Update on Physician Signature Requirement and Face-to-Face Encounter Requirements

Today, the Centers for Medicare & Medicaid Services (CMS) instructed its contractors on how to proceed regarding two policies—(1) the physician signature requirement for requisitions for clinical diagnostic laboratory tests that was finalized in the CY 2011 Physician Fee Schedule final rule, and (2) the face-to-face encounter requirements for home health and hospice that were mandated by Congress in the Affordable Care Act. Both of these policies were effective January 1, 2011.

Physician Signature Requirement

In the CY 2011 Physician Fee Schedule final rule, CMS established a policy requiring a physician's or qualified non-physician practitioner's (NPP) signature on laboratory requisitions. A requisition is the actual paperwork, such as a form, which is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient.

Because of concerns that some physicians, NPPs, and clinical diagnostic laboratories were not aware of, or did not understand, this policy, CMS focused its efforts in the first quarter of 2011 on developing educational and outreach materials to educate those affected by this policy. After further input from the laboratory community, CMS has decided to focus its resources for the remainder of 2011 on changing the regulation that requires signatures on laboratory requisitions because of concerns that physicians, NPPs, and clinical diagnostic laboratories are having difficulty complying with this policy.

Face-to-Face Encounter Requirements

Section 6407 of the Affordable Care Act established a face-to-face encounter requirement for certification of eligibility for Medicare home health services, by requiring the certifying physician to document that he or she, or an NPP working with the physician, has seen the patient. Similarly, section 3131(b) of the Affordable Care Act requires a hospice physician or nurse practitioner to have a face-to-face encounter with a hospice patient prior to the patient's 180th-day recertification, and each subsequent recertification.

In response to concerns that some providers needed additional time to establish operational protocols necessary to comply with these requirements, CMS developed educational and outreach materials, reached out to state and local associations, and held meetings with the industry, as well as open door forums, to educate those affected by these requirements during the first quarter of CY 2011. This also allowed additional time for home health agencies and physicians who order home health services, as well as hospices, to establish internal processes and operational protocols necessary to ensure compliance with the requirements.

Further, in an effort to implement the requirements with as much flexibility as possible, while maintaining the best interest of beneficiaries, CMS provided reasonable timeframes

for when the encounters must occur. More specifically, CMS required that the encounter must occur within the 90 days prior to the start of home health care, or within the 30 days after the start of home health care. In the case of hospice, the encounter must occur no more than 30 calendar days prior to the start of the hospice patient's third benefit period.

At this time, recognizing the importance of ensuring that the vulnerable population served by home health agencies and hospices receive care that is coordinated and monitored by a physician, while also acknowledging that these requirements were mandated by Congress to address potential program integrity concerns, CMS expects home health agencies and hospices to comply with the face-to-face encounter requirements as of April 1, 2011.

Compliance with these important requirements will ensure that home health agencies and hospices work in collaboration with physicians to promote the best possible care for beneficiaries, while also strengthening the integrity of the Medicare program. CMS will continue to carefully monitor the implementation of this policy to ensure that there is no unintended disruption in access to care as providers comply with these requirements.

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