KING & SPALDING

Health Headlines

December 20, 2010

Health Headlines

President Signs Medicare and Medicaid Extenders Act Delaying 25% Reduction To Medicare Physician Payments and Repealing Medicaid Exclusion Provision – On December 15, 2010, President Obama signed the Medicare and Medicaid Extenders Act of 2010 (H.R. 4994) (Act) that, among other things, prevents a 25% reduction in Medicare physician payments from taking effect for one year, through December 31, 2011 and repeals Section 6502 of the Patient Protection and Affordable Care Act.

After passing unanimously in the Senate, the bill cleared the House of Representatives on December 9, 2010, by a vote of 409 to 2. *See* King & Spalding *Health Headlines* (Dec. 13, 2010).

As noted in last week's edition of *Health Headlines*, the Act delays a 25% cut in Medicare physician payment stemming from a 1997 law requiring automatic reductions in physician pay if limitations in a "sustainable growth rate" formula would be exceeded. The estimated cost of the Medicare physician payment extension is $14.9 billion, according to a Senate Finance Committee summary of the Act. The cost is to be paid for beginning in 2014 by modifying the procedures for recouping certain federal subsidies in the health care reform law that supports the purchase of health insurance coverage. The health care affordability tax credit assists lower-income individuals pay for insurance premiums, and the credit is calculated based on the amount of income earned. Should an individual earn more than projected, the IRS may, under preexisting law, recover only a limited amount of the subsidies paid. In order to offset the cost of the payment extension, the flat cap on overpayment recoveries will be modified, allowing the IRS to recoup overpayments according to a sliding scale that takes into account the amount of income an individual earned.

Section 6502, which was repealed by the Act, required that states exclude from the Medicaid program any individuals or entities that own, control, or manage an entity that (or if such entity is owned, controlled, or managed by an individual or entity that): (1) has unpaid Medicaid overpayments; (2) has been suspended or excluded from participating in, or whose participation has been terminated from the Medicaid program; or (3) is affiliated with an individual or entity that has been suspended or excluded from participating in, or whose participation has been terminated from, the Medicaid program.

A copy of the Medicare and Medicaid Extenders Act of 2010 is available by clicking here.

Reporter, *Jesica M. Eames*, Atlanta, +1 404 572 2821, jeames@kslaw.com.

Face-to-Face Encounter: New Home Health Certification Requirement – Effective January 1, 2011, a physician who certifies a patient's eligibility for home health services must document that he or she (or a permitted mid-level practitioner) has had a face-to-face encounter with the patient within 90 days prior to or 30 days after the start of home health care. *See* Home Health CY 2011 PPS Final Rule, 75 Fed. Reg. 70372, 70427 (Nov. 17, 2010). The new regulation, 42 C.F.R. § 424.22(a)(1)(v), implements the Affordable Care Act provision requiring a face-to-face encounter

as a condition of payment for home health services. *See* Patient Protection and Affordable Care Act, Pub. L. 111-148, §§ 6407(a) & 10605. The encounter must be documented on the certification itself or as an addendum. Documentation must specify the time of the encounter and the clinical findings supporting the patient's need for home health services. Home health agencies will be held responsible for ensuring that the certifying physician's face-to-face encounter is properly documented.

CMS has explained that the goal of requiring face-to-face encounters is to improve the quality of care for home health patients by ensuring that certifying physicians have current, first-hand clinical information enabling them to assess a patient's condition with greater accuracy. The face-to-face encounter requirement applies to the initial certification only. 75 Fed. Reg. at 70428, col. 1. An encounter that occurs within 90 days prior to the start of home health care must be related to the primary reason the patient requires home health services. If this is not the case, then another encounter is required within 30 days following the start of care.

The face-to-face encounter must be documented by the certifying physician, but may be performed by either the physician him/herself or by a specified mid-level practitioner who communicates the patient's clinical information to the certifying physician. Permissible practitioners include nurse practitioners or clinical nurse specialists working in collaboration with a physician, a certified nurse-midwife, as authorized by state law, or physician assistants working under the supervision of a physician.

In rural areas, the encounter requirement can be satisfied through the use of telehealth services that meet the statutory requirements for coverage. *See* 42 U.S.C. § 1395m(m). Thus, the physician or practitioner could be located at a remote site while conducting the face-to-face encounter via a telecommunications system. The patient, however, must be located at one of the specified types of "originating sites," which include, for example, physicians' offices, hospitals, and skilled nursing facilities.

A MLN Matters article on the new face-to-face requirement for home health services is available by clicking here. Questions and answers promised by CMS for last week have not yet been posted to Medicare's home health agency website, http://www.cms.gov/center/hha.asp.

Reporter, *Susan Banks*, Washington, D.C., +1 202 626 2953, sbanks@kslaw.com.

CMS Issues Alert Exempting Hospital Outpatient Departments from Advanced Diagnostic Imaging Accreditation Requirement – On December 15, 2010, the Centers for Medicare and Medicaid Services (CMS) issued an email alert informing hospital outpatient departments that they are now exempt from CMS's requirement that imaging providers obtain accreditation for advanced diagnostic imaging services.

CMS had issued a transmittal in July 2010 instructing Medicare Administrative Contractors to require all suppliers of advanced diagnostic imaging services—hospital and nonhospital sites alike—to obtain accreditation from an approved accrediting body by January 1, 2012 in order to continue billing for imaging services such as CTs, MRIs and PETs. A summary of that July transmittal appeared in the July 19, 2010 issue of *Health Headlines,* which is available by clicking here. CMS's recent alert exempts only hospital outpatient departments; absent further notice, nonhospital sites must obtain accreditation by the January 1, 2012 deadline consistent with Section 135(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). CMS's recent alert is available by clicking here.

Reporter, *Christopher Kenny*, Washington, D.C., +1 202 626 9253, ckenny@kslaw.com.

Health Headlines – Editor:

Dennis M. Barry
dbarry@kslaw.com
+1 202 626 2959