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The Affordable Care Act included a provision which simply required that a physician document that the physician or a non-physician practitioner had a face-to-face encounter with a patient in order for the patient to qualify for Medicare home health services. The Centers for Medicare and Medicaid Services greatly expanded the face to face encounter requirements in its implementation of the regulations, and imposed an additional requirement that the physician also include a narrative of the face to face encounter in the documentation explaining why the patient is homebound and why skilled services are necessary to treat a patient's clinical condition. CMS also required that the physician's documentation be a separate and distinct section of the physician's certification for home health services. CMS changed this regulation in 2015 to remove the narrative requirement but now requires that the physician's records contain enough evidence that the patient is homebound and in need of skilled services.

The face to face requirement has been a challenge since its inception in 2011. Despite recent changes which alleviated the narrative portion by physicians it continues to create a hardship for home health agencies but also for patient care. Absolute profit margins in home health are razor thin and likely going down again in 2016. The administrative burden associated with obtaining a valid face to face document stretches even the most efficient of home health providers. The burden falls almost exclusively on the home health agency to educate the physicians and navigate i.e. chase this paperwork.

Nowhere is this more challenging, administratively burdensome and potentially catastrophic than in the post acute care discharge arena. As originally conceived, the face to face requirement was meant to reduce fraud in the billing of home health episodes; so to require this documentation when the patient has been in the hospital clearly runs counter to the original concept. When the patient is seen in an acute facility by many health care providers, none of them are likely have a post-acute role in that patient's care and are less inclined to assist an agency obtain the face to face document. Often these patients are not only the most vulnerable but they are the least likely to be able to obtain the necessary visit with a physician.

We see patients in their home and one of the primary conditions of participation is that the patient has to be "homebound". While there is absolutely an allowance for medical visits to that rule often these patients are unable to make that physician visit. To therefore require them to go out of the home to obtain a face to face visit makes no logical sense and in too many cases is impossible, so that patient suffers at home with no care because of a paperwork burden that benefits no one.

We have examples of this burden daily in our agencies across the west coast and here are a few short stories.

Salem Oregon: Patient is referred to us as she is discharging from a nursing home. The facility MD writes the order for home health but is not willing to sign the face to face documentation nor is he willing to "follow" the patient. The patient has no primary care provider but we find one willing to accept the patient. The patient is willing to try this new doctor as well and we set an appointment. Based on the plan we accept the referral and start to see the patient based on the

original order and plan of care. In this case the patient does not make it to the MD appointment inside of the 30 day window for various reasons that generally boil down to no clinical reason to go and the functional and physical burden to go is too much. Our only choice then is to continue to see this patient pro bono or discharge based on the fact that we do not have a face to face thus cannot bill the episode.

Alamosa Colorado: Patient is referred to home health but has not seen his doctor in many months. The patient has agoraphobia and simply cannot get out comfortably. He agrees to make an MD appointment but is simply unable to keep and make that appointment. The result is he is not able to get home health because the face to face document cannot be obtained. In this case he had significant lower extremity pain and needed nursing and therapy guidance but was not able to obtain it. This is a very rural town and there are no home visits MDs.

Moses Lake Washington: Patient is in a great deal of pain and is generally not mobile. The patient's family who has an established relationship with a primary care doctor visits the doctor and obtains a Home Health referral. We start care based on that referral but need a face to face document signed. No face to face exists. The patient is not able to go to the doctor without ambulance transport which he cannot afford and simply cannot agree to. We tried for some weeks to get this but ultimately the result once again is we have to discharge this patient. In this case there are home visiting Nurse practitioners in this very rural town here again we face a barrier because NPs cannot independently write for home health and complete the face to face.

In 2014 and 2015 our company has had over 393 claims denied for inadequate face to face documentation. Each and every one of these claims had face to face encounter documentation that was signed by a physician. In most cases, the Medicare Administrative Contractors denied the claim because they deemed the physician's narrative inadequate under the regulations. We have appealed each of these denials and have had many of the denials reversed. To date we have had only one denied claim upheld at the Administrative Law Judge level of appeal. At present we have over $1.5 million tied up in appeals of denied face to face encounter claims in various stages of appeal, many of which are at the Administrative Law Judge level of appeal.

These unfortunate examples take place on a near daily basis in the seven states that I oversee and across the country. I appreciate you reading my stories and would be happy to have any further conversation on the topic.

Regards,

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