Home Health Agencies Cannot Provide Services When Face to Face Requirements Are Not Met

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Section 6407 of the Affordable Care Act (ACA) requires a face-to-face encounter between patients and their physicians for certification of eligibility for Medicare home health services. Certifying physicians must document that they or non-physician practitioners working with physicians have seen patients. The encounter must occur within 90 days prior to the start of home care services or within 30 days after the start of home care. Documentation of encounters must be present on certifications for patients that begin on or after January 1, 2011. The Centers for Medicare and Medicaid Services (CMS) informed agencies that they would not enforce these requirements until April 1, 2011. CMS has addressed the issue of the role of discharge planners/case managers in Frequently Asked Questions (FAQ's).

First, the FAQ's seem to allow discharge planners/case managers to extract information from physicians' own medical record entries that include how the patients' clinical condition, as seen during encounters with patients, supports homebound status and the need for skilled care for physicians to use to complete required documentation.

In addition, the FAQ's clearly state that hospitalists, even though they may not supervise home health services after discharge, may document their encounters with patients that meet applicable requirements. Guidance from CMS thus far seems to permit discharge planners/case managers to assist hospitalists with the completion of documentation of their encounters that meets applicable requirements. By the same token, CMS has emphatically stated that home health agency staff may not complete documentation or even assist physicians to complete it.

Anecdotally, it appears that some discharge planners/case managers have taken the position that they will not provide any assistance to meet these requirements because they relate to payment. In other words, so what if home health agencies are not paid for their services and provide them free of charge?

Case managers/discharge planners must bear in mind, however, that home health agencies that provide free services to patients because required encounters do not occur or are not properly documented run the risk of engaging in fraudulent conduct. To the extent that free or voluntary services are perceived as an inducement to patients to initiate, continue, or re-initiate services with particular providers, organizations and practitioners may run the risk of violation of Medicare/Medicaid fraud and abuse prohibitions, especially the federal anti-kickback statute, according to the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services, the primary enforcer of fraud and abuse prohibitions

In addition, the OIG has delineated limits on free items and services that may be provided to patients. Providers may give patients only non-cash items of nominal value. Non-cash items, including free services, may not exceed $10.00 in value at a time and $50.00 in value during a calendar year. Even one visit to a patient's home clearly exceeds these limits.

This means that agencies must discharge patients when face to face requirements described above are not met. Agencies cannot continue to provide services free of charge.

Consequently, discharge planners/case managers cannot sit back and say that they are not going to help with implementation of these new requirements because home health agencies are solely responsible and the only consequence is that agencies will not be paid if requirements are not met. On the contrary, patients will go without services and may have no alternative but to return to hospitals for needed care.

The proverbial "bottom line" for all providers is that the needs of patients must be met. When discharge planners/case managers refuse to work with physicians and home health agencies to make sure that applicable criteria are met, patients ultimately pay the price. This result is simply unacceptable.