Medicare’s Face-to-Face Encounter Rules Vary

By Mike Klug
SMP Resource Center Consultant

Following an April mentor call in which SMPs discussed deceptive marketing for back braces, Kay Meade, outreach and education coordinator for Delaware, reported a troubling development. One client received three braces in the mail based on written orders from three physicians she had never seen. The physicians, evidently employed in some capacity by a marketing firm, assessed the beneficiary during brief phone calls and sent the back brace orders to the firms. The firms then sent the orders to out-of-state durable medical equipment (DME) supplier clients for fulfillment. The beneficiary did not need the braces and the case is under Office of Inspector General (OIG) investigation.

Aside from the questionable legality of an arrangement in which a physician writes orders through a third party on a DME supplier’s behalf – the law does not allow suppliers to hire physicians to write orders – the case raises questions about the need for more face-to-face encounters to deter dubious marketing practices designed to create demand for Medicare-covered services and items. The case also reveals confusion about Medicare’s face-to-face encounter rules. While many DME items require a face-to-face encounter to validate a Medicare claim, back braces are not subject to those rules.

When does the law require physicians or other approved health care providers to see patients face to face as a condition for Medicare payment? There are at least four benefit categories that require a face-to-face encounter as a coverage criterion:

1. Home health care
2. Hospice care
3. Advance care planning
4. Certain types of DME, including hospital beds and power mobility devices (PMDs)

What is a face-to-face encounter?

In the home health context, a face-to-face encounter is an element in the initial process of certifying a beneficiary’s homebound status and need for skilled care. The Affordable Care Act (ACA) added the requirement, effective in 2011, for physicians or certain nonphysician providers, such as physician assistants or clinical nurse specialists, to perform the encounter. According to the Centers for Medicare & Medicaid Services (CMS), the requirement’s purpose was to “discourage physicians certifying patient eligibility for the Medicare home health benefit from relying solely on information provided by the HHAs (home health agencies) when making eligibility determinations and other decisions about patient care.”

continued
The face-to-face encounter should involve firsthand observation and evaluation by a provider who is caring for (or affiliated with a provider who is caring for) the patient. The provider may be the beneficiary’s own attending or family physician or a physician who cared for him or her in a hospital or nursing facility. The provider must document through notes and a certifying statement that the face-to-face encounter took place.

In the hospice context, the ACA requires the hospice physician or a nurse practitioner to have a face-to-face encounter as part of the recertification process for terminally ill patients at the start of their third benefit period (i.e., after the 180th day of Medicare-covered hospice care) and subsequent 60-day benefit periods. The rules do not require a face-to-face encounter at the time of initial certification, in contrast to home health. They also do not require such an encounter at the start of the second benefit period.

For PMDs, CMS guidance calls for a face-to-face examination before a doctor writes a prescription. During the exam, the physician should evaluate and/or treat the patient’s medical condition, tailor the evaluation to the individual, and “determine medical necessity for the PMD as part of an appropriate overall treatment plan.” For certain other DME items, the record of the face-to-face examination “must document that the beneficiary was evaluated and/or treated for a condition that supports the item(s) of DME ordered.”

**Telehealth can count as a face-to-face encounter under certain conditions.**

Medicare rules allow the face-to-face encounter to be performed through a telehealth service in some cases as long as the beneficiary is in a rural health professional shortage area or in a county outside a metropolitan statistical area. Medicare rules specifically allow telehealth encounters to substitute for in-person visits to certify the need for home health care and DME. To comply with the law, telehealth (or telemedicine) encounters must originate in authorized sites that include, for example, physician offices, hospitals, and federally qualified health centers (FQHCs). CMS manuals do not address telehealth encounters in the hospice recertification and advance care planning settings.

**Timing for valid encounters varies.**

Medicare law specifies the time frames during which a face-to-face encounter must occur. They range from the date of service to six months before the date a physician or authorized nonphysician provider writes an order on a beneficiary’s behalf.

- **Home Health:** The encounter must take place 90 days before the start of home health care or 30 days after the start of home health care.

- **Hospice:** The encounter must take place no more than 30 days before the 180th day of hospice care and no more than 30 days before the start of subsequent benefit periods.

- **DME:** The encounter examination must take place in the six-month period prior to the written order for certain types of equipment. (See next section.)
• **Advance Care Planning:** The encounter must take place as part of the annual wellness visit. CMS’ *Benefit Policy Manual* states that “[v]oluntary advance care planning means the face-to-face service between a physician (or other qualified health care professional) and the patient discussing advance directives, with or without completing relevant legal forms.”

**Certain DME items require a face-to-face encounter.**

The ACA also authorized CMS to apply the face-to-face encounter requirement to DME items based on a decision that a provider’s encounter with a patient, prior to ordering equipment, would reduce the risk of waste, fraud, or abuse. Starting in 2013, CMS has maintained a list of DME items that are subject to a face-to-face encounter examination requirement. The current list, revised in March 2015, contains 93 items. Among them are hospital beds, oxygen equipment, nebulizers, home blood glucose monitors, ultraviolet light therapy systems, neuromuscular stimulators, infusion pumps, cervical traction equipment, seat lifts, and wheelchairs and accessories.

As noted, back braces, other prosthetics and supplies, and relatively low-cost equipment like canes and walkers are not subject to the face-to-face encounter rule. But the list of items requiring a face-to-face encounter as a condition of payment is subject to change, and the OIG’s recommendations sometimes persuade CMS to take action. That makes it all the more important for SMPs to follow Kay Meade’s example and report questionable back brace and DME marketing tactics to the OIG through SIRS.

---

This newsletter was supported in part by a grant (No. 90NP0003) from the Administration for Community Living (ACL), U.S. Department of Health and Human Services (DHHS). Grantees carrying out projects under government sponsorship are encouraged to express freely their findings and conclusions. Therefore, points of view or opinions do not necessarily represent official ACL or DHHS policy.