

Hospice FAQ: Telehealth, Waiver & CoP Flexibility

As part of last week's [Interim Final Rule with Comment](#), the Centers for Medicare & Medicaid Services (CMS) included guidance on Issues specific to the use of technology to address hospice requirements. Concurrent with the rule's release, CMS also issued several Section 1135 waivers allowing flexibility on specific requirements included in the hospice Conditions of Participation (CoP).

On Tuesday, March 31, 2020 the National Association for Home Care & Hospice (NAHC) held a webinar during which NAHC staff discussed the new flexibilities. As part of the webinar, attendees posed many questions related to the hospice policies; this article contains responses compiled by NAHC staff, with an introduction that provides background information on the hospice telehealth and technology-based visit flexibilities.

Background: Hospice Telehealth and Technology-based Visits

Included in the Interim Final Rule is guidance that relates to the following:

1. Use of **telecommunications technology** to provide services under hospice routine home care (RHC)
2. **Telehealth** and the Medicare Hospice Face-to-Face Encounter (F2F) Requirement and
3. Billing of hospice-connected attending physician **telehealth** visits

CMS distinguishes between use of **telecommunications systems** for the provision of services under RHC and the use of **telehealth** for purposes of fulfilling the F2F encounter requirement and for hospice billing of medical services provided by a hospice-connected designated attending physician.

For services provided while a patient is on RHC, CMS has indicated that, for the duration of the emergency, hospices may provide services using telecommunications technology provided such use is appropriate and feasible. For such services, CMS does not specify that the technology meets the standard set for "telehealth" but does require that the services are reasonable and necessary and that they are specified on the plan of care. This means that where appropriate hospice providers may use audio-only connections. However, some services may require more sophisticated technologies (two-way, audio-video capabilities). The interdisciplinary team (IDT) must make a determination, on a case-by-case basis, what services may be provided using what technologies, and must document how the services meet the patient's care needs and other goals of care.

Telehealth services under the hospice benefit, for the duration of the emergency, may be used by a hospice physician or NP to perform the F2F, and for physician services billed by the hospice if the practitioner providing the service is hospice-connected and the patient's designated attending physician. CMS has indicated that "telehealth" for purposes of this flexibility must be provided using technology with two-way, audio-video, real-time capabilities. During the COVID-19 emergency, clinicians are permitted to use popular applications that allow for video chat such as Apple FaceTime and Skype, thanks in part to enforcement discretion by the HHS Office for Civil Rights.

Hospice Technology-based Visits

Q: Will CMS count Phone Visits since we do not have Telehealth? These visits are structured and include assessment and goals information. It is more than a “Tuck in” call.

A: For purposes of encounters with patients on RHC, phone visits are permitted as long as they are included on the plan of care (technology specified) and meet the patient’s care needs and goals of care.

Q: For hospice, telehealth is allowed for all disciplines, is that correct? If not, please clarify.

A: Visits by various disciplines under the RHC level of care that are included on the plan of care and are covered under the per-diem payment may be performed using various telecommunications technology. The telecommunications technology is not required to meet the “telehealth” standard (two-way, audio-video, real time) as long as the IDT determines that patient care needs are met and the service/technology is specified on the plan of care.

Q: Are hospice RHC nurse/MSW/chaplain visits now allowed to be via telehealth during this pandemic?

A: As indicated above, RHC visits that are included on the plan of care and that are included the daily per diem may be performed using telecommunications technology provided they are included on the plan of care and are determined by the IDT to meet the goals of care.

Q: Will hospice payments be affected if we are doing televisits for the majority of visits for a patient per the SNF requests/visitor policy?

A: No. Any “televisits” provided by the hospice while the patient is under RHC are considered part of the daily per diem. The interactions must meet the specifications laid out by CMS, however, including that the services are reasonable and necessary for the palliation and management of the patient’s condition, it is appropriate and feasible to provide services via the specified technology and the services and mode of technology are included on the plan of care. Hospices are expected to continue to meet the patient’s care needs, regardless of the mode of service delivery. Hospice claims will process even if no visits are recorded provided other billing requirements are met.

Q: Can clinical visits for hospice patients in respite or GIP care be done via telehealth?

A: The flexibilities outlined by CMS relative to use of telecommunications systems to provide services are **limited to the routine home care level of care.**

Q: Just for clarification...hospice and HH agencies can both utilize telehealth (audio/visual) to continue care, but these do NOT go on claims? For all disciplines? So they can continue to care for patients, but telehealth does not go toward visit count?

A: Correct. Technology-based services provided to hospice patients (with the exception of social worker telephone calls and attending physician medical services provided using telehealth) should NOT be included on claims.

Q: While discussing Comprehensive Assessments on slide 20, the speaker's voice/audio was breaking up and I could not hear what she said about whether Comprehensive Assessments could be accomplished via telehealth versus in person. Can you restate?

Q: The comprehensive assessment for hospice — do all visits need to be in person? Can chaplain or social workers be telehealth?

Q: For Hospice: Can the 21-day comprehensive update visit be completed by telehealth (audio/visual)?

A: Relative to performing the comprehensive assessment using virtual visits, CMS has – informally – stated that there is a great deal of flexibility in the Conditions of Participation (CoPs) relative to use of technology-based visits. As part of the Interim Final Rule with Comment, CMS allows for broader use of technologies but does not explicitly reference use of technologies to complete the comprehensive assessment. Instead, CMS provides clarification around its expectations for use of telecommunications – including that it be feasible and appropriate to address the patient's needs. We believe that CMS has addressed the issue in this way because they want the IDT to give serious consideration to whether or not use of technologies can address a specific patient's needs and the goals of care, on a case-by-case basis. NAHC believes that this flexibility allows for use of technologies to deliver visits that are connected to the comprehensive assessment and routine updates to the comprehensive assessment, again, provided that the technological interaction fulfills the purpose of the visit. This must be established/determined by the IDT. If the IDT determines that an in-person visit is necessary to obtain a full perspective of the patient's conditions and care needs, then in-person visits must be performed for those aspects of the assessment. On an "Office Hours" call held on Thursday, April 9, CMS staff confirmed NAHC's understanding with respect to both the initial and comprehensive assessments. (As of this writing the audio recording of this call was not yet available; when available it will be posted [HERE](#).)

Q: Does the same apply to hospice as HH that you cannot do an admission visit via telehealth but can complete a pre-admission evaluation that way?

A: We do not believe this applies to hospice. Home health episodes begin with the first visit, while the start of hospice care is linked to the effective date of the patient's election of services, as specified on the election statement.

Q: Can the IDT meetings be conducted remotely?

A: Hospices have always had the flexibility to perform the IDG meeting using technology.

Q: Hospice question: Can the plan of care be updated every 15 days per usual if there haven't been any in-person visits since last update (only telehealth visits)?

A: CMS has not provided guidance regarding this scenario. However, nothing in the CMS guidance precludes a hospice from continuing to serve a patient with visits that have been exclusively technology-based. However, the hospice IDT must ensure, through its oversight, that the patient care needs, and goals of care are being met. As a reminder, the updates to the plan of care are to be conducted minimally every 15 days, but any change in the patient's condition should trigger a review of the plan of care.

Q: Are telecommunications systems and the visits provided using them reimbursable by Medicare?

A: There is no payment beyond the hospice per-diem for visits provided using technologies. However, hospices can report the cost of telecommunications technology used to furnish services under RHC during the COVID emergency as “other patient care services” using Worksheet A, cost center line 46, or a subscript of line 46 through 46.19, cost center code 4600 through 4619, and identifying this cost center as “PHE for COVID-19”

Physician Services Using Telehealth

Q: Will Hospice Medical Director, who is not declared Attending, be able to use telehealth to complete a medical necessity visit—which currently bills through Medicare Part A?

A: Based on the information provided in the Interim Final Rule with Comment Period, only a hospice physician or hospice-employed nurse practitioner who serves as the patient’s designated attending physician may provide medical services using telehealth that may be billed by the hospice to Part A. NAHC has strongly urged CMS to revise this requirement to permit hospices to bill for medical services performed using telehealth for any hospice-connected physician.

Q: Do telehealth visits require video or can they be telephone?

A: Telehealth visits (to fulfill the F2F requirement or to provide attending physician services) may not be conducted using audio-only telephone.

Q: And for this purpose will FaceTime on a smart phone count as telehealth?

A: Yes. FaceTime, Skype and other non-public facing telecommunications systems with two-way, audio/video real time capabilities are permitted.

Q: How does my hospice bill for attending physician medical services?

A: Current guidance from CMS indicates that, for claims for non-traditional telehealth services with dates of service on or after March 1, 2020, and for the duration of the COVID-19 public health emergency, the provider should bill with the Place of Service (POS) equal to what it would have been in the absence of the COVID emergency, along with a modifier 95, indicating that the service rendered was actually performed via telehealth.

Hospice Face-to-Face Encounter

Q: What happens if a hospice patient does not have a smart phone or computer for virtual recert for F2F in hospice?

A: As the requirement currently stands, the technology used for the face-to-face encounter must meet the “telehealth” standard, which includes two-way, audio-video, real-time capabilities. However, CMS has indicated that they are still considering whether they might allow use of audio-only telephone interactions for this purpose. During the PHE, clinicians can use popular applications that allow for video chat such as Apple FaceTime and Skype, thanks in part to enforcement discretion by the HHS Office of Civil Rights. NAHC has urged both Congress and CMS to provide additional flexibilities around use of audio-only communications in such circumstances.

Q: Can we discuss with CMS to consider the use of Physician Assistants to be used in Hospice to complete Face to Face and give the PAs same scope of practice within the COPS as the NP.

A: Yes, NAHC is advocating with Congress and CMS that PAs be permitted to perform the hospice face-to-face encounter.

Hospice Waivers and Flexibilities

As stated above, concurrent with the rule's release, CMS also issued several Section 1135 waivers allowing flexibility on specific requirements included in the hospice CoPs. Questions related to these waivers and other flexibilities are below.

Q: Is the HCA 14-day supervisory visit waived for hospice as well?

A: Yes

Q: Regarding the 14-day supervisory visit – this places us out of compliance with state licensure law.

A: If the state licensure law is more stringent than the federal conditions of participation, or the waiver of such CoP, then the hospice should observe the state licensure law.

Q: The comprehensive assessment is now to be completed every 21 days instead of every 15 days, correct?

Q: Current expectation is Comprehensive within 5 days. Please clarify this extension.

Q: Please clarify if the hospice comprehensive assessment requirement is once every 14 days, based upon the slide it appears this has been extended to 15-21 days. Is that correct?

Q: For Hospice: does the waiver for updating the comprehensive assessment refer to IDG or completing the recert visit to update the plan of care?

A: The *update* to the comprehensive assessment must be completed at least once every 21 days during this Public Health Emergency. The requirement that the hospice complete a comprehensive assessment within 5 days after the effective date of the election still remains.

Q: Must the IDT meeting continue every 15 days, and can they be done via Zoom or other means?

A: The hospice is still required to review the plan of care at least every 15 days and this is typically done during an IDT meeting so this should continue. Hospices have always been able to review the plan of care and have the IDT meeting via Zoom or other means and that has not changed.

Q: Does an RN visit need to be completed at a minimum of once every 14 days – not including the supervisory visit that has been clarified?

A: There is a requirement that the comprehensive assessment be updated at least once every 15 days, and this would include an update to the physical, emotional, and spiritual portion of this assessment. Because of this there is common belief that an RN must visit at least once during this timeframe. It

makes sense because of the need for the updated physical assessment that an RN would visit at least once during this period.

Q: Does the waiver of Volunteer level of activity mean that the 5% is completely waived for the year? Or is it just during the down time?

A: CMS is reviewing this.

Q: Can you clarify the Hospice QRP waiver for HIS: Are the waiver dates for the actual submissions or the HIS completion admission/discharge dates?

A: For HIS, the quarters are based on submission of HIS admission or discharge assessments.

Q: Quality reporting question – is this a choice to submit or not submit or is submitting just halted across the industry?

A: Submissions for the HIS and CAHPS are not required through June 30, 2020; however, a hospice may choose to continue to submit and this is acceptable.

Q: Is sequestration still in effect?

A: Yes, until May 1.

Q: The 2% sequestration is effective 5/1. Why so late? Why not 3/1?

A: We do not know why CMS chose the 5/1 date.

Q: Is OIG still able to conduct reviews/audits? We have been going back and forth with them and they insist they have not been told to pause their reviews/audits?

Q: We have a provider who requested delay for OIG audit. They alerted me today that OIG would not honor.

A: Yes, the OIG can still conduct reviews/audits. The OIG has stated it is taking into account burdens on providers and the safety of patients, health care staff and OIG staff as it plans new work and continues ongoing oversight. The OIG does not have to honor a request for a delay of a review or the extension of a record/data submission deadline. The OIG will make these decisions on a case by case basis.

Q: Is there a lookback for the waiver of TPE. Will they go back post payment to review the TPE claims or just pick back up with the current claims billed when the emergency is over?

A: There is not a waiver of TPE, there is a pause in TPE. The TPE audits will resume again after the emergency period.

Q: Any update on Medicare Carve-In?

A: There is no update at this time.

Q: Is there an extension on filing our Cost Report?

A: CMS has extended the cost reporting deadlines for the following to **June 30, 2020**:

- FYE October 31, 2019 and
- FYE November 30, 2019

The filing deadline for FYE December 31, 2019 cost reports is now **July 31, 2020**.

Q: Can nursing homes refuse to let the hospice nurses see our patients; not even letting us in for the CMS 14-day requirement?

Q: For Hospice – what if the facility (SNF & ALF) will not allow hospice staff in to care for patients – What guidance can you provide to the hospice and/or facility?

Q: The SNF in our community that is not allowing us to have a nurse come in unless the patient is expected to die within 72 hours. How are we to keep seeing a patient and updating the POC?

A: This continues to be a problem for hospices nationally. CMS has provided guidance to nursing homes that other health care personnel including hospice staff should be allowed entry into the facility to care for their patients (provided they pass any screenings and are utilizing proper PPE). CMS has also indicated that visitors should be allowed entry to see their loved ones when the resident is at end-of-life. All hospice patients are considered to be at end-of-life. CMS does not have authority over ALFs, but many of the ALFs will refer to the CMS guidance to nursing homes. NAHC has and continues to request further clarification from CMS to nursing homes on this issue.

We suggest that hospices try to work with the appropriate decision makers in these facilities to remind them of the fact that hospice staff are considered other health care workers. If this is unsuccessful, the hospice can implement telecommunications/telehealth with the patient; however, these visits cannot be put on the claim and should only be used in cases where these platforms still allow the hospice to meet the patient's needs (as indicated in the section above).

