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Date: March 30, 2018

Re: Response to Public Comments for GCR 17-074: Face-to-Face Visit Verification

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Comments were received from the Vermont Medical Society, Vermont legal Aid, Inc., VNAs of Vermont, and Yankee Medical Inc.

A summary of comments received, and the Agency of Human Services' response is included below.

Comment: We recommend specifying the Medicaid programs to which the policy applies and including examples of the programs to which it does **not** apply. As we understand it, the policy applies only to acute home health services and does not apply to hospice or to "special" Medicaid programs including maternal-child health, Choices-for-Care, High-Tech and others.

Response: The face-to-face visit requirement applies to home health services as defined by federal regulations at 42 CFR §440.70. The face-to-face requirement for Medicaid applies to items of DME that are also subject to the face-to-face requirement under Medicare. The list of items can be found here and also includes power mobility devices. This information can also be found in the Medicaid Provider Manual.

Comment: We appreciate that Vermont's Medicaid program has no "homebound" status qualifying criteria. We are concerned that the absence of reference to "homebound" in the DVHA policy will create confusion. We recommend explicitly referencing that – unlike Medicare – there is no homebound qualifying criteria under Medicaid.

Response: Current Medicaid Covered Services Rule 7401, Home Health Agency Services reflects that homebound status is not required. This is a current policy that remains in effect.

Comment: Does the requirement include only supplies related to the durable medical equipment or to supplies used by home health also?

Response: The requirement applies to durable medical equipment and supplies that are also subject to the face-to-face requirement under Medicare. The requirement for a face-to-face visit does not apply to supplies used as part of routine care that are not reimbursed separately.

Comment: Medicaid's proposed policy appears to only apply to the billing codes listed by Medicare in this link. Is that all that would be required for power mobility devices as well? Or will Medicaid be looking for a more specialized evaluation like the Face to Face for PMD?

Response: The face-to-face requirement will apply to power mobility devices in that same manner as the other items of DME. Additional requirements for ordering and billing of DME remain in effect as included in Medicaid Rules and the Medicaid Provider Manual.

Comment: Item (5)(B) requires the physician to document, "that the face-to-face encounter occurred within the required timeframes prior to the start of services." This is inconsistent with item (1) which allows the visit to occur up to 30 days AFTER the start of service. We recommend eliminating the phrase "prior to the start of services" from item (5)(B).

Response: The final policy has been revised to reflect this change.

Comment: The *Medicare* Face-to-Face program requires the physician to "certify" (with a signature) the encounter when the visit is conducted by the APRN, clinical nurse specialist, PA or mid-wife. We do not see a similar requirement in the proposed Medicaid policy. We are concerned the inconsistency will be confusing for providers and will reduce compliance with the existing Medicare requirements. We recommend revising item (6) to better align with the Medicare requirement.

Response: The ordering physician is required to document who conducted the face-to-face encounter and incorporate findings into the beneficiary's medical record. The final GCR and Medicaid Provider Manual have been revised to clarify that documentation of the face-to-face visit is a required component of the physician's order for services.

Comment: We recommend further clarifying the sentence in (6), "those clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record." Several members asked if this requires more than a visit note. Our understanding is that a visit note is sufficient. It would be helpful to state explicitly that there is no required form for documenting the face-to-face requirement and that an appropriate "visit note" or facility documentation is adequate. This mirrors Medicare and we understand it to be the intent of the DVHA.

Response: A specific form to document the face-to-face visit is not required. How to incorporate the clinical findings into the medical record is at the discretion of the ordering physician.

Comment: Comments expressed concern that physician practices have not received adequate notice regarding the change and requested a delay in implementation. Also, how physicians will be educated about the new requirement.

Response: The implementation date was extended from February 15, 2018 to April 1, 2018 to assure adequate notice was given to providers. In addition to GCR notices providers will be notified via a banner and information included in the Medicaid Provider Manual.

Comment: Request that DVHA minimize the administrative burden of this policy change. Specific changes requested include: develop optional forms that specify the data elements required and clarify how a physician should document that the encounter is related to the primary reason that the patient requires services.

- While VMS appreciates the flexibility allowed by not requiring a specific face to face form, and strongly suggests that this remain the case, **VMS does suggest that DVHA develop optional forms that could be used that specify the data elements and information DVHA is seeking**. For example, physicians report that documenting the visit for Medicare can be extremely frustrating and time consuming when CMS and specific vendors require certain language or data elements without specifying such. Ideally, these forms could be translated into an EHR template.

Response: The data elements required are included in the final policy, listed in the Medicaid Provider Manual, and will be adopted in Health Care Administrative Rules for Home Health Agency Services and Durable Medical Equipment. The final GCR has been revised to include that the ordering physician must document that the face-to-face visit occurred in any new orders for services where the face-to-face visit is required. DVHA will not require that a specific form be used. How a physician documents that the encounter is related to the primary reason that the patient requires services is at the discretion of the physician and should follow correct coding practices.

Comment: There have been challenges with implementation of the Medicare requirement. Clients have been denied coverage because of a missing date or physician signature. We encourage AHS to add express language in the Vermont Medicaid face-to-face visit verification policy stating that the mere lack of date or signature because of a good faith mistake will not prohibit coverage as long as a paperwork correction has been made.

A new face-to-face visit should not be required. Additionally, if a minor paperwork error exists, we ask that AHS allow coverage. Consequently, we propose AHS add the following provisions to the Policy:

> (7) As long as the face-to-face encounter occurred within the required time frame, defects in the verification documentation may be corrected any time without the need for an additional encounter.
> (8) Where there are minor verification completion errors by the ordering physician, coverage may be allowed.

Response: Providers are required to maintain documentation for the face-to-face visit as described in the final GCR. Vermont Medicaid does not have the authority to assure coverage without proper documentation. The State will allow for corrections to be made to the documentation. A new face-to-face visit will not be required if the occurrence of the visit can be verified.