

Hospice FAQ: The FY2021 Proposed Hospice Payment Rule and Update on Hospice COVID Flexibilities

On April 16, 2020, the National Association for Home Care & Hospice (NAHC) held a webinar addressing highlights of the FY2021 proposed hospice payment rule and an update on flexibilities that the Centers for Medicare & Medicaid Services (CMS) has issued for hospice providers in light of the COVID-19 pandemic. During the webinar, NAHC representatives addressed several questions submitted by the participants. However, there was not enough time to respond to all questions during the webinar. Below are all of the submitted questions and the responses.

Q: Are there handouts for this call?

A: Handouts are available [here](#)

PROVIDER RELIEF FUND

Q: If the CARES money is less than \$150,000, it appears that there is no reporting. Is this correct?

A: Under the [terms and conditions](#) for the initial GENERAL ALLOCATION of CARES Act funds (\$30 billion distributed based on Medicare fee-for-service revenues) any entity receiving more than \$150,000 total in funds under the Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136), the Coronavirus Preparedness and Response Supplemental Appropriations Act (P.L. 116-123), the Families First Coronavirus Response Act (P.L. 116-127), or any other Act primarily making appropriations for the coronavirus response and related activities, is subject to quarterly reporting requirements. The [terms and conditions](#) connected to the second distribution from the GENERAL ALLOCATION of the CARES Act (\$20 billion distributed based on 2018 net revenues) contains similar terminology related to quarterly reporting. It should be noted that the terms and conditions do contain record-keeping requirements and HHS has indicated the intent to conduct oversight to ensure funds were utilized based on the specified terms.

Q: We bill Medicare on a per diem basis. Will we be excluded from the COVID-19 emergency funds?

A: No. Funds have been distributed to hospice providers from the CARES Act funds.

COVID-19-RELATED HOSPICE FLEXIBILITIES

Q: I realize that the 5% activity level for hospice volunteers was waived, but was there also a waiver on the cost savings calculation related to volunteers?

A: No. CMS has not taken action related to the cost savings calculation. This should not pose a problem, however, for hospices to maintain this information and have it available to a surveyor should there be a need to do so as the hospice can show in the calculation the total number of volunteer hours at zero (if that is the case during the PHE) and that no cost savings were realized. There is no set threshold that must be reached for cost savings.

Q: Is there a waiver or flexibility for the Hospice Social Worker or Chaplain to make visits?

A: We suspect you are asking whether social work or chaplain visits may be performed using telecommunications equipment. Under ongoing CMS policy social worker visits may be performed via telephone or in person and may be included on the hospice claim (CMS has separate codes that are applicable to telephone and in-person visits). Chaplain visits may be performed using telecommunications equipment. The type of visits and the means for delivering it should be specified on the plan of care.

Q: I would like to confirm that if we do a telecommunication visit as a comprehensive visit it will be considered compliant with COPs.

A: CMS has indicated that telecommunications can be used for any of the interdisciplinary group (IDG) team visits provided they are reasonable and necessary to address the patient's condition, allow for the goals of care set out in the plan of care to be met and are delineated in the plan of care as a telecommunications visits.

Q: Does the comprehensive assessment at the 21-day mark have to be in person or can it be done by telehealth? Many SNFs are refusing staff entry for the 21-day assessment.

A: Hospices may utilize the COVID-related flexibilities permitting performance of visits using telecommunications equipment to perform required assessments provided the interdisciplinary team (IDT) has specific such on the plan of care and that the full assessment can be completed in this manner. This is a determination that should be made by the IDT.

Q: Does the HHA supervisory visit have to be done via telehealth or will CMS accept a phone call supervision?

A: The requirement for the RN visit every 2 weeks to supervise the hospice aide has been waived for the duration of the emergency. However, CMS does encourage continuing engagement with the aide as possible, which can be done through an audio phone connection.

Q: Telehealth F2F cannot be made by a hospice NP if the NP is not identified by the patient as their attending?

A: The hospice F2F may be performed by a hospice-employed NP regardless of whether the NP is the patient's designated attending physician.

Q: Regarding Telecommunications for "Visits" for RHC: Has there been any clarification from CMS regarding how to handle Missed Visit orders? If we provide a phone visit in lieu of routine visit, are we required to write a Missed Visit order?

A: "Virtual" visits (those provided through use of telecommunications equipment) are not considered a substitute for in-person visits but rather designated on the plan of care where such "visits" are considered appropriate to provide the services (including the discipline and the form of telecommunications to be used). The virtual visit must be delineated on the plan of care as such and, therefore, is not a missed visit.

Q: Can these telecommunication visits be considered a billable visit under the per diem -- for cost reporting purposes.

A: Visits are not reported on the hospice cost report. CMS has indicated that hospices may report the costs of telecommunications technology used to furnish services under the Routine Home Care level of care during the COVID-19 public health emergency as "other patient care services" using Worksheet A, cost center line 46, or a subscript of line 46 through 46.19, and identifying this cost center as "PHE for COVID-19".

Q: Social worker calls - can you confirm that calls that are ONLY audio are to be reported on the claim and not if there happens to be a visual capability?

A: NAHC has sought clarification and CMS has confirmed that social work calls that include a visual component should be billed as telephone calls.

Q: Slide says, "no limitation on technology that can be used (including audio-only connections)... for the initial assessment, is a 2-way audio and visual telecommunication required? In other words, an audio-only connection would not be allowed, correct?

A: It is up to the IDT to make the determination as to whether a visit may be performed using telecommunications and what form of telecommunications is appropriate. Some services may not be able to be fully performed using an audio-only connection. In such cases, it may be necessary to use more sophisticated telecommunications technology or perform an in-person visit.

Q: Can you please provide a CMS source for the "do not use 95 modifier" for hospice MD Medical necessity visits billed through part A. I have a medical director that is certain that this can be done.

A: Following is an article that appeared in an MLN Connects newsletter issued on Friday, April 3, accessible [here](#). Please note the statement at the bottom, which indicates, "There are no billing changes for institutional claims." We have also confirmed with CMS claims processing staff that the 95 modifier is not required on hospice claims for telehealth services. However, hospices are permitted to use the modifier provided the claim will process.

MLN Connects Article:

Billing for Professional Telehealth Distant Site Services During the Public Health Emergency — Revised

This corrects a prior message that appeared in our [March 31, 2020](#) Special Edition.

Building on prior action to expand reimbursement for telehealth services to Medicare beneficiaries, CMS will now allow for more than 80 additional services to be furnished via telehealth. When billing professional claims for all telehealth services with dates of services on or after March 1, 2020, and for the duration of the Public Health Emergency (PHE), bill with:

- Place of Service (POS) equal to what it would have been had the service been furnished in-person
- Modifier 95, indicating that the service rendered was actually performed via telehealth

As a reminder, CMS is not requiring the CR modifier on telehealth services. However, consistent with current rules for telehealth services, there are two scenarios where modifiers are required on Medicare telehealth professional claims:

- Furnished as part of a federal telemedicine demonstration project in Alaska and Hawaii using asynchronous (store and forward) technology, use GQ modifier
- Furnished for diagnosis and treatment of an acute stroke, use G0 modifier

There are no billing changes for institutional claims; critical access hospital method II claims should continue to bill with modifier GT.

Q: is there any flexibility for a delay in filing a NOE beyond the initial 5-day requirement?

A: NAHC has clarified with CMS that the Medicare Administrative Contractors (MACs) may permit an exception for the timely filing requirement if the hospice is able to provide reasonable justification for the delay based on a COVID-related circumstance. These will be determined on a case-by-case basis by the MAC.

Q: Even if we want to go to NH - we are unable to obtain adequate PPE and we have a small staff therefore we do want to expose my staff without proper PPE. Any thoughts?

A: The distribution of PPE from the federal stockpile is being handled by FEMA. We recommend you check with your local emergency officials to see if they can provide you access to the necessary PPE.

Q: Where can we find the existing policy on social worker calls?

A: Section 30.0 of Chapter 11 of the CMS Claims Processing Manual contains instructions related to billing social work visits that are in-person and those that are conducted via telephone.

Q: for TPE audit that was a partial or full denial: should we still appeal? These claims were not paid.

A: If a TPE audit was completed and a final determination was made, it can be appealed. During the PHE, CMS is not reversing any audit determinations that were made.

Q: Is there a procedure for protesting exclusion of hospice staff to facilities? One nursing home is limiting our RN to 1 visit every 14 days and allowing NO aides at all.

A: The formal complaint process with the state survey entity for nursing homes could be followed. The facility is ultimately the entity that decides if it will grant access to outside healthcare personnel such as hospice staff and volunteers.

Q: Our hospice patients are being told the facility is only allowing one hospice in the building for all hospice patients so they need to transfer to that hospice or they will not be able to receive visits unless they transfer. It is their commonly-owned hospice.

A: The facility does have the ability to determine if it will contract with a hospice and which hospice(s) it will contract with. We suggest negotiating with the facility decision makers for an exception during the PHE or a change after the PHE.

Q: Has CMS issues guidance on the elimination of the 2% sequestration adjustment? Is it only for claims with Dates of service from May 1 – Dec. 31, 2020? Any clarity or direction? Thanks for all you are doing, NAHC team.

A: CMS has indicated that the sequester will not be applicable to hospice care provided starting on May 1 through December 31, 2020.

Q: Please verify for HIS SIA requirement during this time telehealth visits still do not count for visits in last 3 and 7 days of life?

A: CMS has indicated that RN and social work visits delivered via telecommunications technology are not to be reported on hospice claims and are not eligible for the SIA payment. We are awaiting CMS instruction relative to reporting of telecommunications visits on the HIS.

Q: Can a cc continue visit daily by an RN be done by telehealth?

A: We believe this question is asking if a continuous home care visit daily that is performed by an RN can be done via telehealth. CMS has indicated that telecommunications visits can only occur with routine home care level of care.

Q: I think CMS has said that we need to document attempts and reasons for managing care through virtual visits.

A: Yes.

Q: Could you please tell me if the waiver for licensure includes an MSW operating without a license. Our MSW has a Master's but has been unable to get their license due to closure of licensing office.

A: This is dependent on the state's licensing allowances during the PHE.

FY2021 PROPOSED HOSPICE PAYMENT RULE

Q: I don't see the link to the sample addendum form with registration material I received. Could you direct me to it?

A: Following is a link to the sample election statement and addendum:

<https://www.cms.gov/files/document/model-hospice-election-statement-and-addendum.pdf>

Q: I wonder why there isn't a form, being that CMS has a Medicare Home Health ABN, HHCCN, and NOMNC forms.

A: The home health forms you have identified have very specific wording requirements but the same is not the case for the election statement addendum; nor does the addendum follow a specific process for beneficiary appeals. However, CMS has provided a model form for use by hospices (please see previous question and link).

Q: If a new drug is ordered for the patient after their admission (and after the addendum is requested & signed), and hospice doesn't believe the new med is related to the terminal prognosis, do you need a new addendum signed?

A: Yes. Anytime there is a change (CMS refers to the change as an update) a new/updated addendum must be provided.

Q: We try to switch patients on admission from brand name to generic equivalent drugs, if related to the hospice admitting diagnosis. Does this have to be covered in the addendum?

A: No, the addendum only need include items unrelated to the terminal diagnosis and related conditions. The situation described in this example is one of an unnecessary/unreasonable medication (brand name which does not need to be provided by the hospice unless there is a clinical/medical reason why the generic equivalent is not acceptable).

Q: Would updates to the addendum be required for any med changes - including discontinuation of meds that are not being covered anyway?

A: This is not clear from the rule so we will be asking for clarification in comments to CMS.

Q: To clarify, if a patient is taking a brand name drug for the terminal or related illness, they have to cover it even if there is a generic, but if that expensive drug is for a diagnosis considered "unrelated", then the drug is "unrelated" as well.

A: We are assuming that "they" in this question is the beneficiary. The beneficiary is responsible for any item, drug or service that is related to the terminal illness or related condition but is not reasonable and necessary such as a brand name that has a generic equivalent and there is not no clinical/medical reason why the generic equivalent could not be used. Medicare never covers an unreasonable or unnecessary item, service or drug. The hospice may decide it wants to cover the brand name drugs when requested by patients, but it is not required to do so.

