

Centers for Medicare & Medicaid Services Center
Special Open Door Forum:
Home Health
Templates and Clinical Data Elements (CDEs)
Moderator: Jill Darling
Thursday, March 1, 2018
3:00 p.m. ET

Operator: Good afternoon. My name is (Julie) and I will be your conference operator today. At this time, I would like to welcome everyone to the Home Health Templates and Clinical Data Elements Conference Call. 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. I would now like to turn the call over to (Sheila Mulligan. Sheila), you may begin.

(Sheila Mulligan): Yes. Thanks, (Julie). Good afternoon, everyone. My name is (Sheila Mulligan) of the Office of Communications. Thank you for joining the special open-door forum. And this is not intended for the press and the remarks are not considered on the record.

If you are a member of the press, you may listen in, but please refrain from asking any questions during the question and answer portion of the call. If you have any inquiries, please contact CMS at press@cms.hhs.gov and that's press@cms.hhs.gov.

And I'm going to be turning the call over to Melanie Combs-Dyer who is the Director of Provider Compliance Group. Thank you.

Melanie Combs-Dyer: Thank you, (Sheila). This is Melanie Combs-Dyer and I am the Director of the Provider Compliance Group in the Center for Program Integrity at

CMS. The Center for Program Integrity is Responsible for protecting the Medicare fee-for-service trust fund from improper payment.

And, at the same, we've been trying to do it in a way that we are reducing provider burden and that's not always easy, but this project is one of the exciting opportunities that we have to try to do both – to decrease improper payments and decrease provider burden.

There is a link in the description of this special open-door forum that takes you through a set of slides that I'll be talking from today. And, on slide two, you can see that I introduced the concept of our medical review documentation compliance and technology contractor.

The DCC is a contractor, Customer Value Partners or CVP and they've been tasked with helping to provide a number of services to CMS to facilitate a provider's medical record documentation and the MAC or the RAC's review of medical record documentation. The way they do that is by creating templates or clinical data elements.

Templates generally have sort of the look and feel of a form, but they don't have to be any particular form. You can just use the data elements in any way that you would like. And clinical data elements are more designed for electronic format. Then, you'll be hearing more about the details of each of these as we go along.

These are really to assist the provider in improving the documentation so that we can make sure that we are reducing improper payments and, hopefully, help to avoid denials and avoid appeals.

Participating in today's special open-door forum is Dr. (Mark Pilley). He is the Medical Director at CVP and (Bob Dieterle). He is the CEO of EnableCare.

On slide three you can see the agenda for today. I'm going through the introduction and background now. Then, I'm going to be turning it over to

(Bob Dieterle) to give an overview of the templates and clinical data elements. And then, we'll be doing a Q&A at the end that will involve all of us.

On slide four you can see a little bit of background on home health improper payment. According to the comprehensive error rate testing report, or CERT report, for fiscal year 2017, the home health improper payment rate was 32.3 percent. That is a really high percentage and equates to \$6.1 billion in improper payments.

And the vast majority of that 89 percent was due to incomplete documentation. So you can see why it's really important that we chose this topic for a template and a clinical data element project.

Slide five talks about where we have posted the templates and associated clinical data element or CDEs and there's really two important documents to be looking for.

There is the home health plan of care/certification and there's two versions of that – the template version and the CDE version. And then, there is the home health services face-to-face encounter and there's two versions of that, the template and the CDE version.

On slide six now, I'm going to turn it over to (Bob Dieterle) and he is going to walk through some more details on the templates and the clinical data elements. (Bob)?

(Bob Dieterle): All right. Thank you, Melanie. I'm assuming you all can hear me.

Melanie Combs-Dyer: Yes, we can. Go ahead.

(Bob Dieterle): OK. Very good. So what we're going to do first is to talk a little bit about what clinical data elements are so as we go through the templates you'll understand how they relate to the various fields, if you will, within each of the templates.

So clinical data elements are really the definitions of the content of an individual field in a template. And these definitions include a unique

identification for that particular field or element, the name of it – human readable name frequently used as the prompt or as the identifier on the template itself, so outpatient name or date of birth – the data type, meaning what kind of information is in this element, is it text, is it a date, is it a number, is it an item from a list or what we call a value set.

There is a selection type. So, for example, can you only enter one item off a list or can you actually enter multiples? Now, those are represented quite differently in the data elements and in the templates and the templates will see it as multiple repetitions of a field. In a data element, you will see it as the ability to go and have it replicated multiple times.

And then, the value set where it's appropriate. A value set could be a list of items that are appropriate to order for a particular service along with possibly their HCPCS codes. Or it could be a list of relevant diagnoses.

But it's some list that is constrained in a particular way. It might only be constrained to a particular clinical vocabulary, meaning it must be a HCPCS code or it might be an RXNorm code, but it's from a list.

On the next slide, we give a couple of examples. Now, we're using some very trivial examples here. We're using patient demographics and provider demographics, but you'll see exactly what we mean by a data element.

So, for example, in the patient demographics, we'll see that PDB1 is the identification is the patient's first name, last name and middle initial all as text.

And down to PDB3 you'll see it's a patient gender which is a selection from a value set, in this case, it's male or female in the example that we gave. In most of our examples we have included other. And then, you'll see other examples here.

In slide eight, you'll see some of the work that we have done in trying to designate whether a particular element is required if you're using this template

– and, by the way, the templates are all optional – or if it is conditional, meaning, if the condition is met, then it would be considered required -- or if it's truly optional.

We are using black Calibri to indicate required, we are using burnt orange italics Calibri to indicate conditional, we're using blue Times Roman to indicate that it is optional, and we are using the purple Tahoma to indicate that it is required for a specific purpose. You'll see that in the plan of care / certification template.

Now, what I'm going to do is move on to the next slide, slide number nine. However, for those of you that really want to follow along and have either opened up or have brought down and printed the templates, you may want to go through the actual template itself to look at the detail.

So the first one we're going to go through is the home health services face-to-face encounter template. At the beginning of this template is a set of guidance talking about the purpose of the template which is basically to assist a non-home health clinician in documenting the face-to-face encounter and establishing the Medicare beneficiary's eligibility and need for home health services.

OK. And it gives you information on when it has to be performed. For example, it can be performed no more than 90 days before the start of the home health services and no more than 30 days after.

The next section I'm – excuse me – patient eligibility for coverage talks about all of the individual items that are required for coverage such as the need for intermittent skilled nursing care, the need for physical therapy. The list is here. I won't go through it, but the list is really to make sure that the provider has the ability to look to see what the criteria are.

Next is the confined to home or home-bound section. To the extent, in the face-to-face encounter, the provider intends to document the home-bound status of the patient, this is the guidance to support that.

So this talks about the two criteria. It talks about the need to have portions of those criteria met to establish the fact that the individual Medicare beneficiary does meet the criteria for home-bound status and, therefore, for the ability to have home health care services.

The next thing is a set of comments about using telehealth in place of a physical face-to-face encounter and the criteria required for that. And then, finally, there is a section on supporting documentation, talking about the type of additional information that can be used to support the physician's medical record.

On the next page, we talk about the template itself. I'm not going to go through the separate CDE document because we will talk about the clinical data elements, a definition of the clinical data elements that corresponds to each of the fields that we'll go through now, or each of the sections.

So the first section is patient information. This is the information required to document the patient's name, their date of birth, their gender, and their Medicare ID.

The next section is related to information about the date of the face-to-face encounter and basically indicating whether it is or it is not intended to be an encounter for the purposes of documenting the need for home health services.

We also have a section here when the provider is incorporating information from the home health agency into the record for them to appropriately indicate that that is where it comes from, that it's identified separately and that they have reviewed it.

The next section is related to diagnoses, in particular, those for the need for home health services and, secondly, for other pertinent diagnoses that are important for the home health agencies to understand or to be documented as part of the encounter.

The next section talks about chief complaint and history of present illness along with associated signs and symptoms, as well as past medical/surgical

history. Now, you'll notice as we get to there that that – the sections so far have either been required or conditional.

Now, we'll see some optional sections coming in such as relevant procedures. So as we qualify here that if those procedures help to document the need or related to the home health services, then they should be considered necessary.

We have a section for medications both new medications, current medications and those that have been modified as well as discontinued. Now, normally, if your data elements are incorporated to a clinical record of an EHR or a template of an EHR, those will be pulled from the larger medication list.

We have a section for allergies. And then, next, we have a section – an optional section -- for review of systems and this covers all the general systems in the order basically from top to bottom of the homunculus. And, as we indicate here, to the extent those are necessary, to document the need for home health services, then they should be considered to be required.

The next section is the pain assessment. Again, to the extent that this is necessary to support the need for home health services, it should be considered required, otherwise, it is optional.

After that, we have the physical exam an optional section. But again, to the extent it's necessary to document the need for home health services, or home-bound status, it should be considered required.

The next section is the physician assessment and summary. That is considered a requirement.

And then, we have a conditional section for the documentation for home-bound assessment. To the extent that during the face-to-face encounter the provider is going to document the confined to home or home-bound status of a patient, then this would be considered required. To the extent that that's going to be done separately, then it would be considered optional. It includes the things that are necessary to identify the two criteria, as well as the related

supporting information, so physical limitations and other textual documentation to support the home-bound status of the beneficiary.

The next section is the treatment plan. Again, optional unless necessary to support the need for home services.

The next section is for orders. This may or may not be used for orders. That's why it's considered optional. This may be done completely separately from the documentation of the face-to-face encounter. But in the event that orders are done here, then we would consider those elements that are necessary to describe the orders to be required. We have a section for intermittent skilled nursing. We have a section for therapy services, including physical therapy, occupational therapy, speech language pathology, and other services is required. There's a section for other orders that are being placed as part of this encounter with the patient.

And then, finally, a section for physician and/or NPP attestation. It's considered optional, but they could do it here to satisfy the requirement that they do not have a financial relationship with a home health care agency.

Then, finally, there are two sections. Either or both of which could be filled out. That's why they are conditional. For the NPP, if indeed the NPP did the face-to-face evaluation; and for the physician. If an order is being placed through this template for home health services, then the physician portion would need to be filled out and signed.

That covers the face-to-face encounter for home health services. The next thing we'll do is we'll go through the home health plan of care/certification template. So, if you have that available to you, you can open it up and follow along; if not, we'll just go through the outline in the slides.

The home health plan of care/certification template does not include the guidance section. At the time this was created, back in the early fall, there were still a lot of ongoing conversation regarding the plan of care and certification requirements and how to represent them explicitly.

We elected not to include a guidance section at that time. If you believe we should be including a guidance section as part of this template, then you may wish to provide that feedback at clinicaltemplates.cms.hhs.gov.

So the actual sections of the home health services – sorry – the home health plan of care certification template are:

Information related to the patient; patient name, date of birth. The gender and Medicare ID are considered optional here.

Information related to the face-to-face encounter, part of it is conditional, part of it is required, and part of it is optional depending upon the particular element. And those are indicated by the relevant color and text.

There's a diagnosis section, again, for those principally related to ordered services, as well as pertinent to other diagnoses, a relevant procedure section, and surgical procedures.

There is a medication section as well as an allergy section to be documented as part of the plan of care.

There is a required functional assessment section that covers functional limitations, permitted activities, and mental status.

There is a section to indicate orders for DME and supplies, safety measures and nutritional requirements as required by the plan of care.

There's a separate section to indicate prognosis of the patient including additional clarification on the selection from the, if you will, prognosis value set of poor, guarded, fair, good, or excellent.

There is a section here to indicate the orders. This is where they would indicate what has been ordered or is being ordered or changes in orders. It includes now length of service, frequency and duration, length of the session – I'm sorry – length of session. It also would include the signature for justifications in the event that skilled nursing is only being ordered as

oversight to unskilled services. One thing we didn't point out in the face to face, we have the same ability in the face to face to order and to sign on the requirement for it. We have a section for therapy services, again, for physical therapy, occupational therapy, speech language pathology and other.

There is a section in here on goals and rehabilitation potential, a section of discharge plans, and finally, there is an indication if this is a subsequent episode as to how much longer skilled nursing services will be needed, and then, finally, a place for the provider to sign off on the plan of care/certification and a final place for the home health agency to document when the signed plan was received.

These are the various sections and elements of the two templates and associated clinical data elements that have posted and are the subject of this special open-door forum. At this point, I'm going to turn it back over to Melanie Combs-Dyer to, I believe, either create a summary or start the Q&A session. Melanie?

Melanie Combs-Dyer: Thank you, (Bob). I just want to refresh the memory of everybody who is participating today that our home health templates and clinical data elements are always considered optional. People who want to continue to document in a medical record without them are certainly free to do so.

We are only proposing these templates and clinical data elements as an aid or an assistant to a provider who would like to consider using them to make sure that they are documenting in their medical record everything that needs to be documented around the face-to-face encounter and the plan of care certification.

At this time, let me turn it to (Julie), our conference operator, to explain how folks can get in the queue to ask a question today.

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 a brief moment to compile the Q&A roster. Again, if you would like to ask a question, press star one on your telephone keypad.

Your first question comes from (Gretchen Anderson) with (Fun Chine) Home Health. (Gretchen), your line is open.

(Gretchen Anderson): Thank you. Yes. My question is on the plan of care document. The length of session, I don't understand what is to put there. Is that a proposed amount of time that we would spend because that, of course, would vary every visit?

Melanie Combs-Dyer:Dr. (Pilley) or (Bob)?

(Mark Pilley): Yes. Well, length of session will be potentially the duration or timeframe such as if you book it at 15 minutes or 30 minutes.

Melanie Combs-Dyer:Dr. (Pilley), am I right that that would be most pertinent if it was – if there was therapy involved with a 15-minute session of therapy or 30-minute session of therapy?

(Mark Pilley): Yes. I would think so.

(Gretchen Anderson): I'm not sure if my line is still open, but I'm a physical therapist, the one who asked the question and we might do gate training, one visit, 10 minutes; and another visit 30 minutes and we might – you know, so I'm not sure – this looks like it's for our orders and we don't get paid by the duration, but are paid by the CPT code, so I'm not sure why the length of time would matter when you're paid by the visit. So I'm still very confused on how one would use the length of session.

Melanie Combs-Dyer:OK. Thank you, (Gretchen). We appreciate your comment and we'll certainly take it under advisement.

Operator: Your next question comes from (Lisa Reichart) with Kelly Homecare and Health. Kelly your – (Lisa), your line is open.

(Lisa Reichart): Hi. My question was we understood that the – any order had to be time signature from the MD and I noticed it wasn't on your plan of care documentation. Is that a requirement?

Melanie Combs-Dyer:Dr. (Pilley)?

(Mark Pilley): Let me make sure I understand your question. You say the time that the order was written?

(Lisa Reichart): Correct.

(Mark Pilley): I don't know that there's any particular – there is – there is a requirement for a date, I think, but I don't think there is any particular requirement for a time. Have you encountered this with...

(Crosstalk)

Melanie Combs-Dyer:Dr. (Pilley), let me – let me see if (Hilary) can answer that question.

(Hilary Loeffler): Hey, (Lisa). This is (Hilary Loeffler). I'm the director of home health and hospice payment. Is this one of the new COP requirements for home health for time for orders?

(Lisa Reichart): Yes.

(Hilary Loeffler): OK. That's great for you to bring up. I think the provider compliance group, they began work on these templates before the COPs were finalized, so we'll take note of that and make sure we fix that.

Melanie Combs-Dyer:Thank you, (Lisa).

(Lisa Reichart): OK. Thank you.

Operator: Your next question comes from (Penny Lovitt) with (Ohan) Consulting. (Penny), your line is open.

(Penny Lovitt): Thank you. In relation to the COP, you might want to consider adding the hospitalization risk and the interventions to mitigate that advanced directives and timely discharge instructions.

Melanie Combs-Dyer:(Penny), you were talking really fast. You got – you said hospitalization risk. You said advanced directive. What was the third one?

(Penny Lovitt): Timely discharge instructions. That's the first time I've ever been told I talk fast.

Melanie Combs-Dyer:Maybe I just write slowly. OK. So hospitalization risk, advanced health care directive and timely discharge. Did I get your comment right?

(Penny Lovitt): Yes. And with the hospitalization risk, you might want to add a section for the interventions to mitigate that.

Melanie Combs-Dyer:Interventions to mitigate, thank you.

(Penny Lovitt): You're welcome.

Operator: Your next question comes from (Cathy McKay) with (Picnic) Bay Home Health. (Cathy), your line is open.

(Cathy McKay): Yes. I just want to re-verify once again that a face-to-face encounter can be done by a nurse practitioner, physical – excuse me – a physician assistant, anything like that, but it actually has to be signed by a licensed medical physician, correct?

(Hilary Loeffler): Hi, there. This is (Hilary Loeffler). So the face to face can be done by an NPP, nurse practitioner, PA, clinical nurse specialist and certified nurse midwife. The actual clinical note itself does not need to be co-signed by a physician.

So the template has a spot for a co-signature if the orders are going to serve for the home health agency because orders have to be done by a physician. But if there's not going to be orders in the – if you're not going to fill out the order section of the template, there wouldn't need to be a co-signature for your clinical note (attached).

(Cathy McKay): Well, what if the – what if the face to face came from a hospitalist and the hospitalist, you know, was on board with the physician and they – the

patient's physician who is actually going to be signing the plan of care, but he doesn't sign the face to face? Now, the face to face that was on in the hospital that has to be signed by a licensed physician?

(Hilary Loeffler): So if there was a face-to-face encounter in the hospital by an NPP and then ...

(Cathy McKay): Yes.

(Hilary Loeffler): ... (inaudible) and the community doc is going to be certifying, no, that note does not need to be co-signed.

(Cathy McKay): So then – so then, that no longer applies. But that was a guideline at one time, wasn't it, that only a certified physician could sign the face to face?

(Hilary Loeffler): Yes. When there was the narrative that needed to be drafted, the physician had to sign because it was a component of the certification of eligibility. It was just a requirement for when we had the narrative that the physician had to sign. But because we did away with the narrative requirement, the clinical note can just stand on its own.

(Cathy McKay): By any one of the...

(Crosstalk)

(Hilary Loeffler): (Cathy), did I answer your question?

(Cathy McKay): Yes. So that was for a nurse practitioner, PA, what you just mentioned? OK.

(Hilary Loeffler): Yes.

(Cathy McKay): All right. Thank you very much. Appreciate your help.

(Hilary Loeffler): You're welcome.

Operator: Your next question comes from (Kathleen Regina) with Brookhaven Home Health. (Kathleen), your line is open.

(Kathleen Regina): Thank you. So the purpose of these templates, first of all – I have a few questions – are to supersede orders (485), plan of treatments. I mean, it seems a little redundant one to the other the health care plan of care and certification to the face to face. They're a little redundant, so we're supposed to be using – can we use both of them or...

Melanie Combs-Dyer: If you are happy with – this is Melanie. If you're happy with the plan of treatment format that you are using today and you're certain that it covers all of the needed documentation to support coverage of the home health services, you're fine. You can stick with it. You don't need to change.

But if you're not sure, if you're getting a lot of denials, if you are unsure whether your plan of treatment form has all the right components, you might want to sit down and compare it to the CMS template or you might want to consider trying the CMS template for a while and see if it's better or worse than the current form that you're using.

(Crosstalk)

(Kathleen Regina): Which template – which template? The plan of care or the face to face or both? Because the plan of care has the face to face on it.

Melanie Combs-Dyer: You can use anything that you want. You can use what you're using now or you can use the new templates. It's your choice, whichever works best for you – for your operation.

(Kathleen Regina): Thank you. I thought that there was a stipulation that the MD – the person signing the face to face and the patient – the person signing the narrative had to be the same physician, it has to be the same physician on the orders?

(Hilary Loeffler): So this is (Hilary) again. So there's no narrative required anymore. So if you're looking at, say, the CMS 485 plan, the certification statement that's always been on there, what we have suggested as an example is to just edit the certification statement and have the physician attest that a face-to-face encounter occurred within the required timeframe and was related to the reason that the patient requires home care and that satisfies certification.

So – but if Melanie’s area is going to pull a claim for audit, you’re going to need to have to produce the clinical note proving that that face-to-face encounter occurred and it’s just a regular clinical note. We’re not asking for physicians or anybody to craft a narrative anymore just to make it easier, just to rely rate on that clinical note.

(Kathleen Regina): The clinical note...

(Crosstalk)

(Hilary Loeffler): Kathleen, did that answer your...

(Kathleen Regina): The clinical note and in their office chart or the clinical note from the hospital? Whose clinical note?

(Hilary Loeffler): Whatever – the clinical note from the hospital or the community docs chart, whatever you’re using to prove that a face-to-face encounter occurred.

(Kathleen Regina): Or could just be the discharge summary from the hospital.

(Hilary Loeffler): Absolutely, yes.

(Kathleen Regina): So what happened to needing the history and physical and any of that and any of this and any – all these pieces from the hospital – the facilities on discharge? So now we can just fill out this form and make sure it’s all filled out properly and we don’t need all that other jargon that you’re going to look for on – when you come to look at the charts?

(Crosstalk)

Melanie Combs-Dyer: The requirements have not changed or (Hilary) has talked about the requirements that have changed in the last couple of years. But we are not changing any requirements with this – with this template or the CDEs.

What we are doing is trying to put in one place all of the data elements that you need to report. Again, this is on a voluntary basis. If you would like to use this plan of care and this face-to-face encounter template, you can.

If you would like to use your own discharge summary and progress note and treatment plan and 485 and whatever else you want to use, you certainly can. But we think this is handy way to remind folks of the important things that they need to include in the plan of care and in the face-to-face encounter.

(Kathleen Regina): I see. Thank you. And I also was on – but I guess some months ago we were on another teleconference and it said that there is no form. So now you just say there is no form, we need all those little pieces put together and now you are saying there is a form. It's just a little bit of...

Melanie Combs-Dyer: There is no required form.

(Kathleen Regina): Right, I know.

Melanie Combs-Dyer: What we are developing now is a draft form and an electronic equivalent of a form and, once we gather everyone's comments and suggestions and run it through the paperwork (reduction act) process, which might take a year or two, we will post it to our web site. But there is no prohibition against using it today.

You can see the draft that's posted now. I'm sure after this call we'll be taking in all of your comments and making some more edits. You can continue to use it.

But you might not need to use it. You might feel completely comfortable that your current progress notes and your current treatment plans include all the required data elements.

If you're sure that your current process for capturing the needed documentation includes everything that Medicare is going to be looking for, you don't need to change anything.

(Kathleen Regina): OK. And if we want to print it up, we're printing it up in this format that says draft?

Melanie Combs-Dyer: You can if you would like to.

(Kathleen Regina): There's no finished product?

Melanie Combs-Dyer: There will be when we complete the paperwork reduction after process.

(Kathleen Regina): Thank you very much.

Melanie Combs-Dyer: You're welcome. And I do appreciate your comment about the word draft. We'll make sure that it's written in a place where it could easily be removed by you if you wanted to or not, not watermarked across the page, making it difficult to read.

(Kathleen Regina): So we could take that off?

Melanie Combs-Dyer: Yes.

(Kathleen Regina): Is that what you're saying? Take the draft off. OK.

Melanie Combs-Dyer: You can create your own form.

(Kathleen Regina): Use this as a template as it is?

Melanie Combs-Dyer: If you want to, yes. These are just suggestions of things that you might want to make sure that you're documenting in your medical records.

(Kathleen Regina): OK. So one thing I have to say, we fill this format, we're using the template, we want to go with this, we fill it out, it's perfect, there will never be another denial if we do this?

Melanie Combs-Dyer: That is certainly the plan.

(Kathleen Regina): OK. We love it. Thank you.

Melanie Combs-Dyer: You're welcome.

Operator: Your next questions comes from (Marcia Moscow) with Northwestern Medicine. (Marcia), your line is open.

(Marcia Moscow): Thank you. I see on the orders part of the plan of care some very generalized orders there, administration of medications, tube feeding, wound care. Is that all that is required, or do we need to put the actual like, wound care, what we're doing and not just the length of sessions, frequency and duration?

Melanie Combs-Dyer: I think that the physician needs to document in the orders or the nurse practitioner or other clinician who is writing the order, whatever information is needed to make sure that the patient is getting the services that are needed during the home health visit.

(Marcia Moscow): OK. So these are just – so we do need more information as it just can't be generalized wound care. We then have to make sure we put on that plan of care, what the actual wound care the doctor ordered are?

(Mark Pilley): I think that's appropriate. This is Dr. (Pilley).

(Marcia Moscow): OK. Thank you.

(Mark Pilley): Yes. I think – yes.

Operator: Your next question comes from (Jo Mason) with Visiting Nurse and Hospice. (Jo), your line is open.

(Jo Mason): Thank you. Good afternoon. I'm wondering on the face-to-face template if this has been stakeholder with a practicing physician in terms of its practicality?

Melanie Combs-Dyer: We certainly hope that there are physicians who are on the line today participating in this call. But we appreciate your feedback that is very important to reach out to them and we can certainly try to see if we can find some specific physicians or nurse practitioners who do order home health and maybe hold a focus group meeting with them and get their input. That's a really good suggestion, (Jo). Thank you.

(Jo Mason): You're welcome.

(Mark Pilley): Melanie, may I say something?

Melanie Combs-Dyer: Yes, please.

(Mark Pilley): There had been previous special open-door forms regarding home health and we have had physicians, physician group, hospital systems that have participated and provided us with feedback at that time. So a lot of the things that we have incorporated in this have resulted from those prior open-door forms.

Melanie Combs-Dyer: Thank you, Dr. (Pilley).

Operator: Your next question comes from (Patricia Ricks) with Access Technology. (Patricia), your line is open.

(Patricia Ricks): Yes. Thank you. Good afternoon, everyone. My question was in regards to the face to face. This is the first time that I've seen the physician and the nurse practitioner attestation in regards to them saying that I certify that I have no financial relationship with the home health agency.

Did you all say – I mean, I know it's in blue there, it's strongly recommended. Is this the first time we've put this here and is this going to be something that we should move forward on and putting on our orders as well?

Melanie Combs-Dyer: This is Melanie and I remember putting this kind of language on the power mobility device template that may have been one of our first ones. I think that might have been a requirement for that particular – a coverage requirement for that particular item.

But I'm not sure that I know if it's a CMS requirement on the home health side. Let me turn it over to (Bob) or (Mark) and see if they know if that is a CMS requirement or if that's just an optional field.

(Mark Pilley): Well, it is a statute requirement that there is no financial relationship between the practitioner doing the face-to-face evaluation and the home health agency. Now, I don't know that there is a requirement that there be a specific signature attestation statement.

But we thought it was an opportune time to present this as a – as a conditional optional type of section to the template itself so it's available, you know, if so desired. And that makes it straightforward and that leaves no doubt.

(Patricia Ricks): My (consensus) with some other physicians feel uncomfortable if we put that on the plan of care to check it off.

Melanie Combs-Dyer: Well, we think that it should be covered. You do need to have no financial relationship. It doesn't have to be at any certain place, but it seems like it might just as well fit here and that's why we put it there.

So if you can think of a better place for us to put it or if you want to take this form and tailor it and create your own form, you certainly can. We just think it might be a nice easy way to capture all the needed documentation in one place.

(Patricia Ricks): Absolutely. Thank you.

Operator: Your next question comes from (Lisa Johnson) with Aspira. (Lisa), your line is open.

(Lisa Johnson): Hi. Thank you very much. My question is regarding the – adding the incorporating home health documentation with the physician's face to face.

Am I correct in my assumption that this can only occur when the face to face happens 30 days after the start of care because there would be no way to incorporate documentation prior to the start of care? So can the physician still incorporate home health documentation when that face to face is done prior to the start of care?

(Hilary Loeffler): Hi. This is (Hilary). Yes, he'll need to just sign, coordinate the home health information just attesting that here she considered it at the time of certification.

(Lisa Johnson): OK. And as long as that is done before the bill is sent we should be OK?

(Hilary Loeffler): Yes.

(Mark Pilley): The physician – this is Dr. (Pilley) – this is Dr. (Pilley). I think home health agencies, if I remember correctly from my days of hands-on practice, commonly would do an assessment of the patient before accepting them into the home health services to be provided by that agency, is that correct?

(Lisa Johnson): Yes.

(Mark Pilley): OK. So that information that you gleaned for that assessment can be – is good information that could be presented to the physicians that we have this information.

A lot of that information is also based on maybe something that happened in the hospital like a physical therapy, occupational therapy or speech language pathology assessment that supports the need for continuation of that therapy once they go home, so.

(Lisa Johnson): Thank you.

(Mark Pilley): Thank you.

Operator: Your next question comes from (Carol Calpajeroni) with Angels Care Home Health. (Carol), your line is open.

(Carol Calpajeroni): Hello. I have a couple of comments. One, yes, we do an assessment, it's a 22-page document called the Oasis. And many physicians don't want 22 pages added to their patient's record.

So I just wanted to make that comment in regards to the assessment that's done. And, of course, we do at the physician's request. I am – I remain concerned about the length of service on the plan of care.

It's – I'm concerned that, let's say, we have a wound – a wound and we believe that will 30 minutes, but when we get there, the patient is agitated or there's an issue that we must address somewhere there or the – or the – and they won't cooperate. Do you understand what I'm saying?

And so, the nurse will document 45 minutes or an hour, but yet we don't have an order for those just keying to 30 more minutes because this is very specific. And I just don't know how any one – not even a physician could estimate length of session.

(Hilary Loeffler): Hi, (Carol). This is (Hilary). I just want to jump in really quick. So one thing that we have put in our benefit policy manual is that a good way for an HHA to convey pertinent information about eligibility to the physician is to put it on that plan of care.

And then, the physician's already signing that, thereby incorporating it into his information. So we've been kind of encouraging HHAs to put that information on the plan of care because then the physician's always going to sign that.

So (since it's on) the Oasis which as you mentioned is a long document, you could very well just put information about home-bound status on the plan of care and the physician will sign that. And that's considered part of the medical record and we'll use – will be used in (pending) eligibility, so.

(Carol Calpajeroni): We do. You know, we have very long plans of care now; many, many, many pages. But I was just commenting on, yes, we do an assessment. It's a 22-page assessment. We really do assess that patient.

(Hilary Loeffler): Thank you.

(Carol Calpajeroni): And now, length the service, can we talk about that – or length the session? That's a big concern because that's a very specific order down to the physician signing and we're going to document – we always document the time we spend with the patient. Every one of us do. I can't imagine anyone that not documenting the length of time.

And if you make it that specific – time specific – and we go over the time or we go under the time, I'm very concerned about how the max are going to look at our records and determine that we didn't follow the plan of care.

Melanie Combs-Dyer: So your recommendation is to delete or eliminate the length of session field?

(Carol Calpajeroni): Yes. I don't believe there's any clinician, not even physicians that could say, it – that every wound care will only take 30 minutes.

Melanie Combs-Dyer: OK. Thank you. Appreciate it.

(Carol Calpajeroni): And then, one – then one, last comment about those financial relationships. I believe the regulation reads significant financial relationships and I'm not quite sure if it's listed but it was – there was a guidance – guideline that said under \$25,000 was considered or over \$25,000 in a year was considered significant.

Melanie Combs-Dyer: Give us just a second to let us see if we can find – that we're looking for the section of the manual that might talk about that.

(Carol Calpajeroni): OK. Because I echo the other home health aide person that said the physician might be concerned about signing such a thing because, you know, there is that qualifier significant.

Melanie Combs-Dyer: I tell you what, why don't we go ahead and take the next call and we'll keep looking for the definition of no financial relationship versus significant financial relationships.

(Carol Calpajeroni): OK. Thank you so much.

Melanie Combs-Dyer:OK.

Operator: Your next question comes from (Mary Carr) with NACH. (Mary), your line is open.

(Mary Carr): Hi, everyone. Yes, I have a clarifying question. Who are these forms supposed to be completed by, the physician or the agency?

Melanie Combs-Dyer:This is Melanie. Typically, I think the face-to-face encounter is completed by the ordering physician or nurse practitioner and, typically, I think the plan of care is completed by the home health agency and signed by the ordering physician.

(Mary Carr): OK. I asked because in one of the previous callers, I got the impression that CMS was permitting the agency to complete the face-to-face encounter and have the physician sign that form.

Melanie Combs-Dyer:I'm sorry. I didn't mean to imply that. So the physician would need to complete the physician encounter form and sign it and the home health agency would need to complete the home – the plan of care and send it to the physician for signature and then everything is just – again, sometimes physicians forget what they need to document in that face-to-face exam and we know of home health agencies that sometimes forget to include certain things that – a plan of care or they're using an outdated treatment plan form that may not include the latest bits of information and so something goes undocumented and then that results in a denial and then that results in appeals.

And by putting out this information, excuse me, we are hoping that we can remind everyone involved in the patient's care what they need to document.

(Mary Carr): OK. Thank you. If that's the case, then the plan of care a signature for the clinician, if, in fact, the agency is going to use that as documentation of the verbal order. I only see a physician's signature line.

(Bob Dieterle): Well, this is (Bob). The – on the plan of care certification, I think we can clarify that the signature in – at the end is intended to be the physician that is actually approving the plan of care.

(Mary Carr): OK. Well, currently now on the – on the plan of care there is – there is a place that the nurse or whomever is transcribing these orders needs to sign. So again, that goes back to my – who – what is the intent?

Is this – is this intended for something the physician completes or the agency or both? Now, I think it's very clear with the face-to-face encounter, but I'm a little concerned about or confused at least on when you developed this, who did you envision completing the plan of care?

Melanie Combs-Dyer: Thank you for the question. The intention is I think the way it typically works is that the home health agency completes the plan of care and the physician or the ordering clinician signs the plan of care. And we can make sure that we have clarified language to that – to that point. Thank you.

(Mary Carr): OK. And I still think you need a signature for the clinician as well.

Melanie Combs-Dyer: Great. So that would be a signature for the home health clinician who's...

(Mary Carr): The home health clinician completing it.

Melanie Combs-Dyer: Got it. Thank you.

Operator: Your next question comes from (Lisa Selman-Holman) with (Selman-Holman) and Associates. (Lisa), your line is open.

(Lisa Selman-Holman): Thank you. Just to follow up on what (Mary) was talking about with the physician's signature. On this plan of care template, it says physician/NPP signature and at the current time at least, non-physician practitioners are not able to sign home health orders. So I'm a little concerned that that is there and it may be misleading to anybody who is, like, jumping on, adopting this form right away.

Melanie Combs-Dyer:(Lisa), thank you for pointing that out. I think that is an error on the form.
(Hilary), can you confirm that?

(Hilary Loeffler): Yes. I can confirm that the physician has to sign the plan of care as we do not allow NPPs to order or sign or search.

(Lisa Selman-Holman): The other comment I wanted to make is procedure codes haven't been required for home health agencies since, I believe, 2011 is when they removed it from COP. 2014 is when CMS said we didn't have to collect the information on Oasis any longer.

And since we switched to ICD-10 in 2015, there would be no way a home health agency would be able to code a procedure. (And) just like ICD-10, (CM) procedure codes are actually PCS.

So I would suggest that the procedures, unless we just put like, you know, procedures that were pertinent and, you know, that you can put down without a code, I think that would be important to the plan of care. But just to put procedures with the code is not a good idea because we're not going to get the information in home health agency.

Melanie Combs-Dyer:I think that's a good suggestion. I don't think there is a CMS requirement that procedure codes be listed on the plan of care. (Bob) or...

(Lisa Selman-Holman): Yes. So – yes, consistent black and that's why, you know, I'm looking at what's required that's in black and it says relevant procedures e.g. surgical repeat until completed ICD-10 CM. So that makes me think you're thinking we're going to code that which we wouldn't be able to code it at all.

Melanie Combs-Dyer:(Bob)?

(Lisa Selman-Holman): And then, a couple of things on the diagnoses, the date on diagnosis and this new status, those are both not required at this point in time but you have them in black on here.

So that was another concern I had where you have the date of first diagnosis is available and I know it's available, so OK. But then, the acute chronic –

acute, chronic, resolving, resolved, managed I think is the other one that's on the other form there.

So those are the concerns I had (by the) way with the signature and then (Mary) asked the question – the other question was if this was actually for the home health agency to fill out to send to the physician as a transcription of the verbal order what the patient needs and the physician then signs it.

Melanie Combs-Dyer:(Bob), did you want to comment on the procedure versus procedure code or the diagnoses being required or status being required?

(Bob Dieterle): I will take that back and we'll review that and if we determine that that indeed is appropriate, we can change the requirements of the ICD-10 PCS code to optional and do the same thing on the start date and status. So let us take that back. Thank you.

(Lisa Selman-Holman): All right. Thank you so much.

Melanie Combs-Dyer:Thank you, (Lisa).

Operator: Your next question comes from (Jennifer Gibson) with Access Technology. (Jennifer), your line is open.

(Jennifer Gibson): Good afternoon. Thank you for your time. We've had some discussions amongst ourselves and some of our clients regarding this physician signature line on the plan of care and I'm just wondering, is there a preferred placement for the signature line on the plan of care such as the last page of the document versus each page, for example?

Melanie Combs-Dyer:CMS does not have any requirements regarding location of signature.

(Jennifer Gibson): Very good. Thank you so much.

Operator: Your next question comes from (Tracy Wodutch) with Association Healthcare. (Tracy), your line is open.

(Tracy Wodutch): Hi. Thank you very much. At the – at the Connecticut Association for Home Health and I think – I want to follow up on a couple of questions that have been asked, one the duration piece.

I, too, have concerns about that and I know you said you're going to look into it. You know, perhaps the only duration that you may see on an order might be the home health aide. Other than that I don't think you'd see duration.

And I also have concerns about the listing out of all the different treatments. And – someone else mentioned, you know, who would fill in. I don't – it just seems so repetitive and cumbersome. And I think there could probably be a little bit more efficient process in getting that accomplished.

Going back to the physician signature line that (Jennifer) just asked about, as far as last page – you know, she asked should it be on the last page, any page, is there any requirement? I thought, and maybe you can correct me – I thought that the physician signature did have to be after the certification statement.

From everything that we're learning through our face-to-face encounter, denial trends that we're seeing throughout the country and the work that the MACs are doing in trying to help the providers comply with the certification requirements, I think that's one of the pieces that's come out, that the signature must be after the certification statement. So, you know, just placement-wise. It doesn't need to be last or whatever but it needs to be after.

And then, I guess I'm really at a loss regarding the whole face-to-face template. I understand that these would be optional and agencies can put in place whatever they want to. But the face-to-face template is – it looks like a reiteration pretty much of the plan of treatment minus the frequency, you know, of services et cetera.

It's just – and for the physician to fill something like this out we already struggle with them filling out what we need currently. This is so many pages that I can't imagine a physician would even begin to fill it out.

I'm just trying to give – I'm trying to be as positive as possible and not – and not complain, but I want you to understand that this is so far beyond what I think the intent of the face-to-face encounter was supposed to be. So I do ask that you consider that.

And the piece about asking for physician's feedback, I know that there have been many open-door forms but we also know how valuable the time of the physician is.

And I have concerns that perhaps physicians have not had enough opportunity – not opportunity, but have not been able to, for whatever reasons, there scheduled constraints whatever – they have not been able to offer adequate feedback for this because I think their feedback would be much needed for something like this. Thank you.

Melanie Combs-Dyer:(Tracy), thank you so much for your three comments. On the duration piece, we'll make a note that you believe it's only needed for aides and probably not for anything else. On your point about the physician signature location and doesn't that need to be after the certification, let me ask (Hilary) to answer that question.

(Hilary Loeffler): Yes. I want to point out most people do use the modified CMS 485 form until to this day but the certification can be separate from the plan of care. So, yes, for the certification, the signature needs to be after the statement.

Melanie Combs-Dyer:And then, on your suggestion or your point about the face-to-face template may not be very popular with physicians, you may be right. We will certainly go back and look and see if we can simplify it in any way, try to streamline it. I believe that it will be probably unlikely that most physicians will use the paper version of this form.

But I do believe that if we work with the IT industry and try to get these CDEs built in to the EHRs, it may be more likely that a physician could actually complete some of the templates. Your point about asking for physicians for their input, we agree and we will be reaching out to physicians. Thank you so much, (Tracy), for your suggestions.

(Tracy Wodutch): Thank you.

Operator: Your next question comes from (Lynette Wrights) with (Wright's) Choice Home Health. (Lynette), your line is open.

(Lynette Wrights):OK. Thank you and hello to everyone. I just want to clarify that the physician that signs the plan of care certification does not have to be the same physician that signs the face-to-face encounter?

(Hilary Loeffler): Yes. That is correct. So if the patient was referred to home health from an acute or a post-acute care setting, the physician signing the plan of care/certification does not need to be the same physician that saw them in the acute or post-acute care setting.

(Lynette Wrights):OK.

(Hilary Loeffler): Thank you.

Melanie Combs-Dyer:Thank you, (Hilary). And let me just tell the operator, I think we have gotten to time. And so, I – I'm not sure. Do I – do I turn it back over to you, operator?

Operator: Go ahead with your closing remarks.

Melanie Combs-Dyer:This is Melanie and I'll give you just a couple of closing remarks. I like to thank everybody for attending today. I really appreciate your time. You guys have given us some wonderful suggestions.

And I will note that we are open to additional suggestions if you would like to send them to us by e-mail. Any feedback or suggestions can be sent to clinicaltemplates@cms.hhs.gov.

That e-mail address again, clinicaltemplates@cms.hhs.gov. It appears on the last page of the slides. Thank you everyone.

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

END