Centers for Medicare & Medicaid Services
Open Door Forum: Physicians, Nurses & Allied Health Professionals
Moderator: Jill Darling
January 29, 2020
2:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode until the question-and-answer session of today's conference. At that time, you may press star, 1 on your phone to ask a question. I would like to inform all parties that today's conference is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the conference over to Miss Jill Darling. Thank you. You may begin.

Jill Darling: Thank you, (Olivia). Good morning and good afternoon everyone. Welcome to today's Physician's Open Door Forum. This is the first one of the new year so happy New Year everyone. Before we get into today's agenda I have one brief announcement. This open door forum is open to everyone but if you are a member of the press, you may listen in but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at press@cms.gov.

And we'll dive right in. We have (Tom Kessler) up first who has an announcement on the new prior authorization process.

(Tom Kessler): Good afternoon. On November 12, 2019 as part of the Hospital Patient Perspective Payment System final rule a new prior authorization process for outpatient - hospital outpatient departments was established and it begins July 1, 2020.

For dates of service beginning July 1, 2020, you must request prior authorization for the following outpatient department services: blepharoplasty, Botulinum toxin injections, penniculectomy, rhinoplasty and vein ablation. Note that medical necessity documentation requirements remain the same.

In addition, we have also established a webpage dedicated to the prior authorization process for which we will actually use to communicate additional information between now and the start of the process on July 1, 2020. That webpage address was actually included as part of the agenda. And, again, the process does begin July 1, 2020. Thank you. And I'll hand it back to Jill.

Jill Darling: Great. Thanks, (Tom). Next we have (Amy Hammonds), who has open payment announcements.

(Amy Hammonds): Thank you, Jill. Hi everyone. Just a few quick updates for the open payments program. I'm sure most of you are familiar with the program but in case if you aren't, open payments is a national transparency program which requires that transfers of value by drug device and biological and medical supply manufacturers that is made to physicians or teaching hospitals be published on our public website. So operate that program.

The open payments data was just refreshed on January 17 so that is our most recent activity that we did. And this refresh includes changes to records, changes to delay in publication flags, changes to the seated records and adjustments for records that were deleted since the previous publication. So that would be any of those updates that were made after the June 2019 publication. So that's what's included in that refresh that we just did.

The reporting entities, so that's those drug and medical device companies, their reporting of the program year 2019 data will officially open on February 1 and they will have until March 31, 2020 to submit those payments to CMS. Following that submission period, there is an opportunity for physicians and teaching hospitals to review, affirm and, if necessary, dispute data that's attributed to them, and that prepublication review and dispute period is on track to take place from April 1, 2020 through May 15, 2020.

In order to take part in the prepublication review and dispute process, physicians and teaching hospitals do have to be registered within the CMS open payment system, and we have information on the open payment resources page for how to go about that registration process. It is done through the EIDM portal.

And just a real quick note on that, if you are needing to access your account or you need to register so that you can participate in that prepublication review and dispute this spring, we are having a planned system outage right now just to do some regular system maintenance and get it ready for that submission period. So I would recommend that if you need to do any kind of registration or anything like that within the system, wait until next week, the first full week of February. That way you'll have full access to that and can get into your account.

If you do have any questions or need help accessing a previously registered account, feel free to reach out to our help desk. Their phone number is 1-855-326-8366, and you can also send them an email at openpayments@cms.hhs.gov. And that's everything from me. Back to you.

Jill Darling: Thank you, (Amy). And last we have (Kelly Vontran) who will talk about the importance of diagnostic reporting and physician documentation under the patient-driven grouping model.

(Kelly Vontran): Hi. Thanks, Jill. Good afternoon everyone. My name is (Kelly Vontran) from the Division of Home Health and Hospice here at CMS. On the December Physician's Open Door Forum, I provided information on Patient-Driven Groupings Model, or PDGM, the new payment model for home health services under Medicare fee for service, which became effective for home health periods of care beginning on after January 1, 2020.

So I am summarizing that information again on today's call for those who were unable to join the December ODF. Because physicians order home health services, certify that a patient is eligible for home health, establish and review the home health plan of care, it is important for physicians to understand the new changes to the Medicare home health payment system.

Since October of 2000, home health agencies were paid under a home health prospective payment system for 60-day episodes of care adjusted for case mix and area wage differences. Under this payment system, there can be significantly higher payment if episodes of care reach certain therapy visit thresholds.

The home health payment is a bundled payment and is meant to cover all home health services, including nursing, therapy and medical supplies. The Bipartisan Budget Act of 2018 included several requirements for home health payment reform that became effective on January 1. These requirements include the elimination of the use of therapy thresholds for case mix adjustments and a change from a 60-day unit of payment to a 30-day unit of payment.

The mandated home health payment reform resulted in the PDGM. The PDGM removes the incentive to over-provide therapy and instead is designed to focus more heavily on clinical characteristics and other patient information to better align Medicare payments with patient's care needs.

In particular, 30-day periods are placed into different subgroups for each of the following broad categories. First there is the admission source, meaning whether the patient was admitted to home health from a community or institutional admission source. Next there's the timing of the 30-day period, meaning whether the period of care is the first 30-day period or a subsequent 30-day period of care.

Next there's the clinical grouping. And based on the reported principal diagnosis a home health period of care will be assigned to a clinical group representing the primary reason for home health services. So a period of care can be assigned to one of the following clinical groups. There is musculoskeletal rehabilitation, neuro/stroke rehabilitation, wounds, behavioral health, complex nursing interventions, such as total parenteral nutrition, and then finally medication management, teaching, and assessment for a variety of surgical or medical conditions.

Next there's the functional impairment level, meaning whether the patient has low, medium or high functional impairment. And finally there's a comorbidity adjustment which is based on certain reported secondary diagnoses. If these diagnoses are reported on the home health claim, a home health period of care receive either no, low, or high payment adjustment to account for the increased resource needs associated with certain comorbid conditions.

Now the role of the physician under the PDGM is important because in order for patients to receive Medicare home health services, the patient must be under the care of a physician and must be receiving home health services under a plan of care established and periodically reviewed by a physician.

Home health agencies rely on documentation from the certifying physician or the acute or post-acute care facility to confirm home health eligibility, substantiate diagnoses that are populated on the home health claim and factor into the payment amount and to help demonstrate the medical necessity of the home health services provided.

This means that accurate reporting of diagnoses by physicians will assist home health agencies in the provision of needed home health care. As I mentioned in describing the case mix variables in the PDGM, the principal diagnosis code on the home health claim will assign the home health period of care to a clinical group that explains the primary reason that the patient is receiving home health services.

Therefore, physician documentation of the patient's diagnoses plays an instrumental role in the payment amount. So for example if you refer your patient for home health services because he or she has a non-healing surgical wound, the home health claim would report that as the principal diagnosis and the home health period of care would be assigned to the wound clinical group, meaning the primary reason for home health services is the wound care. Payment would reflect the increased resource needs typically associated with the assessment, treatment and evaluation of a wound.

However, while the clinical group represents the primary reason a patient requires home health, this does not mean that this would be the only reason for home health services. The other variables in the case mix system will

account for the multi-disciplinary needs of your patients. Accurate diagnosis reporting is essential because payment rates vary between each of the clinical groups to account for the differences and resource use associated with the primary reasons for home health care.

However, certain diagnoses that are vague, unspecified or not allowed to be reported as a principal diagnosis by ICD-10 coding guidelines will not be assigned into a clinical group. Additionally, most sign and symptom diagnoses, if reported as the principal diagnosis, will not be assigned to a clinical group under the PDGM so these signs and symptoms can be reported as secondary diagnoses to more fully explain the patient's overall clinical condition.

If a home health claim is submitted with a principal diagnosis that would to be assigned to a clinical group under the PDGM, the claim would be returned to the home health agency for more definitive diagnosis coding. The reason why certain diagnoses cannot be reported as the principal diagnosis is because clinically it is important for HHAs, home health agencies, to have a clear understanding of the patient's diagnoses in order to safety and effectively furnish home health services.

Additionally, interventions for treatment aimed at mitigating signs and symptoms of a condition may vary depending on the cause. For example, common diagnoses that would not be a sign to a clinical group under the PDGM are generalized muscle weakness, other abnormalities of gait and mobility, low back pain, unsteadiness on feet and weakness. Therefore, it's important for physicians to recognize that these vague and unspecified diagnoses will not group a home health period of care because they do not clearly support a rationale for skilled services.

Additionally, reported secondary diagnoses, meaning comorbidities, factor into the case adjustment methodology under the home health expected payment system, meaning there is additional payment when certain secondary conditions are present. For example, if there is a reported secondary diagnosis of heart failure, home health payment is increased for the period of care to account for the additional resource needs associated with this condition.

Home health agencies can report up to 24 secondary diagnoses that may be eligible for additional payment under the PDGM. Therefore, complete, accurate and specific diagnosis reporting by physicians, along with clinical documentation supporting all diagnoses, is important to make sure that patient characteristics are fully captured under the PDGM and helps ensure appropriate access to needed home health services.

As I mentioned earlier, there has been a change in the unit of payment from a 60-day episode to a 30-day period. However, there are no changes to the timeframes for physicians regarding recertifying eligibility and reviewing the home health plan of care, both of which still need to occur every 60 days. Physicians are separately paid by Medicare for certification and recertification for home health services.

Because of the unit of payment is now every 30 days instead of every 60 days, home health agencies may have more frequent contact with the certifying physician, communicate any changes in the patient's condition to ensure that home health payment is adjusted to account for those changes. Furthermore, the certification and the home health plan of care must be signed timely by the certifying physician because home health agencies will submit a final claim with each 30-day period of care and they need this important signed documentation in order to build some health services.

And though payment is now made on a 30-day basis, home health services are not limited to a single 30-day period of care. An individual can continue to receive home health services for subsequent 30-day periods as long as the individual continues to meet home health eligibility criteria.

The changes to the home health care mix and the unit of payment is more patient-driven and will more accurately pay for needed home health services. Physicians will play an important role in ensuring that home health services is provided in a way that captured their patient's needs.

Thank you for your time and if you have any questions, I'll be happy to answer them at the end of this call.

Jill Darling: Great. Thank you, (Kelly). And, (Olivia), we'll please open the lines for Q&A, please.

Coordinator: Thank you. We'll start the Q&A session. If you would like to ask a question, please press star, 1, unmute your line, record your name clearly when. Your name is required to introduce your question. If you need to withdraw you question, please press star, 2. Again, to ask a question, please press star, 1 and allow a few moments for questions to come through.

And we currently have a question in queue. Actually we have two questions so far. One moment.

Mr. (Hirsh), your line is open.

Mr. (Hirsh): Hello there. I'm calling about - asking about the prior authorization process and I'm wondering if you could give us a little bit of a preview. A few questions is, one, will it be one contractor for the whole nation or will they be

separate depending on different territories? Will CMS be releasing guidelines or medical necessity rules for each of the procedures since right now there are some of the MACs have LCDs and some don't so it's really kind of a free for all.

And then how will the process be done? Will it be fax, will be it phone call, will it be electronic? I think, you know, we want to start orienting our physicians to its happening and we certainly don't want to hear about on June 30 and then have to immediately react. Thank you.

(Tom Kessler): Hi. This is (Tom Kessler). So with regard to the question about medical necessity, the program doesn't actually make any changes to medical necessity requirements so whatever is in place will be in place as of July 1, 2020. With regard to some of the other questions that you asked, again, we are going to use the website as well as things such as, you know, the open door forums to communicate that more detailed information and so I would just look for that. And certainly we appreciate the need for the information prior to June 30. Thank you.

Mr. (Hirsh): Thank you.

Coordinator: Our next question in queue is from Cherie McNett. I hope I said that correctly. Your line is open.

Cherie McNett: Yes, thank you. You said it perfectly. Hi, this is Cherie McNett. I'm with the American Academy of Ophthalmology. I also have questions about the new, Prior Auth. Program.

So one additional one that wasn't covered in the previous questions was, in the final rule it said that there would be an exemption process. And it just

simply says that, you know, some providers may be able to be exempt if they show compliance with Medicare coverage coding and payment rules.

Does that process extend to physicians also? Besides to the HOPD Departments? And if so, if you had been under rack audit and demonstrated that you had met 100% compliance, would that make you eligible to be exempt?

(Tom Kessler): So again, this is (Tom Kessler). And I will again, unfortunately have to say, for some of the information that you're asking about, we will need to post it on the Web site as we get into more details about the minutia or the exact mechanics of the exemption process.

We are not equating the exemption process to the RAC process. I can tell you that. But for the other details, we will, you know, be putting more information onto the Web site. So I would look for that detail about the exemption process in the coming months.

Coordinator: Our next question in queue is from (Jean). Your line is open.

(Jean): Hi, thank you for the good information. I am hopeful that there's someone on the call that can address the review, and verify component of the 2020 Medicare Physician Fee Schedule. That speaks to the fact that a physician, a nurse practitioner, P.A., etcetera, merely needs to document that they reviewed and verified the information on other clinicians or members of quote, "the medical team".

As to, does that supersede current requirements for evaluation and managing documentation that is very clear as to what the physician or other billing provider is required to document, uniquely on their own? Thank you.

Marge Watchorn: Good afternoon. This is Marge Watchorn with the Division of Practitioner Services. Thank you for that question. And there's enough nuance in the policy that we included in the calendar year 2020 Physician Fee Schedule final rule in that area.

But if you could, it would actually be really helpful if you could send me an email with your specific question. I don't have the other members of my here with me in the room. And I want to make sure that we get you the right answer.

(Jean): Oh, that would be so appreciated Marge. Is your email address is - I'm looking and I don't see it in the agenda I may be missing it. What is it?

Jill Darling: If you could send it in to, partnership@cms.hhs.gov we'll get it to Marge.

(Jean): Okay, so wait. Partnership@cms.hhs.gov

Jill Darling: Correct.

(Jean): All right, thank you very much. Appreciate it.

Coordinator: Our next question in queue is (Catherine Wilcheck). I hope I said that correctly. Your line is open.

(Catherine Wilcheck): You did. Thank you. (Tom) you quickly went through a list of about five services that require the authorization on 71. Could you repeat those for me? And what is the Web address for the site where we will do the authorization?

(Tom Kessler): Yes, so the items are blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty, and vein ablation. If you're going to look at the actual final rule, you would actually look to page 61464.

I am not going to try and convey the exact Web site address, because it would literally take me the rest of this call to do it. It is very lengthy. But we have put it in the agenda, and so I would just simply suggest that you go there for it.

(Catherine Wilcheck): Okay, thank you.

Coordinator: Our next question in queue is from (April Ascrola). Your line is open.

(April Ascrola): Hi. I was going to ask the same question regarding the Web site. What site do we use to submit the authorizations? I'm looking at my agenda that was forwarded to me, now, and I don't see a link.

(Tom Kessler): So in terms of submitting the Prior Authorization Request, that's what that address is for. More information about the actual mechanics will be forthcoming and placed on that Web page address.

My understanding that a revised agenda was sent out. And so it is possible that the agenda that you are looking at, is actually a prior iteration of that agenda.

So if you can, take a look for a newly issued agenda, that has the Web page address.

(April Ascrola): Okay. I will try to reach out to the personnel who sent this original invite to me, and see if I can get that. Thank you.

Gene Freund: This is Gene Freund. I did a quick Web search on CMS Prior Authorization initiatives, and there's a page that pops up pretty quickly, that does discuss prior authorization for certain hospital outpatient department services. So it's pretty easy to find.

(April Ascrola): Okay.

(Tom Kessler): Thank you (Gene).

Woman: Thank you.

Coordinator: Our next question in queue is from (Cara Gaynor). Your line is open.

(Cara Gaynor): Hi, this is (Cara Gaynor) with the American Physical Therapy Association. (Kelly), I just want to say thank you for highlighting elements of the new Home Health Payment System, and explaining the difference between the 30-day period and the 60-day episode.

As you noted, services are to be provided in accordance with the home health plan of care established, and periodically reviewed by the certifying physician. And as CMS noted in the 2020 Home Health Final Rule, CMS expects that agencies will continue to provided needed therapy services in accordance with the COPs.

Which state that the individualized plan of care must specific the care and services necessary to meet the patient specific needs as identified in the comprehensive assessment. Including identification of the responsible disciplines, and the measurable outcomes that the agency anticipates will occur as a result of implementing and coordinating the plan of care.

My question is, what is CMS' recommendation for those scenarios where a physician orders and documents a need for therapy in the plan of care, but the agency doesn't provide it.

Kelly Vontran: Hi, thanks for providing that additional context. We are currently looking into ways to communicate the agency's stand on this position. Because you're right, the COPs are pretty clear that the services need to be provided in accordance with the plan of care.

So we are collaborating with our colleagues across the agency to make sure that any identified issues or vulnerabilities are addressed. And you know, we would put them out through our usual mechanisms including through MLN Matters articles, open door forums and through the home health policy mailbox.

Coordinator: Our next question in queue is from (Julie Mueller). Your line is open.

(Julie Mueller): Hi, this is (Julie Mueller). I wanted to know, what is the appropriate to notify CMS of broken links on the CMS.gov site?

So for example, on the National Correct Coding page, all of the links for the January 1, 2020 effective dates, are broken. They appear to be trying to link to the July 2019 files, that aren't there any longer.

Jill Darling: Hi. Would you mind sending that into the Partnership email, please?

(Julie Mueller): Sure.

Jill Darling: Okay, thank you so much.

(Julie Mueller): Thank you.

Coordinator: Our next question in queue is from (Kimberly Domingo). Your line is open.

(Kimberly Domingo): Yes, our question is more related to inpatient rehab in a skilled nursing setting.

We've been getting a lot of denials from the insurance companies saying that, once a patient is on an inpatient rehab unit, that is their end. And they should return home, and are not authorizing as skilled. They say that's a CMS guideline. Can anybody touch base on that?

Jill Darling: Okay, sorry for the delay. We were just having an internal discussion. For that, could you also send that into the Partnership email?

(Kimberly Domingo): Yes.

Jill Darling: Thank you so much.

Coordinator: Our next question in queue is from (Cathy Strautman). Your line is open.

(Cathy Strautman): Hi, I apologize. I did not write down how to disconnect my question. So the question I initially had, is no longer there. But I guess what I'd like to know is, where do I find the answers to these questions that people are asking, that you're saying, oh email them to us.

Is that something that will be posted in the future here? And where would I find those answers?

Jill Darling: Yes, they will be posted in the near future. There is a process that we go through to get the transcript and the audio and the questions and answers posted.

(Cathy Strautman): Sure.

Jill Darling: On the agenda is listed - there's a link to where we post then. Our podcasts and transcripts page. And it's toward the end of - I'm sorry. It's towards the bottom of the agenda.

(Cathy Strautman): Got it. Thank you.

Jill Darling: You're welcome.

Coordinator: Our next question in queue is from Ms. (Brenda Edwards). Your line is open.

(Brenda Edwards): Hi, good afternoon. My question is about a physician ordering labs. This would be in a clinic setting. And the physician, nor no one within our practice, but certainly within his same specialty, has seen that patient before.

Is there guidance as to whether A, first of all, should a physician be ordering labs on a patient before they've seen the patient? And if they do order labs, would that in any way, preclude that physician from billing that first E&M visit then, as a new patient?

(Louisa Sabatino): This is (Louisa Sabatino) from the Provider Billing Group. I just want to make sure I clarify the very last part of that question.

So you're asking if a provider orders labs for a patient they've not ever seen before, are they still allowed to bill that as a new patient?

(Brenda Edwards): Correct. When the patient actually does come in and has that first visit, does that still qualify as a new patient visit? Since it is the first time that they're having a face-to-face contact.

(Louise Sabatino): Yes, it does. So the lab does not have an impact on whether or not the beneficiary is considered to be a new patient. The rules about being a new patient have to do with E&M visits for the same specialty in the same group, in the same three-year period.

So to the extent that it's not an E&M, right. So it's a lab or whatever it is. Then it doesn't count against that new patient-ness.

(Brenda Edwards): Okay. And so then to my first question though, is that - we're getting bogged down on the definition as to what a patient visit can or can't be, etcetera.

But so is it allowable, in Medicare's opinion, that a physician can order labs on a patient that he has not ever seen? And as a pre-visit sort of, to gather information when he hasn't actually seen that patient and is only ordering labs based off of old records or what have you. Is that allowable?

Jill Darling: Thank you for that question. We'll have to take that one. Would you mind submitting that to the Partnership email, please?

(Brenda Edwards): I can certainly do that. Yes, thank you.

Jill Darling: Thank you.

(Brenda Edwards): Mm-hmm.

Coordinator: There are no more questions in queue at this moment.

Jill Darling: All right, well thanks everyone. Really great questions. And thanks to those for sending your questions into the Partnership email. And we'll get some answers for you.

Everyone, you'll get some time back in your day. And have a great day. Thank you.

Coordinator: We have a question in queue from (April Ascrola).

(Tina): This is (Tina). And my question is, I'm on the Web site right now looking. And is there a Prior Authorization Request Form available on the Web site?

(Tom Kessler): Hi, this is (Tom Kessler). And no. Again, we have not actually provided anything regarding the specific mechanics of the process yet, since the process does not begin until July 1 of 2020.

(Tina): Okay.

(Tom Kessler): So over the next several months we'll be getting more information. And we will, as one vehicle, use that Web page to distribute pertinent information.

(Tina): Okay, perfect. Thank you.

Coordinator: There are no questions in queue at this moment. Thank you.

Jill Darling: Great. Thanks everyone. Have a great day.

Coordinator: That concludes today's conference. Participants, you may disconnect at this time. Speakers please allow a moment of silence for your post conference. Thank you.

End