Home Health Templates and Clinical Data Elements (CDEs)
Provider Compliance Group Special Open Door Forum
July 12, 2018
2:00-3:00 pm Eastern Time
Conference Call

Participant Dial-In Number: 1-(800)-857-1738
Conference ID: 7785347

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• CVP, Fairfax, VA 22030  
  www.cvpcorp.com
  • Tasked with providing services to facilitate health care providers’ medical record documentation and Medicare contractors’ review of medical record documentation.
  • Mechanism:
    – Templates and Clinical Data Elements to assist providers in improving documentation.

• Participating CVP technical support for this SODF:
  • Dr. Mark Pilley, Medical Director, StrategicHealthSolutions
  • Robert Dieterle, CEO EnableCare, LLC
Agenda

• Introduction and background – Kevin Young
• Overview of effort to improve documentation – Dr. Mark Pilley
• Changes in templates and clinical data elements – Robert Dieterle
• Q&A – Kevin Young
  Robert Dieterle
  Dr. Mark Pilley
In fiscal year (FY) 2017, the Comprehensive Error Rate Testing (CERT) program reported an improper payment rate of 32.3 percent for home health claims. The total projected improper payments Home Health claims was 6.1 billion dollars. Of the CERT-reviewed claim lines in error, over 89.0 percent were found to have insufficient documentation in medical records to justify Medicare coverage.
Home Health Templates and Clinical Data Elements (CDEs)

The draft Home Health Templates and the associated Clinical Data Elements (CDEs) are available on the CMS.gov website which can be accessed through the link below:


- Home Health Plan of Care / Certification
  - CDEs Draft R2.0 7/9/2018
  - Template Draft R2.0 7/9/2018
- Home Health Services Face-to-Face Encounter
  - CDEs Draft R2.0 7/9/2018
  - Template Draft R2.0 7/9/2018

Also available:

CMS presentation slides to be used in support of the Special Open Door Forum conference call, “Home Health Templates and Clinical Data Elements (CDEs)”, held on July 12, 2018; 2:00-3:00 pm Eastern Time.
Home Health Templates and Clinical Data Elements (CDEs)

What are Clinical Data Elements?

Definitions of the content of individual “fields” in a template

Each CDE has the following characteristics:

• Unique identification (e.g. PDN01, PND02)
• Name (e.g. Patient Name, Date of Birth)
• Data type (e.g. text, date, number, value from a set)
• Selection type (e.g. single, multiple)
• Value Set (list of allowed selections) (e.g. Items to orders, diagnoses)
Example Clinical Data Elements (CDEs)

PBD: Patient/Beneficiary Demographics

PBD1: Patient’s first name, last name, and middle initial (text).
PBD2: Patient’s date of birth (date: MM/DD/YYYY).
PBD3: Patient’s Gender (Single selection from the value set: M/F/O).
PBD4: Patient’s Medicare ID (Medicare ID format and check digit).

PND: Provider Demographics

PND1: Provider first name, last name, middle initial, and suffix (text).
PND2: Provider NPI (Numeric with check digit).
PND3: Provider Telephone Number (xxx-xxx-xxxxxx ext xxxx).
PND4: Provider Direct address (Direct address).
Use of Color and Font for Templates and CDEs

1) CDEs in black Calibri are required
2) CDEs in *burnt orange Italics Calibri* are required if the condition is met
3) CDEs in *blue Times New Roman* are recommended but not required
4) CDEs in *purple Tahoma* are required for certification and, where noted, for recertification
Home Health Face-to-Face Encounter Note Template and Clinical Data Elements (CDEs)

Changes based on March 1, 2018 SODF and email feedback

1) Guidance -- clarified confined to home information
2) Page numbers -- changed to x of y for guidance and template
3) Procedures -- changed ICD-10-CM to optional “Code” and provided instructions to include ICD-10-PCS, HCPCS, CPT Code when available
4) Medications -- replaced C=Current with A=Active and M=Modified with C=Changed
5) Allergies -- added instruction to include all allergies and not just allergies to medications
6) Confined to home – clarified requirements
7) ROS and Physical exam -- replaced “Other” with expanded “Additional observations”
8) Treatment plan and Other orders -- expanded space
9) Attestation – removed optional attestation regarding financial relationship
Home Health Face-to-Face Encounter Note Template and Clinical Data Elements (CDEs)

• Guidance

• Template (sections) (note: CDEs are defined for all “fields”)
  • Required/conditional sections
    • Patient Information
    • Encounter Information including use of HHA records
    • Diagnoses
    • Chief Complaint and related past medical history and procedures
    • Medications and Allergies
    • Assessment
    • Homebound assessment
    • Treatment Plan
    • Signatures
  • Optional sections (required if necessary to support need for home health services)
    • Review of Systems
    • Pain Assessment
    • Physical Examination
    • Orders
    • Attestations
Home Health Plan of Care / Certification
Template and Clinical Data Elements (CDEs)
Changes based on March 1, 2018 SODF and email feedback

1) Guidance -- added guidance section
2) Page numbers -- changed to x of y for guidance and template
3) Removed F2F performer information
4) Created separate section for HI Claim No, MRN, Initial SOC and Cert dates
5) Diagnoses -- removed “principal…” and “other pertinent…” headings
6) Procedures -- changed ICD-10-CM to optional “Code” and provided instructions to include Code from ICD-10-PCS, HCPCS, CPT when available
7) Medications -- replaced C=Current with A=Active and M=Modified with C=Changed
8) Allergies -- added instruction to include all allergies and not just allergies to medications
9) Therapy services -- removed length of session (LOS)
10) Restore function and Maintenance therapy services -- removed frequency and duration
11) Removed question regarding OT services and end of PT services
12) Clarified where physician signature is required and changed format for consistency with F2F
Based on §484.60 - Condition of Participation requirements, the March 1, 2018 SODF, and email feedback sections or elements are included for:

1) Advanced Directives
2) Risk of ED visits and re-admission
3) Patient and caregiver education
4) Patient-specific interventions, education, outcomes, goals and status (removed goals from the rehabilitation section)
5) Verbal orders
6) Frequency, duration and purpose of Visits
7) Additional items the HHA and /or physician chooses to include
8) Communication of POC revisions
9) POC preparer signature, name, and date
10) discharge plan communication (to discharge plan section)
11) psychosocial and cognitive status (to end of functional assessment)
Home Health Plan of Care / Certification Template and Clinical Data Elements (CDEs)

Guidance

Template (sections) (note: CDEs are defined for all “fields”)

Required/conditional/certification and re-certification sections/elements

• Patient Information
• F2F date and other relevant information
• Pertinent diagnoses
• Relevant procedures
• Medications and Allergies
• Functional Assessment
• DME and supplies / Safety Measures / Nutritional Requirements
• Prognosis
• Risk for ED and hospital readmission and necessary interventions

• Patient and caregiver education
• Patient- specific interventions and education
• Orders
• Verbal Orders
• Frequency, Duration and Purpose of Visits
• Additional items from HHA and/or Physician
• Rehabilitation potential
• Discharge plans
• Length of skilled services for recert
• Signature
• POC revisions communicated

Optional sections/elements

• Gender, Medicare ID, Patient HI Claim No and Medical Record Number
• Preparer signature
• Receipt date of signed POC
Home Health Templates and Clinical Data Elements (CDEs)

General Comments/Recommendations?

*Feedback and suggestions on the templates can be sent to: clinicaltemplates@cms.hhs.gov*
Questions?