PUBLICATION

CMS Proposes Relief for HH Face-to-Face and Therapy Reassessment Requirements [Ober|Kaler]

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We recently reported on the difficulties faced by home health agencies (HHAs) in complying with the documentation requirements for the face-to-face (F2F) encounter between a patient and a physician before or shortly after admission to the HHA, which is a condition of payment. We also indicated a lawsuit had been filed on behalf of the industry to invalidate this requirement. Now, it appears that CMS has heard the complaints and is proposing relief.

As part of the CY 2015 proposed rule for the HH PPS [PDF], CMS is proposing to eliminate the requirement that the physician compose a narrative to explain how the clinical findings from the encounter with the patient support the conclusion that the patient is eligible for home health services – i.e., that the patient is homebound and in need of one or more skilled services. CMS agrees with the industry that there should be sufficient evidence in the medical record to support that physician's certification that the patient is home bound and in need of skilled services without the need for the physician to write an additional narrative. The physician still has to certify that he/she has seen the patient within 90 days prior to HHA admission or within 30 days after admission, and must specify the date of the encounter.

As part of this proposal, when conducting a medical review to determine whether the patient is eligible for HH services, the CMS contractors would review the physician's medical record. As an incentive for physicians to be sure that their medical records support the patient's homebound status and need for skilled services, CMS is also proposing that physician claims for certification/recertification eligibility would not be eligible to be paid if the home health claim is denied because the physician's record does not support the patient's homebound status or need for skilled care.

CMS has also proposed these changes:

- Clarifying that the F2F encounter applies only to the initial physician certification (not recertification) – i.e., any time a new start of care assessment is needed.
- Replacing the requirement for therapy reassessments at or close to the 13th and 19th visits with a requirement for a therapy reassessment every 14 days.
- Implementing the second year of the 4-year rebasing process.
- Using a blended wage index (50% current Office of Management and Budget (OMB) area designations and 50% revised OMB area designations).
- A 2.2 percent market basket adjustment.
- For OASIS submissions for the reporting period July 1, 2015-June 30, 2016, setting an initial compliance threshold of 70 percent for the number of OASIS assessments that each HHA must submit to avoid a two percent reduction in their annual payment update. This will increase by 10 percent each of the next two years to a maximum threshold of 90 percent.
- Revising the condition of participation (CoP) for the qualifications for speech language pathologist personnel.
- Testing a Value-Based Purchasing model for HHAs in five to eight states.
- Soliciting comments on possible coverage restrictions on nursing visits made solely for insulin injections.

- Revising the scope of review in ALJ hearings regarding the imposition of civil monetary penalties for CoP violations.

Ober|Kaler's Comments

Assuming the rule is finalized as proposed, HHAs will no longer have to struggle to have physicians write extra narratives to support the patients' eligibility for HH services. While CMS did not explicitly refer to the recently filed lawsuit by the industry, it is clear that the months of industry complaints led to this proposed relief. This change is not without risk for the HHAs, however, as they will now be totally dependent on the physician's own clinical records to substantiate the homebound status and need for skilled services. Nevertheless, HHAs should be pleased that CMS has made this proposal.

HHAs must, however, continue to comply with the current requirements for the F2F narrative until such time as the proposed change becomes final and effective.