

2017 March on Washington Lobby Day Tool Kit

2017 MARCH ON WASHINGTON
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WASHINGTON, DC

Medicare Home Health Face-to-Face Physician Encounter/Certification Reform

Background:

As part of the Patient Protection and Affordable Care Act (PPACA), a Medicare beneficiary must have physician face-to-face encounter to qualify for the home health benefit. However, Medicare's implementation goes far beyond a simple and sensible requirement of a physician encounter, creating an unmanageable paperwork burden for physicians and home health agencies.

Initially, the Centers for Medicare and Medicaid Services (CMS) required an ill-defined physician "narrative" leading to thousands of claim denials solely on the basis that the physician narrative was deemed "insufficient." As a result of these problems, CMS rescinded the narrative requirement beginning January 1, 2015.

The current physician encounter documentation requirement may be worse. Eligibility determinations are now based the physician's record to the exclusion of the rest of the patient's medial record. As a result, eligible patients are denied coverage.

Issue/Concerns:

- Claims are being wrongly denied hindering access to and delaying necessary home health services.
- Unnecessary administrative paperwork requirements have been added to physician's responsibilities, reducing the time available for patient care.
- A lengthy backlog of home health services appeals has developed leaving providers without reimbursement for services already provided.

Talking Points:

- Patient eligibility for Medicare coverage of home health services should be based upon the full patient record, not just a very limited part.
- Physicians should be permitted to focus on patient care not endless Medicare paperwork that simply repeats what is in other documentation.
- While a requirement that patients have a face-to-face physician encounter adds elements of integrity to the Medicare eligibility certification process, duplicative paperwork does not.

What Congress should do:

Support the legislative proposals that:

- Direct CMS to determine a beneficiary's eligibility for Medicare coverage of home health services through a review of the entire patient record, including the records of the home health agency. Where the physician's record may be insufficient to determine eligibility, the home health agency's record can fill information gaps. This will move CMS from a partial record review to a complete record review, ensuring payment accuracy.
- Allow CMS to negotiate settlements for the backlog of 20,000 – 30,000 denied cases currently facing appeal. CMS has indicated that it needs this authority so that the cases can be settled efficiently for all parties.


HOMECARE HOSPICE
National Association for Home Care & Hospice

228 Seventh Street, SE
Washington, DC 20003-4306

For More Information: Please Contact NAHC Government Affairs at 202-547-7424