CMS Q&A: Face-to-Face Requirements

The below questions and answers were taken directly from the Centers for Medicare and Medicaid Services' Website and repurposed for this easy-to-use handout. Visit www.cms.gov or www.VNAA.org for more information.

Question: Could you clarify CMS’ policy about the homebound status of home health patients who can drive?

Answer: The Benefit Policy Manual (Internet-Only Manual 100-02, Chapter 7, Section 30.1.1) explains in detail what it means to be homebound. While we have excerpted portions below, please see the manual for full details. “In order for a patient to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician certify in all cases that the patient is confined to his/her home. An individual does not have to be bedridden to be considered confined to the home. However, the condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving home would require a considerable and taxing effort. If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive healthcare treatment.” A patient’s homebound status is not violated by attendance of religious services or attendance at a State licensed, State certified, or State accredited medical adult day care center. “Occasional absences from the home for non-medical purposes, e.g., an occasional trip to the barber, a walk around the block or a drive, attendance at a family reunion, funeral, graduation, or other infrequent or unique event would not necessitate a finding that the patient is not homebound if the absences are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the healthcare provided outside rather than in the home.” In addition to the information given in our Benefit Policy Manual, we have also addressed this question in a response to an inquiry back in April of 2003. We responded to the query with the following information: “Homebound status is determined on an individual basis, looking at the patient as a whole. If the net effect of driving indicates that the individual has the capacity to get their healthcare routinely outside of the home, then it could challenge their eligibility. The fact that a patient is fit enough to drive raises questions as to whether the basic statutory requirement is met. Because individual circumstances can vary greatly, necessitating determinations on a case-by-case basis, we are reluctant to issue a specific policy that relates to driving in every possible occurrence. Inherent in such a policy would be judgments about the particular circumstances under which it may be appropriate for an individual
to operate a motor vehicle. We believe that such determinations must continue to be made on a case-by-case basis.”

**Question:** Is the face-to-face encounter requirement effective only for patients admitted to home health.....

**Answer:** Yes, that is correct. We have interpreted the language in the statute to apply only to certifications and not recertifications.

**Question:** What effect does the face-to-face requirement have on agency practices for meeting Medicare requirements.....

**Answer:** Long-standing Medicare regulations have described the distinct content requirements for the plan of care and certification. The Affordable Care Act (ACA) requires the face-to-face encounter as an additional certification requirement. Many providers have implemented the requirements for the plan of care and certification by using one form, which meets all the content requirements of both the plan of care and certification. This approach is perfectly acceptable and it will continue to be acceptable. Several years ago, CMS ceased to require that providers use a specific form for the plan of care and/or certification. Providers have the flexibility to implement the content requirements as best makes sense for them.

**Question:** Do both the plan of care and the certification have to be signed by the same physician?

**Answer:** Prior to Calendar Year 2011, CMS manual guidance required the same physician to sign the certification and the plan of care. Beginning in Calendar Year 2011, CMS will allow additional flexibility associated with the plan of care when a patient is admitted to home health from an acute or post-acute setting. For such patients, many asked that CMS allow the contact between the physician who attended to the patient during an acute or post-acute stay to satisfy the encounter requirement, even when the physician may not follow the patient in the community. The commenters asked CMS to allow such physicians to inform the community certifying physician as the law allows non-physician practitioners (NPPs) to do. We are limited by the law that requires the certifying physician to document that the encounter occurred with himself or herself, or a permitted NPP. To adopt as much flexibility as the law allows, we will allow physicians who attend to the patient in acute and post-acute settings to certify the need for home healthcare based on their face-to-face contact with the patient (which includes documentation of the face-to-face encounter), initiate the orders (plan of care) for home health services, and "hand off" the patient to his or her community-based physician to review and sign off on the plan of care. As we described above we continue to expect that in most cases the same physician will certify, establish and sign the plan of care. But, the flexibility exists for home health post-acute patients if needed.
Question: The final rule references homebound status and skilled need. Is the documentation of the clinical findings.....

Answer: The documentation must include the certifying physician's synthesis of how the patient's clinical condition, as seen during the encounter, supports that the patient is homebound and needs skilled services.

Question: Can you please clarify the hospitalist's role?

Answer: The statute requires that the certifying physician must document that the face-to-face encounter occurred with himself or herself, or certain non-physician practitioners (NPPs) who inform the certifying physician. Where the patient is admitted to home health from acute or post-acute care, we believe that current practice associated with the home health certification would apply to the face-to-face encounter as well. In most cases, we would expect the same physician to refer the patient to home health, order the home health services, certify the beneficiary's eligibility to receive Medicare home health services, and sign the plan of care. It would be this physician who would be responsible for documenting on the certification that he or she, or a NPP working in collaboration with the certifying physician, had a face-to-face encounter with the patient. However, we recognize that, in some scenarios, one physician performing all of these functions may not always be feasible. An example of such a scenario would be a patient who is admitted to home health upon hospital discharge. While we would still expect that in most cases, a patient's primary care physician would be the physician who refers and orders home health services, documents the face-to-face encounter, certifies eligibility and signs the plan of care, there are valid circumstances where this is not feasible for the post-acute patient. For example, some post-acute home health patients have no primary care physician. In other cases, the hospital physician assumes primary responsibility for the patient's care during the acute stay, and may (or may not) follow the patient for a period of time post-acute. In circumstances such as these, it is not uncommon practice for the hospital physician to refer a patient to home health, initiate orders and a plan of care, and certify the patient's eligibility for home health services. In the patient's hospital discharge plan, we would expect the hospital physician to describe the community physician who would be assuming primary care responsibility for the patient upon discharge. We also believe that with growing prevalence of NPPs in the acute and post-acute care settings, NPPs may increasingly collaborate with the community-certifying physician regarding the NPP's encounter with the patient in the acute and post-acute settings.

Question: Can the homecare agency title a document with a lead-in phrase such as: I had a face-to-face encounter on.....

Answer: The lead-in phrase is acceptable as long as the physician completes the description of how the clinical findings support homebound status and the
Question: Is the face-to-face required for patients in Medicare Advantage plans?

Answer: No, the face-to-face provision applies only to Medicare fee for service.

Question: May physicians use their own electronic medical records with drop down menus to select from prepared descriptive language when completing the face-to-face encounter ..... 

Answer: Yes. The regulation requires that the certifying physician document how the encounter supports the patient’s homebound status and need for skilled services. We allow the documentation to be either on the certification or as a signed addendum to it. This allows the sort of flexibility where such documentation could be dictated by the physician to one of his support personnel, or to allow it to be generated by the physician's electronic medical record software. Such is common practice for physicians to document their patient encounters.

Question: If the required information is contained in physician documentation, such as a discharge summary from an acute care episode.....

Answer: No. The face-to-face encounter documentation must be included as part of the certification form itself, or as a signed addendum to it and it must include the certifying physician's synthesis of how the patient's clinical condition, as seen during the encounter, supports that the patient is homebound and needs skilled services.

Question: Can the physician document the certification when the physician or hospitalist has the patient’s record in front of him?

Answer: Yes. As long as the face-to-face encounter occurs in the specified timeframe of 90 days prior to the start of care or 30 days after the start of care and the documentation is completed before billing, this scenario is acceptable.

Question: Will documentation of an encounter submitted via an electronic portal and electronic signatures....

Answer: Yes, that is fine. However, it is important to reiterate that the documentation must be part of the certification itself, or an addendum to it.

Question: Can an HHA obtain and record verbal orders regarding the required encounter information.....

Answer: No. We believe that a verbal communication by the physician to the HHA regarding the encounter, where the HHA would then document the
certification and get the physician to sign it, does not satisfy the statutory mandate that the certifying physician must document the encounter.

**Question:** Can a physician certify a patient’s eligibility and document the face-to-face encounter based on information received from another physician.....

**Answer:** No. The law mandates that either the certifying physician, or certain non-physician practitioners (NPPs) who inform the certifying physician can perform the face-to-face encounter. A patient's encounter with an attending physician during an acute stay does not satisfy the requirement unless the attending physician is also the physician who certifies eligibility. However, certain NPPs in the acute care setting may collaborate with the certifying physician. In such cases, an NPP’s encounter with the patient during an acute or post-acute stay may satisfy the requirement.

**Question:** What happens if the certification isn’t documented before a patient is discharged?

**Answer:** We are assuming the question relates to short stay patients. The HHA should treat this scenario as they always have when the patient's care plan goals have been met but the certification is not yet complete.

**Question:** If a facility physician completes the encounter documentation and the community physician completes the plan of care.....

**Answer:** The physician who certifies may bill Medicare for physician certification.

**Question:** Will there be an exceptional circumstance whereby an encounter did not occur but the situation was out of the control of the agency.....

**Answer:** The face-to-face encounter is an additional content requirement associated with the certification. Agencies should deal with the above-described situations as they always have when such occur prior to obtaining a completed, signed certification. Refer to Section 10.11, Chapter 7, Pub. 100-02.

**Question:** Since the HHABN Option Box 1 does not apply, does Option Box 2 (discontinue services for agency business reasons)....

**Answer:** The HHABN, Form CMS-R-296, has been approved by the Office of Management and Budget (OMB) to provide limitation of liability protections to Original Medicare beneficiaries receiving home health services under section 1862(a)(1)(A) of the Act for care that CMS or its contractors determines is not reasonable and necessary under Medicare; section 1862(a)(9) of the Act, for custodial care; section 1862(g)(1)(A) of the Act, for care when the beneficiary is not homebound; and section 1862(g)(1)(B) of the Act, for care provided to a beneficiary who is not in need of skilled nursing care. The HHABN must
not be used to transfer liability to the beneficiary when technical requirements for payment, such as a face-to-face encounter, are not met. The HHABN is not approved for this use. A beneficiary is not financially liable if the certification is incomplete.

**Question:** If a patient has a face-to-face encounter on day 33 after the start of care, will the HHA be denied...

**Answer:** If the certification content requirements are not complete, the agency cannot bill.

**Question:** Will subsequent episodes be covered if face-to-face requirements are not met timely during the first episode?

**Answer:** The face-to-face encounter requirement is necessary for the initial certification, which is a condition of payment. Without a complete initial certification, there cannot be subsequent episodes.

**Question:** Can a resident conduct the face-to-face encounter?

**Answer:** Only the certifying physician or certain NPPs can perform the face-to-face encounter. Additionally, only Medicare-enrolled physicians can certify home health eligibility, per the Affordable Care Act.

**Question:** HHAs, and consultants to HHAs, are looking for guidance as of how to handle patients whose episodes fall into the outlier category. What are HHAs to do with such patients?

**Answer:** As stated in the final rule, CMS is sensitive to the concerns voiced by the industry with regards to insulin dependent diabetes mellitus (IDDM) receiving diabetes management support as well as the support and disease management needs of patients with chronic diseases such as other types of diabetes, CHF, and wound care. CMS is sympathetic to the fact that some beneficiaries who need help administering insulin. As noted in the final rule, in our view, there is no reason to expect a large number of insulin patients unable to treat themselves would all be utilizing a single provider, and this is, in fact, generally the case in all areas of the country except those with sever program integrity issues. Our analysis shows us that approximately 70 percent of HHAs receive between 0 and 1 percent in outlier payments. That being the case, we find it highly suspicious that outlier claims could legitimately be as high of a percentage as we are seeing in certain areas of the country. Suspicious, excessive billing of outlier claims is the reason behind the new outlier policy that includes the 10% cap. As we explained in the final rule, when we account for the areas in which there exist program integrity concerns with suspicious billing activities the vast majority of the remaining home health agencies have outlier dollars below 10 percent of their total home health payments and thus will not be affected by the new...
outlier policy. In fact, after excluding HHAs in areas of the country where fraudulent billing practices are suspected, we expect that less than 2% of all Medicare HHAs will be affected by the 10% cap on outlier payments and of that less than 2% of HHAs, almost all are located in urban areas where beneficiaries have other choices. We also expect that the ability of HHAs to receive up to 10% of their total payment in outliers would partially compensate HHAs for the care associated with this subgroup of beneficiaries. The outlier policy in the HH PPS was NEVER intended to fully compensate HHAs for episodes that incur unusually high costs due to patient home healthcare needs. Rather, the intent of the outlier policy is to mitigate the negative financial impact that unusually high cost patients have on HHAs. We believe that our final outlier policy for CY 2010, that includes a 10% per-agency cap on outlier payments, is consistent with that intent. Under Medicare’s home health benefit, HHAs are expected to provide education and training to help IDDM (and other diabetic) patients self-manage their diabetes. Many homebound patients with diabetes require short-term management for skilled observation, assessment, teaching, and training activities. If the patient is unable to learn to self-manage, including self-administer medication, the HHA would be expected to provide the teaching and training to a caregiver or family member. There will always be a subgroup of patients who cannot learn self-management, do not have a willing and able caregiver, and/or have no community support. However, as already stated, our analysis shows that to be a very small percentage of beneficiaries (when excluding areas of the country where fraudulent billing practices are suspected). We also encourage HHAs to take advantage of the help and support available from organizations such as the American Diabetes Association, the Indian Health Service, and the American Association of Diabetic Educators regarding innovative techniques associated with diabetes self-management training (DSMT). Collaborating with these organizations may allow HHAs to achieve greater success in enabling patients and/or their caregivers to better achieve self-management, and may provide the HHAs with innovative care suggestions regarding their patients. CMS believes that its final outlier policy for CY 2010, that includes a 10% cap on outlier payments at the agency level, in concert with a new 2.5% outlier pool (as opposed to the existing 5 percent outlier pool), and returning 2.5% back into the rates, along with a reduction in the fixed dollar loss (FDL) ratio from 0.89 to 0.67, to be the appropriate policy at this time. As with the implementation of any new policy, CMS will continue to monitor for any unintended consequences that this new policy may cause. Similarly, through monitoring of the HH PPS, if CMS finds that the new CY 2010 outlier policy is not effective and/or achieving our goals, an alternative (as discussed in both the proposed and final rules) would be to eliminate the outlier policy altogether (in future rulemaking).

**Question:** What is the effective date of the new outlier policy? In other words, what determines if a given claim is subject to the new outlier policy?

**Answer:** The new outlier policy communicated in the HH PPS Rate Update for CY
2010 (CMS-1560-F) is a CY 2010 policy, and thus applies to claims paid at the CY 2010 rates. Posted on CMS' website, on the home health agency center page at: http://www.cms.hhs.gov/center/hha.asp, CMS has communicated that final instructions (via the normal Change Request/Transmittal process) describing the changes that will be made by Medicare contractors to implement this new outlier policy are currently being developed and are expected to be released sometime in early December.

HHAs should note that HH PPS billing instructions are not changing as a result of this policy. CMS will provide an update as to the status of those instructions at our next Open Door Forum (ODF) on Wednesday, December 2nd. On that same page of the CMS website, under the section entitled, "How to Stay Informed", there are links to 1) the web page where the public can sign up to be on the HH PPS mailing list (called our listserv). The same information posted to our website, was also sent out via an announcement using this listserv, and 2) the web page where folks can learn how to sign up and participate in our Open Door Forum for Home Health, Hospice, & Durable Medical Equipment.

The direct link to information on the Open Door Forums is: http://www.cms.hhs.gov/OpenDoorForums/17_ODF_HHHDME.asp

The direct link to information on the upcoming December 2 ODF is: http://www.cms.hhs.gov/OpenDoorForums/Downloads/H3DME120209.pdf