Home Care Face-to-Face Mandate

A Major Problem, A Simple Fix

THE POLICY

Under a provision of the Affordable Care Act (ACA), a home care provider cannot bill Medicare for services to a home health patient until the provider has obtained a signed narrative from the physician indicating that the patient had a face-to-face encounter with that physician 90 days prior to the start of home care or 30 days after the start of home care. As part of this certification, physicians must also document several detailed clinical findings in order to support the need for home care services, **duplicating** many CMS requirements that already exist for documentation of home health services using the 485/plan-of-care form (see next page).

THE PROBLEM

The vast majority of doctors and home care providers are conducting and documenting these mandated face-to-face encounters in good faith. **Unfortunately Medicare is denying payment for thousands of home health services based largely on documentation technicalities** that have more to do with format than substance, and that have nothing to do with the appropriateness of care.

The face-to-face requirement essentially **expects doctors to duplicate clinical documentation that the physician already provides** in the '485' form or plan-of-care. This form has long been a required piece of documentation for authorization of home care services. But with the advent of the face-to-face rule, **physicians must now essentially rewrite elements of the 485/plan-of-care form as a separate, signed narrative –** even though the plan-of-care already meets most elements of the face-to-face requirement and could itself be used, instead of duplicated, to meet the face-to-face mandate. According to a nationwide home care provider survey, **52% of face-to-face claim denials resulted mainly from Medicare determining that the physician documentation was insufficient,** even though medically necessary care was provided.

Even the federal Office of the Inspector General (OIG) has weighed in on this problem. It found that physicians are experiencing difficulty in compliance with the cumbersome requirements, recommending a more uniform method for physicians to document face-to-face. The OIG report did not indicate that claims were fraudulent in any way, or that patients did not receive services – only that the onerous and duplicative narrative report was inadequate to meet CMS standards.

Seventy-five Members of Congress also agree with the home health industry, stating in a bipartisan letter that the "complicated, confusing and overlapping documentation requirements … exceed the intent of the law passed by Congress."

Clearly the current requirements have placed undue limitations on access to care for the vast majority of Medicare beneficiaries whose clinical conditions are, without question, supported by the Medicare benefit and whose need for home care is explicitly demonstrated in the 485/plan-of-care.

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A SIMPLE FIX

This face-to-face problem is complex, **but the solution is simple**. The 485/plan-of-care form already documents: a patient's need for home care services; the patient's eligibility for home care services; the clinical findings that support this determination; the physician's medical orders for care; the physician's signature; and more. A simple notation could be included on the 485 form or plan-of-care to provide a physician's certification that he or she has had a face-to-face encounter with the patient, rather than require a whole rewriting of the 485/plan-of-care as a 'narrative.'

The existing 485 Form/plan-of-care already…

Certifies the need for home care services and confirms the patient's homebound status

26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan and will periodically review the plan.

Signed by Physician

Lists the patient's medications, diagnoses, functional limitations, mental status, ambulation issues, and more – clearly indicating the need for home care and the appropriateness of Medicare services.

11.ICD-CM 42830	Principal Diagnosis DIASTOLIC HF NOS	Date 090712 E	ASPIRIN 81 mg TABLET 1 tab ORAL Daily
12.ICD-CM N/A	Surgical Procedure	Date	CALCIUM + D 600 mg calcium (1,500 mg)-100 CAPSULE 1 ORAL 2 times daily
13.ICD-CM 49121 4168 4019 V462	Other Pertinent Diagnoses OCB W EXACERBATION CHR PULMON HEART DIS HYPERTENSION NOS DEPENDENCE ON SUPPL	Date 090712 E 090712 E 090712 E 090712 O	ADVAIR DISKUS 250 mcg-50 mcg/Dose DISK W/DEV 1puff INHALATION 2 times daily (See Addendum)

14.DME and Supplies: Has - Wheeled Walker Has -(See Addendum)	15.Safety Measures: 1 - Establish emergency plan 2 -(See Addendum)
16.Nutritional Req.: 2 - Low(See Addendum)	17.Allergies: NKDA

18.A. Functional Limitations				18.B. Activities Permitted			
1 Amputation	5 Paralysis	9 Legally Blind		1 Complete Bedrest	6 Partial Weight Bearing	A Wheelchair	
2 Bowel/Bladder (Incontinence)	6 X Endurance	A Dyspnea With Minimal Exertion		2 Bedrest BRP	7 Independent At Home	B Walker	
3 Contracture	7 X Ambulation			3 X Up As Tolerated	8 Crutches	C No Restrictions	
4 Hearing	8 Speech	B Other (Specify)		4 Transfer Bed/Chair	9 Cane	D Other (Specify)	
				5 Exercises Prescribed			
19.Mental Status:	1 X Oriented	3 X Forgetful		5 Disoriented	7 Agitated		
	2 Comatose	4 Depressed		6 Lethargic	8 Other		

Signed by Physician

What more is needed?

NAHC and The Forum of State Home Care Associations recommends simply adding language to the 485/plan-of-care where the physician can certify the face-to-face encounter in place of a separate narrative. This can be accomplished in a single line of Congressional legislation:

> *"Physician documentation of the face to face encounter shall consist solely of a simple and concise confirmation that such encounter occurred and that is provided by notation on the same plan of care document the physician signs to order the home health services required by the patient."*