



Repeal or Reform the Physician Face-to-Face Encounter Requirement for Home Health

Background: As a condition of payment for Medicare home health coverage, Section 6407 of the Affordable Care Act of 2010 (ACA) establishes that a patient must have a face-to-face (F2F) encounter with the physician who certifies the need for home health services. The encounter also can be provided by certain non-physician practitioners, such as physician assistants and nurse practitioners, and it must occur no more than 90 days prior to the home health start-of-care date or within 30 days after the start of care. However, when a non-physician practitioner provides the encounter, the patient's physician must still certify that the encounter occurred and compose documentation detailing the finding from the encounter in addition to any documentation produced by the non-physician practitioner.

While we support the intention behind Section 6407 – which was to increase the need for direct encounters between patients and physicians – we are perplexed as to why the U.S. Centers for Medicare and Medicaid Services (CMS) chose to implement this rule using arcane documentation methods.

Prior to billing Medicare home health services, home health agencies have long been required to obtain a signed and dated form from the physician which outlines the full plan of care. This comprehensive form, known as the 485 form, includes the complete plan of home care outlined by the physician. A separate face-to-face documentation process is largely duplicative of this existing plan-of-care procedure.

CMS's implementation of the F2F encounter rule has led to great confusion among physicians, home health agencies, and other parties involved. CMS has tried to mitigate the confusion in various ways, but the requirements remain difficult to understand and apply. As a result, the rule is creating an access-to-care barrier as practitioners find that it is easier to care for patients in alternative settings to home health care.

In 2014, the National Association for Home Care and Hospice (NAHC) filed a lawsuit challenging one particular aspect of the rule – a requirement that physicians complete a “narrative” to document eligibility for home health and the occurrence of an F2F encounter. CMS subsequently eliminated this physician narrative component – but not the rule itself – in the 2015 home health prospective payment system final rule, effective January 1, 2015. However, the narrative requirement remains in place for all claims between April 2011 and December 31, 2014. This leaves HHAs vulnerable to extended claims reviews for years to come under an unmanageable standard now abandoned by CMS which has acknowledged the difficulties imposed by its now-former narrative documentation approach.



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Now, in place of the narrative, CMS is requiring that physicians have sufficient documentation in their own files to support the certification of a patient's homebound status and skilled care need. Yet CMS has not issued adequate guidance on how HHAs are to comply with this new requirement.

Both under the original standard – requiring a physician narrative – as well as the new standard, the HHA is not in control of the documentation, yet it suffers the risk of a payment denial. Further, the subjectively technical requirements on documentation pose the likelihood of claim denials on patients who are, in fact, homebound and in need of skilled care.

Furthermore, Medicare beneficiaries who are homebound or, even worse, bedbound have faced additional access-to-care burdens, especially in rural or remote areas. Many have not been able to travel to their doctor's offices to satisfy the face-to-face requirement.

HCA's Recommendations: HCA urges Congress to repeal the face-to-face provision and devise more constructive ways to secure physician involvement in home health care. If repealing the face-to-face regulations is too onerous, we strongly urge Congress to require CMS to do the following:

- Revise the requirements to eliminate or significantly modify the physician documentation requirements as set out in the Medicare rule to eliminate the need for a physician to spell out why the patient's clinical condition requires Medicare covered home health services or to maintain sufficient documentation in their own files.
- Have CMS modify this requirement so the F2F mandate can be met through the completion and collection of the separately signed and perhaps modified 485 form.
- Establish exceptions to the requirements for patients who have been recently discharged from an inpatient setting, individuals in rural areas where access to a physician or non-physician practitioner is limited, and individuals for whom a physician attests to the patient's inability to leave the home for a physician encounter and is unable to have a physician perform a home visit.
- Provide financial protection to home health agencies that admit a patient in good faith with the reasonable expectation that a qualified F2F encounter has or will occur on a timely basis with appropriate documentation that is compliant with Medicare standards in the event of noncompliance through no fault of the home health agency.
- Allow a non-physician practitioner to perform the encounter, certify that the encounter occurred, and compose all necessary documentation of the findings from the encounter.

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