HCPro
a division of BLR

Clinical Management Strategy for Homecare Providers

Homecare DIRECTION

Volume 23
Issue No. 3
MARCH 2015

Email: *info@beaconhealth.org* • Website: *www.beaconhealth.org*

Home health agencies, physicians still face challenges after F2F narrative nixed

Editor's note: This article is the first in a two-part series that covers the industry's continuing malcontent with face-to-face documentation requirements in the wake of the physician narrative. In part two, experts will weigh in on the latest drafts of the voluntary electronic template to aid physician documentation in this realm and its proposed paper counterpart. They will also discuss what needs to change to fuel improvements in this ever-contentious sphere.

For more coverage of face-to-face issues, see last year's June, July, and December issues of **Homecare DIRECTION.**

When CMS first announced its plans to do away with the physician narrative component of required face-to-face encounter documentation last July, many home health agencies met the news with cautious—or in some cases, unbridled—optimism. However, as 2015 dawned, and providers launched new efforts to secure sufficient evidence of patients' home health eligibility without the framework (however limited) the narrative provided, this hopefulness gave way to confusion and frustration.

"Everyone's in a panic," says **Nicola Kelly, RN,** owner of Coastal Home Health Solutions in Palm Beach Gardens, Florida. "They just don't know exactly what's expected. A lot of people have latched on to this thing that now there's no longer a narrative ... and they were delighted about that until they realized now [CMS is] going to be looking at the physician's progress and clinical note to have all that information."

Providers and their advocates list an array of obstacles to this new means of eligibility justification, including scanty guidance from CMS and poor compliance by physicians due to their own confusion and cramped schedules. Such tensions continue to mount as a new wave of reimbursement decisions—and potential

HCPro
a division of BLR

Homecare DIRECTION (ISSN: 1069-4560) is published monthly by Beacon Health, a division of HCPro. It is devoted to clinical management and regulatory issues and developments within the home health care industry. This publication is intended to offer guidance and suggest practical techniques for providers related to the delivery and documentation of homecare services. However, the publisher assumes no liability whatsoever in connection with its use.

Subscription price: $337/year. Contact Beacon Health for • multiple-copy subscription prices • site licenses • reprint permission • back-issue orders.

Production and business offices:
Beacon Health, P.O. Box 3049,
Peabody, MA 01961-3049
Telephone: 800-553-2041
Fax: 781-639-0179
Email: *info@beaconhealth.org*
Website: *www.beaconhealth.org*

STAFF TRAINING QUIZ: ANSWER KEY

1. c

2. b

3. d

4. c

denials—based on the first round of claims filed under the new requirements looms closer: Kelly thinks providers may begin seeing the financial outcomes of their latest documentation efforts as early as March or April, depending on the lengths of their patients' episodes.

The tale of the narrative

The home health sector has expanded rapidly in recent years thanks to the nation's swelling population of elders and an increasing emphasis on providing home-based care to cut costs and better accommodate patients' wishes. This growth has also ushered in intensified efforts by the federal government to safeguard against fraud and abuse throughout the industry, which has been flagged as at risk for these misdeeds.

Consequently, in a concerted effort to both cut down on improper Medicare payments to home health agencies and promote the delivery of patient-centered care, the Affordable Care Act (ACA) has mandated since 2011 that physicians document that they, or an allowed non-physician practitioner, have had a face-to-face encounter with a patient before certifying the individual's eligibility for the home health benefit. The legislation also established an expected timeline for this encounter: It must take place within 90 days prior to the start of care or up to 30 days afterward.

At the same time, CMS began enforcing a new documentation requirement not explicitly spelled out in the ACA, which quickly became the primary target of stakeholder fire. The additional provision directed physicians to write, sign, and date a narrative explanation of why a patient is both homebound and in need of skilled nursing or therapy services based on observations made during the encounter—an expectation providers, physicians, and their advocates decried as overly burdensome and ill-articulated, and one that the National Association for Home Care & Hospice **blames** for "tens of thousands" of home health claims denials. The trade association is still pursuing a lawsuit it launched before CMS' elimination of the narrative requirement to help providers recoup losses in revenue due to the provision.

The federal government has also made some startling discoveries surrounding the narrative.

Last year, the Office of Inspector General found that between 2011 and 2012, 32% of home health claims that required face-to-face encounters didn't fulfill CMS' documentation standards, resulting in an estimated $2 billion of improper payments. And the situation got bleaker from there: During a recent open door forum (ODF) about the **latest drafts** of electronic and paper templates intended to help physicians better fulfill face-to-face requirements, Melanie Combs-Dyer, director of the provider compliance group at CMS, **pointed to** insufficient documentation in this arena as one of the drivers behind the staggering 34.1% spike in improper payments between the November 2014 reporting period (51.4% improper payments) and the same time frame in 2013 (17.3%).

'Replacing one burden with another'

In response to this considerable backlash, CMS introduced and eventually **finalized** its July proposal to strike the narrative, an update that took effect this January. However, in place of the narrative, the agency now expects there to be sufficient evidence in the documentation completed by a certifying physician for a patient's record (e.g., discharge summary, progress or visit note) to support that individual's eligibility for home health.

Although Combs-Dyer said that the move had a "greatly simplifying" effect on face-to-face documentation requirements, many experts aren't convinced.

"They're just replacing one burden with another burden for the home health agencies and the physicians," says Kelly.

This sentiment is echoed by experts across sectors, who cite a host of factors that make the weight of this new burden comparable to the last.

DeAnn Briscoe, BSN, RN, COS-C, senior education consultant at Foundation Management Services, Inc., a Denton, Texas-based education and services provider for homecare and hospice professionals, thinks the new provision is too bogged down by semantics to constitute a true regulatory update.

"None of the requirements have really changed," says Briscoe. "The physician doesn't have to provide a narrative, but in ... their visit note or their discharge summary, they still have to state why they're referring to home health."

In addition, many providers think the required placement of this evidence—in a physician-kept record—severely limits not only their contributions to the defense of a patient's eligibility for home health services, but their very access to the materials that determine their payment.

To mollify stakeholders who expressed this concern in comments on the 2015 proposed rule, CMS added a new provision in the final edition that requires physicians to share a patient's record with an HHA upon request. However, Kelly believes this directive does little good without a specific consequence attached for noncompliance.

Physician-agency fissures

But lackluster incentive is just one obstacle to garnering sufficient documentation from physicians, according to providers.

A more immediate problem is the inadequate or delayed awareness of many physicians that a change in requirements took effect in the first place, says **Michelle Morales,** administrator at Serenity Home Health, LLC, in Wichita, Kansas.

"We were faxing [physicians] the form they were supposed to complete with the narrative, and then January hit, and they were like, 'Where's our form?' " Morales says.

She attributes this blindsiding to CMS' failure to disseminate enough information about the change.

But poor education isn't the only major issue facing physicians, says **Constance F. Row, LFACHE,** executive director of the American Academy of Home Care Medicine, an Edgewood, Maryland–based professional association for physicians who work with home health populations.

"Any agency can always say, 'Well, physicians need to be better educated,' but ... the issue is efficiency, and the issue is how much CMS is asking for in relationship to the actual amount of time physicians have," Row explains, adding that this expectation is disproportionate to the payment physicians receive for home health certifications.

Row acknowledges well-documented gaps in physicians' education about the home health industry that extend back to medical school curriculums. However, she contends that a more urgent challenge with the face-to-face requirements is that physicians, especially those whose home health patients make up a small percentage of the population they serve, don't have enough time to read the scant—and confusing—guidance CMS has supplied regarding the change in documentation directives (i.e., MLN Matters article **SE1436**), let alone to author a detailed justification for each eligible individual.

Despite their frustrations over compliance shortfalls and perception that some physicians can be resistant to suggestions for improvement, home health providers are also sympathetic to this plight.

"Doctors are busy enough," says Kelly. "They're expected now to do the face-to-face encounter, the physical examination of the patient, and fill in [extensive] documentation. It's unreasonable."

Adding to the burden are the unique criteria for home health eligibility.

"I can't think of one other industry ... that requires that a patient be homebound," says Briscoe. "It is unique to home health, and so I think that's a struggle for physicians to bring that language into their practice."

This inherent challenge in referring to the setting has been compounded in recent years by both the new and old face-to-face requirements, which experts say direct physicians to document in a way that differs fundamentally from how they write in virtually all other contexts (i.e., using descriptive explanations instead of listing diagnoses and procedures to order services).

Far-reaching fears

Regardless of their outlook, experts seem to share a grave fear: that if physicians continue to be shouldered with shifting and steepening documentation requirements, they will begin shying away from referring to home health.

"Pretty soon, they're just not going to want to order homecare because it's too time-intensive, and there are just too many things that have to be included," Morales says.

And Kelly says if the deluge of requirements and cited instances of noncompliance continues, agencies themselves may become more reluctant to take on patients who could put them at risk for claim denials.

She adds that this skittishness would wind up hurting the very people both agencies and physicians are charged with serving.

"The agencies are there to provide care to the patients, and the agencies are suffering, but ultimately in the end, the patients are going to suffer, too," she explains.

In addition, Briscoe questions whether the documentation requirements are effective enough at flagging fraud to justify the extra burden they place on agencies and physicians.

"If the intent of the face-to-face encounter is to fight fraud, the fraudulent agencies will probably find a way around this too," she says.

She adds that the original ACA provisions that require a certifying physician (a third-party clinician who has no financial stake in the home health agency) to have a face-to-face encounter with a patient to vouch for their home health eligibility is practical. But in terms of documenting this visit, she explains that physicians have long been required to sign the certification statement located on the patient's plan of care (Form CMS-485)—a policy that she thinks is just as effective at establishing the validity of a patient's eligibility as the much more taxing documentation expected on top of this signature today.

Clearing the compliance fog

Despite widespread stakeholder distaste for the new documentation requirements, Row points to a silver lining: CMS eventually translated the industry's resounding criticism of the physician narrative into policy change.

"The good news is, of course, the change in the narrative requirement. And that certainly is good news and is something that we have advocated for, for a long time," she says.

In addition, Morales thinks that, eventually, the new requirement could be an improvement over the narrative—provided that CMS circulates more information for both providers and physicians.

In the meantime, she's leaning heavily on her marketing and front office teams to liaise with physicians' offices to secure patients' records and ensure their contents include sufficient justification of a patient's home health eligibility, even if it means sending marketers out to a physician's office to speak to the front desk staff, well, face-to-face.

Prior to the new requirements taking effect, Morales also sent marketers to physicians' offices with a sheet explaining the changes—a step that Kelly encourages all agencies to take, especially with the impending period for reimbursement decisions under the new requirements.

In addition to distributing makeshift educational materials, experts recommend requesting and/or creating additional documents to flesh out patient records.

To grant providers additional control over the materials that could affect their reimbursement, CMS specified in the final rule that agencies can share their own notes with certifying physicians for inclusion in the medical record. Morales is taking advantage of this allowance by sending physicians a clinical summary of

each patient that articulates the agency's findings upon his or her admission. In addition, Briscoe suggests that after receiving and reviewing a physician's face-to-face encounter documentation, providers should send in excerpts from the patient's comprehensive assessment, complete with OASIS items that support the physician's specific explanation of eligibility, an option exampled in MLN SE1436.

One caveat for submitting supplemental documentation: CMS requires physicians to review and sign any materials placed in a patient's medical record. Accordingly, agencies should stress this expectation to their referral sources when providing them with additional documents for a patient's file.

Briscoe also suggests that providers ask physicians to include an attestation letter for extra support of a patient's eligibility. She says this letter should describe, with detail and specificity, why the physician referred the individual to home health, including evidence of homebound status and the need for skilled services.

However, Row cautions against stretching physicians too thin with an onslaught of requests for documentation that, although perhaps ideal, is optional.

"To the extent that they can, [agencies] need to accept what documentation is already in the medical record rather than making physicians fill out more and more different forms," she says. "Physicians are simply too busy and to make things more complicated than they already are is simply going to make physicians less and less willing to spend the time to do all this."

To decrease frustrations surrounding necessary documentation requests, Morales emphasizes the importance of cultivating relationships with physicians—a process that can not only boost client rates, but can also establish trust and facilitate effective collaboration in the face of challenging new expectations. She says that this cohesion between her agency and referring physicians has eased the adjustment period to the new face-to-face requirements.

"Physicians understand that we are all struggling to try to meet the regulatory requirements with limited time and resources and will work with us to the extent that is necessary to ensure compliant documentation," she says. "We try to help them as much as we can, and we would never ask them to do anything that we wouldn't stand by them for."

Besides making every effort to guide physicians and support their efforts, Morales says fostering familiarity between them and the agency's visit staff is a crucial step toward achieving a productive working relationship.

"If one of our nurses or one of our therapists calls the physician, and [the physician] knows them, then they're going to give them what they need," she explains.

Row echoes Morales' call for comradery. Despite the palpable discord between the time constraints of physicians and the documentation needs of agencies, she explains that through collective advocacy efforts, physician groups—like their HHA counterparts—are striving to improve the face-to-face situation across the board.

"We are trying to work with other physician organizations to advocate on behalf of the patients," she says. "If we're successful in doing that, we will also have advocated on behalf of the agencies because … we're all in this together."