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## MEMORANDUM

### NEW FACE TO FACE REQUIREMENTS FOR HOME HEALTH SERVICES

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The Conditions of Participation (“COP”) for home health services (“HHS”) have long required a physician to certify that (i) the patient needs intermittent skilled care or physical, speech or occupational therapy; (ii) HHS and required because the patient is confined to home; (iii) a plan for furnishing the services has been established; and (iv) the services were provided while the individual was under the care of a physician (42 CFR §424.22(a)). This “certification” and the plan of treatment has to be performed by a physician who does not have a financial relationship with the home health agency (“HHA”) as defined in the Stark law unless one of the Stark exceptions is satisfied. The HHS must be recertified every 60 days (42 CFR §424.22(b)).

The Affordable Care Act amended the law and regulations by adding a new requirement that prior to making the certification the certifying physician “must document that the physician [or as described below the non-physician practitioner]...had a face to face encounter...with the [patient] within a reasonable time frame.” By regulation, CMS has interpreted the law as requiring that the certifying physician document (a) that the condition for which the patient was being treated in the face to face encounter is related to the primary reason the patient requires HHS; and (b) why the clinical findings of such face to face encounter support findings that the patient is homebound and in need of either intermittent skilled nursing services or therapies (42 CFR §424.22(a)(1)(v)(b)). The documentation of the face to face encounter must also show, by including the date of the face to face encounter, that it occurred “no more than thirty days prior to the home health start of care date or within two weeks of the start of the home health care.”

The physician’s documentation must be on the HHS certification form but as a separate and distinct section of the certification or an addendum to the certification. It must be clearly titled, dated and signed by the certifying physician (42 CFR §424.22(a)(1)(v) and (D)). In addition to the documentation that accompanies the certification, the physician’s practice medical record must also document the occurrence of the face to face encounter with information that is “consistent” and “supportive” of his documentation in the HHS certification (42 CFR §424.22(a)(1)(v)).

If the face to face encounter occurred within 30 days of the start of care but the condition for which the patient was being treated at the time of the encounter was not related to the “primary reason” the patient requires HHS or if the face to face did not occur within the 30 days prior to the start of HHS, then the certifying physician (or as discussed below the non-physician practitioner) must have a face to face encounter with the patient within two weeks of the start of HHS.

In other words, if a patient’s condition changes significantly between the time of the face to face encounter and the start of HHS and the “primary reason” the patient needs HHS is unrelated to the patient’s condition at the time of the original face to face encounter, another face to face encounter is required within two weeks of the start of HHS. In the comments to the regulations CMS said the face to face encounter had to be “incident to” the HHS involved. The regulations state that there has to be “clinical correlation” between the face to face encounter and the “associated” HHS (42 CFR §424.22(a)(1)(v)(D)).

Although the documentation and certification obligations discussed above are imposed on certifying physicians, the actual face to face encounter may be performed (a) by telehealth in compliance with Section 1834(m) of the SSA; or (b) by a nurse practitioner or clinical nurse specialist working in collaboration with the physician, a CRNA or a physician assistant under the supervision of a physician (each referred to hereafter as “non-physician practitioner”). The non-physician practitioner conducting the required face to face encounter must document their clinical findings and communicate them to the certifying physician who then utilizes those clinical findings to complete the documentation on the HHS certification and the requirements of the face to face encounter documentation (i.e., that the clinical findings support why the patient is homebound and in need of either intermittent skilled nursing care or therapy services and that the condition for which the patient was being treated in the face to face encounter was related (clinical correlation) to the primary reason the patient requires HHS. Clearly, the non-physician practitioner’s clinical findings need to be attached to or included in the physician’s office record for the patient as part of the office record’s “supportive” documentation of the face to face encounter and HHS certification.

There is no independent reimbursement for face to face encounters. The regulations state that to assure clinical correlation between the face to face encounter and the associated HHS, the physician must document that the “condition for which the patient was being treated in the face to face patient encounter is related to the primary reason the patient requires” HHS. Thus, the physician (or non-physician practitioner) should conduct the face to face while treating the patient for the condition which is the primary reason for (clinically correlated to) the HHS certification. They should bill not for the face to face encounter but for the treatment being provided during the face to face encounter.

For a number of years, the regulations have provided that the physician certifying the need for HHS and establishing the plan of care cannot have a “financial relationship” with the HHA as that term is defined in the Stark Law unless the financial relationship satisfies one of the Stark exceptions. Financial relationships in the Stark Law include both direct and indirect relationships as well as ownership/investment relationships and compensation relationships. Stark exceptions for employment and personal service relationships permit physicians to have employment contracts and personal service contracts both directly and indirectly with the HHA as long as certain requirements are met. Among the requirements are that the physician’s compensation not vary based on the value or volume of his HHS referrals.

While the Affordable Care Act permits non-physician practitioners to perform the face to face encounter, they may not be employees of the HHA. Thus, nurse practitioners working in collaboration with certifying physicians to perform the face to face encounters cannot be employees of the HHA. Nothing precludes the non-physician practitioners from being employed by other entities, even if under common ownership with the HHA. As a precaution, because the non-physician practitioners are performing physician functions which serve the basis of the physician's HHS certification (referral), we recommend that the non-physician practitioner's relationship comply with the Stark exceptions and Antikickback safe harbors for employees and personal service contracts. Among other things, this means written contracts establishing a fixed compensation that does not vary based on the value or volume of HHS referrals resulting from their face to face encounters.

We see no objection to a physician support company (even if related to the HHA) employing non-physician practitioners to perform face to face encounters when treating patient medical conditions. We also see no objection to a company related to the HHA contracting with private physician practices to provide those practices with non-physician practitioners who will conduct face to face encounters while providing care for other conditions. The non-physician practitioners will need to have a collaborative practice agreement ("CPA") with the certifying physician. The contracts between the physician support company and the certifying physician for the physician's agreement to collaborate with the nurse should be drafted to comply with Stark exceptions and Antikickback safe harbors. This means that, in the absence of an employment relationship, these contracts must be for a minimum of one year and the fees paid to the collaborating physician must be consistent with fair market value for the services they provide. Those fees may not vary with the value or volume of patients the collaborating physician refers to the nurse.

Because the regulations state (i) that the face to face encounters must be "related to" the primary reason the patient is being referred for HHS; (ii) that if the face to face is "not related" to the primary reason for the HHS it must be redone; and (iii) that the physician must document that the conditions for which the patient was "treated in the face to face encounter" is related to and have a "clinical correlation" to the primary reason for the HHS, we do not believe a face to face encounter performed solely for the purpose of documenting clinical findings to support HHS and which does not include any treatment of a related condition, will satisfy the regulations.

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