CHAP Community Health Accreditation Partner

Home Health Blanket Waivers
(March 30, 2020)

The following information is based on CMS "Blanket" Waivers effective March 1, 2020 and which will end no later than when the COVID 19 PHE (Public Health Emergency) ends. "Blanket" Waivers apply to all providers noted, as opposed to waivers granted to individual companies or organizations. The regulatory language referenced in the waiver follows each statement for clarity as to the scope of the waiver.

Homebound Definition Changes with COVID 19 Patients:

- A patient is considered homebound:
  - when their physician advises that they cannot leave the home because of a confirmed or suspected COVID-19 diagnosis, or
  - if the patient has a condition that makes them more susceptible to contract COVID-19 if they leave the home.
- If a Medicare beneficiary is homebound due to COVID-19 and needs skilled services, a HHA can provide those services under the Medicare Home Health benefit.

More Practitioners Can Certify and Re-certify Home Health Eligibility and Order Home Health Care:

- A nurse practitioner (NP), or clinical nurse specialist (CNS), or a physician assistant (PA) may order home health services, establish and review a plan of care (sign the plan of care), certify and re-certify patient eligibility for Medicare home health in addition to a physician.
- HHS will not conduct audits to ensure only physicians signed during the PHE.
- Ensure that you know and act within the state practice laws for NPs, CNSs and PAs.
- NOTE: Be aware if under your state licensure law, you can accept orders from these practitioners.

Initial Assessments by Telehealth:

- CMS is waiving 42 CFR § 484.55(a), home health agencies can perform initial assessments and determine patients' homebound status remotely or by record review. Telehealth requires a live audio and video mode with the patient, telephone is not acceptable.

484.55(a) *Standard: Initial assessment visit.* Verify home bound status.
(1) An RN must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.
(2) When rehabilitation therapy service (speech language pathology, physical therapy, or occupational therapy) is the only service ordered by the physician who is responsible for the home health plan of care, and if the need for that service establishes program eligibility, the initial assessment visit may be made by the appropriate rehabilitation skilled professional.

COVID-19 Diagnostic Testing

- A home health nurse may obtain the sample for COVID-19 diagnostic testing during an otherwise covered visit of a Medicare home health patient already receiving Medicare home health services. The sample is then sent or made available for the laboratory COVID-19 testing.

Telehealth:

- HHAs can provide more services to Medicare beneficiaries using telehealth within the 30-day episode of care. The virtual visits must be included in the plan of care and specifically noted as such, for example 4 nursing visits weekly, 2 via telehealth and 2 in person.
- Telehealth does not replace needed in-person visits as ordered on the plan of care. The use of such technology may result in changes to the frequency or types of in-persons visits outlined on existing or new plans of care.

Waived On-Site HHA Aide Supervision for Medicare and Medicaid:

- Waived onsite visits for both HHA Aide Supervision: CMS is waiving the requirements that a nurse conduct or other professional to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan; and,
- This waiver also suspends 2-week aide supervision by a registered RN for home health agencies, but virtual supervision is encouraged during the period of the waiver.

  484.80(h)(1) *Standard: Supervision of home health aides.* (1)(i) If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech-language pathology services, a registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions described in §484.80(g), must make an onsite visit to the patient's home no less frequently than every 14 days. The home health aide does not have to be present during this visit.

OASIS Assessment Timing:

- The current 5-day completion requirement for the comprehensive assessment and the 30-day OASIS submission requirement are being extended. The comprehensive assessment may be completed within 30 days and delayed OASIS submission is permitted. Patients still must have an assessment to determine and be able to appropriately meet their care needs.

Medicaid Home Health Services and Equipment:

- Medicaid home health regulations now also allow non-physician practitioners to order medical equipment, supplies and appliances, home health nursing and aide services, and physical therapy, occupational therapy or speech pathology and audiology services, in accordance with state scope of practice laws. •

Requests for Anticipated Payments (RAPs):

- MACs can extend the auto-cancellation date of RAPs during the PHE. Contact your MAC.

Home Health Review Choice Demonstration Paused – IL, OH, TX

- Effective March 29, 2020, certain claims processing is *paused*.
- MACs will process claims submitted prior to March 29, 2020 under normal claims processing requirements.
- Claims for home health services on or after March 29, 2020 and before the end of the PHE in IL, OH and TX are NOT subject to the review choices made by the home health agency under the demonstration.
- MACs Claims that have received a provisional affirmative pre-claim review decision and are

submitted with an affirmed Unique Tracking Number (UTN) are excluded from future medical review.

- HHAs participating in pre-claim review may submit their claims without requesting such approval from the MAC and claims submitted without a UTN will not be stopped for prepayment review and will not receive a 25% payment reduction.
- MACS will continue to review any pre-claim review requests already submitted
- Providers may continue to submit new pre-claim review requests for review during the pause. Claims that have received a provisional affirmative pre-claim review decision and are
- The MACs will conduct post-payment review on claims subject to the demonstration that were submitted and paid during the pause.
- Review Choice demonstration will not begin in North Carolina and Florida on May 4, 2020,

Medical Claims Review:

CMS has suspended the following medical reviews for the duration of the PHE:

- most Medicare Fee-For-Service (FFS) medical review during the emergency period (MACs) under the Targeted Probe and Educate program –
    - any reviews in process will be suspended and claims released and paid.
- post-payment reviews conducted by the MACs, Supplemental Medical Review Contractor (SMRC) reviews and Recovery Audit Contractor (RAC)
    - Reviews are suspended and released
- Additional Documentation Requests (ADRs) will not be sent during the PHE pause,
    - ADRs issued before the PHE pause will be released and processed as normal. Following the end of the PHE for the COVID-19 pandemic,
- CMS may conduct medical reviews during or after the PHE if there is an indication of potential fraud.

Delaying Cost Reports:

- For the following fiscal year end (FYE) dates are extended to June 30, 2020.
    - FYE 10/31/2019 cost reports due by March 31, 2020 and
    - FYE 11/30/2019 cost reports due by April 30, 2020.
- Delaying the filing deadline of the FYE 12/31/2019 cost reports due by May 31, 2020 is extended to July 31, 2020.

Accelerated/Advanced Payment:

- An accelerated/advance payment is intended to provide necessary funds when there is a disruption in claims submission and/or claims processing. During the PHE any Medicare provider/supplier who may submit a request to the appropriate Medicare Administrative Contractor (MAC). Each MAC will work to review requests and issue payments within seven calendar days of receiving the request.
- CMS has extended the repayment of these accelerated/advance payments to begin 120 days after the date of issuance of the payment. Providers can get more information on this process here: www.cms.gov/files/document/Accelerated

Appeals - Medicare Advantage (MA) and Medicare Fee-for-Service (FFS):

- MA plans may extend the timeframe to adjudicate organization determinations and reconsiderations for medical items and services (but not Part B drugs) by up to 14 calendar days if:

  - the enrollee requests the extension;
  - the extension is justified and in the enrollee's interest due to the need for additional medical evidence from a noncontract provider that may change an MA organization's decision to deny an item or service; or,
  - the extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the enrollee's interests
- FFS MACs and QICs (qualified independent contractors). MA and Part D plans, as well as the Part C and Part D IREs may:
  - process an appeal even with incomplete Appointment of Representation forms, however, any communications will only be sent to the beneficiary; •
  - process requests for appeal that don't meet the required elements using information that is available; and,
  - to utilize all flexibilities available in the appeal process as if good cause requirements are satisfied.

- Additional Guidance • The Interim Final Rule and waivers can be found at: https://www.cms.gov/about-cms/emergency-preparednessresponse-operations/current-emergencies/coronavirus-waivers.