

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**LIMITED COMPLIANCE WITH
MEDICARE'S HOME HEALTH
FACE-TO-FACE
DOCUMENTATION
REQUIREMENTS**



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EXECUTIVE SUMMARY: Limited Compliance With Medicare’s Home Health Face-to-Face Requirement

OEI-01-12-00390

WHY WE DID THIS STUDY

The Patient Protection and Affordable Care Act (ACA) requires that physicians (or certain practitioners working with them) who certify beneficiaries as eligible for Medicare home health services document—as a condition of payment for home health services—that face-to-face encounters with those beneficiaries occurred. This study (1) determined the extent to which physicians who certified home health care documented the face-to-face encounters, (2) described the nature of face-to-face documentation, and (3) assessed the Centers for Medicare & Medicaid Services’ (CMS) oversight of the face-to-face requirement.

HOW WE DID THIS STUDY

We reviewed 644 face-to-face encounter documents to analyze the extent to which the documents confirmed encounters and contained the required elements. We interviewed the four Home Health and Hospice Medicare Administrative Contractors (HH MACs) to describe how they ensure that home health agencies met the face-to-face encounter requirements. We also reviewed guidance documents and policies from CMS or the HH MACs about monitoring the face-to-face requirement.

WHAT WE FOUND

For 32 percent of home health claims that required face-to-face encounters, the documentation did not meet Medicare requirements, resulting in \$2 billion in payments that should not have been made. Furthermore, physicians inconsistently completed the narrative portion of the face-to-face documentation. Some face-to-face documents provide information that, although not required by Medicare, could be useful, such as a printed name for the physician and a list of the home health services needed. CMS oversight of the face-to-face requirement is minimal.

WHAT WE RECOMMEND

We recommend that CMS (1) consider requiring a standardized form to ensure that physicians include all elements required for the face-to-face documentation, (2) develop a specific strategy to communicate directly with physicians about the face-to-face requirement, and (3) develop other oversight mechanisms for the face-to-face requirement. CMS concurred with all three of these recommendations.

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OBJECTIVES

1. To determine the extent to which physicians who certified home health services documented face-to-face encounters with the beneficiaries within the required timeframe.
2. To describe the nature of the face-to-face documentation.
3. To assess the Centers for Medicare & Medicaid Services' (CMS) oversight of the face-to-face requirement.

BACKGROUND

The Patient Protection and Affordable Care Act (ACA) provides new tools to enhance CMS's efforts to prevent and detect fraud in its programs. For example, the ACA requires certain categories of providers with an increased risk for fraud, such as home health agencies (HHAs), to comply with enhanced fraud-prevention provisions. Among other steps, the ACA requires that physicians (or certain practitioners working with them) who certify beneficiaries as eligible for Medicare home health services document—as a condition of payment for home health services—that face-to-face encounters with those beneficiaries occurred.¹

Medicare Requirements for Home Health Services

Medicare beneficiaries who are generally confined to their homes may be eligible to receive certain medical services at home.² These home health services include part-time or intermittent skilled nursing care, physical and/or occupational therapy, speech-language pathology, medical social services, and part-time or intermittent home health aide services.³ To qualify for home health services, Medicare beneficiaries must (1) be homebound; (2) need intermittent skilled nursing care, physical therapy or speech therapy, or continuing occupational therapy; (3) be under the care of a physician; and (4) be under a plan of care that has been established and periodically reviewed by a physician.⁴ For each 60-day episode of care that a beneficiary receives from an HHA, Medicare makes a standardized payment. For the HHA to receive that payment, a physician

¹ P.L. 111-148, § 6407(a), as revised by § 10605 (adding the face-to-face requirement at Social Security Act, § 1814(a)(2)(C)). Face-to-face encounters may be performed through telehealth visits subject to the requirements in § 1834(m).

² Social Security Act, § 1814(a)(2)(C).

³ Social Security Act, § 1861(m); CMS, *Medicare Benefits Policy Manual (MBPM)*, Pub. No. 100-02, ch. 7, § 40.

⁴ 42 CFR § 424.22.

must certify the beneficiary's initial need for home health services and homebound status and must recertify the need at least every 60 days.⁵

Homebound Status

Medicare considers beneficiaries homebound if, because of illness or injury, they have conditions that restrict their ability to leave their places of residence. Homebound beneficiaries do not have to be bedridden, but should be able to leave their residences only with "considerable and taxing effort." Absences from home should be infrequent, for short durations, or for health care treatment.⁶

Intermittent Skilled Nursing or Therapy Services

The Social Security Act defines "part-time or intermittent services" as "skilled nursing care that is either provided or needed on fewer than 7 days each week or less than 8 hours of each day for periods of 21 days or less."⁷ The skilled nursing care must be provided by a registered nurse or licensed practical (vocational) nurse under the supervision of a registered nurse.⁸ Home health aide services may include personal care, such as bathing and dressing; feeding; and simple dressing changes that do not require the skills of a licensed nurse.⁹ Therapy services must be performed by a qualified therapist or therapy assistant under the supervision of a qualified therapist.¹⁰

Requirement To Be Under the Care of a Physician

Medicare requires that to be eligible for home health services, beneficiaries be under the care of a doctor of medicine, osteopathy, or podiatric medicine.¹¹ As of April 1, 2011, CMS began requiring full compliance with the requirement that the certifying physician or clinician have a face-to-face encounter with the beneficiary as a condition of payment for home health care.¹²

Established Plan of Care

Medicare pays for home health services only if they are provided under a plan of care that a physician establishes and periodically reviews.¹³ The physician must review, sign, and date the plan at least once every 60 days.¹⁴

⁵ 42 CFR § 424.22.

⁶ *MBPM*, ch. 7, § 30.1.1.

⁷ Social Security Act § 1861(m).

⁸ *MBPM*, ch. 7, § 40.1.1.

⁹ *MBPM*, ch. 7, § 50.2.

¹⁰ *MBPM*, ch. 7, §§ 40.2–40.2.4.3.

¹¹ 42 CFR § 424.22(a)(iv).

¹² ACA, § 6407(a), as revised by § 10605; CMS notice accessed at <http://www.cms.gov> on November 14, 2013.

¹³ 42 CFR § 424.22(a)(iii).

¹⁴ *MBPM*, ch. 7, § 30.2.6.

If a beneficiary does not receive at least one covered skilled nursing visit, physical therapy visit, speech-language pathology service visit, or occupational therapy visit within the 60-day episode, CMS considers the plan to be terminated.¹⁵

Face-to-Face Requirement

For the initial home health episode of care only, the certifying physician must document a face-to-face encounter with the patient.¹⁶ The HHA must obtain documentation that the face-to-face encounter with the patient occurred and that the encounter was related to the primary reason the beneficiary needs home health care. If the certifying physician does not complete the documentation correctly, CMS can deny the HHA payment because the face-to-face requirement is a Medicare condition of payment.¹⁷ CMS holds the HHA financially accountable for ensuring that the documentation from the physician meets the applicable criteria.

CMS allows physicians to use a standard form to document the visit. However, CMS does not permit a form that the HHA completes and the physician merely signs; the physician must actually complete the documentation. The documentation must include the following elements to meet the condition of payment.¹⁸

1. The certifying physician must complete and sign the face-to-face documentation, regardless of who performs the face-to-face encounter. Federal law mandates as a condition of payment that the certifying physician, the physician who cared for the patient in an acute-care or post-acute-care facility, or a permitted nonphysician practitioner have a face-to-face encounter with the patient whom the physician is certifying for home health services. CMS has clarified that a patient's physician for acute care or post-

¹⁵ MBPM, ch. 7, § 30.2.9.

¹⁶ Social Security Act, § 1814(a)(2)(C); see also 42 CFR § 424.22(a)(1)(v) (2012) (prior to the amendment at 77 Fed. Reg. 67068 (Nov. 8, 2012) (effective Jan. 1, 2013)).

¹⁷ The existence of an evaluation and management (E&M) claim does not fulfill the face-to-face requirement. E&M claims include visits and consultations performed by physicians and nonphysician practitioners. In most situations, if the provider billed Medicare for a face-to-face visit with the home health beneficiary, he or she would use an E&M code on the claim.

¹⁸ Social Security Act, § 1814(a)(2)(C). See also 42 CFR § 424.22(a)(1)(v) (2012) (prior to the amendment at 77 Fed. Reg. 67068 (Nov. 8, 2012) (effective Jan. 1, 2013)); MBPM, ch. 7, § 30.5.1.1; and CMS, MLN Matters Article #SE1219, *A Physician's Guide to Medicare's Home Health Certification, including the Face-to-Face Encounter*, release date May 7, 2012.

acute care can conduct that encounter as long as he or she informs the certifying physician of that encounter.¹⁹

2. The certifying physician must title, date, and sign the document.²⁰
3. The face-to-face documentation must be titled as such. CMS does not require physicians to use a specific form to document the face-to-face encounter; as long as the face-to-face encounter documentation contains all content requirements and is properly titled, the certifying physician can use a discharge summary, a clinic note, or an original form to satisfy the requirement.
4. The date of the encounter must be on the document.
5. The face-to-face encounter must occur within 90 days prior to the start of care or within 30 days after the start of care.
6. As required by Medicare, this documentation must include a brief narrative that describes (1) why the patient is homebound and (2) why the skilled service(s) is necessary to treat the patient's illness or injury. This narrative can address the homebound status and reason for skilled service(s) in two separate sections or combine them in one section.

Related Office of Inspector General Work

In 2012, the Office of Inspector General (OIG) found through a medical record review that 98 percent of beneficiaries met Medicare coverage requirements for home health services.²¹ However, OIG also found that HHAs submitted 22 percent of claims in error because services were not medically necessary or claims were coded inaccurately, resulting in \$432 million in improper Medicare payments. OIG concluded that given the general concern about risks to the Medicare program in the home health area, further investigations beyond the medical record review are needed to determine whether beneficiaries are eligible, services are furnished, and Medicare requirements for payment are met.

¹⁹ 76 Fed. Reg. 68526, 68593, and 68606 (Nov. 4, 2011). After our review period, CMS further revised 42 CFR § 424.22(a)(1)(v) to allow an acute-care or post-acute-care NPP to perform the face-to-face encounter in collaboration with or under the supervision of the acute or post-acute physician and to allow that physician to inform the certifying physician. 77 Fed. Reg. 67068, 67106, and 67163 (Nov. 8, 2012) (effective Jan. 1, 2013).

²⁰ After our review period, CMS revised 42 CFR § 424.24(a)(1)(v)(F), effective January 1, 2013, so that it no longer provides that only the certifying physician can title and date the certification. 77 Fed. Reg. 67068, 67163–64 (Nov. 8, 2012).

²¹ OIG, *Documentation of Coverage Requirements for Medicare Home Health Claims*, OEI-01-08-00390, March 2012.

In 2012, OIG found that HHAs did not meet all Federal reporting requirements for Outcome and Assessment Information Set (OASIS) data, which are the basis for home health payments, quality assessments, and information for consumers.²² In 2009, HHAs did not submit required OASIS data for 392,180 claims (6 percent), which represented over \$1 billion in Medicare payments. OIG recommended that CMS identify all HHAs that failed to submit OASIS data and that the agency apply a 2-percent payment reduction to them.

In 2009, OIG found aberrant billing patterns in home health outlier payments in 24 counties nationwide.²³ One county in Florida, Miami-Dade, accounted for more home health outlier payments in 2008 than the rest of the country combined.

METHODOLOGY

SCOPE

This study determined the extent to which certifying physicians documented face-to-face encounters with beneficiaries. This study is national in scope. It is based on Part A claims from January 1, 2011, through December 31, 2012.

Claims Analysis. We obtained all home health Part A claims (7,835,502) from January 1, 2011, until March 31, 2012, to determine the number of initial home health episodes because only these episodes require face-to-face encounters. We determined that 4,226,413 of those claims (54 percent) required face-to-face encounters with the physicians who certified home health services. We then looked at all claims dated on or after April 1, 2011 (2,471,332), which was when CMS started enforcing the requirement.

For those beneficiaries in the first episode of home health care, we obtained all Part B claims with dates of service from 90 days prior to or 30 days after the start of home health care. We used the physician's National Provider Identifier (NPI) number from the Part A home health claim and linked it with any Part B claims coded for E&M that had the same NPI number. We found that 68 percent of claims (1,679,050) had matching Part B E&M claims with the ordering physicians and 32 percent (792,282) did not.

²² OIG, *Limited Oversight of Home Health Agency OASIS Data*, OEI-01-10-00460, February 2012.

²³ OIG, *Aberrant Medicare Home Health Outlier Payment Patterns in Miami-Dade County and Other Geographic Areas in 2008*, OEI-04-08-00570, December 2009.

Face-to-Face Encounter Documentation. We selected a stratified random sample of 680 home health claims and requested from the HHAs the documentation of the corresponding face-to-face encounters. To determine whether home health claims with matching E&M claims were more likely or less likely to meet the Medicare face-to-face requirement, we stratified the sample on the basis of whether the Part A home health claims had corresponding E&M claims.

The first stratum included 340 claims that lacked corresponding E&M claims. We received 313 face-to-face documents, a 92-percent response rate from this stratum. The second stratum included 340 claims that had corresponding E&M claims. We received 331 face-to-face documents, a 97-percent response rate from this stratum. We had a 95-percent total response rate for our data collection of face-to-face documents.²⁴ We analyzed the extent to which the documents confirmed encounters. We also analyzed the face-to-face document to determine the extent to which it met the required elements. We compared the percentages of face-to-face documents with E&M visits and those without them.

We found no relationship between the presence of an E&M claim and the likelihood that home health agency submitted the face-to-face documentation. Thus, we present data in the aggregate. All results are weighted to the proportion of the stratum in the population.

Interviews and Document Review

We conducted structured interviews with the four Home Health and Hospice Medicare Administrative Contractors (HH MACs) regarding how they ensure that HHAs meet the face-to-face requirements. We reviewed guidance documents or policies from CMS and the HH MACs about monitoring the face-to-face requirement.

Limitations

This study did not assess the necessity of home health services, and we did not make clinical determinations about the appropriateness of the narrative portion of the face-to-face document. We limited our analysis to describing this narrative text and the absence of required information. We also did not independently verify that the information on the face-to-face documents was accurate or that the face-to-face encounters were related to the primary reasons that the beneficiaries needed home care.

²⁴ We will refer all HHAs that did not provide copies of the face-to-face documents to CMS.

For a variety of reasons, an E&M claim corresponding to the home health beneficiary's face-to-face visit may not exist. The physician may not have submitted a claim for the service, or the face-to-face encounter may have occurred outside of the physician's office. For example, if the encounter occurred in the hospital, the certifying physician may use the hospital physician's documentation of that encounter. In addition, the presence of an E&M claim alone does not fulfill the face-to-face requirement; the certifying physician must also complete the documentation confirming that visit.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

For 32 percent of home health claims that required face-to-face encounters, the documentation did not meet Medicare requirements, resulting in \$2 billion in payments that should not have been made

Medicare requires as a condition for payment for home health services that physicians who certify home health eligibility provide appropriate supporting documentation of face-to-face encounters for the initial episodes of care. The face-to-face encounter alone does not satisfy the requirement; the certifying physician must also complete documentation that is clearly titled, signed, and dated. Our review of claims for initial episodes of home health care showed that 32 percent either had no face-to-face documents or had face-to-face documents that lacked at least one of the required elements (see Table 1). We found no difference between the home health claims that had corresponding E&M claims and the home health claims that did not in the percentage of claims that did not meet Medicare requirements.

Face-to-face documentation was missing in 10 percent of claims

The 10 percent of claims without face-to-face documents totaled \$605 million. The HHAs either confirmed when we asked them that they did not have those documents, or they sent other documents, such as physician's orders, home health referrals, and inpatient notes, which do not meet Medicare's requirements if not appropriately titled as the face-to-face documentation.

Of the face-to-face documents that were submitted, 25 percent were missing one of the required elements

The most commonly missing element was the signature of the certifying physician. Seventeen percent (\$941 million) of the face-to-face documents were signed by persons other than the certifying physicians. Medicare regulations allow attending physicians who cared for the patients in a recent acute-care or post-acute-care setting, or nonphysician practitioners working with the certifying physicians, to conduct the exams. However, the certifying physician must document that the encounter took place, regardless of who performed the encounter. For 10 percent of documents, we were unable to determine whether the signature was that of the certifying physician because the physician's printed name—which is not a required element—was missing. (We did not consider these documents to be missing in our calculations.) The remaining elements—an encounter date within the required timeframe, an appropriately titled

document, the date of the encounter, the date the physician signed the document, and the existence of a physician’s signature (from either the certifying physician or another physician)—were missing much less often. (See Appendix A for examples of face-to-face documents.)²⁵

Table 1: Home Health Documents That Did Not Meet Medicare Requirements

Medicare Requirement	Percentage Missing From Document*	Claim Amount (in Millions)
Face-to-Face Documentation	10%	\$605.3
Elements Required for Face-to-Face Documentation	Percentage Missing From Document	Claim Amount (in Millions)
Signature of Certifying Physician	17%	\$941.1
Date of Encounter Within the Required Timeframe	4%	\$310.7
Appropriate Title	3%	\$150.2
Date of Encounter	2%	\$118.8
Date When Physician Signed Document	2%	\$106.7
Physician Signature**	1%	\$42.3
Total Claims Missing the Face-to-Face Document or Elements of the Face-to-Face Document***	32%	\$2,037.0

Source: OIG analysis of face-to-face documents, 2013.

*All percentages significant at the p<.05 level.

**Physician signature left blank.

***Does not add because of overlapping errors.

Physicians inconsistently completed the narrative content on the face-to-face documentation

The face-to-face documentation must include a brief narrative that describes that patient’s clinical condition and the way in which the patient’s clinical condition supports his/her homebound status and the need for skilled services. This can be accomplished in as little as three sentences. CMS provided the following example in a guidance document:

The patient is temporarily homebound secondary to status post total knee replacement and currently walker dependent with painful ambulation. PT [physical therapy] is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decomposition or adverse events

²⁵ These are examples of face-to-face documents collected during this study. We are not expressing an opinion whether these examples meet Federal requirements.

from the new COPD [chronic obstructive pulmonary disease] medical regimen.²⁶

Physicians can document this information in a variety of ways. Some physicians use separate statements for each need for skilled services and reason that patient is homebound (see Appendix A-1). Others write one combined statement similar to the CMS example (see Appendix A-5). CMS gives physicians discretion as to how they document this information; however, CMS will consider the face-to-face documentation incomplete without this narrative. Because the face-to-face requirement is a Medicare condition of payment, CMS will deny the payment for the initial and all subsequent episodes of care.²⁷

Narratives did not always appear to follow CMS guidance for describing homebound status and necessity for skilled services

Some face-to-face documentation failed to specify why the patient was homebound or to include the reason the skilled service was necessary. In those face-to-face documents that had separate statements for each piece of the narrative, 12 percent were missing narratives supporting the patients' homebound status and 6 percent were missing narratives regarding the need for skilled services.²⁸

Some of the language in the narratives does not appear to conform to guidance about what constitutes appropriate and sufficient documentation. CMS and its contractors released guidance that included examples of language that would be considered inappropriate if used alone.^{29, 30} (See Table 2 for examples.) We found that, in their descriptions of the beneficiaries' homebound status, 16 percent of documents said that the beneficiaries were weak and 14 percent said that the beneficiaries were unable to leave home unassisted. (See Table 3 for the reasons most commonly cited in the narrative text.)

²⁶ CMS, *Home Health Face-to-Face Question & Answer*, February 28, 2013. Accessed at <http://www.cms.gov> on August 7, 2013.

²⁷ Ibid.

²⁸ Because we did not render an opinion about the appropriateness of the narratives, we did not determine whether these face-to-face documents failed to meet CMS requirements.

²⁹ CMS, *Home Health Face-to-Face Question & Answer*, February 28, 2013. Accessed at <http://www.cms.gov> on August 7, 2013.

³⁰ CGS, *Face-to-Face Documentation for Home Health Certification: Important Information for Certifying Physicians and Nonphysician Practitioners*. Accessed at http://www.cgsmedicare.com/ohb/pubs/mb_J15/2013/08_2013/index.html on August 7, 2013.

Table 2: CMS Contractors’ Examples of Text That Is Insufficient To Support Home Health Claims

Text Insufficient To Support Homebound Status	Text Insufficient To Support Need for Skilled Services
Weak	Family is asking for help
Unable to drive	Continues to have problems
Unable to leave home	List of tasks for nurse to do
Dementia or confusion	Patient unable to do wound care
Functional decline	Diabetes

Source: CGS, 2013 Face-to-Face Documentation for Home Health Certification: Important Information for Certifying Physicians and Non-physician Practitioners.

Table 3: Most Commonly Used Narrative Text Supporting Homebound Status

Characteristic	Percentage of Narrative Texts That Cited Characteristic
Taxing effort to leave home	17%
Weakness/fatigue	16%
Unable to leave home unassisted	14%
Unsteady gait/risk of falls	13%
Decreased mobility	10%
Shortness of breath/dyspnea	9%
Poor endurance	7%

Source: OIG analysis of face-to-face documents, 2013.

The most commonly used phrase was “taxing effort to leave home.” Physicians used this phrase in 17 percent of face-to-face documentation to explain their patients’ homebound status. In fact, in about half of those documents, the physicians did not list any other reasons. The phrase “taxing effort to leave home” is included in CMS’s definition of homebound, and, therefore, offers no specific statement about the patient’s condition.³¹

³¹ MBPM, ch. 7, § 30.1.1.

Some of the language in the narratives was similar to the language that CMS and its contractors cited as inappropriate. Moreover, the combinations of many of these phrases in the same document raised questions about whether using multiple phrases that are considered inappropriate individually constitutes a narrative that CMS and its contractors would find sufficient to justify the need for home health when used together.

HH MACs vary as to whether they accept forms with checkboxes in the face-to-face documentation

HH MACs appear to interpret CMS’s guidance on forms with checkboxes—i.e., forms that list several possible conditions or characteristics, with a box next to each that the physician can mark with a check—differently. CMS allows forms with checkboxes in limited situations; however, the option next to each checkbox must contain the physician’s assessment specific to that patient. In our interviews, one of the four HH MACs offered that it does not accept forms with checkboxes unless the physician writes additional information.³² Another HH MAC said that it looks at each form on a case-by-case basis and makes its determination, in part, on the basis of whether the form was designed by the HHA or the physician. The use of checkboxes in some forms also raised questions about the extent to which the narrative content meets Medicare requirements. Six percent of face-to-face documents used checkboxes on the forms. (See Image 1.)

Image 1: Checkboxes on Face-to-Face Document

I certify that my clinical findings support that this patient is **homebound** (i.e., absences from the home require a taxing effort, are for medical appointments and services, or are infrequent and of short duration for other reasons such as religious services, etc.) as evidenced by:

- Patient is unable to drive (permanently or temporarily) due to current illness, surgery, or debility
- Patient is non-weight bearing or requires assistance/assistive device(s)
- Patient requires constant supervision for safety reasons (either cognitive or functional, or both)
- Patient has a mental health diagnosis that prevents their ability to leave home
- Other: _____

Source: Example from OIG face-to-face document review, 2013.

³² CMS does not allow checkboxes created by HHAs. CMS does allow checkboxes created by physicians or generated from physicians’ electronic health records. CMS, *Home Health Face-to-Face Question & Answer*, February 28, 2013. Accessed at <http://www.cms.gov> on March 12, 2014.

Some face-to-face documents contain elements that, although not required by Medicare, provide information that could be useful

Medicare requirements specify which elements must appear on the face-to-face document; however, additional elements could add clarity to the document.

NPI. Seven percent of documents listed the certifying physicians' NPIs. Including this number makes it easier to identify the physician, especially when the handwriting is illegible. The printed names of the physicians were illegible in 4 percent of the documents.

Printed Name of Physician. In addition to the required physician signature, most documents included the printed (either handwritten or typed) names of those physicians. Ten percent of face-to-face documents were missing a printed name. Many signatures were illegible, and a printed name may be the only way to identify the certifying physician.

Name of Nonphysician Practitioner. Medicare regulations allow a nonphysician practitioner to complete the face-to-face encounter. Five percent of documents provided a dedicated space to identify those individuals.

Letterhead of HHA or Hospitals. Slightly over half (58 percent) of the documents contained the letterheads of either the HHAs or the hospitals. This could indicate that these facilities use standardized forms for the physicians to complete.

List of Home Health Services Needed. Most face-to-face documents had checkboxes to indicate a need for nursing (81 percent), physical therapy (80 percent), or speech/language pathology (76 percent). Far fewer documents included checkboxes for occupational therapy (36 percent), home health aide services (21 percent), or a medical social worker (20 percent). (See Image 2 for an example.)

Image 2: List of Home Health Services Needed

<p>I certify that, based on my findings, the following <u>services are medically reasonable and necessary:</u></p> <ul style="list-style-type: none"><input type="checkbox"/> Skilled Nursing<input type="checkbox"/> Physical Therapy<input type="checkbox"/> Speech Language Pathology<input type="checkbox"/> Occupational Therapy<input type="checkbox"/> Medical Social Worker Consult<input type="checkbox"/> Home Care Aide (for personal care)
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Source: Example from OIG analysis of face-to-face documents, 2013.

CMS oversight of the face-to-face requirement is minimal

CMS does not have a specific program to oversee compliance with the requirement for face-to-face documentation. Instead, it reviews the documentation when it conducts a medical record review as part of its general effort to deter and detect home health fraud. Because the face-to-face encounter is required for the initial episodes only, just a fraction of those reviews would include the face-to-face document.³³

In their medical record reviews, the four HH MACs do not verify the information on the face-to-face documents. In particular, they do not confirm that the physician who signed the document is actually the certifying physician. HH MACs cited lack of access to Medicare Part B physician claims and limited time and resources as major reasons why they do not verify the information.

Although they do not verify the face-to-face document, the HH MACs do offer guidance and training on the requirement. All four HH MACs point to training that they offer HHAs about the face-to-face requirement, including Web sites, Web seminars, and provider presentations. Two HH MACs also reached out to the physician community in an attempt to address problems they have seen, such as insufficient narratives and failure to sign and date the documents. However, in our interviews with HH MACs, they told us that they are limited in their interactions with physicians, because activities such as training for those providers are not the responsibility of the HH MACs.

Like the HH MACs, HHAs rely on physicians' accurately completing the face-to-face documents. All four HH MACs reported that HHAs had expressed frustration about the burden that the face-to-face document imposes. HHAs are held financially accountable for failure to obtain the face-to-face documentation but have no authority to compel physicians to complete it either timely or accurately.

³³ Reviews of claims for continuing home health care do not require a face-to-face visit.

CONCLUSION AND RECOMMENDATIONS

Home health fraud has been well documented, and efforts to uncover it are ongoing. In July 2013, CMS issued a temporary moratorium on new home health providers in parts of Florida and Illinois to fight fraud in Medicare.³⁴ As another fraud prevention strategy, Medicare also requires as a condition of payment that a beneficiary have a face-to-face encounter with the physician, or certain practitioners working with them, who initially certified that patient for Medicare home health services. However, our findings show that 32 percent of claims for home health services that required face-to-face encounters did not meet Medicare requirements, resulting in \$2 billion of payments that should not have been made.

We also found that CMS lacks an adequate oversight mechanism to ensure that this face-to-face requirement is met. Ensuring that an oversight mechanism is in place will also prove instructive for CMS as it implements a similar face-to-face requirement for durable medical equipment in the future.

We recognize that the very design of the Medicare home health payment system makes oversight of the face-to-face requirement difficult. Four HH MACs process Part A and B home health claims. However, the actual physician encounter that would establish the face-to-face eligibility is covered under Part B, which may be administered by a separate MAC. As a result, matching claims associated with one beneficiary under the two separate systems is not readily achievable. In addition, HHAs, which are required to obtain the face-to-face documents in order to receive payment, have no authority to compel physicians to complete and sign the documents.

As a way to help bridge this gap and to further the intent of the face-to-face requirement, we recommend that CMS:

Consider requiring a standardized form to ensure that physicians include all elements required for the face-to-face documentation

To enhance oversight and to clarify completion of the required elements, CMS should consider requiring the use of a standardized form to serve as the face-to-face documentation. Because over half of the face-to-face documents are completed using standardized forms from hospitals or HHAs, this should not be a significant adjustment for most physicians.

³⁴ 78 Fed. Reg. 46339 (July 29, 2013).

Develop a specific strategy to communicate directly with physicians about the face-to-face requirement

CMS needs to provide additional formal training and outreach about the importance of completing the face-to-face document. Because HH MACs' responsibility to conduct provider outreach does not extend to physicians, HH MACs are not directly training physicians. It is therefore incumbent upon CMS to identify ways to educate the physician community about the requirements.

Develop other oversight mechanisms for the face-to-face requirement

Relying on medical record reviews to ensure that HHAs are meeting the face-to-face requirement is clearly not sufficient. CMS could work with the various payment contractors to develop other review procedures to ensure compliance. This charge has heightened importance given CMS's plans to implement the face-to-face requirement for durable medical equipment.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all three of the recommendations in this report. To address our first recommendation, CMS stated that it will consider whether requiring a standardized form will help resolve issues identified in our report. We recognize that using a standardized form may eliminate some flexibility for physicians; however, CMS must ensure that all required elements are present on the face-to-face document.

To address our second recommendation, that CMS develop a specific strategy to communicate directly with physicians about the face-to-face requirement, CMS plans to issue additional educational materials to physicians.

To address our final recommendation, CMS stated that it is implementing an oversight plan through the Supplemental Medical Review Contractor (SMRC). CMS will have the SMRC conduct document-only reviews for every HHA in the country to validate a sample of the face-to-face encounters.

Lastly, we withdrew a recommendation from our draft reports that CMS require physicians to include their NPIs on the face-to-face document. As of July 1, 2014, CMS will require that HHAs report the NPI of the certifying physician and the physician who signed the plan of care, if different from the certifying physician.³⁵ We believe that this new requirement satisfies our original recommendation without imposing any additional burden.

For a full text of CMS's comments, see Appendix C.

³⁵ CMS Manual System, Pub. No. 100-04, Medicare Claims Processing, Transmittal 2789, Change Request 8441, Sept. 20, 2013.

APPENDIX A-1: SAMPLES OF FACE-TO-FACE DOCUMENTS

Home Health Certification Addendum / Face-to-Face Encounter Acknowledgement Report

PROVIDER ACKNOWLEDGING FACE-TO-FACE ENCOUNTER: Fax: _____ Diagnosis: 187.7 950 MALIGNANT NEOPLASM OF LIVER 162.0 MAL NEOPLSM BRONCHUS&LUNG UNS SITE 786.21 INCOMPLETE BLADDER EMPTYING 401.0 UNSPECIFIED ESSENTIAL HYPERTENSION 584.0 ACUTE KIDNEY FAILURE, UNSPECIFIED Services Provided: SN Agency Taken Date: _____	CLIENT: SOC Date: _____ Episode Dates: _____ DOB: _____
--	---

Home Health Certification and Face-to-Face Encounter Acknowledgement

1. ENCOUNTER DATE: _____
2. REASON FOR ENCOUNTER (DIAGNOSES) Urinary retention & Ascites

I CERTIFY THAT BASED ON MY FINDINGS:

3. HOME HEALTH SERVICES ARE MEDICALLY NECESSARY FOR THIS PATIENT, INCLUDING EITHER INTERMITTENT SKILLED NURSING AND/OR THERAPY

BECAUSE: Due to multiple medication changes which require teaching as well as instruction re daily weights + monitor abdomen for increasing ascites.

4. WHAT ARE THE FUNCTIONAL LIMITATIONS THAT MAKE ABSENCE FROM THE HOME A CONSIDERABLE AND TAKING EFFORT TO LEAVE?

BECAUSE: patient is unable to ambulate > 10 feet & assist requires presence of 24 hr caregiver to assist & all adl's

COMPLETING THE F2F ENCOUNTER DOCUMENT DOES NOT REQUIRE YOU TO FOLLOW/SIGN THE RESULTING LASE ORDER

PHYSICIAN SIGNATURE: _____

DATE: _____

APPENDIX A-2

HOME HEALTH FACE TO FACE ENCOUNTER			
1. Home Health Provider's Name, Address and Telephone Number:		2. Physician's Name and Address:	
3. Patient's Name:	4. Start of Care Date:	5. Certification Date:	
6. Medical Record Number:	7. Date of Birth:	8. Gender M <input type="checkbox"/> F <input checked="" type="checkbox"/>	9. ICD-9-CM: Primary Dx: Date:
10a. Date of Face to Face Encounter:		10b. Face to Face Encounter related to primary reason for homecare? <input checked="" type="checkbox"/> Y <input type="checkbox"/> N (circle one)	
<p>11. Brief Narrative Statement: State physical findings from face to face encounter that indicate reason patient is homebound and requires intermittent skilled nursing services and/or therapy services. This document is an addendum to the initial certification as required by the Centers of Medicare and Medicaid Services.</p> <p>Services Required: Nursing: <input checked="" type="checkbox"/> MSW: <input type="checkbox"/> PT: <input checked="" type="checkbox"/> OT: <input type="checkbox"/> ST: <input type="checkbox"/> HH Aider: <input checked="" type="checkbox"/> Pain Management: <input type="checkbox"/> Fall Prevention: <input type="checkbox"/> Depression Monitoring: <input type="checkbox"/> Diabetic foot care including foot care: <input type="checkbox"/> Pressure Ulcer Prevention: <input type="checkbox"/></p> <p>Notify physician of these findings: _____ *Please note clinical findings that support the need for services ordered: <i>Breast Ca</i></p> <p style="text-align: right; font-size: 2em; opacity: 0.5;">COPIED</p>			
12. Physician's Signature and Date signed:		13. Date Provider Received signed document:	
14. Document Author and Signature date:			

APPENDIX A-3

Documentation of Face to Face Encounter

Patient Name and Identification: _____

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on: (Insert date that visit occurred):

Month _____ Day _____ Year _____

The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health care (List medical condition):

I certify that, based on my findings, the following services are medically necessary home health services (Check all that apply):

- Nursing
- Physical therapy
- Speech language pathology

To provide the following care/treatments: (Required only when the physician completing the face to face encounter documentation is different than the physician completing the plan of care):

My clinical findings support the need for the above services because:

See chart

Further, I certify that my clinical findings support that this patient is homebound (i.e. absences from home require considerable and taxing effort and are for medical reasons or religious services or infrequently or of short duration when for other reasons) because:

Physician Signature _____

Date of Signature _____

Physician Printed Name _____

RECEIVED

APPENDIX A-4

Physician/Patient Face-to-Face documentation				
1. Patient's H.I. Claim No.	2. Start Of Care Date	3. Certification Period From: _____ To: _____		4. Medical Record No.
6. Patient Name			7. Provider's Name	
<p>8. I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on: _____</p>				
<p>9. The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health care:</p> <p style="margin-left: 40px;">Senile Dementia, DM II Renal NT ST Uncontrolled, Chronic Ckd NOS, Insomnia NOS, Diarrhea, H/o UTI, HTN, Pure Hypercholesterolemia, urinary incontinence NOS.</p>				
<p>10. I certify that, based on my findings, the following services are medically necessary home health services:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Nursing <input type="checkbox"/> Physical therapy <input type="checkbox"/> Speech language pathology <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Medical Social Worker <input type="checkbox"/> Home Health Aide 				
<p>11. My clinical findings support the need for the above services because:</p> <p style="margin-left: 40px;">See #9</p>				
<p>12. Further, I certify that my clinical findings support that this patient is homebound (i.e. absences from home require considerable and taxing effort and are for medical reasons or religious services or infrequently or of short duration when for other reasons) because:</p> <p style="margin-left: 40px;">Incontinence, contractures, ↓ decreased Hearing, ↓ Endurance, Assistance by devices to Ambulate Safely. Homebound patient.</p>				
13. Physician name and address:				
14. Physician signature:				15. Date

APPENDIX A-5

HOME HEALTH FACE-TO-FACE ENCOUNTER CERTIFICATION

Patient Name: _____

Case Number: _____

Physician Signing Certification:

Home Care Agency: _____

I, a Medicare-enrolled physician, or non-physician practitioner* (CHECK ONE)

had a face-to-face encounter with the above-named patient on _____ (Date of Encounter)

for the following medical condition(s) PNA, Anemia

which is related to the primary reason the patient needs home care.

The following clinical findings support that the patient is homebound (homebound means that there exists a normal inability to leave home, and consequently, leaving home requires considerable and taxing effort) and that the patient needs intermittent skilled nursing and/or therapy (physical or occupational therapy or speech pathology):

Patient is homebound as he requires the assistance of another individual to leave home. He needs intermittent skilled nursing for disease management + medication reconciliation. He will also benefit from home PT and OT for restoration of functioning.

Physician Signature _____

Date _____

* Per CMS's regulation (42 C.F.R. §424.22), "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." This documentation must include the "date of the encounter, an explanation of why the clinical findings of such encounter support that the patient is homebound and in need of either intermittent skilled nursing or therapy services as defined in § 408.42 (a) and (c)."

** A non-physician practitioner includes a nurse practitioner, clinical nurse specialist working in collaboration with the physician, a certified nurse midwife or a physician assistant under the supervision of the physician.

APPENDIX A-6

Physician's Documentation of Face-to-Face Encounter

Patient Name _____

On (date) _____ the above named patient was evaluated with a face-to-face

encounter. Based on this evaluation this patient is appropriate for home care because he/she is homebound due to

SOB, weakness, pain, requires max assist.

and requires skilled services for to monitor & teach disease process by skill
nurse related to pain's cardiac symptoms.

Signature _____

Date _____

APPENDIX B – CONFIDENCE INTERVALS

Characteristic	Sample Size	Percentage (95-Percent Confidence Interval)
Claims that did not meet the face-to-face requirement	644	32.2% (28.4%–36.0%)
Claims without face-to-face documentation	644	9.7% (7.2%–12.1%)
Face-to-face documents that were missing at least one required element	583	25.0% (21.2%–28.6%)
Face-to-face documents without appropriate titles	583	2.8% (1.5%–4.2%)
Face-to-face documents that were not dated by physicians	583	2.0% (0.2%–1.8%)
Face-to-face documents missing dates of face-to-face encounters	583	1.6% (0.5%–2.7%)
Face-to-face documents not signed by physicians	583	1.0% (0.2%–1.8%)
Face-to-face documents not signed by certifying physicians	583	17.0% (13.8%–20.2%)
Face-to-face documents not completed within the required timeframe	583	4.2% (2.5%–6.0%)
Face-to-face documents not dated by physicians	583	2.0% (.9%–3.2%)
Face-to-face documents lacking printed names or containing illegible printed names for the signing physicians	583	13.7% (10.7%–16.7%)
Face-to-face documents using checkboxes	583	6.1% (4.0%–8.1%)

Source: OIG analysis of face-to-face documents, 2013

Cont'd

Characteristic	Sample Size	Percentage (95-Percent CI)
Face-to-face documents for which it was not possible to determine whom the signatures belonged to	583	11.9% (9.0%–14.7%)
Face-to-face documents missing at least one required element	583	21.5% (18.0%–25.0%)
Face-to-face documents missing narrative justifying beneficiaries' homebound status	583	11.9% (9.0%–14.7%)
Face-to-face documents without narrative for beneficiaries' need for skilled services	583	5.9% (3.9%–7.9%)
Face-to-face documents with narrative citing taxing effort for beneficiaries to leave home	583	17.3% (14.0%–20.6%)
Face-to-face documents with narrative listing beneficiaries' weakness/fatigue	583	16.0% (12.9%–19.2%)
Face-to-face documents with narrative describing beneficiaries as unable to leave home unassisted	583	14.2% (11.2%–17.3%)
Face-to-face documents with narrative listing beneficiaries' unsteady gait	583	13.1% (10.2%–16.1%)
Face-to-face documents with narrative listing beneficiaries' decreased mobility	583	9.6% (7.1%–12.2%)
Face-to-face documents with narrative listing beneficiaries' shortness of breath/dyspnea	583	9.0% (6.4%–11.5%)
Face-to-face documents with narrative listing beneficiaries' poor endurance	583	6.0% (4.6%–8.1%)
Face-to-face documents listing the physicians' NPIs	583	6.8% (4.6%–9.1%)
Face-to-face documents with illegible printed names for the signing physicians	583	4.1% (2.2%–5.8%)

Source: OIG analysis of face-to-face documents, 2013

Cont'd

Characteristic	Sample Size	Percentage (95-Percent CI)
Face-to-face documents with a space to list a nonphysician practitioner	583	5.0% (3.2%–6.7%)
Face-to-face documents with letterhead of hospitals or HHAs	583	58.3% (54.1%–62.6%)
Face-to-face documents with a checkbox for nursing	583	81.4% (78.0%–84.8%)
Face-to-face documents with a checkbox for physical therapy	583	79.7% (76.3%–83.2%)
Face-to-face documents with a checkbox for speech therapy	583	76.2% (72.5%–79.9%)
Face-to-face documents with a checkbox for occupational therapy	583	36.1% (32.0%–40.3%)
Face-to-face documents with a checkbox for home health aide services	583	20.9% (17.4%–24.4%)
Face-to-face documents with a checkbox for medical social worker	583	19.8% (16.4%–23.2%)

Source: OIG analysis of face-to-face documents, 2013

Table B1: Claims That Should Not Have Been Paid

Reason Claim Should Not Have Been Paid	Sample Size	Dollars (95-Percent Confidence Interval)
Claim did not meet Medicare requirements	644	\$2,027.0 (\$1,728.7–\$2,325.3)
Claim did not provide a face-to-face document	583	\$605.3 (\$479.5–\$731.1)
Face-to-face document was signed by someone other than certifying physician	583	\$941.1 (\$820.6–\$1,061.7)
Face-to-face document was not completed within the required timeframe	583	\$310.7 (\$222.1–\$399.2)
Face-to-face document did not have an appropriate title	583	\$150.2 (\$100.4–\$200.0)
Date of face-to-face encounter was missing	583	\$118.8 (\$55.6–\$182.1)
Face-to-face document was not signed by a physician	583	\$42.3 (\$22.0–\$62.7)
Face-to-face document was not dated by physician	583	\$106.7 (\$60.6–\$152.8)

Source: OIG analysis of face-to-face documents, 2013

APPENDIX C

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JAN 31 2014

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Limited Compliance with Medicare's Home Health Face-To-Face Documentation Requirements"
(OEI-01-12-00390)

Thank you for the opportunity to review and comment on the subject report. Congress mandated face-to-face encounters in order to increase physician involvement with Medicare home health (HH) beneficiaries and, as part of the certification for Medicare HH services, to assure a patient's eligibility for the Medicare HH benefit.

The OIG reports that 32 percent of HH claims that required a face-to-face encounter did not meet Medicare requirements, either missing the face-to-face documentation altogether or lacking in at least one of the required elements. To address those inadequacies, OIG recommends that CMS consider requiring a standardized form for documenting the physician encounter, conducting physician specific outreach, and evaluating alternative oversight mechanisms. The OIG's analysis and recommendations are focused on strengthening the HH face-to-face requirements to ensure that valid and meaningful physician involvement is occurring, and that the health care needs of Medicare HH beneficiaries are met. CMS appreciates OIG's analysis and recommendations, and will continue to work with health care providers, specifically physicians, non-physician practitioners, and home health agencies (HHAs), to help them comply with the HH face-to-face requirements

The OIG recommendations and CMS responses to those recommendations are discussed below.

OIG Recommendation

The OIG recommends that CMS consider requiring a standardized form to ensure that physicians document all elements required for the face-to-face documentation.

CMS Response

The CMS concurs with this recommendation. We will consider whether or not a form will help resolve the issues identified in OIG’s report. However, we note that the use of a standardized form would eliminate some of the current flexibilities that providers are afforded. Providers are allowed to utilize existing information in the medical record, rather than completing a separate form, to document the face-to-face encounter. For example, the certifying physician can currently use the clinical note or discharge summary, as long as it meets the documentation requirements described in 42 CFR section 424.22; so long as the clinical note or discharge summary is dated and titled, the physician may simply sign the clinical note or discharge summary to document face-to-face encounter.

OIG Recommendation

The OIG recommends that CMS require physicians to include their National Provider Identifier (NPI) numbers on the face-to-face documentation.

CMS Response

The CMS non-concurs with this recommendation. OIG notes on page 16 of the draft report that, as of July 1, 2014, HHAs will be required to report the NPI of the certifying physician, if different from the physician who signed the plan of care, on the HH claim. The certifying physician is responsible for documenting the face-to-face encounter per the regulations at 42 CFR section 424.22, and the signature of the certifying physician is required on the face-to-face encounter document. If the intent of the recommendation was to address illegible signatures, CMS already has measures in place. Please refer to the Program Integrity Manual (PIM) Chapter 3.3.2.4 titled, “Signature Requirements” that discusses the steps to take when a signature is illegible, such as requesting a signature log or an attestation. This is a direct link to chapter 3 of the manual: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf>

Because of the measures in place under CMS’ PIM regarding signature requirements, along with the fact that beginning July 1, 2014, the NPI for both the certifying physician and the physician signing the plan of care are to be reported on the HH claim, we do not see the value added of having the NPI of the certifying physician on the face-to-face documentation.

OIG Recommendation

The OIG recommends that CMS develop a specific strategy to communicate directly with physicians about the face-to-face requirements.

CMS Response

The CMS concurs with this recommendation. We plan to issue additional educational materials to assist physicians in understanding and complying with the face-to-face encounter requirements. Examples of educational materials may include Medicare Learning Network

Connects™ articles, web-based training that can count towards continuing medical education credits and a special open door forum.

OIG Recommendation

The OIG recommends that CMS develop other oversight mechanisms for the face-to-face requirements.

CMS Response

The CMS concurs with this recommendation. CMS is implementing an oversight plan of HHAs through the Supplemental Medical Review Contractor (SMRC). The SMRC will perform approximately five document-only reviews for every HHA in the country to validate that the most recent/valid face-to-face encounter is in the medical record. This will allow CMS to have better oversight of HHAs and the face to face requirement since one CMS contractor will be overseeing implementation. Utilizing one CMS contractor for this review allows CMS to have a centralized source of data, leads to consistency in the review process and less variability in results. At the end of this one year service-wide review of every agency, CMS will review the final report by the SMRC and evaluate results and recommendations.

The CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

ACKNOWLEDGMENTS

This report was prepared under the direction of Joyce Greenleaf, Regional Inspector General for Evaluation and Inspections in the Boston regional office; Russell Hereford, Deputy Regional Inspector General; and Kenneth Price, Deputy Regional Inspector General.

Danielle Fletcher served as the team leader for this study. Other Office of Evaluation and Inspections staff from the Boston regional office who conducted the study include Amy Glynn. Central office staff who provided support include Clarence Arnold, Heather Barton, Mandy Brooks, and Christine Moritz.

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