REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (I-12)
Face-to-Face Encounter Rule
(Resolutions 813-I-11, 716-A-12 and 723-A-12)
(Reference Committee J)

## EXECUTIVE SUMMARY

At the 2011 Interim Meeting, the House of Delegates referred Resolution 813, which was introduced by the Indiana Delegation. The Board of Trustees assigned this resolution to the Council on Medical Service for a report back to the House of Delegates at the 2012 Interim Meeting. Resolution 813-I-11 asked that our American Medical Association (AMA) work to establish a unique billing code (G code) for completion of the face-to-face encounter form and reimbursement for the code, and investigate the possibility of incorporating the questions required for the face-to-face encounter into a new modified form 485 for the sake of simplicity and efficiency. The resolution specified that this new modified form should also have a higher level of reimbursement than the current form 485.

At the 2012 Annual Meeting, the House of Delegates referred two additional resolutions that addressed the face-to-face encounter requirement for certification of eligibility for Medicare home health services. Resolution 716-A-12, introduced by the Michigan Delegation, asked "that our AMA work with the Centers for Medicare and Medicaid Services (CMS) to study alternatives to the requirements for face-to-face interaction to certify the need for home health care services to better address the issue of patients who could benefit from these services but who may not be able to present at the doctor's office because of severity of illness or short time interval between the discharge process and obtaining an appointment at a busy office." Resolution 723-A-12, introduced by the Arizona Delegation, asked "that our AMA seek, through all appropriate means, to require that the provider who actually discharges the patient from the hospital, rehabilitation facility or nursing home to home health care is responsible for completing the face-to-face encounter form." The Board of Trustees assigned these resolutions to the Council so that they could be addressed as part of its report for the 2012 Interim Meeting.

The Council recognizes that payment for complex administrative services, including the face-to-face encounter requirement, remains insufficient for many physicians and their practices. The Council recommends that the AMA work with CMS to ensure that physicians understand the alternative means of compliance with Medicare's face-to-face encounter policies and related payment policies, continue to work with CMS to educate home health agencies on the face-to-face documentation that is required as part of the certification of eligibility for Medicare home health services, and continue to monitor legislative and regulatory proposals to modify Medicare's face-to-face encounter policies and work to prevent any new unfunded mandatory administrative paperwork burdens for practicing physicians.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-I-12

Subject: Face-to-Face Encounter Rule
(Resolutions 813-I-11, 716-A-12 and 723-A-12)

Presented by: Donna E. Sweet, MD, Chair

Referred to: Reference Committee J
(Veronica K. Dowling, MD, Chair)

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> That our American Medical Association work to establish a unique billing code (G code) for completion of the face-to-face encounter form and reimbursement for the code; and
>
> That our AMA investigate the possibility of incorporating the questions required for the face-to-face encounter into a new modified form 485 for the sake of simplicity and efficiency. This new modified form should also have a higher level of reimbursement than the current form 485.

At the 2012 Annual Meeting, the House of Delegates referred two additional resolutions that addressed the face-to-face encounter requirement for certification of eligibility for Medicare home health services. Resolution 716-A-12, sponsored by the Michigan delegation, asked "that our AMA work with the Centers for Medicare and Medicaid Services to study alternatives to the requirements for face-to-face interaction to certify the need for home health care services to better address the issue of patients who could benefit from these services but who may not be able to present at the doctor's office because of severity of illness or short time interval between the discharge process and obtaining an appointment at a busy office." Resolution 723-A-12, introduced by the Arizona Delegation, asked "that our AMA seek, through all appropriate means, to require that the provider who actually discharges the patient from the hospital, rehabilitation facility or nursing home to home health care is responsible for completing the face-to-face encounter form." The Board of Trustees assigned these resolutions to the Council so that they could be addressed as part of its report for the 2012 Interim Meeting.

This report provides background on the face-to-face encounter requirement for Medicare home health services, outlines options for completing face-to-face encounter documentation, highlights billing and payment issues associated with the face-to-face encounter requirement, summarizes relevant AMA policy, and presents policy recommendations.

BACKGROUND

Section 6407 of the Patient Protection and Affordable Care Act (ACA) established a face-to-face encounter requirement for certification of eligibility for Medicare home health services. Under such certification of eligibility, a Medicare participating physician must certify that:

- The patient needs or needed home health services because they are or were confined to the home;
- The patient needs or needed skilled home health services on a sporadic basis;
- A physician has established and reviewed a plan of care; and
- The patient is or was under the care of a physician when home health services are or were provided.

The Medicare face-to-face encounter requirement for home health services is one of the major face-to-face requirements of the Medicare program. The following table highlights the key Medicare face-to-face requirements with their intervals, including existing home health, hospice, and durable medical equipment requirements.

Key Medicare Face-to-Face Requirements and Intervals

| Medicare Face-to-Face Requirement | Interval |
|---|---|
| Home health services | For initial certification of the home health benefit, face-to-face encounter is required to occur within the 90-day period prior to the start of care, or within 30 days after the start of care. |
| Hospice | Must have face-to-face encounter no more than 30 days prior to the 3rd benefit period recertification. For every recertification thereafter, there must be a face-to-face encounter with the patient no more than 30 days prior. |
| Durable Medical Equipment (DME) | The ACA requires that an order for certain DME must be written by a physician or non-physician provider who has had a face-to-face encounter during the 6 months prior to the written order for each item or during such other reasonable timeframe as specified by the Secretary. Proposed regulations issued by the Centers for Medicare and Medicaid Services proposed that a face-to-face encounter must occur no more than 90 days before the order is written or within 30 days after the order is written. (Proposal does not include prosthetic devices, orthotics, and prosthetics that require a written order before delivery.)*<br><br>For power mobility devices, a face-to-face encounter must occur within the 45-day period prior to the supplier receiving the written prescription, and before such device is delivered. |

*CMS Proposed Rule CMS 1590-P. "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013." Posted July 7, 2012.

As noted in the table, the face-to-face encounter for certification of eligibility for Medicare home health services is required to occur within the 90-day period prior to the start of care, or within 30 days after the start of care. Of note, face-to-face encounter documentation is only required for the initial certification of the home health benefit. After a 60-day period, physicians must decide whether to recertify the patient for another 60 days.

Under this new requirement, physicians need to certify and document that they, or a non-physician provider with whom they work, have seen their patients in need of home health services, including through a telehealth service. Specifically, the ACA allows for the following non-physician providers to perform the face-to-face encounter with a patient:

- A nurse practitioner or clinical nurse specialist, collaborating with the physician as outlined in state law;
- A certified nurse-midwife as authorized by state law; and
- A physician assistant, who may, under the supervision of the physician, perform the face-to-face encounter and inform the certifying physician, who would then document the encounter as part of the certification of eligibility.

In subsequent rulemaking, as part of the calendar year (CY) 2012 home health prospective payment system (PPS) final rule, the Centers for Medicare and Medicaid Services (CMS) added that the physician who cared for the patient in an acute or post-acute facility, and who had privileges in such a facility, could also perform the face-to-face encounter and inform the certifying physician. The certifying physician would then document the encounter as part of the certification of eligibility. In addition, as part of its proposed rule addressing the home health PPS rate update for CY 2013, hospice quality reporting requirements, and survey and enforcement requirements for home health agencies, CMS proposed to allow a non-physician provider in an acute or post-acute facility to perform the face-to-face encounter in collaboration with or under the supervision of the physician who has privileges and cared for the patient in the acute or post-acute facility. The collaborating/supervising physician would then be allowed to inform the certifying physician of the patient's homebound status and need for skilled home health services.

Educational materials on the face-to-face encounter requirement, including "Home Health Face-to-Face Encounter Questions & Answers" of CMS and a MLN Matters® article, can be found on the AMA website at www.ama-assn.org/go/regrelief.

OPTIONS FOR COMPLETING FACE-TO-FACE ENCOUNTER DOCUMENTATION

Resolution 723-A-12 sought to require that the provider who actually discharges the patient from the hospital, rehabilitation facility or nursing home to home health care be responsible for completing the face-to-face encounter form. The Council notes that such a change in requirements would make the policy addressing the face-to-face encounter requirement more stringent. Current policy does not define the specific physician who should perform or certify the face-to-face encounter. The change proposed in Resolution 723-A-12, by specifying the particular physician who needs to perform or certify the face-to-face encounter, would therefore limit the physicians who could complete the face-to-face encounter documentation. Such a policy change also may restrict the ability of some physicians to order home health services. For example, if a patient of a primary care physician is admitted to the hospital, the primary care physician may rely on other physicians who have hospital privileges, including hospitalists, to care for the patient while admitted, and discharge the patient from the hospital. However, after the patient is discharged from the hospital, it may be the primary care physician who orders the home health care. The primary care physician may see the patient face-to-face within the 90-day period prior to the start of care, or within 30 days after the start of care – thus fulfilling the current face-to-face encounter requirements – even though the primary care physician is not the physician who cared for the patient in or discharged the patient from the hospital. The change proposed in Resolution 723-A-12 may prevent the primary care physician from being able to order home health services for the patient.

Resolution 716-A-12 sought to ensure that the face-to-face encounter process does not impede access to home health services by patients who are not able to present at the doctor's office because of severity of illness or short time interval between the discharge process and obtaining an appointment at a busy office. Under current law and regulations, there are options through which the face-to-face encounter requirement can be fulfilled:

- The patient's discharge summaries could be used by the certifying physician as documentation of the face-to-face encounter if they otherwise meet the requirements for face-to-face encounter documentation, including being clearly titled as face-to-face encounter documentation.
- The certifying physician may use documentation of a face-to-face visit that occurred during the 90-day period prior to the start of home health care services to fulfill the face-to-face encounter requirement, thereby removing the need for an additional face-to-face encounter with the patient after discharge.
- The certifying physician could conduct a house call to fulfill the requirements of the face-to-face encounter, which is a covered service under Medicare.
- As authorized under state law, a nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant collaborating with or under the supervision of the physician could perform the face-to-face encounter, either in the office or at the patient's place of residence, and then the certifying physician could then document the encounter as part of the certification of eligibility.

BILLING AND PAYMENT FOR THE FACE-TO-FACE ENCOUNTER REQUIREMENT

Resolution 813-I-11 presumed that physicians are required to complete a unique face-to-face encounter form to satisfy the requirements of the face-to-face requirement. However, as a result of AMA advocacy, CMS does not require a particular form or format to be used to document the face-to-face requirement for home health services.

The regulatory text governing the face-to-face encounter requirement states that "the documentation of the face-to-face encounter must be a separate and distinct section of, or an addendum to, the certification, and must be clearly titled, dated and signed by the certifying physician." For patients admitted to home health following an acute or post-acute stay, the plan of care form, Form CMS-485, can satisfy the face-to-face encounter requirement if it includes an addendum containing the face-to-face encounter documentation requirements (e.g., include a brief narrative that supports the patient's homebound status and need for skilled services) signed by a physician who cared for the patient in the acute or post-acute setting, as long as all content requirements of the certification and face-to-face documentation are otherwise met. Discharge summaries may be used by the certifying physician as documentation of the face-to-face encounter if they otherwise meet all the documentation requirements for face-to-face documentation and are clearly titled and dated as face-to-face documentation.

The Indiana State Medical Association (ISMA) was invited to provide additional information to the Council concerning referred Resolution 813-I-11. In its response to the Council, ISMA stated that although clarifications have been made to the face-to-face encounter requirement, the review and certification of the face-to-face encounter still require additional time and cognitive effort on the part of certifying physician. Specifically, the ISMA made the following additional requests:

- Create unique billing codes (G codes) for review and certification of the face-to-face encounter that would be billed in conjunction with the appropriate code for care plan oversight.
- If separate G codes for review and certification are not developed, then increase payment for care plan oversight (G0181 and G0182) to reflect the additional work related to the face-to-face encounter.

In evaluating the new request by ISMA, the Council notes that "review" is not a service that is typically covered for separate payment. "Review" typically describes the review of test(s) results as a part of the larger medical decision-making process that is one of the three key components of an E/M service. Also, "certification" is an action that is not typically reported by Current Procedural Terminology (CPT®) codes, except in places like code 99080 (for special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form). Completion of brief standard reports, including return to work forms and hospital discharge summaries, are not reported separately, including the forms described in the nursing facility assessment codes. In addition, the Council notes that the AMA does not advocate directly for the creation of G codes. AMA Policy H-70.919 states that "the CPT Editorial Panel is the proper forum for addressing CPT code set maintenance issues and all interested stakeholders should avail themselves of the well-established and documented CPT Editorial Panel process for the development of new and revised CPT codes, descriptors, guidelines, parenthetic statements and modifiers."

Currently, physicians may bill Medicare for certifying and recertifying all patients that are eligible for the Medicare home health benefit. Code G0180 is used when a physician certifies an initial plan of care for a home health patient, and code G0179 is used when a physician recertifies a home health patient for a subsequent episode of care. Recertification must occur every 60 days. Physicians may also submit claims for care plan oversight services provided to qualifying patients (i.e., those with complex, multidisciplinary care needs requiring 30 minutes or more of care plan oversight within a calendar month).

The performance of a face-to-face encounter typically requires a minimum of two of the three key components of an E/M service: history, exam, and medical decision-making. These services are typically reported with E/M codes based upon the site of service in which they are performed.

If physicians need to make a house call for a face-to-face visit, there are mechanisms through which they can be paid by Medicare as part of regular E/M codes. Physicians can use codes 99341-99350 for new patients in their private homes and codes 99324-99337 for domiciliary care facilities, such as assisted living facilities. Care plan oversight services for patients under the care of a home health agency are reported with codes 99374-99380.

AMA POLICY

With respect to payment for more complex documentation and certification, Policy H-385.984 states that when more complex administrative services are required by third parties, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage, it is the right of the physician to be recompensed for his incurred administrative costs. Policy H-70.953 states that the AMA will work to assure that physicians are not subjected to excessive and unreasonable documentation requirements when ordering laboratory services, home health and durable medical equipment and/or when justifying a CPT code. Policy H-210.981 recognizes the importance of removing economic, institutional and regulatory barriers to physician house calls, and urges CMS

to consider the adoption of criteria and methods that will strengthen the physician's role in authorizing home health services, as well as how such criteria and methods can be implemented to reduce the paperwork burden on physicians. Policy H-330.936 urges CMS and other payers to require that durable medical equipment and home health and other outpatient medical services be ordered by the physician responsible for the patient's care, with appropriate documentation of medical necessity, before such services are offered to the patient or family. Policy D-160.945 advocates for timely and consistent inpatient and outpatient communications to occur among the hospital and hospital-based providers and physicians and the patient's primary care referring physician; including the physician of record, admitting physician, and physician-to-physician, to decrease gaps that may occur in the coordination of care process and improve quality and patient safety.

DISCUSSION

Physician responsibilities associated with fulfilling the face-to-face requirement for certification of eligibility for Medicare home health services are part of a much larger concern that physicians have with being paid for a variety of administrative responsibilities, such as filling out forms and certifications. The Council recognizes that payment for complex administrative services, including the face-to-face requirements highlighted in this report, remains insufficient for many physicians and their practices. Policy H-385.984 reiterates the right of physicians to be compensated for more complex administrative services. Also important is that physicians understand the alternative means of compliance with Medicare's face-to-face encounter policies and related payment policies. The Council believes it will be imperative for the AMA to continue to monitor legislative and regulatory proposals to modify Medicare's face-to-face encounter policies and work to prevent any new unfunded mandatory administrative paperwork burdens for practicing physicians.

The Council recognizes that communication between hospital-based physicians and primary care physicians is essential in the processes of performing and certifying the face-to-face encounter, to ensure that patients are able to access the home health services they need. In that light, the Council believes that the AMA needs to continue to advocate for timely and consistent inpatient and outpatient communications to occur between the hospital and hospital-based providers and physicians and the patient's primary care referring physician, including the physician of record, admitting physician, and physician-to-physician, as outlined in Policy D-160.945.

There is also a need to ensure that the process of certifying eligibility for Medicare home health services is streamlined and that physicians are not required to fill out unnecessary forms to document the face-to-face encounter. The Council is cognizant that many physicians are being required by home health agencies to complete a variety of different forms as part of the certification of eligibility for Medicare home health services. In particular, some home health agencies are requiring physicians to complete extra forms to meet the face-to-face requirement, whereas the face-to-face documentation can be simply included on the certification itself or appear on a separate addendum to the certification. Therefore, the Council believes there is a need for the AMA to work with CMS to continue to educate home health agencies on the face-to-face documentation that is required as part of the certification of eligibility for Medicare home health services.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 813-I-11, Resolution 716-A-12 and Resolution 723-A-12, and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-385.984, which supports payment for complex administrative tasks required by third-party payers. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy D-160.945, which advocates for timely and consistent inpatient and outpatient communications to occur among the hospital and hospital-based providers and physicians and the patient's primary care referring physician to decrease gaps that may occur in the coordination of care process and improve quality and patient safety. (Reaffirm HOD Policy)

3. That our AMA work with the Centers for Medicare and Medicaid Services (CMS) and appropriate national medical specialty societies to ensure that physicians understand the alternative means of compliance with and payment policies associated with Medicare's face-to-face encounter policies, including those required for home health, hospice and durable medical equipment. (Directive to Take Action)

4. That our AMA work with CMS to continue to educate home health agencies on the face-to-face documentation required as part of the certification of eligibility for Medicare home health services to ensure that the certification process is streamlined and minimizes paperwork burdens for practicing physicians. (Directive to Take Action)

5. That our AMA continue to monitor legislative and regulatory proposals to modify Medicare's face-to-face encounter policies and work to prevent any new unfunded mandatory administrative paperwork burdens for practicing physicians. (Directive to Take Action)

Fiscal Note: Staff cost estimated at less than $4,580 to implement.

References are available from the AMA Division of Socioeconomic Policy Development.