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Transcript

Making Sense of the New Medicare Face-To-Face Requirements for Home Healthcare and Hospice

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We're fortunate to have four faculty with us today - Dr. Michael Fleming, Dr. Steven Landers, Dr. Mary Naylor, and Mr. Jeffrey Jeter. Dr. Fleming is Chief Medical Officer for Amedisys Home Health Services. He is a clinical associated professor of family medicine at LSU Health Science Center in Shreveport, Louisiana, and clinical assistant professor of family and community medicine at Tulane School of Medicine. Dr. Fleming has more than 30 years of medical field experience and is a past president of the American Academy of Family Physicians and the Louisiana Academy of Family Physicians. And he was founding president of the Louisiana Healthcare Quality Forum. Dr. Fleming also serves as Chief Medical Officer of Antidote Education Company.

Dr. Fleming?

Michael Fleming: Thank you. Joining me today are Dr. Steven Landers, Dr. Mary Naylor, and Jeffrey Jeter. Mr. Jeter is the Chief Compliance Officer and Corporate Counsel for Amedisys Home Health Services. Prior to joining Amedisys, Mr. Jeter served as Assistant Attorney General for the Louisiana Department of Justice, where he prosecuted healthcare fraud and nursing home abuse. He received his Juris Doctorate and also holds a master's in public administration degree from Louisiana State University. Additionally, he is a graduate of the prosecutor training course at Northwestern University of Chicago. He has also served as an instructor at both the Federal Law Enforcement Training Center and the Louisiana Law Enforcement Commission Officer Training Program.

Dr. Steve Landers is a family doctor and geriatrician at the Cleveland Clinic where he directs their Center for Home Care and Community Rehabilitation. Dr. Landers' clinical practice emphasizes in-home geriatric assessment and in-home

primary care (housecalls) for vulnerable elders, and his administrative responsibilities include serving as Medical Director and Chief Executive for Cleveland Clinic's home care services, inclusive of their Medicare Certified Home Health Agency, Hospice, Home Infusion Pharmacy, and Home Respiratory Therapy programs.

Dr. Mary Naylor is the Marian S. Ware Professor in Gerontology and Director of the New Courtland Center for Transitions and Health at the University of Pennsylvania School of Nursing. Since 1989, Dr. Naylor has led a interdisciplinary program of research designed to improve the quality of care, decrease unnecessary hospitalizations, and reduce healthcare costs for vulnerable, community-based elders.

Dr. Naylor is also the National Program Director for the Robert Wood Johnson Foundation program, "Interdisciplinary Nursing Quality Research Initiative" aimed at generating, disseminating, and translating research to understand how nurses contribute to quality patient care. She was elected to the National Academy of Sciences, Institute of Medicine in 2005. She also is a member of the RAND Health Board, the National Quality Forum Board of Directors, and Chairs the Board of the Long Term Quality Alliance. She was recently appointed to the Medicare Payment Advisory Commission, MedPAC. Dr. Naylor received her MSN and PhD from the University of Pennsylvania and her BS in Nursing from Villanova University.

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Dr. Fleming?

Michael Fleming: The learning objectives for this activity: upon completion of this activity, participants should be able to discuss the face-to-face encounter requirements of the CMS rule on healthcare providers that work together with home healthcare and hospice and assess the guidance comments provide (inaudible) encounter rule.

Our agenda that you will see today, we will begin with Mr. Jeter providing an overview -- a legal overview and CMS guidance on face-to-face. Dr. Landers will then discuss the face-to-face with a look at the rule. And then Dr. Naylor will present the quality issues with face-to-face. Following this, we will have an opportunity for you to ask questions, which will be directed to our speakers.

So beginning, I will introduce to you Mr. Jeffrey Jeter. Mr. Jeter?

Jeffrey Jeter: Great. Well, good morning, or good afternoon, depending on what time zone you may be in. Appreciate the opportunity to discuss the intricacies and the workings of the new face-to-face requirements.

And at the outset, I think it would be important for me to point out, particularly to physicians who have a substantial geriatric patient base, that there are separate face-to-face encounter rules that are applicable to home healthcare and hospice. And there are a lot of similarities between the two face-to-face encounter rules, but there are also some differences, and it warrants us looking at both of them separately to make sure that we understand exactly what it is that is expected of the physician with both the home health patient and the hospice patient.

So to begin with, let's start with the face-to-face rules that are applicable to home healthcare. The face-to-face encounter rules are effective for patients that are admitted on or after April 1 of 2011. Now, this deadline has been pushed back, and initially it was slated for January, but they pushed it back to April 1. I would point out that there seems to be some buzz behind the scenes that the government's being asked to extend this even further, maybe toward a July implementation date, but that's merely speculative at this point. And I think all practitioners should be ready and able to handle the face-to-face encounters as of April 1, 2011. And then if CMS decides to extend that deadline, then you'll have additional time to get prepared for it. But right now, the key date is April 1, 2011.

Now, the requirements here on the home health side are applicable only to patients who are being initially certified for home healthcare services. So it does not apply to patients that are already on service as of the effective date, nor do the face-to-face encounter rules apply to patients in home health that are being recertified on or after April 1, 2011. So it is really focusing in on the initial certification and the appropriateness of the patient for home healthcare at the very beginning of their home health treatment. And again, all of this is applicable as of April 1.

One common question that seems to come up is, all right, is this purely Medicare only? What about Medicare, Medicaid? What about Medicare Advantage plans? And the government here is focused primarily on Medicare, so it's required and mandated only for patients that have Medicare as the primary or secondary payer. With respect to Medicare Advantage patients, there is no requirement that Medicare Advantage beneficiaries have a face-to-face encounter, but it is left open to the individual MA plans as to whether they may separately require it. So it's going to be kind of a circumstance-based test, so on a case-by-case basis. You may have an MA plan that elects to do it, but the MA plans are not obligated to do it.

With respect to Medicaid, slightly similar story. There's no requirement for Medicaid patients, although there is a case-by-case basis for states. So for example, Ohio has a face-to-face encounter rule for their particular Medicaid beneficiaries. So in your individual state, you will need to check and see if Medicaid requires it separately, but there is not, at this point, a mandate from the federal government for Medicaid recipients to also have a face-to-face encounter.

All right, so the next big question then for your home health patients is, as a physician, what am I really required to do under these regs? And it sounds very simple on its face, but it is complicated in terms of some of the details. But when you boil it down, physicians are now required, with their home health patients, to perform two basic tasks. And the first is to document that an eligible face-to-face encounter has occurred with the patient. And then, secondarily, then, the physician is required to certify the patient's eligibility to receive the home health benefit.

So let's start with the requirement that you conduct an eligible face-to-face encounter. There are a number of conditions that you must satisfy in order for a face-to-face encounter to be deemed eligible under the statute. And so what they're requiring is that an eligible face-to-face encounter be one that is, first, conducted by either a physician, a nurse practitioner, a clinical nurse specialist, or a physician's assistant. So that encounter could be conducted by any one of those particular individuals, but note that only the physician is allowed to complete the face-to-face forms. So they're expecting the doctors to do the documentation, although the underlying visit could be conducted by a physician or one of the ancillary providers that work closely with the physician.

Then secondly, an eligible face-to-face encounter is one that is related to the primary reason that the patient requires home health services. In general, that should be the reason that the patient was seeing the doctor at the time of the face-to-face encounter, but you need to be wary because that's not always going to be the case. So for example, if you had a patient encounter that incur -- that occurred within the relevant time period, within that time window, that would otherwise constitute an eligible face-to-face encounter, but the reason that you were seeing the patient was unrelated to the reason that the patient was requiring home health services, then that particular encounter that you had would not count as a face-to-face encounter, and you would be then required to do a separate face-to-face encounter with the patient that addressed the specific reasons that the patient was needing home healthcare services.

And then I guess third, most important, an eligible face-to-face encounter is one that occurs within a particular window of time. And on the home health side, that window of time is some time between 90 days before the start of care for home health and not more than 30 days after the start of care. So in a situation where you may not have seen the patient for the reason they're receiving home healthcare, you could have seen that patient 30, 60, 90 days before their home care started. But even though you saw them, it wasn't related to the reason

they were getting home care, that patient then would come back to you for that face-to-face encounter some time from the time they started their home care to 30 days after that. And that's really why they built in that post-start of care 30-day window.

All right, next, moving on, then. You've now done the face-to-face encounter. The next question then that arises is how do we document that face-to-face encounter and what is the government looking for the physician to do in that documentation. It's important to note that the face-to-face encounter documentation is considered by the government to actually be separate from the plan of care, from that CMS form 485, although the face-to-face encounter documentation can be styled and looked at as an addendum to that 485, or as its own standalone independent form. But regardless of how it's styled, there are certain things that that face-to-face encounter form must have on it.

First and foremost, it's got to have a title on it that references that it's for a face-to-face encounter. That's one of the things the government is going to be looking at. Secondly, then, they expect you to document the date that that face-to-face encounter occurred, keeping in mind that you do have to get that visit into that relevant time window. Next, then, they're expecting the physician to identify the reason that the patient is needing home health services. So in other words, they're asking that you document what is really the supporting medical condition that is necessitating home health treatment for this particular patient. And then, similarly, they're expecting you to identify the skilled need of the patient for home health services, so do they need nursing? Do they need therapy? Do they need social work? Those types of issues they're expecting you to define in that face-to-face documentation.

Number five is going to be, I think, a big area that physicians are going to have to focus on because it's something that, from a regulatory perspective, is often very complex. But the face-to-face documentation is going to need to identify the reasons that the patient is homebound, or in other words, why is the patient requiring the services of home health and not needing to go back to a physician's office or receive that treatment outside the home.

And then the last two points seem kind of minor, but they are big issues that the government has spent a lot of time, effort and energy in the regulations trying to flesh out here, and that is that the face-to-face documentation must have the signature of the certifying physician. And again, even though you may have an NP or a PA or a clinical nurse specialist doing the face-to-face encounter, it is the physician's signature that counts on the face-to-face encounter form. And then, secondly, they expect that the physician dates the document. And it's not enough to not have your signature date and the home care agency come in and fill it in behind you or stamp it or anything like that. They're actually expecting that to be dated by the physician.

All right. So with respect to the documentation, then, there are some limitations on the documentation that the government has imposed, and we

need to spend just a few moments looking at exactly what the government says the documentation cannot do. So the question has come up, and CMS has had to answer on several occasions, what does that encounter documentation look like? Can we use some standardized form? And in particular, can we use a form that's been created and populated by the home care agency? And the government has routinely come back and said, no, no, no, they do not want standardized forms, and they do not want documentation that is supplied by the home care agency and merely signed off on by the doctor. The expectation here, from a policy perspective, is the government wants the physicians more intimately involved in the patient's home care services, and they want the doctor to be intimately involved in ensuring that that patient is appropriate for home care.

So they're not going to permit physicians to use a standardized encounter documentation that you just kind of sign off on or check off a couple of boxes. And the home care agency should not be completing those forms and just handing them off for the doctors' signature. Again, the expectation is that it's going to be the physician who is the one most intimately involved in creating this documentation. And again, they -- CMS continues to highlight the role of the NP, the role of the PA, and the role of the clinical nurse specialist, and doing the visit does not extend to signing that face-to-face encounter documentation.

All right, so now moving to hospice. Again, there are some similarities between the hospice and home care face-to-face encounter rules, but there are also several differences. The face-to-face encounter rules applicable to hospice are also effective as of April 1, 2011, but the time window in which you get that face-to-face encounter in is different for hospice. For hospice, the hospice physician, or a nurse practitioner, must have a face-to-face encounter with the patient before the 180-day recertification period expires, and then there must be another face-to-face encounter that's repeated for every 60-day recertification period after that.

Now, with respect to hospice, very similar to the applicability rules for home care. It's required only for patients that have Medicare as the primary/secondary payer. But again, individual states may have their own separate requirements, and MA plans may, on their own, require it with respect to hospice, although it's not mandated.

All right, so looking at the face-to-face encounter and certification for hospice, the hospice regs permit either the hospice physician or a nurse practitioner to perform that face-to-face encounter. Now, it's a little bit different than the home care side because they're not allowing physician assistants or clinical nurse specialists or other kinds of home care -- healthcare professionals to do that face-to-face encounter. For hospice, it is limited to the physician and the nurse practitioner.

Another substantial difference is that the hospice physician can be employed by the hospice agency or can be a contractor, such as a medical director with the

hospice agency. That's not permitted on the home care side. Additionally, the nurse practitioner, if that -- if that particular role is being used to do the hospice face-to-face encounter, is required to be an employee of the hospice agency. And then volunteer physicians and NPs are, for purposes of these regs, considered to be employees and may perform the encounters.

And then moving on, the content of the hospice certification is slightly different than that of the home health certification, as one would naturally expect, because of the differences in the services. The hospice certification form is required to include, first, an attestation that either that physician or nurse practitioner perform the face-to-face encounter, and it has to indicate the date that that encounter occurred, although it's interesting to note that, you know, the date of that attestation does not have to be the same date as the actual encounter. They can be on two different dates.

And then, if the face-to-face encounter is performed by an NP, that nurse practitioner is required to attest that the information that he or she collected during the encounter was given or was provided to the certifying physician. So then the NP has a role and has a sign-off that they have to do on the hospice face-to-face forms. And then, with respect to the specific content of the hospice certification, there is a physician narrative requirement that is required in order for that patient to be hospice eligible. And what they're asking for, and what CMS expects, is for there to be a brief narrative explanation of the clinical findings that justify hospice and that support that the patient has a life expectancy of six months or less. And again, they're expecting that narrative to be composed by the physician, to be written by the physician, and not merely to be something that's signed off on based on information provided by the hospice agency.

So the regs specifically say it's got to be composed by the physician, and it should reflect the patient's individual clinical circumstances. So they don't want a cookie-cutter approach. They don't want something where, every single hospice patient, it simply says this patient is terminal because they have cancer. They expect to see a level of particularity and specificity for each patient. And they specifically say that you should not have just checkboxes or standardized verbiage that you use over and over again. Again, they want it individualized for the patient.

The narrative attestation for hospice has also got to include some what I would call magic language. The government has said, you know, there really isn't magic language, but, at the same time, it should kind of-sort of look like this. And that attestation should say something to the effect of, by signing my signature, I attest that I composed the above narrative based on my review of the medical record or, if applicable, my examination of the patient. And that attestation has to appear above the physician's signature, and the physician is expected not only to sign the certification but then to also date it. But this can be done either manually or electronically.

So this next slide I think will lay out a lot of the differences between the hospice face-to-face encounter and the home health face-to-face encounter. And I think it's a good guide particularly if you have patients that are receiving both hospice and/or home health. It helps to lay out for you the slight differences between them.

The first major difference is, you know, hospice focuses on the propriety of continuing services. The requirement doesn't kick in until the recertification periods arise. Home health, by contrast, only focuses on the propriety at the time services are being initiated. Hospice is recurrent, whereas home health is a one-time only certification and face-to-face encounter. Under hospice, the agency staff may assist, which is simply, I think, an outgrowth of just the hospice benefit and how it's reimbursed. But on the home care side, the agency staff are not supposed to assist in helping the doctor do either the encounter or the certification.

Obviously, the timing is different. The window for hospice, again, is 30 days before [and up to 2 days after in exceptional circumstances]. The timing on the home care side is 90 days before to 30 days after. And then, another substantial difference between the hospice and home health face-to-face encounter rules is that, with hospice, there is an allowance made for exceptional circumstances related to that time window. And it's really built around issues where you may have a late-night admission or a weekend admission, and the government allows, you know, exceptional circumstances to expand that time window. But again, it's because of the, oftentimes, midnight type admissions and the critical need for hospice services for a patient who is terminal and, you know, in a lot of instances, the dying process has already commenced.

And then, lastly, the payment modalities are slightly different. Hospice, the payment can be made to the physician for the face-to-face visits by hospice, but the agency for the home care face-to-face encounters cannot directly pay the physician for that face-to-face encounter. And I know Dr. Landers is going to touch on some of the compensation issues, so I will leave that to his domain.

Michael Fleming: Dr. Landers?

Steven Landers: Great. Thank you. Thanks for including me. You know, this is one of these topics where I think, when you start digging in and looking at it, initially you're like, "Oh, man, you know, a new regulatory concern. There's a lot of paperwork issues. What a burden." But really, I think, you know, stepping back a minute, what we're really talking about is how do we help our patients stay home with home health. And that's a really rewarding aspect of medical practice. So, you know, in spite of the -- you know, the regulatory issues and some of the paperwork things, this is a really key part of medicine. Actually, you know, in-home care and keeping people home was invoked in the Hippocratic Oath, and it's a core part of what we do. So, you know, I look at this as a bit of a challenge for us, but also an exciting time to talk about how do we help keep people at home.

Now, a lot of what's been covered -- the nuts and bolts have already been covered. I just want to take a moment to talk about some questions that come up, and also some other perspectives from a physician standpoint that might help our understanding of this issue. One of the questions that I've heard a number of times is can a hospitalist, or a physician only seeing the patient in the hospital, certify the home health. And I think that the -- there's a couple directions here. I think the most common scenario would be that the hospital-based physician that's having this encounter would document and certify the need for home health based on the face-to-face encounter they had in the hospital and then hand that patient off to a community physician who would sign the plan of care and would also make note of the face-to-face encounter documentation provided in an addendum.

And most of the time, the management of that home care patient is going to be handed off to that community physician. Now, I do think that there are some clinical situations and in some practices where the hospital physician intends to follow that patient in the initial post-acute period. And in those instances, if the intention and the practice would be for that hospital-based physician to be the ongoing care provider during that home health episode, they may do both, sign the certification and the plan of care.

Now, this face-to-face issue is part of the general topic of certification of home care, and for that matter certification of hospice. My focus is on the home care side. And one of the often-overlooked issues in the certification of home care is that there are reimbursement mechanisms for physician review and documentation related to certifying home care. So this is a good opportunity for physicians to re-familiarize themselves with those billing codes and for home care agencies to re-familiarize themselves with these codes to remind their physician partners about this opportunity. This is one of the few instances in primary medical care where non-encounter-based services are reimbursed.

And so, while, you know, we often will cringe with -- about paperwork and what burden that might entail, often because we say, you know, we're not paid for it. Well, in the instance of reviewing and signing home care certification plans of care, we can be reimbursed for those services. So I do want to point out that the initial certification of home care HCPCS code is G0180, and you need to document that you've reviewed and signed the plan of care and any communication you might have had about changing that plan of care with the home care agency. Maybe you recommended a different medication or a different discipline be involved, what have you, and just keep a documentation of that, and that should be sufficient for submitting a claim for that service.

And it has roughly similar work RVUs associated with it as a level three office follow-up visit, which is a very common service provided in a primary care or ambulatory care setting. Recertification is slightly less RVUs associated with it. Again, the face-to-face encounter is required for the initial certification of home care only, but you can bill for the recertification. And then there's also the care

plan oversight, again just reminding ourselves as physicians and the home care folks out there that there are ways for physicians to get some reimbursement for this work.

And then, with the face-to-face encounter, as best I can tell and for the feedback I've seen from the government, that if those encounters were included as part of reimbursable evaluation and management services that the clinicians provide, then, you know, those visits are paid for, as well. So the physician that's seeing the patient to take care of them and, as part of their care, prescribe home healthcare, that should be reimbursed as part of their regular care. And then, when they go through that plan of care, review the plan of care, make changes, communicate with the agency and sign that, that is another separately reimbursable service.

I just want to walk through an example of how this may work particularly with a patient coming home from the hospital. So a common scenario might be an older adult who's hospitalized with a heart failure exacerbation. Most of these patients, as we know, don't just have one problem but also have multiple chronic issues. And in this instance, the patient has arthritis and low vision. And when going home after this heart failure exacerbation, needs nursing due to the medication changes and the high potential for relapse of the heart failure as well as potentially physical therapy due to de-conditioning during this, you know, time where they basically were sitting around in the hospital, and there's also a concern, you know, with the arthritis, the low vision, this recent debility that they may be at risk for falls.

So in this instance, you know, the physician that's seeing the patient might document, "I saw the patient today for the diagnoses of heart failure, gait (ph) abnormality. And based on the encounter, I certify the patient needs skilled home care, and the specific services are skilled nursing and physical therapy. The patient's appropriate for home care because leaving the home is difficult and taxing, and the patient leaves the home infrequently. Specific issues individualized to this patient are teaching new medication regimen, assessment for side effects of the new medicines, like hypotension. Maybe we overshot with the doses of medicine for managing their heart failure, and their blood pressure's going to go too low. Also, observation of relapse. They need teaching about diet, sodium restriction and checking their weights. And their gaits become unsteady and they need a physical therapy assessment and home safety assessment, and likely gait training program to improve their strength, balance and endurance."

So that is an example of what might be in the doctors' chart, what might be on that addendum in this instance. Also, let's say the physician is submitting a charge for the home care certification. Often there's a question of what do you document? What's -- what should be in the chart? I think if the plan of care looks okay and it's what you're expecting and it all lines up, I think just simply putting in the chart that the patient's home health 45 plan of care was reviewed and signed, that relevant medical records were reviewed and that no changes

were indicated, would be a reasonable enough reimbursement for billing for those certification codes. And, you know, most of the content of my presentation I've gleaned from some of these references which will be available.

So I think that's my two cents worth, and I think now Dr. Naylor is going to be presenting.

Michael Fleming: Steve, thank you for including those references so that all of our registrants can have those to review.

Dr. Naylor?

Mary Naylor: Thanks, Dr. Fleming, Mr. Jeter, and Dr. Landers, Michael, Jeffrey, and Steve. I'm delighted to join you on this webinar and to join all of you out there in virtual world.

I am interested in kind of building on some of the themes that have been started in terms of offering a personal perspective, a bigger picture perspective on the opportunities and issues associated with the patients and family caregivers, and give some perspectives also from the community of nurses, nurse practitioners, clinical nurse specialists, physician assistants and other providers. So next slide.

So, you know, building on Steve's notion that this in one sense represents an opportunity, an important opportunity to improve patient and family caregiver outcomes and the care they experience, and here are some of my thinking around that. The first is that, you know, this is an encounter. It's a face-to-face encounter. It enables perhaps better assessment. Clearly, the encounter is taking place to understand the reasons for home health, the skill needs, that this person is homebound, et cetera, but it's an opportunity to identify what are problems, maybe new problems, earlier opportunities to identify those problems and act on them.

And in that sense also represents an opportunity to improve the patient and family caregiver engagement in their care. Certainly this does represent an opportunity to increase collaboration, the face-to-face connection with patients and among other health team members, and to improve continuity, again, just given the timing of when face-to-face encounters have -- need to occur, both for home care and hospice, to strengthen continuity among multiple providers. Next slide.

On the flip side, every time there's an opportunity, there's also clearly a set of challenges that might exist. And so home health agencies may be unwilling to accept or to continue to care for patients when they don't have timely encounter documentation. From the patient's perspective, this additional need to go for an encounter, especially if it's not at their home, and for their family caregivers, can be perceived as an additional burden if they don't fully understand what the encounter is for and how they might benefit, and if, in

fact, they don't -- if it's not perceived as adding benefit to the value of patient care.

It may further add to fragmentation if you introduce another provider into the care. Poor communication among patients and families, certifying physicians, non-physician providers, home health agency nurses, all of these now may be involved in care and players in this care. And if there's not great communication, the capacity potential for increased fragmentation.

There might be a mismatch if providers don't fully understand, physicians don't fully understand why this is, what this encounter is designed to achieve, et cetera. There could be referrals to other than home health services to avoid having to go through all of the documentation, certification that's required. And that might not be the best match with patients' needs. And in all of this, in terms of especially the patient's perspective, there may be duplication of services. Next slide.

Alternatively, we -- you know, it's kind of like flipping the coin each time. Now you have an engagement of nurse practitioners, CNS, clinical nurse specialists, physician's assistants and other providers, and here might be an opportunity to maximize on the unique contributions of these providers. Nurse practitioners, clinical nurse specialists, focus on comprehensive care needs of patients across as they move from one side of care to another; the capacity to engage nurse practitioners and clinical nurse specialists, physician's assistants in the care of patients in their homes in a more direct and intimate way; the capacity to facilitate nurse practitioner and other nurse -- non-physician provider's collaboration with physicians, and to ultimately advance team-based care. Next slide.

But again, recognize placing F2F within the context of what's going on, it is not the only new requirement that exists. There are multiple requirements, and so this is going to require adaptation of teams and primary care practices, home health agencies to multiple requirements. The NP's role in the face-to-face in home health in particular is limited to the patient encounter and communication of findings with physicians. And this is in the context of a recent IOM report that is really promoting maximizing on scope of practice for owners as nurses within home health agencies, nurse practitioners, clinical nurse specialists, et cetera. And so we see states changing scope of practice laws, and we -- a requirement that may not be a match for that changing face of practice.

It is my understanding of -- welcome Jeffrey's and Steve's comments on this -- that these encounters by nurse practitioners and others must be consistent with the Stark rules. And I want to reflect on what might be happening in home health agencies. So Jeffrey told us about the role and sort of boundaries in terms of home health agencies, but in many ways there will be pressure on these home health agencies to promote patients' acceptance of the need for a face-to-face encounter, when it's not taking place, when it needs to take place in outside of the patient's home, to, you know, really assist, as home health staff

often do, in arranging for the community services that need to make things happen to assure physicians' compliance in a timely way, and so -- and other administrative challenges.

So in terms of recommendations -- next slide -- I think we need people to fully understand what are the potential benefits to patients and family caregivers and local champions to really help promote the value of the face-to-face encounter, especially from the patients' and family caregivers' perspective. And we need to make sure that patients and family caregivers understand these new expectations, new opportunities that they are going to be having as a result of this change. And clearly, there's a continued need for webinars, such as this, to make sure people all are on the same page in terms of expectations, and again, focus on patients' benefits.

I certainly hope that, as this moves forward, we think about the capacity to streamline and standardize documentation systems. We certainly need to be constantly monitoring adherence and assessing the impact of this change on all stakeholders, not just on the providers of care. and finally, as we get to new places in our understanding about which practitioners now within their states are able, within scope of practice laws, to deliver what kinds of services, I hope that we can get to a point where we continually update these regulations to be consistent with both changes in scope of practice and evidence about their impact.

Thank you.

Michael Fleming: Great. Thank you, Mary.

Now, you have -- all of you that are registered and on with us have the opportunity to type questions. I'll go through and ask the questions and -- of our experts, and we will -- hopefully we'll be able to answer as many of your questions as we can.

Jeffrey, this question from one of our registrants, "Will the new technologies, such as Skype, qualify for the face-to-face encounter?"

Jeffrey Jeter: The not-so-simple answer is yes and no. I think, as the face-to-face encounter rules were drafted, I think the government contemplated that there would be tele-health technologies available to meet the requirements. However, when you dig down and you look at the requirements for tele-health, it makes it very difficult from a practical standpoint.

So for example, you may be able to use Skype under a tele-health model, but in order for it to qualify, that patient would have to be at an acceptable originating location, and the patient's home is not deemed to be an acceptable originating location. So while it is possible to be done, in a -- from a practical standpoint, that patient would probably have to go to a -- one office in a doctor's office to

have a tele-health visit with a doctor sitting in another office. So I think there are some practical difficulties here.

And much like anything that the government rolls out, with a new change in a regulation or some new major reform, there are always opportunities to improve that over time. And I think figuring out the right way to handle the tele-health application is going to be something that's going to have to be handled in subsequent regulations over the forthcoming years. And I really think, ultimately, that's where we're going to move because it is the most efficient way to do it. It's safest for the patient. But I think our technology has outpaced our regulations in some respects, and so we need to do a little bit of tidying up from the regulatory standpoint.

Michael Fleming: Okay, next question. How should, or how can home health agencies be helping me to meet these requirements? Steve?

Steve Landers: I think the short answer is that this is a responsibility of the physician and physician's practice to get these things done. Now, I think helping a physician practice understand the rules and helping educate them, helping provide feedback on their systems and processes for addressing this is appropriate. I do think that, you know, if there's access to information that the doc doesn't have and that can be of help, I think that that's reasonable. But by and large, this is a physician responsibility, but the -- I think the home care providers can educate docs, and their staff, for that matter, on the logistics.

Jeffrey Jeter: Yes, I would tend to agree with Dr. Landers. I think the educational opportunities are out there, and home care should be taking advantage of those. In particular, as Dr. Landers went through the care plan oversight, certification and recertification rules, those are some opportunities that are there for physicians, and home care agencies should be pointing those out and assisting physicians to the extent that, obviously, we can and still be in compliance with the law.

Additionally, physicians are expected to understand homebound status, and I think these new face-to-face encounter regulations elevate the type of understanding that doctors need to have about homebound status. And it is not an easy topic to really understand, and I think home care agencies are in a unique position to be able to educate physicians about the subtleties of homebound status so that, when the physician is certifying and signing off that the patient's homebound, that they're doing so with full knowledge of what the regs provide, and you don't miss opportunities for patients who may need home care services, and that you're also then documenting appropriately the needs for those that end up receiving home care services.

Mary Naylor: And let me just add--.

Steve Landers: --I think that -- oh, I'm sorry, Mary. Go ahead.

Mary Naylor: No, I was just going to say, I -- in -- you know, on the opportunity end, I think this does represent a really terrific opportunity for physicians, both those based in hospital and community, to get a better understanding of what home care offers and the nature of services and the kind of issues and challenges that home care agencies can address. So it -- you know, beyond the face-to-face encounter itself, it does represent a real great opportunity for improved collaboration and understanding not just about what needs to take place for this rule to be effective, but rather where and how this collaboration can result in better outcomes for patients.

Steve Landers: Yes, absolutely. And I just want to add one more point to what Jeffrey was saying about the homebound issue, is -- and this goes back to -- actually I was on a panel a couple weeks ago with Congressman Ed Markey, who was involved with the legislation behind the definition. And what he pointed out is that we specifically in Congress made it so that, you know, patients that need outpatient medical care, for whatever reason, or patients that are in an adult day program can have access to home care services if that's appropriate. And many physicians don't have a -- don't know the -- in some cases the exceptions, if you will, or the opportunities for patients to get care at home, and they have a very narrow view of homebound. And this, again, is an opportunity to explain who might be appropriate, the breadth of services that might be offered, and how to really help people.

Jeffrey Jeter: And let me just add to that. I think, at the end of the day, it's really easy for everybody to wring their hands about these regulations. And from a home care agency's perspective, it complicates how they treat their patients. From a physician's perspective, it's easy to say, "Well, it's just one more piece of documentation that I'm being forced to do." But I think, if you take a step back and you look at the opportunity to improve the quality of care that's being delivered to our patients, the face-to-face encounter rules I think are a great tool to help us do that. And really, the government wants the doctors to be involved in the home healthcare being delivered to their patients, and this is certainly a way to push that forward. And as we think about healthcare and how it's evolving over the coming years and the opportunity to look at it really as a continuum of care with the physician really at the core of it, driving decisions about their patients' care, I think this pushes us down the road of improving quality of care and decreasing cost and handling the healthcare crisis that we're facing in this country in a much more effective and cost-efficient manner.

Mary Naylor: Let me just -- one final point, and just to also think about the unique and important contributions of non-physician providers in this whole continuum of services that we're talking about. So the real opportunity here is also to think about ways in which nurse practitioners and clinical nurse specialists and physician's assistants really can uniquely contribute in collaboration with the team, physicians and patients, to make things happen. So talking about the efficiency and effectiveness of services really also helps to figure out how to capitalize on those contributions.

Michael Fleming: Okay, next question. Are certified electronic signatures accepted? Jeffrey?

Jeffrey Jeter: Yes. The regs say that this can be done electronically.

Michael Fleming: Great. There are some of you -- we've had a number of questions, and there's some of the questions we're not going to get to during the time of the webinar. And I want you to know that we will answer those personally. We have your e-mail addresses. And I will make sure that you get an answer to your question.

Another question, how important is that attestation statement for hospice face-to-face? The questioner says, "I've done probably 30 face-to-face visits so far this year and have not written something like that." Jeffrey?

Jeffrey Jeter: Yes. The government has indicated that this narrative attestation is essential, and actually the narrative attestation requirements preceded the face-to-face encounter regs. So, you know, I think having that attestation in there -- and again, it doesn't have to be verbatim, but the government is expecting to see kind of certain aspects to it in there, that, you know, it was done by the physician and that the types of evaluation was done and that the patient was appropriate for hospice care. You can word it, I think, in any way that you specifically want to as long as you're hitting on the main topics that the government wants to see.

Michael Fleming: Great. Well, a comment is that I have a document from CMS that states that an NP, a CNS, PA or physician can complete the face-to-face. So what does this mean with that document from CMS? You guys want to comment on that?

Jeffrey Jeter: It's probably the distinction between doing the encounter and doing the documentation. You know, certainly they want the NP, the clinical nurse specialist or the PA to have the ability to actually do that encounter itself, and I think that that goes with the whole policy implication of providing more effective and efficient care. But they're expecting to see the documentation signed off on by the physician.

Mary Naylor: So the distinction is exactly that. The actual encounter can be by any qualified non-physician providers with communication to the physician about the findings of the encounter and the actual certification adaptation. So I think that that's -- you know, this was a real opportunity to understand who could, you know, do that kind of assessment and to whom it needed to be communicated for certification.

Michael Fleming: A question: does the -- does the ruling of House Resolution 3200 as being unconstitutional in its entirety have any bearing on the continued need for these visits?

Jeffrey Jeter: Well, you know, the -- as kind of web background, I think we all know that several federal courts have found the Patient Protection Affordable Care Act to

be unconstitutional. The basis for the unconstitutionality really centers on what the courts feel is kind of an over-reach by the government's authority under the Commerce Clause to mandate insurance coverage to be purchased by individuals.

There's a split among the different circuits that have looked at it, both as to the constitutionality and unconstitutionality of it. And then, at the same time, there's a split in the circuit as to whether the entire statute is now unconstitutional or whether just this individual mandate portion of the Affordable Care Act can be stricken and the remainder of the statute is valid.

I think what is most telling is CMS has not announced that the face-to-face encounters are now off the table because of the constitutionality decisions by the courts. And really, this is just the enabling statute, so CMS promulgated the regulations based on the Act, but those regulations have not been withdrawn. So this is something that we've played out over time. Certainly this will end up at the Supreme Court. And so there may be a day where they come and say, no, the entire statute is stricken, or the entire statute is valid. But if they strike it at that point, then I think CMS would have to revisit it. But as of now, it's on the books and it is slated to go into effect April 1.

Michael Fleming: Steve, what about patients who are certified and then go to the -- go back to the hospital, are discharged from home health, and then have another initial certification at the start of their new care plan?

Steve Landers: I think for that new care plan, basically you have to start with that start-of-care date for that new plan of care, for that initial start of care. and if there was an encounter in the appropriate time period preceding that start of care related to the reason that the person was getting home care that hasn't really dramatically changed, then that could probably be documented on the certification, you know, on the addendum to the certification that that be included. If it -- if the prior encounter was unrelated, let's say, you know, they were getting home care because of heart failure or they fell, broke their hip, went in the hospital, you would need -- you know, and the reason they were getting home care after the hospital was related to hip fracture care, you'd have to be sure that the -- there was an encounter that documented, you know, something along those lines because it would be a different issue. But if it's in the right timeframes and it's relevant to their home care, it should be fine to use those encounters.

Michael Fleming: If we -- if the physician has a form that has documentation of face-to-face encounter and the physician's logo at the top, is this okay to be using in order for the physician to get -- to document the face-to-face encounter?

Jeffrey Jeter: My view is that it would be appropriate. I don't think the government is hung up too much on additional things that are on the form, whether it's a logo or a letterhead or something else. I think they're looking for the substance of that document, and are you documenting that you had that face-to-face encounter? Are you documenting that the patient's appropriate for home care services, et

cetera? If there are other things that are on it, I don't think that makes the document inherently defective.

Steve Landers: Yes. I think the underlying issue on the question also was about, you know, there's the statement that the home care company cannot provide standardized documentation. But can a physician who -- as part of their documentations, can they craft their own, you know, templates, if you will, and forms? And in some of the Q&A back and forth with CMS, it seems like that's considered reasonable. If that's a tool that the physician created, or their practice created for their own management of home care patients. But that's not something that can be provided by the home health provider.

Michael Fleming: There's a question from a hospice physician. Do we need to see each hospice patient if they have seen their primary care provider within the time window?

Jeffrey Jeter: I think, as long as they have seen a physician, I don't think that whether or not it's the hospice physician is necessarily impactful.

Michael Fleming: Steve, any comment on that?

Steve Landers: The -- for the hospice face-to-face, that encounter would have to have been contracted with the hospice. So assuming that the hospice made arrangements for that -- and we can confirm this with a follow-up on the e-mail, but my understanding is that that needs to have been a physician that was either employed or contracted with the hospice program.

Jeffrey Jeter: And a lot of that is driven just simply by how the reimbursement flows for hospice. It generally flows entirely to the hospice provider, and then it's kind of meted out to the ancillary providers and, in a lot of cases, to the physicians that are performing work.

Michael Fleming: If a home health discharges a patient to hospice, will there be a need for another face-to-face encounter for the hospice side?

Jeffrey Jeter: My view would be yes, unless there is another face-to-face encounter that met the requirement for the hospice. So conceivably you could have one doctor that does it all and it meets all the relevant timeframes. Probably not a likely scenario. So again, if you step back and think, conceptually, what is the government driving at, they're trying to make sure that the patient has been seen by a doctor and is appropriate for the services they are receiving. So for the home care side, if the same type of encounter would qualify for hospice based on what the doctor saw, then it could be, but I think it's generally going to require separate face-to-face encounters.

Michael Fleming: I want to remind all that have joined us that this webinar and the content will be available online for six months so that you can get these slides and review and use them. You'll be able to obtain this at www.antidotecme.com/face2face.

We thank you for participating in today's seminar, and we thank our faculty for joining us. Please take a moment to answer the questions that will pop up. Upon successful completion of the post-test, your certificate will then be displayed and available for download in PDF format. We look forward to you participating in future webinars with us. Thank you.