

National Survey Reveals Massive Administrative and Documentation Cost Burden of Physician Face-to-Face Requirement for Home Care

The results are in from a new home care provider survey on the impact of the onerous **Medicare home health face-to-face (F2F) requirement**.

Under this requirement of the Affordable Care Act, a home care provider cannot bill Medicare for services to a home health patient until the provider has obtained signed documentation from a certifying physician indicating that the patient had a face-to-face encounter with that physician 90 days prior to the start of home care or 30 days after the start of home care.

This F2F documentation process is separate from the existing and longtime established “plan of care” – or 485 form – which is also signed by the physician and already certifies appropriateness for home care.

Drawing nearly 3,000 comments from over 900 respondents, the nationwide survey on this issue asked home care providers about their experiences with F2F-related: claim denials from Medicare contractors; physician-engagement issues; cost impacts due to unbillable claims; compliance costs; and other related concerns. The survey was prepared and circulated by the **Forum of State Home Care and Hospice Associations**, an affiliation of state home care association leaders who are members of the National Association for Home Care and Hospice (NAHC).



F2F-related enforcement audits and claim denials are well underway in many of the nation’s Medicare Administrative Contractor (MAC) jurisdictions. **For 52% of the survey respondents who experienced F2F claim denials, the denials primarily resulted from MACs determining that the physician documentation was “inadequate,”** even though care was provided and the physician did sign the certification.

In fact, **the estimated cost of claims that home care providers could not bill due to F2F issues was as high as \$50,000 for 68% of home care provider respondents.** Such costs were between \$50,000 and \$100,000 for 15% of respondents, and between \$300,000 and \$1 million for 4% of respondents.

The survey results as a whole illustrate that documentation issues had a far greater impact on claim denials than did the timeliness of the F2F visit (only 7.5% of respondents said timeliness was a primary cause of claims denials) or the lack of a certifying physician signature (only 9.6% of respondents indicated this was a primary cause of claims denials).

Such findings reveal that confusion over how to document F2F – more so than the actual F2F requirement itself – is causing the most problems. In fact, **60% of respondents felt the MACs are requiring more documentation of the F2F than is actually required by law**, reflecting concerns voiced by Members of the U.S. House and Senate who recently wrote a bipartisan letter to the federal Centers for Medicare and Medicaid Services (CMS) about the “complicated, confusing and overlapping documentation requirements that exceed the intent of the law passed by Congress.”

This Congressional letter, signed by more than 75 Members of Congress, urges CMS to allow the F2F requirement to be met through the use of the existing 485 form instead of a separate, duplicative and overlapping documentation requirement. Several respondents to the survey indicated that such a change would substantially alleviate the burden of the F2F encounter requirement.

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Compliance with the requirement has also proven to be a logistical and administrative strain on providers. In cases where home care providers have sought to obtain additional or more complete documentation from physicians prior to billing for services, 51% of respondents indicated that the follow-up documentation was provided but it, too, was inadequate in most cases. **Twenty-four percent of respondents indicated that physicians most often refused to provide any additional or more complete documentation.**

Alarming, the written comments to the survey reveal that **many physicians told providers they would no longer refer to home health due to the repeated requests for documentation**, especially since none of these administrative activities by the physician or home care agency is reimbursable. And since the cost liability for billing F2F-compliant claims falls on the home care provider – not the physician – many physicians have expressed an unwillingness to expend time and resources for learning the complex documentation requirements or working to complete those requirements accurately when their own reimbursement is unaffected.

When asked to offer a dollar estimate of the administrative cost of compliance, home care providers most often cited a figure that hovered around \$100,000 a year. Many providers have had to hire additional staff simply to track down documentation and ensure that it is accurate prior to billing for services.

Respondents had many practical suggestions that would improve this process and still meet the Congressional intent of F2F. These suggestions included: a universal CMS-approved form; more education to physicians by CMS; use of the 485 form/plan of care (already familiar to physicians) to meet the requirement; and not requiring additional documentation of the F2F encounter for patients discharged from an institutional setting, given that a physician would have seen the patient immediately prior to home health (as required by the law and the intent of Congress) due to the post-acute nature of the home health services ordered.

Conclusion

These findings support the home care community's contention that F2F – and the documentation requirements specifically – are overly complicated and an unnecessary strain on provider resources. The Forum of State Home Care and Hospice Associations again urges further Congressional action with CMS to mitigate this administrative burden of F2F by simply modifying the existing 485 form for purposes of documenting physician oversight of Medicare home health services and considering some of the other practical suggestions offered by survey respondents for alleviating the enormous burden of F2F.

KEY FINDINGS

68% of providers said the cost impact of Medicare claims that could not be billed, due to F2F, was as high as \$50,000. This does not include the tremendous financial loss associated with actual claim denials by Medicare Administrative Contractors.

The administrative cost of F2F compliance is typically \$100,000 a year.

Many physicians indicate they will no longer refer patients to home health because of the F2F requirement, creating an access-to-care issue.

24% of respondents said physicians refused to provide appropriate documentation.

For 52% of the survey respondents that experienced F2F claim denials, these denials were primarily the result of "inadequate" F2F documentation – not the absence of a F2F encounter.