

**Medicare's Proposed Home Health Rule for 2015:
CMS Suggests Only Limited Relief to the
Face-to-Face Encounter Documentation Requirements but
Continued Compliance Burdens on Home Health Agencies**

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On July 7, 2014, the Centers for Medicare & Medicaid Services ("CMS") published proposed changes to the Medicare Home Health Prospective Payment System ("HH PPS") for calendar year 2015 ("Proposed Rule").¹ The Proposed Rule would update the HH PPS payment rates effective January 1, 2015, including continued implementation of the rebasing adjustments as required by the Affordable Care Act ("ACA").² CMS projects that these proposed payment rate changes would result in overall payment reductions to home health agencies ("HHAs") of \$58 million, or 0.30 percent. CMS proposes a number of additional changes, including recalibration of the home health case-mix weights and changes to the home health quality reporting program requirements that would establish a minimum submission threshold for the percentage of OASIS assessments that an HHA must submit each reporting period. CMS is also asking for comments on a home health value-based purchasing model that it is considering testing in certain states beginning in 2016.³

The Proposed Rule would also make significant changes to the physician face-to-face encounter requirements for HHA reimbursement. CMS claims that the changes would "simplify" the face-to-face encounter documentation requirements through elimination of the physician narrative requirement; however, CMS will expect the information formerly contained in the physician narrative to be documented in the medical record of the

¹ CMS-1611-P, 79 Fed. Reg. 38,366 (proposed July 7, 2014).

² Patient Protection and Affordable Care Act of 2010, Pub. L. 111-148, *as amended* by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 (collectively referred to as the "Affordable Care Act"), § 3131(a).

³ CMS has published a Fact Sheet summarizing all of the changes included in the Proposed Rule, which is available at <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-07-01.html>.

certifying physician or the discharging facility. To incentivize physicians to supply sufficient documentation, CMS proposes to deny the physician's claim for certification or re-certification if the HHA claim is denied due to insufficient documentation to support beneficiary ineligibility. Yet, the Proposed Rule fails to provide any clarity as to what will constitute "sufficient" documentation. As a result, even with these proposed changes, HHAs will continue to bear both the risk of financial loss from denied claims and the burden of assuring that the certifying physician "sufficiently" documents the beneficiary's eligibility to receive services under the Medicare home health benefit. ***Public comments to the Proposed Rule are due by September 2, 2014.***

Current Face-to-Face Encounter Documentation Requirements

The ACA amended the requirements for physician certification of patient eligibility for home health services to mandate that, prior to certifying a patient's eligibility for the home health benefit, the physician must document that the physician himself or herself, or an allowed non-physician practitioner ("NPP") had a face-to-face encounter with the patient.⁴

Current CMS regulations implementing the face-to-face encounter requirement state that:

The physician responsible for performing the initial certification must document that the face-to-face patient encounter, which is related to the primary reason the patient requires home health services, has occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care by including the date of the encounter, and including an explanation of why the clinical findings of such encounter support that the patient is homebound and in need of either intermittent skilled nursing services or therapy services[.]⁵

This "explanation" is commonly referred to as the physician narrative requirement. HHAs have been required to comply with the face-to-face encounter documentation requirements since April 1, 2011.

CMS explained in the Proposed Rule that the face-to-face encounter requirement was enacted, in part, to "discourage physicians certifying patient eligibility ... from relying solely on information provided by the HHAs when making eligibility determinations."⁶ CMS also stated that the goal of the ACA provision was "to achieve greater physician accountability in certifying a patient's eligibility and in establishing a patient's plan of care."⁷

⁴ Affordable Care Act § 6407(a). Current CMS regulations also allow for the physician who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health care, to perform the face-to-face encounter. See 42 C.F.R. § 424.22(a)(1)(v)(A)(2).

⁵ 42 C.F.R. § 424.22(1)(a)(v) (emphasis added).

⁶ 79 Fed. Reg. at 38,371–38,372.

⁷ *Id.* at 38,374–38,375.

Concerns Voiced Regarding CMS's Implementation of the Physician Narrative Requirement

Despite CMS's intentions to foster greater input and accountability from physicians, HHAs and physicians alike have faced significant challenges in understanding and meeting the face-to-face encounter documentation requirements, particularly those for the physician narrative. CMS noted in the Proposed Rule that the FY2013 improper payment rate for home health services, as determined by the Comprehensive Error Rate Testing ("CERT") Program, was 17.3 percent (as compared to the national Medicare fee-for-service improper payment rate of 10.1 percent).⁸ The majority of these improper payments were due to insufficient documentation, primarily errors related to the physician narrative portion of the face-to-face documentation.

2014 HHS OIG Study

The Department of Health and Human Services, Office of Inspector General ("OIG"), also published a study regarding compliance with Medicare's home health face-to-face documentation requirements.⁹ The study found that for 32 percent of home health claims, the documentation did not meet Medicare requirements, either due to missing face-to-face documents or face-to-face documents that lacked at least one of the required elements.¹⁰ The OIG also found that physicians inconsistently completed the narrative documentation requirements, while conceding that HHAs have no authority to compel physicians to complete and sign the face-to-face encounter documents.

The OIG, therefore, recommended that CMS consider requiring a standardized form to assist physicians with including all the elements required for documenting the face-to-face encounter. The OIG also recommended that CMS develop a strategy to communicate directly with physicians about the face-to-face documentation requirements, noting that the home health Medicare Administrative Contractors ("HH MACs") are not directly training the physicians because their provider outreach responsibility does not extend to physicians.

Concerns Raised by the Home Health Industry

In addition to the documentation compliance struggles identified by the OIG, the home health industry has raised multiple concerns regarding the implementation and enforcement of the physician narrative requirement, which CMS noted in the Proposed Rule.¹¹ HHAs have voiced concern that CMS has not provided adequate, reasonable,

⁸ 79 Fed. Reg. at 38,375–38,376.

⁹ DEP'T OF HEALTH & HUMAN SERVICES, OFFICE OF THE INSPECTOR GENERAL, OEI-01-12-00390, LIMITED COMPLIANCE WITH MEDICARE'S HOME HEALTH FACE-TO-FACE DOCUMENTATION REQUIREMENTS (April 2014) [hereinafter OIG REPORT].

¹⁰ *Id.* at 8. The OIG found that 10 percent of the claims were missing face-to-face documentation, while 25 percent of the claims were missing at least one required element of the documentation. *Id.*

¹¹ 79 Fed. Reg. at 38,376.

and clear guidance regarding what constitutes “sufficient” physician narrative documentation. Also, the HH MACs have inconsistently interpreted the existing guidance, something also noted by OIG.¹² HHAs have expressed frustration that their reimbursement is tied to compliant physician documentation without incentives in place to encourage physician compliance. Concerns have also been raised that the physician narrative requirement is excessive and redundant because evidence to support the physician’s certification is available in the clinical records. Finally, the industry has argued that CMS exceeded its statutory authority in requiring the physician narrative when the ACA provision simply mandates that the certifying physician document that a face-to-face encounter occurred.

The ongoing home health industry frustration recently culminated in the filing of a lawsuit by the National Association for Home Care & Hospice (“NAHC”) challenging the physician narrative requirement.¹³ Prior to filing, NAHC requested that CMS suspend retroactive reviews of physician narratives until it eliminates the requirement from its regulations.¹⁴ CMS did not meet this request, but informed NAHC that it planned to issue possible revisions to the narrative requirement in an upcoming proposed rule. NAHC filed its lawsuit after it determined that “it was not in the best interest of the home health community [to] take a chance on the possibility of a proposed rule that might provide some undefined change in the requirements which would take effect no earlier than late October” given the “endless series of claims denials” HHAs are experiencing.¹⁵

CMS’s Proposed Changes to the Face-to-Face Physician Narrative Requirement

In light of these concerns, CMS is proposing to eliminate the physician narrative requirement from 42 C.F.R. § 424.22(a)(1)(v).¹⁶ The certifying physician will still be required to certify that a face-to-face encounter related to the primary reason that the patient requires home health services occurred no more than 90 days prior to the start of home health services or within 30 days after the start of the home health care and was performed by a physician or allowed NPP. The certifying physician will still also be required to document the date of the encounter as part of the certification.

The Proposed Rule also states that in determining a patient’s eligibility to receive services under the home health benefit, CMS will review “only the medical record for the patient from the certifying physician or the acute/post-acute care facility (if the patient in that setting was directly admitted to home health) used to support the physician’s certification of patient eligibility.”¹⁷ If the medical record used by the physician in certifying eligibility is not “sufficient” to demonstrate that the patient was eligible for

¹² OIG REPORT, *supra* note 8, at 12. For example, although CMS allows physicians to use forms with checkboxes in limited situations, some HH MACs do not accept any forms with checkboxes. *Id.*

¹³ Nat’l Ass’n for Home Care & Hospice, Inc. v. Sebelius, 1:14-cv-00950 (D.D.C. 2014)

¹⁴ NAHC Press Release, June 6, 2014, available at http://www.nahc.org/NAHCReport/nr140605_1/.

¹⁵ *Id.*

¹⁶ 79 Fed. Reg. 38,376. The physician will still be required to document a narrative when the physician orders skilled nursing visits for management and evaluation of the patient’s care plan. *See* 74 Fed. Reg. 58,111 (Nov. 10, 2009).

¹⁷ 79 Fed. Reg. at 38,419.

home health services, CMS will not pay for the home health services rendered. In addition, the Proposed Rule provides that a physician's claims for certification/recertification will not be covered if the HHA's claim is denied due to insufficient documentation to support the patient's eligibility for home health services. This change will not be promulgated by regulation; instead, CMS plans to implement this proposal through future sub-regulatory guidance.

Finally, the Proposed Rule would clarify when a face-to-face encounter is required. CMS has previously issued guidance stating that a face-to-face encounter is required for "initial episodes" (*i.e.*, the first in a series of episodes separated by no more than a 60 day gap). CMS is proposing to clarify that the face-to-face encounter is required for certifications, and not recertifications, rather than initial episodes. CMS is also proposing to clarify that a certification is considered to be any time that a new start of care OASIS is completed to initiate care.¹⁸

What the Proposed Changes Would Mean for HHAs, Physicians, and Other Stakeholders

While CMS has said that the Proposed Rule is intended to simplify the face-to-face encounter documentation requirements, reduce the burden for HHAs and physicians, and mitigate instances where physicians and HHAs unintentionally fail to comply with certification requirements, the Proposed Rule does not go far enough to meet these aims. Even though CMS would remove the physician narrative provision, it would still require the physician's or facility's records to document the information currently required in the physician narrative (*i.e.*, the clinical findings that demonstrate that the patient is homebound and in need of intermittent skilled nursing services or therapy services). What's more, CMS still has not provided any guidance to assist HHAs or physicians in understanding what constitutes "sufficient" documentation of the patient's eligibility to receive home health services.

The Proposed Rule, therefore, does little to resolve the ongoing tension between HHAs and physicians over sufficient documentation. As described above, patient eligibility for home health services will continue to be entirely dependent upon the content and quality of documentation completed by physicians, which HHAs have limited ability and authority to control. The Proposed Rule's attempt to create a financial incentive for physicians to sufficiently document patient eligibility may prove unsuccessful because the reimbursement for a physician's certification claim is fairly insignificant.¹⁹ Therefore, the level of risk shared between the HHA and the physician would continue to be disproportional: the physician's insufficient documentation may cost him or her reimbursement for a single certification claim, whereas the same insufficient documentation may cost the HHA payment for a 60-day episode of home health care services, which can exceed \$2,300.

¹⁸ *Id.* at 38,377.

¹⁹ The identified codes for the physician certification and recertification visits are G0179 and G0180.

In addition to not adequately addressing the home health industry's concerns, CMS does not sufficiently address the concerns raised in the OIG's study. The Proposed Rule ignores the OIG's recommendation that CMS develop a standardized form to clarify the required elements for documenting the face-to-face requirement. Similarly, the Proposed Rule does not include a strategy for CMS to communicate the face-to-face encounter documentation requirements directly with physicians.

Perhaps as important as any changes made on a going-forward basis, the Proposed Rule does not provide HHAs with any relief or clarity regarding claims that have been submitted or will be submitted before the proposed changes would go into effect in January 2015. Similarly, the Proposed Rule does not provide any relief or clarity for claims that are currently under review and appeal. All of these claims remain subject to denial for insufficient documentation.

Proposed Legislative Changes

While the NAHC litigation remains relevant, there are also efforts being made to achieve a legislative fix to the physician narrative requirement. NAHC and the Forum of State Home Care Associations have suggested an amendment to section 6407 of the ACA that would provide that "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."²⁰ In essence, the amendment would modify the CMS Form 485 plan of care ("CMS-485") to include language allowing the physician to certify that he or she performed a face-to-face encounter to evaluate the patient's eligibility for home health services. NAHC has noted that the CMS-485 already requires the physician to certify the patient's need for home care services and confirm the patient's homebound status, and includes a listing of the patient's medications, diagnosis, functional limitations, mental status, and ambulation issues. Since the physician is already required to complete the CMS-485, the addition of fields or language to capture the occurrence of the face-to-face encounter would not additionally burden the certifying physician. The use of the CMS-485 for documenting the face-to-face encounter would also provide clarity to physicians and HHAs as to the documentation needed in order to avoid claim denials.

Conclusion

The CMS physician narrative component of the face-to-face encounter documentation requirements is ripe for change. Both HHAs and physicians should expect some degree of change to occur with the final rule, which is expected to be released in October. Since the Proposed Rule does not address all of the concerns surrounding the physician narrative requirements, HHAs, physicians, referring facilities, and other interested stakeholders should consider submitting comments to CMS. ***Any interested party can submit comments on the Proposed Rule until 5:00 p.m. on September 2,***

²⁰ *Major Problem, Simple Fix*, National Association for Home Care & Hospice, available at <http://www.hca-nys.org/documents/HomeCareF2FComplexProblemSimpleSolution.pdf>.

2014. Epstein Becker Green attorneys have extensive experience in thinking creatively and strategically about conceptualizing and drafting comments.

Stakeholders should also monitor the NAHC litigation as well as any legislative efforts, in order to best plan for any potential changes to the physician narrative requirement or to the face-to-face encounter requirement, more broadly.

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For additional information about the issues discussed in this Client Alert, please contact one of the authors or the Epstein Becker Green attorney who regularly handles your legal matters.

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