Policy, Billing and Guidelines in Telehospice and Telepalliative Care

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Richelle Marting is an attorney, registered health information administrator, and certified coder who focuses on healthcare coding, billing, and reimbursement issues. She has practical, in-the-trenches experience with coding and billing issues. She has served as an outpatient multi-specialty surgery coder, hospital-based outpatient coder and a compliance coordinator for a large multi-specialty medical group. As an attorney she advises clients proactively on complex reimbursement questions and has guided multiple clients through extensive Medicare and OIG audits and investigations. Richelle has been designated as a forensic expert in a number of HIPAA privacy and reimbursement lawsuits.
Overview

- General Guidelines
- Pre-Pandemic Coverage Restrictions
- COVID-19 PHE Flexibilities
- Coding and Billing: Now and on the Horizon
Standard of care, consent, hospice election, privacy are all important considerations in telehospice and telepalliative care.
ESTABLISHING THE RELATIONSHIP

- **KSA 40-2,212**: telemedicine can establish a provider-patient relationship
  - Telemedicine: the delivery of healthcare services or consultations while the patient is at an originating site and the healthcare provider is at a distant site. Telemedicine shall be provided by means of real-time two-way interactive audio, visual, or audio-visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support healthcare delivery, that facilitate the assessment, diagnosis, consultation, treatment, education and care management of a patient's healthcare. KSA 40-2,211
- **KSA 40-2, 211**: email and fax is insufficient
ESTABLISHING THE RELATIONSHIP

• RSMo 191.1145 et seq:
  • Can be established by telemedicine encounter, if the standard of care does not require an in-person encounter, and in accordance with evidence-based standards of practice and telemedicine practice guidelines that address the clinical and technological aspects of telemedicine
    • Can be audio only
    • Sufficient technology to establish informed diagnosis as though the medical interview and physical examination has been performed in person
    • A questionnaire completed by the patient, whether via the internet or telephone, does not constitute an acceptable medical interview and examination for the provision of treatment by telehealth
  • Consultation with another provider who has an established relationship and consulting provider’s agreement to participate in care
  • Not informal consultation by out of state provider, outside provider-patient contractual relationship
• Missouri DHHS guidance after state emergency ended:
  • a physician-patient relationship is established through a physical examination conducted in-person or through telemedicine
ESTABLISHING THE RELATIONSHIP

- **Oklahoma:** Can be established by telemedicine, but not by audio-only
  - Cannot be used to establish a valid physician-patient relationship for purposes of prescribing opiates, synthetic opiates, semisynthetic opiates, benzodiazepine, or carisprodal, but may be used to prescribe opioid antagonists or partial agonists
  - The duties and obligations created by a physician-patient relationship shall not apply until the physician affirmatively undertakes to diagnose and treat the patient or participates in the treatment of the patient
- Keep these state rules in mind as we look at CMS flexibilities for hospices
ESTABLISHING THE RELATIONSHIP

- Hospice workflow: Initial comprehensive assessment. “An in-person initial and comprehensive assessment is standard practice and crucial to establishing the patient-hospice relationship.”
- Will look at requirements on how this may be conducted
CONSENT

- **Kansas and Oklahoma**: Same consent rules as general services
- **Missouri**: Telehealth providers shall obtain patient’s or the patient’s guardian’s consent **before telehealth services are initiated** and shall document the patient’s or the patient’s guardian’s consent in the patient’s file or chart.
- **Medicare**: During the PHE, may be at the time of service (but see Missouri)
  - After the PHE, also needs to be prior to services (but see Kansas, Oklahoma)
- Telehealth may not be secure
- Document
PRIVACY AND SECURITY

• OCR encourages advising that “third party applications potentially introduce privacy risks”
• Patient right under Medicare to have a confidential clinical record, incorporates HIPAA
• HIPAA and right to agree or object
• Competence and surrogate decision-makers
STANDARD OF CARE

- **42 CFR 410.78(c):** Telepresenter not required unless medically necessary
- **KSA 40-2,212:** Same standards of practice for in-person services apply to telemedicine services
ACCESSIBILITY

• To what extent do hospice patients and caregivers have adequate access to non-public facing applications and internet?
Hospice physician or APRNs serving as the patient’s designated attending generally may bill for hospice services

Pre-Pandemic Coverage Restrictions in Hospice and Palliative Care
PRE-ELECTION EVALUATION AND COUNSELING

- Furnished by physician employee or med director of the hospice
- Not on the CMS list of telehealth services
• Hospice Certification: 42 CFR 418.22
  • Certifying patient is terminally with prognosis of a life expectancy of 6 months or less
  • Beginning of first 90-day period
  • Subsequent 90 day period
  • Every 60-day period after
  • **Face-to-face** if patient reaches 3rd benefit period
  • Hospice physician or APRN
  • Not a separately billable service on its own; administrative in nature
  • **Note:** Attending physician can be physician, APRN, or PA. An attending providing medically necessary service could perform certification during the visit, but Pas are not authorized to perform face-to-face encounter
    • Statutory restriction under Section 1814(a)((7)(D)(i)
  • “Nothing in statute or regulation precludes a hospice designated attending physician from furnishing services via telehealth”
• **Timing of Initial Certification:** Generally before submitting a claim
  • No more than 15 calendar days prior to effective date of an election or subsequent benefit period
• If face-to-face encounter for patient reaching 3rd benefit period is via telecommunications technology, is an administrative expense
HOSPICE CERTIFICATION, RECERTIFICATION

- Keep in mind content requirements; these don’t change with telehealth
  - For example: “If the narrative is part of the certification or recertification form, then the narrative must be located immediately prior to the physician's signature”
- Signed by medical director or physician member of IDG and hospice attending physician (see Medicare versus Missouri definitions)
HOSPICE CERTIFICATION, RECERTIFICATION

The statute is silent as to whether a face-to-face encounter solely for the purpose of Medicare hospice recertification (meaning there is no direct patient care) could be conducted via telecommunications technology by the hospice physician or NP. Given that a face-to-face visit solely for the purpose of recertification for Medicare hospice services is considered an administrative requirement related to certifying the terminal illness as required in section 1814(a)(7)(D)(i) of the Act, we believe that such visit could be performed via telecommunications technology as a result of the PHE for the COVID-19 pandemic.
HOSPICE CERTIFICATION, RECERTIFICATION

- Hospice Certification: 42 CFR 418.22
  - During a PHE, visit for the sole purpose of hospice recertification can be via telecommunications technology
  - “Telecommunications technology” means A/V
HOSPICE ATTENDING PHYSICIANS

- **19 CSR 30-35.010**: Hospice attending physician is an MD or DO (not APRN, PA)
- **OAC 310:661**: Attending physician means a doctor of medicine or osteopathy, identified by the patient or representative at the time the patient or representative elects to receive hospice care, as having the most significant role in the determination and delivery of the patient's medical care
- **Kansas**: Can be a physician, APRN, or PA
Telecommunications is permitted for many hospice services during the PHE

Flexibilities from the COVID-19 PHE
GENERAL HOSPICE CARE

- 42 CFR 418.204
  - Routine home care: hospice services can be provided via telecommunication system
  - Include on the plan of care
  - Tie to patient-specific needs as identified in comprehensive assessment
  - Describe how use of technology will achieve goals outlined in plan of care
**HH. Hospice**

1. **Question:** Can hospices furnish services using telecommunications technology during the PHE for the COVID-19 pandemic?

   **Answer:** Yes. Hospices are able to furnish services using telecommunications technology during the PHE when a patient is receiving routine home care. This can include telephone calls (audio only or TTY), two-way audio-video telecommunications technology that allow for real-time interaction between the patient and clinician (e.g., FaceTime, Skype), and remote patient monitoring. It would be up to the clinical judgment of hospice as to whether such technology can meet the patient’s/caregiver’s/family’s needs and the use of technology should be included on the plan of care for the patient and family.

   New: 5/1/20
2. **Question:** Can hospice physicians/hospice nurse practitioners conduct the required face-to-face encounter for re-certifications using telecommunications technology?

**Answer:** Hospices are allowed to use 2-way audio-video telecommunications technology that allows for real-time interaction between the patient and the clinician (e.g., FaceTime, Skype) to satisfy the face-to-face encounter requirement, which is required for the third benefit period (after the patient has typically been receiving hospice for six months) and each subsequent 60-day benefit period thereafter. An explanation of why the clinical findings from the hospice face-to-face encounter support that the patient still has a life expectancy of six months or less is required as part of the recertification narrative. We do not believe that telephone calls (audio only or TTY) would provide the necessary clinical information for a hospice physician to determine whether the patient continues to have a life expectancy of six months or less. As such, telephone calls (audio only or TTY) cannot be used to satisfy the hospice face-to-face encounter requirement.

New: 5/1/20
3. **Question:** Can hospices include services furnished using telecommunications technology on the hospice claim that it submits to Medicare for payment?

**Answer:** Only in-person visits (with the exception of social work telephone calls) are to be reported on the hospice claim submitted to Medicare for payment. For purpose of service-intensity add-on (SIA) payments, only in-person visits performed by registered nurses and social workers provided during routine home care during the last seven days of life are eligible for these add-on payments. As a reminder, the SIA payments are made above and beyond the routine home care per diem payment amount. On the hospice cost report, hospices can report the costs of telecommunications technology used to furnish services under the routine home care level of care during the PHE for the COVID-19 pandemic as “other patient care services” using Worksheet A, cost center line 46, or a subcriteria of line 46 through 46.19, cost center code 4600 through 4619, and identifying this cost center as “PHE for COVID-19”.

New: 5/1/20
4. **Question:** Can hospices complete the initial and comprehensive assessments virtually or over the phone during the PHE for the COVID-19 pandemic?

**Answer:** Assuming that the patient is receiving routine home care during the initial and comprehensive assessment timeframe, furnishing services using telecommunications technology (e.g., using two-way audio-video telecommunications technology that allows for real-time interaction between the clinician and the patient, like FaceTime or Skype, or using audio-only or TTY telephone calls), would be compliant if such technology can be used to the extent that it is capable of resulting in a full assessment of the patient and caregiver's needs to inform an individualized plan of care. The initial and comprehensive assessment are the foundation of the plan of care, laying out the patient and family needs/goals and outlining the plan for the delivery of these services. An in-person initial and comprehensive assessment is standard practice and crucial to establishing the patient-hospice relationship. During this PHE, we expect in most, but not all, situations that the initial and comprehensive assessment visits would be done in person (especially when assessing skin/wound care; uncontrolled pain/symptoms; effectively teaching patient/caregiver medication administration, etc.). The assessments must identify the physical, psychosocial, emotional,
Hospice physician or APRNs serving as the patient’s designated attending generally may bill for hospice services.

Coding and Billing: Now and on the Horizon
PROVIDER ENROLLMENT

• **During the PHE:** CMS allows providers to deliver telehealth from provider’s home without adding home address on Medicare enrollment

• **During the PHE:** If provider delivers telehealth from other location, needs to enroll with Medicare as a practice location (see applicable 855 form, Section 4)

• **After the PHE:** Awaiting guidance on permanent rules for practice location enrollment
CODING AND BILLING

• Pre-election evaluation and counseling (see 42 CFR 418.205)
  • HCPCS code G0337 Hospice Pre-Election Evaluation and Counseling Services; revenue code 0657
  • *Not on the CMS list of telehealth services*
  • Only covered once per lifetime per patient
  • Physician
  • Employee or medical director of hospice
  • Cannot be billed by attending physician or by hospice for attending’s pre-election evaluation and counseling
  • Request/referral in writing
  • Document the service
• **Hospice Certification**
  - IFC was silent on whether patients could be initially certified via telehealth
  - However, “Nothing in statute or regulation precludes a hospice designated attending physician from furnishing services via telehealth”
  - See 42 CFR 418.22 discussing certification requirements: “(iii) The narrative shall include a statement directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his/her examination of the patient.”

• **Interdisciplinary Group Services**
  - Can be via telecommunications during PHE, including audit
CODING AND BILLING

• No separate payment from per diem for hospice telehealth services
• Only in-person visits, with the exception of social work telephone calls, may be reported on the claim for purposes of the hospice claim submission. 

Richelle’s Note: implies for hospice services

• Hospices can report the costs of telecommunications technology used to furnish services under the routine home care level of care during the PHE for the COVID-19 pandemic 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”
CODING AND BILLING

• **Attending Physician Services**
  - Does not include APRNs or others not designated as attending (considered either nursing or administrative)
  - Employed by or under arrangement with hospice
  - Where the service is related to the hospice patient’s terminal illness, but was furnished by someone other than the designated “attending physician” [or a physician substituting for the attending physician] the physician or other provider must look to the hospice for payment
  - Independent attending physician submitted to Part B MAC
    - If service involves a professional/technical component, independent attending bills -26; looks to hospice for payment of -TC
    - Modifier -GV
  - If another physician covers for a hospice patient’s designated attending physician, the services of the substitute physician are billed by the designated attending physician under either the reciprocal billing or fee-for-time compensation arrangement (formerly referred to as Locum Tenens Arrangements) instructions
    - Use –GV in conjunction with –Q5 or –Q6
CODING AND BILLING

- **During the PHE**, POS where service would have been furnished if in-person (e.g. 12 patient’s home)
- **During the PHE**, use -95
- **After the PHE**, use POS 02
- **GW** – Service not related to the hospice patient’s terminal condition
ON THE HORIZON

• 2/1/22: National Hospice & Palliative Care Organization and the American Academy of Hospice and Palliative Medicine urging Congress to extend PHE flexibilities
Resources

- National Hospice and Palliative Care Organization Palliative Care Source Series, [Best Practices for Using Telehealth in Palliative Care](https://www.nhpca.org/)
- 42 CFR 418.205
- [CMS-1744-IFC](https://www.cms.gov/
- 1814(a)(7)(D)(i)
- 42 CFR 418.22
- COVID-19 Interim Final Rule With Comment Period: [CMS-1744-IFC](https://www.cms.gov/
- 20 CSR 2150-2.240
Questions?

Available Through Heartland Telehealth Resource Center for Technical Assistance
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