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Stakeholders question whether physician templates can temper face-to-face documentation burdens

Editor's note: This article is the second in a two-part series that covers the industry's continuing malcontent with face-to-face requirements in the wake of the physician narrative. In part one, which was featured in last month's issue, experts discussed providers' general qualms with the revised documentation expectations ushered in this January and offered strategies for compliance.

In February, CMS held its first in a series of special open door forums (SODF) to solicit stakeholder feedback about a pair of voluntary templates (one paper, one electronic) the agency has been developing to help physicians pen (or electronically plug in, as the case may be) more compliant face-to-face encounter documentation. CMS has succeeded in garnering ample input, though the cadence of this commentary suggests it may have fallen short in its attempts to alleviate administrative burdens for physicians and consequent threats to agencies' reimbursement: The first two SODFs were rife with questions, criticisms, and sometimes at-odds suggestions for revising the standing templates.

"[The] frustration echoed in the open door forum calls I've listened to is that there's always the balance of how to tell physicians [they] need to document in different ways, and … the templates still don't fully address what will be considered sufficient documentation," says **Serra J. Schlanger, Esq.,** associate in the healthcare and life sciences practice in the Washington, D.C., office of Epstein Becker & Green, PC, a national law firm. "How much information is really going to be enough is still going to be the ongoing question."

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STAFF TRAINING QUIZ: ANSWER KEY

1. c

2. a

3. b

4. d

Ambitious intent

The templates are CMS' response to home health agencies' repeated requests for guidance about the ill-satisfied (and recently revised) face-to-face documentation requirements, said Melanie Combs-Dyer, director of the agency's provider compliance group and moderator of the template SODF series, during the March call. Indeed, in fiscal year 2014, the Comprehensive Error Rate Testing program found that more than half of Medicare home health claims were paid improperly. Of the 1308 faulty claim lines reviewed by the contractors, approximately 90% were found to have insufficient documentation errors, the majority of which were due to inadequate support of face-to-face encounters.

In an effort to cut down on these startling error rates and to quiet outcries from the home health industry, CMS finalized its proposal to strike the physician narrative beginning in calendar year 2015. In place of the narrative—which was widely considered the most onerous component of face-to-face requirements—the agency now expects there to be sufficient evidence in the certifying physician's documentation for a patient's record (e.g., discharge summary, progress note, or visit note) to support that individual's eligibility for home health.

Although CMS touts the revised requirements as simplified, Schlanger says this claim is overstated and might have initially confused some agencies.

"CMS made a great deal out of saying, 'We're getting rid of the narrative,' and … I think while that's technically accurate, [it] might have given some providers a false sense of what is going to be required," she explains. "The same kind of information is still required now—it's just in a different place."

Despite the agency's overselling, Schlanger does acknowledge that the update has provided some relief for physicians, who need no longer articulate a patient's home health eligibility in both their progress notes and a separate narrative statement.

To further lessen the administrative load, CMS is positioning the clinical templates as viable substitutes for a physician's typical method of generating progress notes when visiting with a prospective home health patient. But a face-to-face provision in this year's final rule that allows agencies to send physicians supplementary documentation, combined with misleading language in earlier template versions and conflicting answers from officials on the March SODF, left some stakeholders baffled over who can complete the template.

Although the template is intended solely for physician documentation, a couple weeks after the March SODF, CMS issued an apology about the discrepant information provided by officials on the call, underscoring that materials supplied by an agency hoping to bolster evidence of a patient's home health eligibility in the physician's medical record will be considered during claims reviews. (For suggestions on fleshing out physician-kept records and other strategies to facilitate compliance, see part one in this article series.)

In addition to haziness surrounding the purpose of the templates, stakeholders say CMS is overestimating how much time, energy, and study physicians are willing—or able—to dedicate to home health–specific documentation.

"We're continuing to be concerned about the level of documentation for home health in relationship to other things that physicians order," says **Constance F. Row, LFACHE,** executive director of the American Academy of Home Care Medicine (AAHCM), an Edgewood, Maryland–based association for physicians and other health professionals who provide home-based primary medical care. "For most busy physicians who don't have that many patients who need home health … our fear is that they just won't go near these forms."

In addition to these taxing expenditures, Schlanger says the templates seem to demand some peculiar foresight from physicians, who must anticipate which patients will require home health services prior to a visit and remember to swap out their typical progress note template for the setting-specific alternative.

"You're almost asking people to identify ahead of time what kind of note they should be filling out based on whether [they] think [a patient] will need home health services or not, and I'm just not sure that's realistic or even particularly feasible," Schlanger explains.

Electronic template should be dynamic, interoperable

In addition to these general concerns, stakeholders point to a number of attributes distinct to either the electronic or paper template that may hamper future utility.

The electronic version, a joint venture by CMS and the Office of the National Coordinator for Health IT, has been in the works for over a year and will eventually be changed from its current form—a three-page PDF containing checklists of predetermined clinical elements for defending home health eligibility—into dynamic electronic health record (EHR) fodder with skip capability for more streamlined documentation, said Combs-Dyer during the March call. However, she also acknowledged the process could take years, based on today's sluggish progress in developing and piloting EHR infrastructure to support a template for ordering power mobility devices.

But some experts say time won't be the only barrier to producing a successful final product.

"[The template] is much too complicated and doesn't necessarily fit with the EMRs [electronic medical records] that physicians often have," Row explains. "Administrative simplification is what needs to be done here, and at the moment, CMS seems to be going in the opposite direction."

Row says that AAHCM and other physician groups have been sending CMS targeted suggestions for simplifying the template and its EHR translatability. For example, she suggests arranging clinical items into drop down menus and including explanations of all setting-specific eligibility requirements.

Based on such feedback, CMS has already added a prominent box in the latest electronic and paper drafts that specifies Medicare's criteria for homebound status—which often tops the list of face-to-face compliance issues due to insufficient justification for said status in physician documentation.

And this isn't the only template revision CMS has made based on stakeholder input. For all the shortcomings experts see in the current drafts, some also acknowledge that the agency has made big strides since it rolled out the first iteration of the electronic template, which was a staggering six pages long.

"I looked at it, and I was almost crying," says **Nicola Kelly, RN,** owner of Coastal Home Health Solutions in Palm Beach Gardens, Florida. Kelly says that after this shaky start, she's been encouraged by CMS' efforts to slim the template.

If CMS can manage to accommodate more of the needs voiced by stakeholders, Kelly believes the electronic template could become a useful tool to help home health agencies stay compliant, ward off audit slip-ups, and ultimately protect reimbursement by providing physicians with some much-needed direction.

"I think [the template can] help the physicians paint a clearer picture of the patient," she explains. "Physicians like to be led into what they have to write, and that's what it basically does."

She's also a fan of CMS' increasing use of check boxes on the template, recalling how the feature facilitated easy EHR documentation during her days as a hospital nurse.

In addition to such functionality, Row stresses that

the EHR version of the home health template—as well as the templates made for ordering services in other settings—needs to emphasize interoperability and standardization. This focus would complement today's legislative pushes to foster more cohesion and comparability along the continuum (e.g., the IMPACT Act); in addition, a standardized resource would facilitate compliance and efficiency among physicians, who would be less likely to trip over template quirks unique to individual settings and services.

For example, Row says the formatting for the definition of homebound on the home health template should align with that of setting-specific definitions on other current and prospective electronic templates.

"Whatever it is [that] has to be met, the criteria, the terminology, the way it's presented and everything else ought to be as simple as possible and as straightforward and as uniform as possible across settings," she explains, adding that the template should also accommodate other common payer sources (e.g., Medicare Advantage, Medicaid) and their distinct claims requirements.

Calls for conflicting features on paper template

Although less difficult to actualize, the future of the electronic template's paper counterpart is also less certain. CMS is still weighing stakeholder input to determine whether to eventually finalize this version.

CMS launched the paper template's development after that of the electronic iteration to accommodate providers without EHR systems. The agency released the first draft of the prospective template last month and a second version—significantly revised based on feedback provided during and after the first SODF—prior to the March call.

"The changes are pretty astounding," says Schlanger. But they are also a mixed bag, highlighting the difficulty in balancing the industry's clashing demands for brevity and detailed guidance.

The first draft of the paper template contained a combination of checklists and open areas for longer form elaboration—features that aligned it closely with past versions of the electronic template. However, in an effort to diminish stakeholders' alarm over the intimidating length of the original draft, CMS slashed its page count from five to just over one, swapping out its clinical element lists for fill-in-the-blank sections—both necessary moves, says Schlanger.

"Once a paper form is more than a back and a front, nobody is going to fill it out completely, so in that case, I think it's easier to incorporate check boxes into an electronic format," she explains. Other experts echo this view, citing the impracticality of unwieldy checklists on a paper document.

However, with the template's more approachable appearance comes a sparse, open-ended format that Schlanger says may stop short of conveying home health's unique documentation needs.

"The new version of the paper format that they've given [is] not really tempered to home health services," she explains. "At the moment, it doesn't seem as though it gives any more guidance about what [information] should go in certain areas."

In addition, the paper template's new leeway may be uncomfortably reminiscent of the scanty direction offered during the narrative era.

"Sometimes what the physician had written in face-to-face [narrative] documentation appeared to [make it] very plain that the patient needed [home health] services, yet when you sent the face-to-face in on a medical review, it was denied," says **DeAnn Briscoe, BSN, RN, COS-C,** senior education consultant at Foundation Management Services, Inc., a Denton, Texas–based education and services provider for homecare and hospice professionals. "So sometimes it would leave me wondering, 'What exactly do they want us to write, short of the physician writing a short novel on why the patient is homebound or requires home health services?' "

To prevent these unexpected denials in today's post-narrative environment, Briscoe would like to see CMS include more predetermined language on the paper template.

"CMS would … have options of what language exactly they want used," Briscoe explains. "They're giving suggestions, but sometimes it's not realistic, and sometimes it hasn't been clear to the industry … exactly what they want written."

In an effort to accommodate stakeholders' vying needs, Combs-Dyer floated the possibility of developing

two paper templates: a shorter, open-ended version and a longer alternative that contains more guiding language.

Consult current templates, but use caution

Because the face-to-face templates have changed so dramatically between drafts, Schlanger advises agencies against integrating them into everyday operations until their contents are more stable.

"We've seen pretty considerable changes between the varying templates, so I don't know that rushing to roll out these templates to physicians would necessarily provide comfort that … an agency is going to be in compliance," she explains.

However, Schlanger notes that even in their unfinished form, the templates can still provide key insights into the level and type of information CMS expects to find in face-to-face documentation.

"The more drafts that we see and the more conversations that we have gives a better indication—or at least some indication—about what [CMS officials] are looking for, and what their thought process is," she says.

Consequently, Schlanger urges providers to review each draft release, paying special attention to which items change and which stay the same between iterations. In particular, she points to the definition of homebound as an important (and most likely enduring) addition to both template versions that agencies should emphasize to their referral sources.

While the templates are still in flux, providers are left to process this year's documentation requirement changes without definitive guidance—which highlights the need for agencies to build strong relationships and open communication lines with partnering physicians, says Schlanger.

"Home health agencies really do need to work with their providers and their referring physicians to make sure the correct information is in those physician records," she says. "Figure out a good way to work with support staff and the physicians to make sure the records are reviewed and incorporated."

Once these connections are established, Schlanger recommends asking physician office contacts for all relevant documentation at the time of each patient's home health admission. This practice can help agencies gauge whether there's sufficient support of eligibility in the medical record and get a jump start on filling in any gaps before the threat of financial penalties comes into play.

"I think the industry has figured out … at some point, they're going to keep getting audit requests," Schlanger says. "Providers probably don't want to wait for their first audit request and a deadline to figure out their process for getting records from their physicians."

Coding corner

Digesting the terminology needed to code digestive conditions in ICD-10

Editor's note: "Coding corner" is a monthly column written by ***Joan L. Usher, BS, RHIA, ACE, COS-C,*** *an AHIMA-approved ICD-10-CM trainer and president & CEO of JLU Health Record Systems in Pembroke, Massachusetts. To submit coding questions or a topic for discussion, email Associate Editor Delaney Rebernik at* drebernik@hcpro.com.

Although there are no official coding guidelines for the "Diseases of the Digestive System" chapter in the ICD-10 manual, this does not mean that coding in this realm is simple. In fact, coding certain digestive conditions will require greater clinical detail than in ICD-9. Read on for in-depth explorations of two such cases.

Example #1: Crohn's disease

Crohn's disease (also known as regional enteritis) is an inflammatory bowel condition that can cause a wide variety of symptoms and afflict any part of the gastrointestinal system. When coding for Crohn's disease (K50.-), the location of the specific bowel(s) affected needs to be identified (i.e., small intestine, large intestine, or both intestines). In addition, complications of the condition (i.e., rectal bleeding, intestinal obstruction,