PUBLICATION

DME Face-to-Face Encounter Final Rule Effective October 1, 2013 [Ober|Kaler]

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This article has been updated since its original posting.

The 2013 Final Physician Fee Schedule included final regulations for the durable medical equipment (DME) face-to-face encounter requirement for Medicare and Medicaid beneficiaries. These regulations implement Section 6407 of the Affordable Care Act and were supposed to be effective July 1, 2013. CMS recently delayed the effective date to October 1, 2013, to allow DME suppliers to comply with the new regulations. The final rule is similar to the proposed rule although there are several changes made in response to stakeholder comments that are intended to reduce the administrative burden of the new regulations.

The final rule requires a face-to-face encounter and a written DME order for certain types of DME. Beginning on October 1, 2013, a DME supplier is required to have (1) documentation of a face-to-face encounter between a Medicare or Medicaid patient and either a physician or mid-level practitioner (physician's assistant, nurse-practitioner or clinical nurse specialist) and (2) a written order for certain high-risk DME ("Specified Covered Items"). The DME supplier must keep the documentation of the encounter and the DME order for at least seven years.

The final rule adopts most of the proposed face-to-face requirements. During a face-to-face encounter a needs assessment, an evaluation, or treatment must occur that supports the need for each covered DME. The encounter must be documented in the patient's medical record and include information relevant to the ordering of the DME, which may include patient history, a physical examination, diagnostic test results, diagnoses, treatment plans or other information. A single face-to-face encounter can support more than one order for DME, provided that the encounter documents the need for each order. In response to a request that a specific form should be used to document the encounter, CMS commented that practitioners were free to use their own forms but cautioned against using ones that limited description entry space or relied heavily on "check boxes." CMS also explained that the encounter can occur in a hospital inpatient setting prior to discharge to allow patients to receive DME items without a separate encounter.

If a mid-level practitioner conducts the face-to-face encounter, then a physician must sign or cosign the medical record to certify that the encounter occurred. CMS determined that this approach was the best of several options in the proposed rule. Physicians who review and cosign for the encounter can bill a new G-code, G0454, for the certification. The national reimbursement for that code is $8.85.

The final rule also prohibited an "incident to" encounter from satisfying the face-to-face encounter requirement. This means that physician practices that traditionally bill midlevel practitioners as "incident to" physician services will need to bill qualifying encounters to Medicare as a mid-level practitioner service and not on an "incident to" basis.

The most significant change from the proposed rule is that the face-to-face encounter must occur in the six months prior to the DME order, which is identical to the requirement in the Affordable Care Act. CMS originally proposed that the encounter could occur no more than 90 days before the DME order or within 30 days after the DME order. CMS explained that the proposed rule created an excessive administrative burden on DME

suppliers because the suppliers would have no practical way to require beneficiaries, physicians and midlevel practitioners to conduct the encounter and provide the necessary documentation after the order was written.

The final rule differed slightly from the proposed rule for the written order requirement. The DME order requires only the following: (i) the beneficiary's name, (ii) the DME item, (iii) the NPI and signature of the ordering physician or practitioner, and (iv) the date of the order. CMS explained that the other proposed data elements, the diagnosis and proper usage instructions, were an undue administrative burden.

CMS also made a slight revision to the Specified Covered Items from the proposed rule, although the bottom line remains the same -- DME suppliers should check the DME List of Specified Covered Items (Table 89 of the final Physician Fee Schedule) to confirm if a face-to-face encounter is necessary. CMS' criteria for determining Specified Covered Items includes the following: (i) any DME with a price ceiling of more than $1,000; (ii) any DME determined by CMS on its own or after a determination by a Medicare Administrative Contractor or another federal oversight agency to be susceptible to fraud, waste or abuse and added to the list of Specified Covered Items through future rulemaking; and (iii) items that currently require a written order prior to delivery in accordance with the Program Integrity Manual. The regulations specifically state that the following types of DME are Specified Covered Items: transcutaneous electrical nerve stimulation (TENS) units, rollabout chairs, oxygen and respiratory equipment, hospital beds and accessories, and traction-cervical devices. CMS added ventilators, chest wall oscillators and continuous positive airway pressure / bilevel positive airway pressure (CPAP/BiPAP) items to the Specified Covered Items list in response to comments from stakeholders. CMS also specifically noted that DME items that are subject to regulations that explicitly state that a face-to-face encounter is not necessary will be removed from the Specified Covered Items list

Ober|Kaler's Comments

The face-to-face encounter requirements are now effective October 1, 2013, and DME suppliers have an extension to prepare for the new requirements. DME suppliers should already be familiar with the list of Specified Covered Items found in Table 89 of the Physician Fee Schedule and should be prepared to get and retain copies of the necessary DME documentation for seven years.

Physicians may offset the increased administrative cost of reviewing and cosigning face-to-face encounters with the new G code. Physicians do not need to “certify” their own face-to-face encounters and should not bill the new G code for those encounters. Physicians should also consider the financial impact of conducting their own face-to-face encounters or having mid-level practitioners conduct the encounter and bill for the encounter at the mid-level practitioner reimbursement amount and the G code for the physician certification.