How to Face Face-to-Face Head On

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ACA Mandate

- Under a provision of the Affordable Care Act (ACA), a home care provider cannot bill Medicare for services to a home health patient until the provider has obtained a signed narrative from the physician indicating that the patient had a face-to-face encounter with that physician 90 days prior to the start of home care or 30 days after the start of home care.

- As part of this certification, physicians must also document several detailed clinical findings in order to support the need for home care services.
The Problem

The vast majority of doctors and home care providers are conducting and documenting these mandated face-to-face encounters in good faith.

Unfortunately Medicare is denying payment for thousands of home health services based largely on documentation technicalities that have more to do with format than substance, and that have nothing to do with the appropriateness of care.

The face-to-face requirement essentially expects doctors to duplicate clinical documentation that the physician already provides in the '485' form or plan-of-care.

According to a nationwide home care provider survey, 52% of face-to-face claim denials resulted mainly from Medicare determining that the physician documentation was insufficient, even though medically necessary care was provided.

The Solution

• The face-to-face problem is complex, but the solution could be simple.
• The 485/plan-of-care form already documents: a patient’s need for home care services; the patient’s eligibility for home care services; the clinical findings that support this determination; the physician’s medical orders for care; the physician’s signature; and more.
• A simple notation could be included on the 485 form or plan-of-care to provide a physician’s certification that he or she has had a face-to-face encounter with the patient, rather than require a whole rewriting of the 485/plan-of-care as a ‘narrative.’
Documentation in the certifying physician’s medical records and/or the acute/post-acute care facility’s medical records is used to determine the patient's eligibility for Medicare home health care.

To be eligible, a physician must certify that the patient meets the following requirements:

• Confined to the home;
• Under the care of a physician
• Services are provided under a plan of care established and periodically reviewed by a physician;
• Be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or
• Have a continuing need for occupational therapy.

F2F Requirements

The regulations at 42 CFR 424.22 list the requirements for eligibility certification & recertification:
F2F Requirements

- The requirements differ for eligibility certification & recertification; however, if requirements for certification are not met, then claims for subsequent episodes of care, which require a recertification, will be non-covered— even if the requirements for recertification are met.
- Required for start of care home health certification on/after **January 1, 2011**

Problems Encountered

- Many roadblocks along the way especially with physician cooperation
- F2F forms were very incomplete and often too generic
- Denials ensued
- Probe and Educate Audits began
Round 1 Results

In Oct 2015, HH&H Medicare Bulletin reported results of a widespread edit for all HH providers.

- Based on these reviews, CGS reported that F2F documentation was one of the top reasons for denials
- 4621 were either partially or fully denied
- 63% of claims were denied for insufficient F2F documentation
- 23% of claims were denied for no response

Probe and Educate Round 1

- This round required all Medicare HH agencies (HHAs) that didn’t pass at least one chart audit, to submit five Additional Documentation Requests (ADRs) for prepayment review.
- According to first round data, 92% of the HHAs received payment denials on at least one but up to five on the Probe & Educate Reviews.
- CMS considered the results of this review a major agency failure.
First Round Denial Reasons

1. Actual F2F encounter document was not submitted
2. Certifying physician did not document date of F2F encounter
3. Community physician was not identified when a physician who would not be following the patient after discharge signed the certification
4. Estimated length of skilled services was not documented in the recertification document
5. Required elements for initial certification (initial plan of care, initial certification, initial encounter documentation) were not submitted for recertification

So Changes Were Made

- In 2015 CMS finalized a change that, beginning Jan 1, 2015, an agency is required to obtain documentation from the certifying physician and/or the acute/post acute care facility’s medical records for the patient to serve as a basis for certification and eliminated the narrative requirement as part of F2F document.
- Documentation must become part of the patient’s permanent record.
### Regulations

- Agency must be able to provide documentation to CMS and its review entities upon request.
- Per the regulations at 42 CFR 424.22(c), if the documentation used as the basis for the certification of eligibility is not sufficient to demonstrate that the patient is or was eligible to receive services under the Medicare HH benefit, payment will not be rendered for HH services provided.

### F2F Form No Longer Enough

Based on this information from the regulation, for medical review purposes:
- If agency is using a F2F form to send to the physician, there is still the requirement that the provider obtains a some form of written information from the physician’s office record in addition to the completed form for medical review purposes.
- The agency cannot complete the F2F form and simply submit that form to the physician for a signature and expect that to meet the requirement.
Additional information that may be used:

- Although the home health agencies (HHAs) documentation is not used to demonstrate the patient's eligibility, the HHAs documentation can be incorporated into the certifying physician's medical record and used to help support the patient's homebound status and need for skilled care.
- HHAs are encouraged to send documentation to the physician at the same time the certification is sent to be signed.

F2F Form No Longer Enough

- HHA documentation may include, the admission summary, part of the Outcome and Assessment Information Set (OASIS), therapy evaluation or therapy notes, and nurse's notes.
- This information must be corroborated by other medical record entries in the certifying physician's medical record and the certifying physician must sign off on the HHAs documentation, prior to submitting the claim.
Round 2 Begins

- Agencies with claim reviews in the first round with only one or zero claim errors did not receive reviews in round two.
- All other HHAs with more than one errors should have received a second probe and educate review request.
- If an agency took advantage of free education offered after first round of reviews, the second round of reviews only extended back to date of the education.

Round 2

- In the second round, MACs focused on the HHA's compliance with the F2F policy as well as to make sure all other coverage and payment requirements were met.
- Based on the results of these reviews, MACs conduct provider specific educational outreach.
- CMS instructed MACs to deny each non-compliant claim and to outline the reasons for denial in a letter to the HHA, which was sent at the conclusion of the probe review portion of the process.
Round 2

- For claims that are denied or partially denied after being reviewed, the MAC auditor will contact the HHA by phone on the day that the review takes place.
- If during a call with a nurse reviewer about a denied service, it is determined the ADR response was incorrectly denied, the provider does not need to request a redetermination. The review contractor will reopen the claim and make the change to the claim.

Round 2 Early Results

- October to December 2017
- 5HC01 – The physician certification was invalid since the required face-to-face encounter was missing/incomplete/untimely.
- 108 claims denied for a denial rate of 29%
When conducting a HH Probe & Educate review, CMS instructed MACs to review the 5 sample claims for compliance with:

- Certification/recertification documentation of patient eligibility for Medicare HH services
- F2F encounter requirements
- Coding
- Medical necessity
- Medicare coverage and payment criteria

What are They Looking for?

Particular review and scrutiny areas focus on:

- Excessive lengths of stay (120 to over 300 days average LOS)
- Questionable patient eligibility & medical necessity
- Failure to obtain required F2F documentation for all cases
- Coding that does not have supporting documentation as to severity

Additional Documentation Requests
New Guidance on Documentation

- Face to Face documentation required on all new SOCs
- Effective Jan 1, 2015, the narrative on a F2F form no longer required.
- Documentation in the patient’s medical record shall be used as a basis for certification of HH eligibility.
- Reviewers will consider HHA documentation if it is incorporated into the patient’s medical record held by the certifying physician and/or the acute/post-acute care facility’s medical records (if the patient was directly admitted to HH) and signed off by the certifying physician.
- Documentation does not need to be on a special form.

Helpful Tips

1. The actual clinical note for the F2F encounter visit (such as progress note or the facility’s discharge summary) is to be submitted by the HHA when responding to all ADRs.
2. The F2F attestation form that was commonly used prior to 2015 with a brief clinical narrative is no longer required and is not sufficient.
3. Include in your submitted documentation any recent acute/post-acute care facility therapy notes, social work or discharge planning records, history & physicals, and other clinical progress notes.
Helpful Tips

4. If information from the HHA, such as the initial and/or comprehensive assessment is being used to support the patient’s homebound status and need for skilled care, it must be signed, dated and incorporated into the certifying physician medical records.

5. When the physician from the acute/post-acute care setting is certifying patient’s eligibility for the HH benefit and completing the F2F encounter, but will not be following the patient after discharge, he/she must identify the community physician who will be following the patient after discharge.

6. It is critical that the HHA provide the certification and F2F encounter documentation from the SOC episode when claim under review is a recertification claim.

7. Recertification must include an estimate by the recertifying physician of how much longer the skilled services will be required.

8. Because FTF is required on all new Start of Care episodes, do not discharge patient and readmit if the recertification is late.
Suggestion

26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan and will periodically review the plan.

Discharge Summary
Progress Notes

POC – Plan of Care
Requirements on Different Pages

Comprehensive Assessment
Who Are the Allowed Providers?

“...must be performed by the certifying physician himself, a physician that cared for the patient in the acute or post-acute care facility (with privileges who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to HH) or an allowed non-physician practitioner (NPP).”

Non-Physician Practitioner

Nurse Practitioner or Clinical Nurse Specialist working in accordance with State law and in collaboration with the certifying physician or in collaboration with an acute or post-acute care physician, with privileges, who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to HH.
Non-Physician Practitioner

- NPPs performing the encounter are subject to the same financial restrictions with the HHA as certifying physician.
- Keep in mind that the F2F documentation is part of the certification and **only** a physician can certify the patient for homecare.

Documentation Guidelines

- The **certifying physician** must document that the F2F visit took place, regardless of who performed the encounter.
- If the F2F encounter was not performed by the certifying physician, the NPP or physician who cared for the patient and performed the F2F must provide the F2F record of the F2F encounter to the certifying physician.
- NPPs performing a F2F encounter in an acute/post-acute facility must inform the physician they are collaborating with, or under the supervision of, so that the physician can inform the certifying physician of the clinical findings of the F2F.
The certifying physician cannot merely co-sign the encounter documentation if performed by an NPP.

He or she must complete/sign the form or a staff member from his or her office may complete the form from the physician’s encounter notes, which the certifying physician would then sign.

The F2F encounter documentation must be clearly titled, dated, and signed by the certifying physician before the HHA submits a claim to Medicare and must include:

- The date of the F2F encounter, and
- Clinical findings to support that the encounter is related to the primary reason for home care, the patient is homebound, and in need of Medicare covered HH services.
Targeted Probe & Educate (TPE)

Change Request 10249:
- Effective October 1, 2017
- Based on data analysis of claims payment, CGS will identify areas with the greatest risk of inappropriate program payment.
- All service-specific and provider specific reviews as well as round two of the Home Health Probe & Educate Program were phased out.

Targeted Probe & Educate TPE

Key Points:
- CGS selects providers for the TPE process based on the following:
  - Analysis of billing data indicating aberrancies that may suggest questionable billing practices; or
  - On targeted review and is transitioned to the TPE process based on error rate results; or
  - On service specific review error rate results.
- CGS will mail a letter to those who have been selected for TPE review. The letter will outline the reason for selection, and will provide an overview of the TPE process and contact information.
Targeted Probe & Educate TPE

Key Points:

• TPE consists of up to three rounds of review with up to 20-40 claims selected (pre or post payment) with each round. Subsequent rounds will begin 45-56 days after individual provider education is completed. Discontinuation of review may occur if appropriate improvement, and error rate below the target threshold is achieved during the review process.

• An Additional Documentation Request (ADR) will be generated for each claim selected. CGS has 30 days from the date the documentation is received to review the documentation, and make a payment decision.

• No response to ADRs (denial reason 56900) counts as an error.

Targeted Probe & Educate TPE

Key Points:

• A letter with the review results will be mailed at the conclusion of each round. The letter will include the number of claims reviewed, the number of claims allowed in full, the number of claims denied in full or in part.

• Providers with a moderate to high error rate will be offered an individualized education session where each claim found in error will be discussed and any questions will be answered. CGS offers education sessions via webinar, web-based presentation, or traditional teleconferences. Other methods may also be available.

• When high denial rates continue after 3 rounds of TPE, CGS will send a referral to CMS for additional action.
TPE Process

- While a claim is under review, it could also be denied for reasons other than F2F issues.
- It’s critical that when your agency starts auditing charts, that you focus on all aspects of documentation and not just on F2F documentation.
- Don’t delay—respond promptly to ADRs.
- QA charts completely before submission.
- Provide everything at one time.

TPE Process

- If episode requested is a recertification, be sure to include the original documentation from SOC that warranted the F2F.
- Do not use sticky notes or highlighters to mark pages. Use an index page instead.
Homebound Status

MLN Matters article MM8444, Home Health – Clarification to Benefit Policy Manual Language on Confined to the Home Definition:

- Clarifies definition of patient being “confined to home”
- Reflects definition in Social Security Act (Section 1835(a))
- Removes vague terms to ensure clear & specific definition
- Not a change in homebound definition
CMS advises that an individual shall be considered “confined to the home” (homebound) if the following two criteria are met:

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**Homebound Criteria**

**Criteria-One:** The beneficiary must either: Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the use of another person in order to leave their place of residence

**OR**

Have a condition such that leaving his or her home is medically contraindicated
Criteria-Two: There must exist a normal inability to leave home; AND
Leaving home must require a considerable & taxing effort. Absences from the home for health care treatment (including adult daycare) or religious services are allowed, and do not negate the beneficiary’s homebound status.

Inadequate Homebound Examples

<table>
<thead>
<tr>
<th>Homebound Status</th>
<th>Need for Skilled Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional decline</td>
<td>Family needs assistance</td>
</tr>
<tr>
<td>Dementia or confusion</td>
<td>Continues to have problems</td>
</tr>
<tr>
<td>Difficult to travel to appointments</td>
<td>No one able to do</td>
</tr>
<tr>
<td>Unable to drive or leave home</td>
<td>______</td>
</tr>
<tr>
<td>Weakness or abnormal gait</td>
<td>Stable Diabetes or any other diagnosis</td>
</tr>
<tr>
<td>Status post-surgery</td>
<td></td>
</tr>
</tbody>
</table>
Acceptable Homebound Example

“The patient is temporarily homebound secondary to status post total knee and currently walker dependent with painful ambulation. PT is needed to restore ability to walk without support. Short-term skilled nursing is needed to monitor for s/s of decomposition or adverse events from new COPD med regimen.”

Acceptable Homebound Example

“Wound care completed to left great toe. No s/s of infection, but patient remains at risk due to diabetic status. Skilled nurse visits to perform wound care and assess wound status. Patient on bed to chair activities only.”
Acceptable Homebound Example

“CHF, weakness, 3+ edema in R & L legs; needs cardiac assessment, monitoring of signs & symptoms of disease, and patient education; homebound due to shortness of breath with minimal exertion, e.g., walking 5 feet.”

Acceptable Homebound Example

“Status post right total hip replacement. Needs physical therapy to restore ability to walk without assistance. Homebound temporarily due to requiring a walker, inability to negotiate uneven surfaces and stairs, inability to walk greater than 5-10 feet before needing to rest.”
The question is not whether the patient drives but **should** the patient drive at all.

Question all frequent scheduling problems or missed visits.

If patient goes out occasionally, evaluate & document:
- Remember, agency needs to decide if patient meets HBS. Document status on each visit & summarize on 60 day summaries.
Suggestions

Don’t ignore or procrastinate on responding to probe. Check DDE system often.

Chances are you will receive all 5 requests at one time - send all documentation at the same time.

Send with return receipt request.

Mitigate damages. Leave no page unturned. Scrutinize every part of record, not just the F2F.

Don’t make them dig for documentation!

Point out everything clearly. Use cover sheet & index.

If records reviewed fail to meet the required standard, more will be requested and probe will deepen.

Recertifications
Physician Recertifications

- The plan of care must be reviewed and signed by the physician at least every 60 days when there is a need for continuous home care unless:
  - a beneficiary transfers to another HHA; or
  - a discharge & return to HH during the 60-day episode

- Must be conducted between days 56-60 of the episode

- Recertification should occur at the time the plan of care is reviewed, and must be signed & dated by the physician who reviews the plan of care

Recertifications

- Keep in mind that previous episode orders expire on day 60.
- Make every attempt to secure new signed orders prior to day 60.
Physician Recertifications

The physician must include an estimate of how much longer the skilled services will be required and must certify (attest) that:

1. The HH services are or were needed because the patient is or was confined to the home as defined in §30.1.
2. The patient needs or needed skilled nursing services on an intermittent basis (other than solely venipuncture for the purposes of obtaining a blood sample), or PT, or SLP services; or continues to need OT after the need for SN, PT, or SLP services ceased.

3. A plan of care has been established and is periodically reviewed by a physician.
4. The services are or were furnished while patient is or was under the care of a physician.
and Finally

- Remember that if you receive an ADR for a recertification, you must send the original episode where the F2F was warranted.
- If you pass this next round of audits, you will be off CMS’s radar for F2F.
- Don’t procrastinate!
- Don’t make them search. Direct them to what you want them to review.
- Continue to educate physicians & clinicians.

Speaker Information

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