Hospice Care During a Pandemic

A LOOK AT WAIVERS, BARRIERS AND STRATEGIES FOR SAFE CARE

PROVIDED FOR MY CLIENTS AND HPCAI AS A SERVICE FOR IOWA HOSPICES---
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Coding COVID-19

As of April 1st, a specific ICD-10 code has been established for patients with COVID-19: U07.1

- This "U" chapter is entitled "Reserved for future use"
- To be used as primary if known positive
- List additional effects of infection, such as pneumonia after U07.1, such as "other viral pneumonia- J12.89"

Do **not** use U07.1 if only "suspected"

- Use the symptom codes

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Tale of Two Months

January 31st- HHS declares a Public Health Emergency

February 6th, CMS issues first guidance for all healthcare providers on emergency preparedness and infection control https://www.cms.gov/files/document/qso-20-09-all.pdf

This started the orchestra of government agencies' work

- OCR released guidance on flexibilities and mandates share COVID patient information for public health purposes
- CDC updates daily www.cdc.gov

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CMS Directs Hospice 3/9/20

CMS issues first memo specifically to hospice agencies

https://www.cms.gov/files/document/qso-20-16-hospice.pdf

- Directs need to assess emergency plan
- Directs need to screen staff and volunteers
- Directs need to screen patients
- Discusses PPE

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National Emergency Declared 3/13/20

CMS issued it's first COVID guidance to state surveyors on infection control in facilities and restriction of visitors

- HOSPICE noted in guidance as **exempt** from this restriction
- https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf

Under a national emergency, CMS has authority to provide additional guidance, and additional **flexibilities** under the "1135 waivers"

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1135 Waivers- 3/13/20

HOSPICE was absent in the blanket waivers

These are applicable to all. Examples include:

- **Expansion of telehealth to facilitate a visit between a patient and physician**, and not be put at risk by going to a physician's clinic during an emergency
- **Triage of survey activities** to focus on immediate jeopardy and infection control

https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf

States, associations or organizations may also request in writing a waiver for other specific "asks"

See your state's waivers at: https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page

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HIPAA Flexibilities 3/17/20

Regarding telehealth visits the OCR published guidance relaxing strict guidelines re: security (**emphasis added**)

- "Effective immediately, the Office of Civil Rights (OCR) will exercise its enforcement discretion and **will not** impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers **in connection with the good faith provision of telehealth** during the COVID-19 nationwide public health emergency"
- A covered health care provider can use any nonpublic facing remote communication product that is available to communicate with patients
- Applications **allowed**: Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype However, public facing communication should not be used in the provision of telehealth.
- Applications **not allowed**: Facebook Live, Twitch, TikTok, and similar video communication applications that allow public interfacing.

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Shared Decision Making Tool 3/19/20

In attempt to ensure fully informed decisions were made by hospice patients with COVID-19, NHPCO provided a tool to assist with this conversation for all hospices

https://www.nhpco.org/wp-content/uploads/COVID-19-Shared-Decision-Making-Tool.pdf

FEMA now involved with support for PPE distribution

- Find your state office: https://www.fema.gov/emergency-management-agencies

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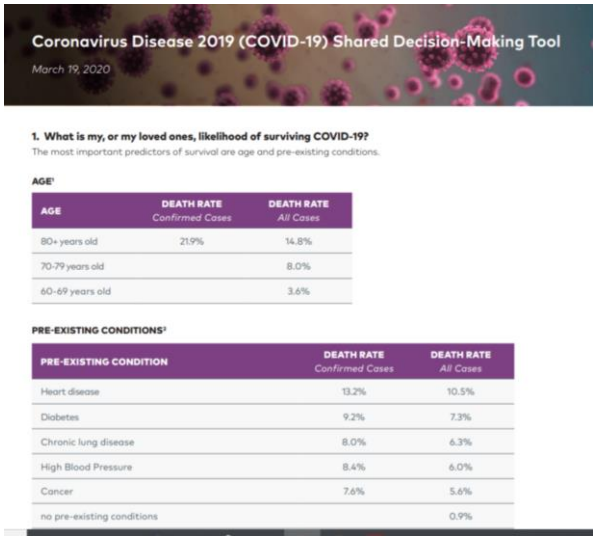

Guiding the Conversation

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Relief for Hospice Quality Reporting 3/23/20

CMS announced relief from quality reporting timeframes

Extension for quality reporting of HIS and CAHPS

No penalty for delayed submissions during emergency

- HIS exception through June 30th, 2020
- Hospice CAHPS exception through September 30th, 2020

- https://www.cms.gov/newsroom/press-releases/cms-announces-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting

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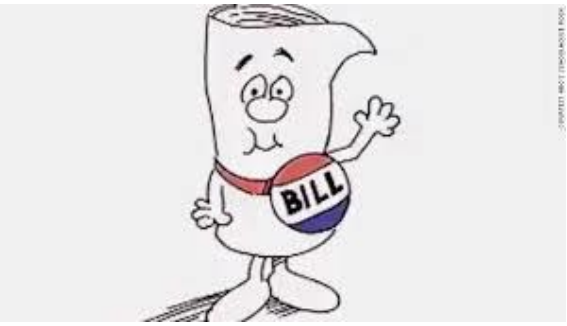
CARES Act 3/27/2020 "Now I'm a LAW!"



Coronavirus Aid Relief and Economic Security Act

- https://www.congress.gov/116/crec/2020/03/25/CREC-2020-03-25-pt1-PgS2063-3.pdf

Two Trillion dollars relief package, passed by Congress and signed into law on 3/27/20

Two major provisions for hospice

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Hospice Provisions

1. The legislation allows face-to-face encounters for recertification for hospice care to be completed by NP or physician using telehealth **during the emergency period**

2. The legislation also includes the temporary suspension of the 2 percent sequestration cut to hospice, beginning on May 1, 2020 and ending on December 31, 2020

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3/30/30 IFC/Hospice Waivers: CMS Stated Goals and Focus for Flexibilities

1) To ensure that local hospitals and health systems have the capacity to handle a potential surge of COVID-19 patients

2) Remove barriers for physicians, nurses, and other clinicians to be readily hired so the healthcare system can rapidly expand its workforce;

3) Increase access to telehealth in Medicare to ensure patients have access to physicians and other clinicians while keeping patients safe at home;

4) Put Patients Over Paperwork to give temporary relief from many paperwork, reporting and audit requirements so providers, and States can focus on providing needed care to Medicare and Medicaid beneficiaries affected by COVID-19.

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1135 Blanket Waivers for Hospice

Published March 30th, Effective March 1st, 2020

Relaxes COP compliance

Only effective through end of the emergency period

CMS granted these on a national basis for all hospices, in all states, for all Medicare patients

- Many states 1135 waivers mirror these

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Comprehensive Assessment Timeframes

The timeframes for updating the assessment may be extended from 15 to 21 days (§418.54)

Best case scenario- the hospice RN can see the patient at least every 21 days to do a full comprehensive assessment

- If not? In this emergency- again- do the best you can.

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Non-Core Services and Volunteers

Waive Non-Core Services: CMS is waiving the requirement for hospices to provide certain non-core hospice services during the national emergency, including the requirements at 42 CFR §418.72 for physical therapy, occupational therapy, and speech-language pathology.

Volunteers: CMS is waiving the requirement at §418.78(e) that hospices are required to use volunteers (including at least 5% of patient care hours). It is anticipated that hospice volunteer availability and use will be reduced related to COVID-19 surge and potential quarantine.

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Supervisory Visits May be Remote

CMS is waiving the requirement for in-person/on-site supervision of hospice aides (42 CFR §418.76(h)

Supervision should be done remotely by phone and/or video

Document how supervision occurred and ensure the components of the supervisory visit standard are still answered

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IFC for Policy Revision in Response to COVID-19

CMS continues to work toward breaking down barriers to patient care during this health crisis

Released March 30th, 2020 as a "Final rule", and applicable March 1st, 2020

https://www.cms.gov/files/document/covid-final-ifc.pdf

"IFC-1744"= Interim Final rule with **Comment**

- http://www.regulations.gov. Follow the "Submit a comment" instructions. Must comment by June 5th
- 60 days from Federal Register Publish date (April 6th)
- Questions? Hillary Loeffler, (410) 786-0456, HomeHealthPolicy@cms.hhs.gov

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Hospice FTF Flexibilities

• Amending the regulations at § 418.22(a)(4) on an interim basis to allow the use of telecommunications technology by the hospice physician or NP for the face-to-face visit when such visit is solely for the purpose of recertifying a patient for hospice services during the PHE for the COVID-19 pandemic.

• If FTF is only for administrative need for certification, this is not billable (no change here!)

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Updated 418.22- Certification of Terminal Illness

During a Public Health Emergency, as defined in § 400.200 of this chapter, if the face-to-face encounter conducted by a hospice physician or hospice nurse practitioner is for the sole purpose of hospice recertification, **such encounter may occur via a telecommunications technology** and is considered an administrative expense. Telecommunications technology means the use of interactive multimedia communications equipment that includes, at a minimum, the use of audio and video equipment permitting two-way, real-time interactive communication between the patient and the distant site hospice physician or hospice nurse practitioner.

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Could There Be More Flexibilities?

Yes! CMS seemed to emphasize that telehealth was solely for the FTF encounter, but any visit performed by telehealth during this emergency, by the hospice physician or an NP who is also identified as the patient's attending physician can be billed

- Coverage and payment didn't change, just the means for the "visit"

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418.204 "Special Coverage Requirements"

CMS further encourages hospices to implement telehealth for the team's visits to reduce exposure and risk

"Use of technology in furnishing services during a Public Health Emergency. When a patient is receiving routine home care, during a Public Health Emergency as defined in § 400.200 of this chapter, hospices may provide services via a telecommunications system if it is feasible and appropriate to do so to ensure that Medicare patients can continue receiving services that are reasonable and necessary for the palliation and management of a patients' terminal illness and related conditions. The use of such technology in furnishing services must be included on the plan of care, meet the requirements at § 418.56, and must be tied to the patient specific needs as identified in the comprehensive assessment and the plan of care must include a description of how the use of such technology will help to achieve the goals outlined on the plan of care."

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CMS Example

A terminally ill 85-year-old male with heart failure has been receiving hospice services and recently developed a fever, sore throat and cough. The patient has been diagnosed with suspected COVID-19 and his hospice plan of care now includes medications for symptom management. He is mildly short of breath but does not require supportive oxygen therapy. The patient's wife is concerned about potential for worsening cardiac and respiratory symptoms as a result of the patient's risk for increased complications due to COVID-19. **The hospice plan of care has been updated to include remote patient monitoring with a telecommunications system to assess the patient's daily weight and oxygen saturation levels.** The plan of care identifies the **measurable goal** that the patient will maintain an oxygen level above 92 percent and the patient will not gain more than 2 pounds in a 24-hour period. The plan of care identifies interventions if either of these goals are not met. **The remote patient monitoring allows for more expedited modifications** to the plan of care in response to the patient's changing needs.

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How Are You Applying This?

At IDG, review care and determine the need to alter the POC to include telehealth and/or remote monitoring

- Patients who are refusing visits at this time, or the facility in which they live is refusing access to patients
- Patients whose symptoms are controlled and some or all of their currently planned visits may be feasibly completed remotely
  - Update the plan to distinguish in-person visits and remote encounters in POC
  - Update goals to include goals for the remote encounters

Identify where you will document these remote encounters so they are not identified on the claim

- Could use "visit notes" if you have a way to make them "non-billable"
- Could use coordination of care note, etc

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What Guides Us?

Typically hospices run on the platform of compliance with the COPs

In the emergency, CMS has made clear this is not the focus! What a paradigm shift!

CMS is not completing any surveys (except Immediate Jeopardy or infection control) and will not be performing any audits during the emergency period

Our hospice should be compliant when it is feasible, but when there are barriers related to this crisis- our platform is based on clinical judgement and ethical decision making

1. **Beneficence** guides us to 'doing good' for our patients
2. **Nonmaleficence** steers us to 'do no harm' either intentionally or unintentionally

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So, Let's Talk...

How are you monitoring your team for s/s of COVID each day?

What options do we have when our team gets ill and we have very few nurses to begin with?

How are you documenting your patient screen for COVID?

What options do we have for IDT?

How are you reducing the risk of exposure for the patient, and the team?

- Reduce frequencies? Reduce the number of team disciplines? For all, or case by case?

What are we doing in the instances where the patient or facility are turning our visits away?

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And finally, PPE

We have seen this moving target, even from CDC change over concerns of a shortage.

At minimum, with all patients who are NOT confirmed or suspected COVID, every team member must wear a surgical type mask, or other face covering

- This is to protect the patient and their family
- 20% estimates of asymptomatic spread

Do you have what you need for a COVID-19 patient?

How are you tracking amount of supplies on hand?

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Thank YOU! Be Well, and Be Safe!

CONTACT ME ANYTIME:
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