a visit? First off, I just want make clear that only one visit code can be billed for that nursing or therapy visit.

We would expect that the clinicians would use their clinical judgment in categorizing visit in a manner similar to how they plan and prioritize an individual visit all based on the individual patient's needs. Only one code can be billed and that should be the code that reflects the primary service being rendered in that home health visit, i.e. the primary reason for the visit.

A follow up to that question, folks were asking where can one find the specific G-codes that are to be used for reporting nursing and therapy under the home health PPS beginning in January and where can we expect further guidance on the implementation of these new codes. The new and revised G codes that we described in the final rule were recently included in the release of the [2011 HCPCS tape](#) that that can be found on the CMS website.

And I'll give you a location here real quick. If you go to <http://www.cms.gov/hcpcsreleasecodesets/anhcps>. That's plural. That's one word. HCPCS release codes sets/anhcps. Now when you're on that page you're going to get a listing of a bunch of different transmittals and you want to select the file name that says 2011 alphanumeric HCPCS file.

Now just FYI to help you navigate when you open up that file, the new and revised G-codes fall into the range of G0151 to G0164 and you'll see the codes there with the revised descriptions. Or if it's a new code, you'll see the new codes with their descriptions. Now there is a CR (Change Request) describing the implementation of these codes that's in the clearance process and we expect that to be released to the public shortly.

The final area where we had some questions come up was in the area of therapy. A number of commenters on the proposed rule asked that CMS delay the implementation date of the therapy documentation provisions and the requirement for assessment visits at the 13th and 19th therapy visit by a quarter in order to allow more transition time for providers.

Now in the final rule, we communicated that we would in fact delay the effective date for these requirements until April 1, 2011 to allow agencies that do not currently have such practices in place additional time to transition.

Now the follow up question for that was for what episodes or claims then will those requirements become effective? Is it for episodes ending on or after April 1<sup>st</sup> or beginning on or after April 1.

In order to allow home health agencies more time to transition to these new therapy requirements our intent is for these requirements to be effective for episodes beginning on or after April 1. That should give providers a full quarter to go ahead and transition into this new reporting. And then after that I'll hand it off. Lori's got an issue too she wants to bring up?

Lori Anderson: Yes, thanks Randy. We received a few other questions associated with the therapy coverage clarifications. Most of them seem to be centered on what the requirements are when more than one discipline of therapy is being provided. We thought we had described that pretty clearly in the final rule, but based on the number of questions that we received, we'd like to address here and then we'll address in a very detailed fashion in our manual.

We – where more than one therapist is provided – discipline of therapist is providing services to the patient in our final rule, we described that we expect that the qualified therapist must perform the therapy service which per the plan of care would be as close as possible to the 13th and the 19th visit and also every 30 days. So the therapist of the appropriate discipline would be responsible for going out.

The therapist would be responsible for going out. The therapist instead of the therapy assistant at that regularly scheduled therapy visit, as described in the plan of care, this is close as possible to the 13th and 19th visit without going past the 13th and the 19th visit. And at that visit the qualified therapist would be responsible for objectively measuring the appropriate goals per their therapy discipline and documenting the effectiveness of that therapy using that objective measurement.

So they would assess the patient as that assessment is needed in order to address that disciplined therapy goal. So we received a number of questions about that, I hope that clarifies it for you. We also adopted in the final rules some flexibility associated with that 13th and 19th visit requirement as it

relates to rural providers and also allowed some flexibility associated with the 13th and the 19th visit where exceptional circumstances that were documented in the medical record precluded the therapist from performing the visit at the 13th and 19th visit.

One of the additional questions we had related to this was what criteria will CMS consider to be outside of the control of the therapist? Meaning there's exceptional conditions that I just described as it relates to the qualified therapist delivery of the required therapy service prior to this at the 13th and the 19th visit. And those determinations will be made on a case by case basis. We're not going to have rules from there.

As – as these cases would be reviewed there would be clinical judgment associated with that determination. I think those are all of the formal presentation clarifications that we have associated with the home health final rule today. So Bill, we can open those doors to question and answer.

Bill McQueeney: OK Matthew, let's take our first caller please.

Operator: At this time, I would like to remind everyone in order to ask a question press star then the number one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster. Your first question comes from the line of Mary Saint Pierre. Your line is open.

Mary Saint Pierre: Hi, everyone. I do have a couple of questions, clarification. One is when will CMS begin the physician education about the face to face encounter requirements. The second is what documentation is required by the hospitalist and then the community physician in a case where the hospitalist will be conducting the face to face encounter, certifying home health services, ordering home health services, but won't be following the patient into the community. And then what will be required by the community physician when the community physician assumes responsibility for the patient?

Randy Thronset: Hey Mary, this is Randy. I'll take the second one there. if I understand your question right it's if the hospital physician is the one that's actually certifying that the conditions have been met than they're the ones that are going to have

to provide the documentation because that documentation of face to face encounter is part of that certification. So it would be the hospital that would be responsible for that.

Mary Saint Pierre: OK and so even the hospitalist won't be following the patient in the community, the hospitalist may certify the face to face, the homebound, all of the orders?

Lori Anderson: Yes.

Randy Thronset: Yes. We talk about that on 70430 in the middle column in the rule there.

Mary Saint Pierre: Right. That – it was just unclear as to whether the hospitalist had to continue to assume responsibility and so you're clarifying that that is not the case. They don't have to continue to assume responsibility. Is that right?

Randy Thronset: That's correct. They initiate the orders. They certify the patient and then they ultimately hand it off or transfer it off to that community physician.

Mary Saint Pierre: So all right so that's great. That's great news. That will make things easier for the agencies. And then once the patient is under the care of the community physician then that physician would then establish a new plan of care for the patient as we currently do?

Lori Anderson: Well, while we continue to update and be responsible for the plan of care. I think as we described it, it's really the hospital physician who is initiating the plan of care by initiating the orders, the initial orders, and then in that discharge plan the responsibility to hand off the patient to the community physician would occur and then the community then would become responsible for the plan of care, which was initiated by the hospital attending and could then sign the plan of care and continue.

Mary Saint Pierre: OK, but wouldn't the hospitalist have to sign it initially?

Lori Anderson: No. as we described in the rules, we – there are a number of different variations to this (Mary) and we don't want to be as prescriptive but you know oftentimes there may be sometimes when it makes sense for the hospital

physician to complete the care and sign the plan of care and then do the hand off to the community physician.

And there may be other times, where it's more – it makes better sense for the hospital physician to do the certification, document that the face to face encounter occurred and how the clinical findings support eligibility and simply initiate the plan of care and then hand over the responsibility of the patient to – in the discharge claim to our community physician who would then finish the plan of care and ultimately sign it. So it really is – you know it's not one answer fits all.

We are, we do understand that those sorts of scenarios are – there are a variety of different scenarios that may occur, and we're trying to be as flexible as we can given the statutory requirement here, and therefore want to enable the attending during the – hospital stay to be able to do the certification and document that the encounter occurred.

Mary Saint Pierre: OK, I just want to be certain that agencies will not have a problem if they have one document from a hospitalist that said that he conducted the face to face encounter and the patient qualifies and the assumption would be that that hospitalist would need to sign that, whatever that form is. But then...

Lori Anderson: That certification...

Mary Saint Pierre: ...but in addition to that they would have a plan of care...

Lori Anderson: That's right.

Mary Saint Pierre: ...from the community physician? It's kind of, I can't in my mind picture how these things would be combined...

Lori Anderson: Right, well you're right Mary.

Mary Saint Pierre: ...but they will be being that (Randy) said that they can't be separate parts, they're all part and parcel of a single certification.

Lori Anderson: Well you're right Mary as we described in the rollout, a perfect scenario would be the same doctor would be certifying, doing the encounter, documenting the encounter, establishing the plan of care, signing the plan of care, but in the real world sometimes that perfect scenario, it just isn't feasible. And we do want to ensure that the hospital physician who is the attending physician of the patient has the ability to certify home health eligibility and document the encounter.

So the certification and the documentation of the encounter or that matched set that Randy was talking describing, they can't travel separately, the documentation of the face to face is part of the certification. It can be an addendum or it can be part of the certification. Those are very – they're together, but we do, we have described that we understand that often times there's some flexibility with how the plan is initiated and who would ultimately sign it.

Is that...

Mary Saint Pierre: I think that helps. And as long as I (see) you're got, manual guide makes it clear what to do in those situations. What piece of paper signed by whom is required in those unusual situations. That would be extremely helpful.

Lori Anderson: OK, that's a good suggestion, and that's kind of a good segue into the first part of your question which is what sort of physician education do we have planned, and we've been talking about this on the various Open Door Forums for a few months. And we have been getting some time on the physician Open Door Forums. Of course we've got the regular Medlearn (Medicare Learning Network) articles that will be coming out soon, and the rule, of course.

We would ask the association if they have additional suggestions as to how we can better communicate these new statutory requirements, so Mary please feel free to send us in some suggestions. If you have some ideas as to how we can better perform this sort of education please let us know.

Mary Saint Pierre: OK, and we've already posted – I sent you those model physician letters that we shared with providers during a webinar. We've posted them on our website available for any home health agencies to use. So that was certainly one way that we are trying to get the word out to physicians.

Lori Anderson: OK, thank you very much.

Bill McQueeney: Matthew, our next caller please?

Operator: Your next question comes from the line of Mary Ann Laverde. Your line is open.

Mary Ann Laverde: One of my questions was already answered regarding the hospitalists, but I did have a question I needed to clarify as far as the therapy reassessments on the 13th and the 19th visit. It's my understanding that you're talking about each separate therapy in their own, do their own reassessment at the 13th and 19th visit.

So if you had PT and OT in on a case you would have two reassessments, each of them doing their own at their 13th visit?

Lori Anderson: Well.

Randy Thronset: It's correct.

Lori Anderson: Well it's correct that each discipline needs to do their own assessment, but they need to be cognizant that when that 13th and 19th is. So it's not that the OT does it at the OT 13th visit, and the PT does it at the PT 13th visit. Rather the OT needs to do that, the qualified OT not the assistant, needs to perform that regularly scheduled service that is due closest to the 13th visit. And that's the 13th therapy visit, not the 13th OT visit.

Mary Ann Laverde: OK, so as soon as we hit 13th whether it's going to be the PT visit or the OT visit it doesn't matter. All the disciplines will do a reassessment as close to the 13th as possible.

Lori Anderson: They would do the visit. That's right. The qualified therapist, we would expect the qualified therapist to be the one performing that therapy service as close as possible to that 13th and 19th visit.

And of course by – when the qualified therapist you know performs that service the expectation would always be that they would do a patient assessment related to the goals of their discipline and be able to objectively measure progress and effectiveness – progress and/or effectiveness of the therapy being provided and document that.

Randy Thronset: And the whole idea of, if I can just interject, the whole idea behind that is that these assessments occur before we reach these thresholds for therapy of the 14th and the 20th. That's where agencies get that bump up in payment because that's where our first two therapy thresholds are. I just want to be clear that those assessments by those different disciplines qualified therapists, the idea is that they occur before that threshold of 14th and 20th is met, and we describe that in the rule.

Mary Ann Laverde: Yeah I know, that's where there's been some confusion is because if you have like say, PT go out on say on the 13th visit and they're scheduled frequency is three times a week. And you have the qualified physical therapist do that reassessment on the 13th visit, but then OT is maybe going in once a week and they're not going to be going out for another – maybe...

Lori Anderson: Yeah, and that is – there does need to be some coordination there. I mean the therapy service is ordered as this is not an additional visit. This is the qualified therapist instead of the assistant would be responsible for going out as close as possible, and we did adopt that flexibility in the final rule based on comments, as close as possible to that 13th and 19th visit. And I just want to reiterate that patients that receive 13 and even more so 19 visits, that's a lot of therapy in the course of an episode.

So we just need to ensure that there is that sort of qualified therapist involvement in those cases which we have determined are high therapy cases. And as such they do warrant a higher payment, and we want to ensure that

qualified therapist is very involved with the patient for these high therapy cases and is measuring the effectiveness of that therapy.

Mary Ann Laverde: Yeah I understand the rationale behind it, that's why it kind of confuses me because I can see, if you had like two disciplines, two separate therapists in on a case and that first one is going to be able to assist the goal of doing the reassessment around the 13th visit, but that subsequent therapist, say the OT or speech therapist, is going to go beyond that.

Randy Thronset: They can. That's the whole idea that Lori was mentioned. You know there has to be some coordination amongst the different disciplines here because the requirement is that regardless of whether you have one therapy discipline, two or three, if there are up to three all of those qualified therapists will have to have performed that assessment, that qualifying assessment within the timeframes described.

So if the physical therapist, if their assessment visit happens to hit on the 13th but yet there's an OT that is also providing services, maybe not as frequently, then they had better, had performed that assessment for the OT before that 13th visit because it's cumulative. As Lori said it's not – they don't work in a vacuum. The whole idea is to combine therapy visits, those thresholds of 14 and 20 that we have all the disciplines assessing that patient before those thresholds are met.

Mary Ann Laverde: OK, thank you.

Bill McQueeney: Thank you. Who's next, Matthew?

Operator: Your next question comes from the line of Michelle Funk. Your line is open.

Michelle Funk: Well some of my questions have been answered and I thank you very much. My main question come from if you can please just go one step further in clarifying yourself when you say that the plan of care and the face to face documentation cannot be separated. So I'm very confused at how this will work because typically in, at least in my neck of the woods, most of our referrals do come from the hospital. It's not a unique case or something extraordinary to the norm. It is the norm, so I'm kind of confused on you

know how lenient that's actually going to be whenever we're surveyed? And you know can you just kind of talk about that just a little bit more please?

Lori Anderson: Well I think what Randy said was that the face to face documentation that is – that the certifying physician is responsible for doing, needs to be either part of the certification itself or an addendum that is with the certification. You can't have this addendum that documents the face to face encounter as a separate document altogether from the certification of eligibility.

Michelle Funk: I understand that, but – I'm sorry to interrupt, but if the hospitalist ordered the care, certified yes, the patient does need home care and turns it then over to the primary care physician then he wouldn't sign the plan of care. It would be the primary care physician.

Lori Anderson: That is often true. That's often the case, and we understand that. And our policy that's described in the final rule does not prohibit that. It's – however that, what our statutory requirement is is that the certifying physician must document that the face to face encounter occurred so that – that documentation of the encounter and the certification need to be together.

But we do understand that often times it's often the community physician who signs the plan of care although that referral and the initial orders are probably initiated by the hospital attending.

Michelle Funk: Thank you.

Bill McQueeney: OK Matthew, do you have another question?

Operator: Yes, your next question comes from the line of Mary Wickins. Your line is open.

Mary Wickins: Thank you for taking my question. As you may know, some fiscal intermediaries have been aggressively using pre-pay audits to pressure home health agencies regarding the self improvement standard and going back to the self improvement standard.

I guess everybody knows this is a standard use by FI's where care is denied as not medically necessary and reasonable if the patient is not getting better or not getting better quickly enough. Can you comment, and then I have a little follow up question, on the two recent United States District Court rulings (Papchik and Anderson) which essentially strike down the improvement standards. These were both reported by the New York Times in early November.

My concern is the use of the improvement standard by FI's coupled with pre-pay audits. You may know that some Medicare advocacy groups charge that this is a coercion, if you will, of home health agencies to deny this care. So my questions for you are: is it still appropriate to be using the improvement standard. In particular is it appropriate for FI's to use pre-pay audits, some of which are 30 percent of the revenue coming into that HHA, when these standards have been struck down by the courts.

And secondly since CMS is putting forth these new rules, especially in the physical therapy area to better codify how you want to control potentially excessive skilled therapy visits, would it be prudent or wise at this point to use those rules instead of the improvement standard?

Lori Anderson: OK, well first of all I think that one of our goals in the home health rule this year and last year as well, we started it last year, was to really clarify what our skilled requirements are even more so than they were already in regulation. I thought those were pretty clear. So we don't have a rule of thumb improvement standard in home health. So, and I think we were pretty clear as it regards you know, as far as therapy what our coverage requirements are in existing regulations.

I'm not sure I understand what you're talking about with what the fiscal intermediaries are doing, but you're welcome to send me some examples of things that you believe are being done incorrectly via e-mail and we'd be happy to research that more.

To my knowledge I think that our fiscal intermediaries seem to have a pretty good you know a good handle on what our policies are, but feel free to send me an e-mail.

Mary Wickins: OK. Can I get your e-mail address?

Lori Anderson: Sure, [Lori.anderson@cms.hhs.gov](mailto:Lori.anderson@cms.hhs.gov).

Mary Wickins: OK, thank you Lori.

Lori Anderson: Sure.

Operator: Your next question comes from the line of Shirley Devot. Your line is open.

Shirley Devot: Yes, I would like you to address the regulation about physicians having to date the certification and that some health agencies can no longer date stamp certifications that are not signed, or not dated.

Lori Anderson: OK, well I think that – I think that our manual guidance has been clear on that for a very long time. We did – we did fold in to our regulatory language that longstanding manual guidance which requires the physician to date that.

Shirley Devot: Right, but we were always – if the physician did not date it, we could always date stamp when it was received.

Lori Anderson: Well that would have been then in conflict with longstanding manual guidance, so you know that was one of the things that we clarified in our regulation this year. But like I said, it's longstanding manual guidance.

Shirley Devot: OK.

Operator: Your next question comes from the line of Jennifer Handle. Your line is open.

Jennifer Handle: Yes, hello. I'm from hospice of Michigan and our question – we've read the final rule relating to the face-to-face visits being required prior to patient admission when a patient is entering the third benefit period or later.

But there's a section of the American Academy of hospice and Palliative Medicine Guidelines for Physicians for the face-to-face research case in process which states that patients being re-admitted to hospice in the third or later Medicare hospice Benefit period because they have accumulated days of care during an earlier hospice admission, the required face-to-face encounter must occur prior to the hospice physician's certification.

The written or oral certification must occur within two calendar days of admission. It is presumed that the face-to-face encounter should occur within that timeframe. And then it goes on to say, CMS does not address how to manage situations in which the patient dies after admission but before a face-to-face encounter can be accomplished.

So our question is can you clarify whether or not hospice providers have a two day window within which to perform the face-to-face visit after admitting the patient entering his third benefit period or later, or if the face-to-face visit must occur prior to admission?

Lori Anderson: Yes, I don't think we – I don't think – I'm not sure that we have the statutory authority to go beyond what we've described in the rule, but we're still researching that. It appears that we do not have the statutory authority to extend that. I haven't seen the specific guidance that you – that you're describing, but I'm not sure that we have the statutory authority to do that.

Jennifer Handle: So in other words like if we got a call like on a Friday night or a Saturday morning and the patient is actively dying but the doc isn't available until Monday, should we delay admitting the patient until that face-to-face visit can be arranged?

Lori Anderson: So we need to research – we actually have had – had them researching that exact question and we're just not sure we have the statutory authority to provide any additional information other than that which we have in the rule. But if we should receive any more information on that topic, we'll certainly let everyone know.

Jennifer Handle: My second question is the final rule makes it clear that if a doc does a face-to-face visit here, she must be the same doc to complete the questionnaire and perform the re-certification. However, if the nurse-practitioner does the face-to-face, the hospice doc obviously must be the one to write the questionnaire to complete the recert for the patient.

So the question is, we cover the entire state of Michigan, and in the very rural area of our state we have a newly hired doctor who is willing and able to perform the face-to-face visits. But she isn't the doctor that has been following the patient through the (IDP's). The doc who attends the (IDP's) has his own practice and limited additional available time to perform face-to-face visits.

Why can't the IDP hospice physician use his colleague's face-to-face clinical findings in determining whether to re-cert these rural patients just as he would be able to if an NP (Non-Physician Practitioner) had done it?

Lori Anderson: Again, I believe that that's – that's the way the statutory language reads. But go ahead and send us an e-mail and let us research that a little bit more.

Jennifer Handle: All right. I mean one of – one of our problems is that the stated purpose of having the same doc do both is accountability. That's what the final rule says.

Lori Anderson: Right.

Jennifer Handle: But the regulation does allow for hospices to use contact the physicians and (fellows) in this capacity. Our feeling is that there'd be greater accountability if the doctor who's been following the patient all along and knows that her medical history was taking all factors into account in making the recertification decision, including not only the face-to-face visit clinical findings, but input from their case manager, patient medical history, social work input, et cetera.

So we're seeing an inconsistency here in the way you know certain parts of the final rule are suggesting that the clinical findings of the face-to-face are not the only thing that should be considered, that all other input should be considered. But if you require that doc that does the face-to-face visit to be

the one also re-certing and that can be a contracted doc that really has little to no connection with the hospice, it's not likely that you're going to get as thorough an analysis.

Lori Anderson: Well again if you send me an e-mail, I can research it further, but it's my recollection that the statutory language requires that that certifying physician, which is the hospice physician, either has to do the face-to-face or have the – have the hospice then pay (inaudible) as well.

Randy Thronset: Right. And that can be a contracted physician. So, but they still have to be the certifying physician.

Lori Anderson: Right, I mean that's the – that's the important link there. It's a certification of terminal illness that the physician who is – who is certifying that terminal illness needs to – needs to – needs to document it, needs to attest that that face-to-face encounter occurred.

Jennifer Handle: What's (inaudible) if it's an NP doing the face-to-face and the doctor using his or her clinical findings, or if it's another hospice physician who (inaudible)...

Lori Anderson: And again – and again, that's a statutory – that's a statutory language issue. I understand your concern. There's a similar one on the Home Health side. We've attempted to implement these provisions as flexibly as we possibly can, given the statutory language.

So, but go ahead and send me an e-mail and I'll make sure that that is the case for the hospice provision. I'm pretty sure it is. And then you know again, where the language is a statute is very prescriptive, sometimes we don't have a lot of flexibility there.

Jennifer Handle: Well, in the proposed rule though, it wasn't that specific. It was the final rule that clarified this. So you know that's what I'm wondering too, in the proposed rule...

Lori Anderson: Right.

Jennifer Handle: it was not clear at all that it had to be the same doc. It was only in the final rule that that was clarified.

Randy Thronset: And that – and that's the purpose of rule making is that oftentimes in proposed rules when we get comments from folks, we find areas where we – where we have to be more specific in clarifying, and that's what we tried to do in the final rule.

Jennifer Handle: All right, well I'll send an e-mail.

Lori Anderson: (Inaudible).

Bill McQueeney: OK. We're approaching three o'clock, Matthew, if you have one short question; I guess we can get in.

Operator: OK, your next question comes from the line of Julie Baxter. Your line is open.

Julie Baxter: Hi, I'm from Aurora Healthcare in Wisconsin. I have just one quick question. Currently on our plans of care there is certification or most of us have certification language in, I think it used to be box 25 or 26.

If we have our face-to-face encounter documented as an attachment – so an addendum, so a separate sheet of paper – and the primary care physician – that's done by our hospitalist – and the primary care physician is actually the one who is going to be signing the plan of care, is that certification language still going to be required on the plan of care?

Lori Anderson: Well you know again, we don't have specific form requirements for the plan of care and the certification, so I'm having trouble picturing what you're talking about. The requirement is that the certifying physician must document that the face-to-face encounter occurred and that either he or she is the one who performed the face-to-face encounter.

Or a non-physician practitioner, that we've described the caveats associated with that, who informs the certifying physician, so you need to ensure that that

is what you're – what the documentation shows, and that has to be part of the certification. So, I hope that answers your question.

Julie Baxter: And we have seen an increased number of additional development requests. Is that due to the fact that CMS is increasing the number of prepayment probes that they're doing?

Lori Anderson: Well...

Julie Baxter: (Inaudible).

Lori Anderson: We don't have anyone here from our program integrity side. So I think that you know I think that there certainly is an increase in some of our oversight efforts and especially in targeted areas of the country, but that's all we can really say.

Julie Baxter: OK, thank you.

Bill McQueeney: Thank you very much Matthew and I want to thank everybody who's been on the call today, both our experts here, in the regional offices, and all of you who had questions. Thank you very much.

We'll be back in six weeks. Keep in mind that there is an opportunity to hear an encore version of this teleconference – be up shortly. And then after that, we will also be posting a transcript and mp3 file of the entire session. The call in encore number is (800) 642-1687.

I want to wish all of you happy holidays and we'll see you in a new year.  
Bye-bye.

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

END