

## Supporting Statement – Part A

### Supporting Statement for Paperwork Reduction Act Submissions Medicare Program: Home Health Face-to-Face Encounter Progress Note Templates

#### **A. Background**

The Centers for Medicare & Medicare Services (CMS) is requesting the Office of Management and Budget (OMB) approval of the collection of data required to support the eligibility of Medicare home health services. Home health services are covered under the Hospital Insurance (Part A) and Supplemental Medical Insurance (Part B) benefits of the Medicare program. It consists of part-time, medically necessary skilled care (nursing, physical therapy, occupational therapy, and speech-language therapy) that is ordered by a physician.

In 2014, a final rule was published that updated the Home Health Prospective Payment System policy and implements a provision of the Affordable Care Act as a condition of payment (79 FR 66032); November 4, 2014) Section 3131(a) of the Affordable Care Act established a face-to-face encounter requirement for certification of home health services, by requiring that prior to certifying a patient's eligibility for the home health benefit, the physician must document that the physician or a Medicare permitted non-physician practitioner (NPP) has had a face-to-face encounter with the patient<sup>1</sup>. Additionally, the Affordable Care Act allows the Secretary to determine a reasonable timeframe for the encounter to occur. To implement the above provision of the Affordable Care Act, CMS finalized 42 CFR 424.22 (a)(1)(v) which requires that the physician responsible for performing the initial certification document that the face-to-face patient encounter occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care.

CMS also implemented three changes to the face-to-face encounter requirements for episodes beginning on or after January 1, 2015<sup>2</sup>. The first change eliminated the narrative requirement. Due to the substantial increase in improper payments and concerns voiced by the home health industry, CMS eliminated the narrative requirement as part of the face-to-face documentation.

However, the certifying physician is still required to certify that a face-to-face patient encounter occurred and document the date of the encounter as part of the certification of eligibility. For medical review purposes, CMS requires documentation in the certifying physician's medical records and/or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) to be used as the basis for certification of patient eligibility.

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<sup>1</sup> <https://www.gpo.gov/fdsys/pkg/FR-2014-11-06/pdf/2014-26057.pdf>

<sup>2</sup> Ibid.

Second, if a home health claim is denied, the corresponding physician claim for certifying/re-certifying patient eligibility for Medicare-covered home health services is considered non-covered as well because there is no longer a corresponding claim for Medicare-covered home health services. Lastly, CMS clarified that a face-to-face encounter is required for certifications, rather than initial episodes; and that a certification (versus a re-certification) is generally considered to be at any time a new start of care assessment is completed to initiate care.

In April 2014, the HHS Office of Inspector General (OIG) released a report entitled “Limited Compliance with Medicare’s Home Health Face-To-Face Documentation Requirements<sup>3</sup>.” In this report, the OIG recommended that CMS “should consider requiring a standardized form to ensure that physicians include all elements required for the face-to-face documentation.” In an effort to comply with this recommendation and with the aim to help reduce the amount of errors in submitting claims for home health services, CMS has developed a home health electronic template and a paper template to assist with documenting a home health face-to-face examination. CMS believes the use of the progress note templates may help assist physicians when documenting the home health face-to-face encounter for Medicare purposes. The use of these templates will be completely voluntary. They are intended only to assist physicians and other practitioners who order home health services in documenting the required elements in their progress notes.

## **B. Justification**

### **1. Need and Legal Basis**

In 2014, a final rule was published that updated the Home Health Prospective Payment System policy and implements a provision of the Affordable Care Act as a condition of payment ((79 FR 66032); November 4, 2014).

Also in 2014, the Office of Inspector General (OIG) conducted a study that reviewed 644 face-to-face encounters, the documentation did not meet Medicare requirements, resulting in 2 billion in payments that should not have been made<sup>4</sup>. 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 (Limited Compliance with Medicare’s Home Health Documentation Requirements, Report OEI-01-12-00390; April 9, 2014). The OIG recommended 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 the physicians about the face-to-face requirement, and (3) develop other oversight mechanisms for the face to face requirement. CMS concurred

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<sup>3</sup> <http://oig.hhs.gov/oei/reports/oei-01-12-00390.pdf>

<sup>4</sup> Ibid.

with all these recommendation (Medicare’s Home Health Documentation Requirements. Report OEI-01-12-00390.

In fiscal year (FY) 2014, the Comprehensive Error Rate Testing (CERT) program found that more than half (51.4 percent) of the home health claims were paid improperly.<sup>5</sup> Of the 1308 CERT-reviewed claim lines in error, approximately 90 percent were found to have insufficient documentation errors. The majority of these errors were due to inadequate documentation supporting the face-to-face requirement.

## 2. Information Users

The primary users of these new clinical templates will be physicians and/or Medicare allowed NPPs. The templates will help users to capture the necessary information needed to complete the face-to-face encounter documentation. This will help physicians and/or Medicare allowed NPPs comply with Medicare policy requirements, thereby reducing the possibility of a home health claim not being paid because of failure to meet Medicare requirements. Providers may submit the template as part of additional documentation requests made by Medicare review contractors. CMS’ Medicare review contractors will use the information to verify compliance with Medicare policy requirements.

## 3. Use of Information Technology

Physicians and/or allowed NPPs may use various information technologies to store these clinical record templates as long as they are consistent with the existing confidentiality in record-keeping regulations at 42 CFR 485.638. CMS does not use technology, but the HHA could use Electronic Health Record vendors to document the electronic submission.

## 4. Duplication of Efforts

Section 3131(a) 6407 of the Affordable Care Act established a face-to-face encounter requirement for certification of home health services, by requiring that prior to certifying a patient’s eligibility for the home health benefit, the physician must document that the physician or a Medicare permitted non-physician practitioner has had a face-to-face encounter with the patient. Additionally, the Affordable Care Act allows the Secretary to determine a reasonable timeframe for the encounter to occur. To implement the above provision of the Affordable Care Act, CMS finalized 42 CFR 424.22 (a)(1)(v) which requires that the physician responsible for performing the initial certification document that the face-to-face patient encounter occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care.

<sup>5</sup> <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports-Items/Downloads/AppendicesMedicareFee-for-Service2014ImproperPaymentsReport.pdf?agree=yes&next=Accept>

To date, this information was collected through medical documentation submitted to the review contractors to support Medicare coverage requirements. This information would be sent via mail, fax, or electronically.

These clinical templates are unique reporting forms that seek to capture the same information. They are voluntary and are not intended to be duplicative. Given the lack of success in collecting this information without a template, CMS hopes this voluntary form will improve compliance.

5. Small Businesses

The use of these voluntary new clinical templates will not place a significant reporting burden on small business providers. Physicians and/or Medicare allowed NPPs already maintain the clinical information, regardless of format, in the beneficiary's medical record. Because the burden estimates for providers are directly related to patient care, we estimate that a smaller patient census will lead to a reduced burden since smaller businesses have fewer staff, fewer patients, and complete less data collection etc.

6. Less Frequent Collection

CMS policy requires that the physician responsible for performing the initial certification document that the face-to-face patient encounter occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care. If physicians and/or allowed NPPs fail to document that the encounter occurred, their claim might not be paid. Providers are required to have this type of documentation to prove a Medicare claim is paid in good faith. Less frequent information collection by a physician and/or an allowed NNP would impede efforts to establish compliance with the face-to-face encounter requirement and violate the coverage requirements for the Medicare home health benefit.

7. Special Circumstances

Absent legislative amendments to the face-to-face encounter rule, we are unable to anticipate any circumstances that would change the elements in the clinical templates developed from this package.

8. Federal Register/Outside Consultation

The 60-day Federal Register notice published on August 12, 2015 (80 FR 48320). The 30-day Federal Register notice published on December 28, 2015 (80 FR 80771).

9. Payments/Gifts to Respondents

There will be no payments/gifts to respondents.

10. Confidentiality

Normal medical confidentiality practices are observed in accordance with 45CFR part 160, subparts A and E of part 164 of the HIPPA privacy rule.

11. Sensitive Questions

There are no questions of a sensitive nature associated with this information collection.

12. Burden Estimates (Hours & Wages)

Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Social Security Act require that, prior to certifying a patient as eligible for Medicare's home health benefit, the physician must document that the physician himself or herself or a Medicare permitted NPP has had a face-to-face encounter (including through the use of tele-health services, subject to the requirements in section 1834(m) of the Act)", with the patient. Therefore, the burden associated with using these new clinical templates is the time and effort put forth by the physician or the Medicare allowed NPP. Furthermore, because the physician or an allowed NPP has always been required to review the clinical information needed for deciding whether or not to certify or recertify the patient for Medicare home health services, we estimate it would take one physician or NPP approximately 10 minutes to complete the electronic clinical template and approximately 15 minutes to complete the paper clinical template.

We believe there are three main groups who could utilize this form: a general internist (i.e., the community general practitioner), a Medicare allowed NPP, and a hospitalist. Using Bureau of Labor Statistics<sup>6</sup> (BLS), we estimated the cost of a general internist would have a mean hourly rate of \$94.48 and a nurse practitioner (representing our Medicare approved NPP) would have a mean hourly rate of \$48.68. Since we could not find a listing for a hospitalist on the BLS, we used a different source to find the median hourly rate for a hospitalist.<sup>7</sup> The hospitalist median hourly rate used is \$102. CMS assumes each group would utilize the template a third of the time. For each group listed, we added 100 percent of the hourly wage rate to the wage rate to account for overhead and fringe benefit costs.

The burden estimate is based on the number of Part B claims billed with G0179/G0180, which are the codes the physicians bill when certifying or recertifying a patient for home health. Using a refined number, in 2014 there were 2,619,060 of these claims. We attributed half, or 1,309,530 claims, to the use of the electronic template and half, or 1,309,530 claims, to the use of the paper template. It should be noted that the electronic template is still a paper version of the elements that an EHR vendor could use to

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<sup>6</sup> [www.bls.gov](http://www.bls.gov)

<sup>7</sup> <http://www1.salary.com/Physician-Hospitalist-hourly-wages.html>

incorporate into EHR; however, this format is not a required format for EHR vendors to use.

Based on the above criteria, we estimate the annual burden to be 546,074 hours and \$89,250,336. The chart below shows how the estimate was calculated.

**Physician/NPP Annual Burden for Completing the Electronic Clinical Template**

<i>Provider Type</i>	<i>Hourly Rate</i>	<i>Burden Hours (1/6 Hour)</i>	<i>Number of Claims</i>	<i>Annual Burden (Hours)</i>	<i>Annual Cost Burden Estimate</i>
<i>General Internist</i>	\$188.96	0.167	436,510	72,897.17	\$13,774,649.24
<i>Nurse Practitioner</i>	\$97.36	0.167	436,510	72,897.17	\$7,097,268.47
<i>Hospitalist</i>	\$204	0.167	436,510	72,897.17	\$14,871,022.68
<b><i>Subtotal</i></b>			<b>1,309,530</b>	<b>218,691.51</b>	<b>\$35,742,940.39</b>

**Physician/NPP Annual Burden for Completing the Paper Clinical Template**

<i>Provider Type</i>	<i>Hourly Rate</i>	<i>Burden Hours (1/4 Hour)</i>	<i>Number of Claims</i>	<i>Annual Burden (Hours)</i>	<i>Annual Cost Burden Estimate</i>
<i>General Internist</i>	\$188.96	0.25	436,510	109,127.5	\$20,620,732.40
<i>Nurse Practitioner</i>	\$97.36	0.25	436,510	109,127.5	\$10,624,653.40
<i>Hospitalist</i>	\$204	0.25	436,510	109,127.5	\$22,262,010.00
<b><i>Subtotal</i></b>			<b>1,309,530</b>	<b>327,382.5</b>	<b>\$53,507,395.80</b>
<b><i>Grand Total</i></b>			<b>2,619,060</b>	<b>546,074.01</b>	<b>\$89,250,336.19</b>

13. Capital Cost

There are no additional capital costs.

14. Cost to Federal Government

There are no costs associated with this change to the Federal Government. The creation of these clinical templates for physician and/or Medicare allowed NPP use does not create additional federal level costs. The use of the templates created with this package is entirely voluntary and is intended only to assist the physician or allowable Medicare NPP in documenting patient eligibility.

15. Changes to Burden

Providers are required to have this type of documentation to prove a Medicare claim is paid in good faith. This information was previously collected under OMB control number 0938-0969 which covers prepayment medical review. We will remove the burden under

this collection. This template is just an alternative format. No new documentation or requirements are being added.

16. Publication/Tabulation Dates

We do not plan to publish any of the information collected.

17. Expiration Date

The expiration date will be displayed.

18. Certification Statement

There are no exceptions to the certification statement.