A Whole New World: The Face-to-Face Makeover

Presented by
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F2F Background

- Originally a provision of the 2011 Final Rule
- The regulations at 42 CFR 424.22 list the requirements for eligibility certification and recertification
  1. Need for the skilled services
  2. Homebound status
  3. Occurred within the required timeframe
  4. Was related to the primary reason the patient requires home health services
  5. Was performed by an allowed provider type
- The requirements differ for eligibility certification and recertification; however, if the 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 documentation from the certifying physician that all new SOC patients had a F2F encounter within 90 days prior to the SOC or 30 days after the SOC
- Home health agencies (HHAs) should obtain as much documentation from the certifying physician’s medical records and/or the acute/post-acute care facility’s medical records (if the patient was directly admitted to HH) as they deem necessary to assure themselves that the Medicare HH patient eligibility criteria for certification and recertification have been met
- 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 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.
- Many roadblocks along the way especially with physician cooperation
- Denials ensued
- A 2015 Final Rule Provision finalized a change that, beginning Jan. 1, 2015, an agency is required to obtain documentation from certifying physician and/or acute/post acute care facility’s medical records for the patient to serve as a basis for certification & eliminated the narrative requirement as part of the F2F document
- Documentation must become part of the patients permanent record

F2F Form

Based on this information from the regulation, for medical review purposes:

- If the agency is using a F2F form to send to the physician, there is still the requirement that the provider obtains a note or some 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 to meet the requirement

Statistics

- In July 2013, CGS HH&H Medicare Bulletin reported results of a widespread edit for all HH providers.
- Based on these reviews, CGS reported that FTF documentation was one of the top reasons for denials (5FFTF)
- 1,377 claims were reviewed between July 1 & December 31, 2013
- 765 claims were denied for insufficient F2F documentation – 80%
Top Reasons for Denial

Most denials were attributable to two reasons:

- Insufficient documentation to support the need for skilled care
- Insufficient documentation to support homebound status. Specifically:
  - documentation to support the need for skilled care and/or homebound status lacked any clinical findings
  - documentation read like orders rather than clinical findings (e.g. gait training, wound care, teaching)
  - documentation included vague subjective finding such like “weakness” or “confusion”

Certification Requirements

1. Homebound. Home health services are or were required because the individual is or was confined to the home.

2. Skilled Care. The patient needs or needed intermittent skilled nursing care (other than solely venipuncture for the purposes of obtaining a blood sample), physical therapy, and/or speech language pathology services.

3. Plan of Care. A plan for furnishing the services has been established and is, or will be, periodically reviewed by a physician who is a doctor of medicine, osteopathy, or podiatric medicine (a doctor of podiatric medicine may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under state law).

4. Under Physician Care. Home health services will be or were furnished while the individual is or was under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine.

5. Face-to-Face Encounter. A F2F patient encounter occurred no more than 90 days prior to the HH start of care date or within 30 days after the start of HH care, was related to the primary reason the patient requires HH services, and was performed by an allowed provider type defined in 42 CFR 424.22(a)(1)(v). The certifying physician must sign and also document the date of the encounter as part of the certification.

New Guidance on F2F Documentation

- Effective January 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 home health 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 home health) and signed off by the certifying physician.
- The documentation does not need to be on a special form.
Who Are the Allowed Provider Types?

“must be performed by the certifying physician himself or herself, 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 (NPP)

- A nurse practitioner or a 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.
- A certified nurse midwife, as authorized by State law, under supervision of the certifying physician or under supervision of 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;
- A physician assistant under the supervision of the certifying physician or under the supervision of 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.
- NPPs performing the encounter are subject to the same financial restrictions with the HHA as the certifying physician.
- Keep in mind that the F2F documentation is part of the certification and only a physician can certify the patient for homecare.
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 and specific definition
- Not a change in homebound definition

Homebound Criteria

CMS advises that an individual shall be considered “confined to the home” (homebound) if the following two criteria are met:

- **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 assistance 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 and taxing effort. Absences from the home for health care treatment (including adult day care) or religious services are allowed, and do not negate the beneficiary's homebound status.

Acceptable Homebound Examples

Descriptive and quantifiable explanations of clinical findings to support homebound and need for skilled care examples:

1. “The patient is temporarily homebound secondary to status post total knee and currently walker dependent with painful ambulation. PT is needed to restore the 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.”

2. “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.”

Is Driving Acceptable

- 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 and document on next visit;
  - where patient went
  - purpose for outing
  - how long were they out
  - how patient tolerated outing
- Remember, agency needs to decide if patient meets HBS. Document status on each visit and summarize on 60 day summaries.
Probe & Educate

Probe & Educate Reviews
- CMS is conducting pre-payment reviews of HH claims for episodes beginning on or after August 1, 2015.
- CMS contractors will conduct these reviews using a Probe & Educate strategy through an end date to be determined.
- The purpose of this Probe & Educate process is to ensure that HHAs understand the new patient certification requirements.
- Because HH episodes have a 60-day certification, CMS anticipates the first documentation requests will be sent on or about October 1, 2015.

Criteria for Probe & Educate
Five key criteria **must** be found somewhere within the “complete” medical record. The reviewed medical record will include not only the home care provider’s documentation but also the primary physician’s office notes and assessments. In addition it would include the discharging facility’s or the physician office record documenting:
1. Need for skilled services
2. Homebound status
3. Encounter occurred within the required time frame
4. Encounter was related to the primary reason for HH
5. Encounter was performed by an allowed provider type

Probe & Educate Process
- Intermediary will request and review records from 5 patients per agency
- Intermediary will provide to the agency a notification letter if any documentation is missing along with a specific # to speak to a representative and receive the “education” part of the probe.
- 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.

Probe & Educate Review Change
Claims Subject to Review as Part of the Probe & Educate Process
- MLN Matters #SE1524
**Probe & Educate Review**

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<tr>
<th></th>
<th>No or Minor Concerns</th>
<th>Moderate/Major Concerns</th>
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<tbody>
<tr>
<td>5 claim sample</td>
<td>0-1*</td>
<td>2-5*</td>
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<tr>
<td><strong>Action</strong></td>
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<tr>
<td>For each provider with no or minor concerns, CMS will direct the MAC to:</td>
<td>For each provider with major to moderate concerns, CMS will direct the MAC to:</td>
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<tr>
<td>1. Deny non-compliant claims; and</td>
<td>1. Deny non-compliant claims; and</td>
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<tr>
<td>2. Send detailed review results letters explaining each denial</td>
<td>2. Send detailed review results letters explaining each denial</td>
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| 3. Send summary letter that:  
  • Offers the provider one-to-one phone call to discuss claim denials if any; and  
  • Indicates that no more reviews will be conducted under the Probe & Educate process | 3. Send summary letter that:  
  • Offers the provider one-to-one phone call to discuss claim denials if any; and  
  • Indicates that the reviews contractor will REPEAT Probe & Educate process with an additional 5 claim sample; and |
| 4. Await further instruction from CMS | 4. Repeat Probe & Educate of 5 claims with dates of services after the implementation of education |

*Note: If the HHA fails to submit 5 claims, the provider will be considered of moderate concern (unless four claims were reviewed and the MAC approved all four).

**Probe & Educate Suggestions**

- Don’t ignore or procrastinate on responding to Probe. Check DDE system often.
- Chances are you will receive all five requests at one time – send all documentation at the same time
- Mitigate damages. Leave no page unturned. Scrutinize every part of the record, not just the F2F.
- Send with return receipt request.
- If a significant # of the 5 records review fail to meet the required standard, more will be requested and probe will deepen.
- DON’T MAKE THEM DIG FOR DOCUMENTATION! Point out everything clearly. Use cover sheet & index

**Early Results of Probe & Educate Review**

Medicare Administrative Contractor CGS has partially denied 508 of 594 claims it has reviewed early on during CMS home health “Probe and Educate” review.

<table>
<thead>
<tr>
<th>#1 Denial Reason</th>
<th>Certification issues – 57%</th>
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<tbody>
<tr>
<td>• F2F missing/invalid (91%)</td>
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<tr>
<td>• Untimely POC (2%)</td>
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<tr>
<td>• POC/certification not signed (2%)</td>
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<td>• Missing certification (2%)</td>
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<tr>
<td>• Recertification estimate missing (1%)</td>
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<tr>
<td>• Initial cert missing/invalid (1%)</td>
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| #2 Denial Reason                     | No response to ADR – 30% |

| #3 Denial Reason                     | Medical necessity of therapy services – |

**Source: CGS**

The types of denials so far: certification, homebound, therapy not reasonable.

Some details about the certification denials:

- F2F documentation is missing, incomplete, untimely
- Primary reason is that the medical documentation does not support the need for homecare or the homebound eligibility criteria
- The five certification elements are not signed off by the certifying physician
- If the claim is a recertification claim, initial documentation of the F2F is not provided (including the initial plan of care)
- Documentation of the actual face to face encounter was not provided (physician office note or discharge summary)
30.5.2 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 and return to home health 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 and dated by the physician who reviews the plan of care.

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 the patient is or was under the care of a physician.

Medicare does not limit the number of continuous episode recertifications for beneficiaries who continue to be eligible for the HH benefit. The physician certification may cover a period less than but not greater than 60 days

If the narrative is part of the recertification form, then the narrative must be located immediately prior to the physician’s signature.

If the narrative exists as an addendum to the recertification form, in addition to the physician’s signature on the recertification form, the physician must sign immediately following the narrative in the addendum.

Recerts for Management & Evaluation (M&E)

When skilled management & evaluation services are ordered:
The following is required as part of the physician’s certification for HH care:

1. The physician must include a brief narrative
   a. describing the clinical justification of the need for a registered nurse to ensure that essential non-skilled care is achieving its purpose, and
   b. and necessitates a registered nurse be involved in the development, management, and evaluation of a patient’s plan of care due to the patient’s underlying condition or complications.

2. If the narrative is part of the certification or recertification form, then the narrative must be located immediately prior to the physician’s signature.
3. If the narrative exists as an addendum to the certification or recertification form, in addition to the physician’s signature on the certification or recertification form, the physician must also sign and date immediately following the narrative in the addendum.
Content & Physician Signature

- If a patient's underlying condition or complication requires a registered nurse to ensure that essential non-skilled care is achieving its purpose, and necessitates a registered nurse be involved in the development, management, and evaluation of a patient's care plan, the physician will include a brief narrative describing the clinical justification of this need.

- If the narrative is part of the certification or recertification form, then the narrative must be located immediately prior to the physician's signature.

- If the narrative exists as an addendum to the certification or recertification form, in addition to the physician's signature on the certification or recertification form, the physician must sign immediately following the narrative in the addendum.

Management & Evaluation (M&E)

- M & E (G 0162) visits require the services of an RN

- Skilled services by a licensed nurse (RN only) for management and evaluation of the plan of care, each 15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the HH or hospice setting).

- Plan of care MUST be COMPLEX & UNSKILLED

- Requires RN oversight
  - RN is vital
    - coordinate
    - oversee plan to minimize risk of hospitalization
  - Complex care means:
    - That many facets involved, which are unskilled
      - multiple medications
      - treatments

Documentation

Good documentation & evaluation of the patient & home – Include factors such as:

- Home setting that is unsafe or inaccessible
- Multiple caregivers in the home
- Caregivers unwillingness to participate
- Absences of caregivers
- Dysfunctional caregivers
- Caregiver limitations

- Providers – Documentation is the key to avoiding denials – Remember “If it isn’t documented it wasn’t done” – What is acceptable and what is not – Don’t lose sight of medical necessity and skilled need.

- May be necessary to revert to Skilled or Observation & Assessment visits periodically.

- No time limit. But visits that are too frequent or too infrequent could raise a red flag.
NGS has completed its medical review of the first 300 claims submitted in J6 for the Home Health Probe and Educate. Based on the trends noted during this early review, we are providing some additional guidance and reminders to assist the HHAs in responding to the request for medical records and to avoid some denials. This article will identify the top five reasons for denial noted thus far and give some tips on the documentation needed to support a complete certification and face-to-face encounter.

**Denial Reason**

1. The actual clinical note for the face-to-face encounter visit (physician’s progress note or the facility’s discharge summary) is not being submitted by the HHA when responding to the ADR. The face-to-face attestation form that was commonly used prior to 2015 is frequently being sent as the face-to-face encounter documentation; as of 2015, this attestation with a brief clinical narrative is no longer required and is not sufficient. Rather, the actual visit that comprised the face-to-face encounter must be supplied. CMS IOMPublication 100-02, *Medicare Benefit Policy Manual*, Chapter 7, Section 30.5.1.2 indicates that documentation from the certifying physician’s medical records and/or the acute/post-acute care facility’s medical records are to be used to determine eligibility for the Medicare home health benefit. It further states that this medical record must contain the actual clinical note for the face-to-face encounter visit.

   **TIP:** Make sure to submit the actual medical record of the face-to-face encounter with your records for NGS to review. This information can be found most often in clinical and progress notes and discharge summaries.

2. The eligibility requirements to substantiate that the patient has the need for skilled home health services and is homebound is not justified by the documentation in the certifying physician’s and/or the acute/post-acute care facility records. These parameters are often not being addressed in the actual medical records when they are submitted. According to CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 7, Section 30.5.1.2, “The certifying physician and/or the acute/post-acute care facility medical record (if the patient was directly admitted to home health) for the patient must contain information that justifies the referral for Medicare home health services. This includes documentation that substantiates the patient’s: need for the skilled services; and homebound status.”
**TIP:** Any documentation from the physician’s or acute/post-acute care facility’s medical records can be used to help substantiate the need for home health services and homebound status. Including documentation in addition to just the face-to-face encounter visit may help to support homebound status and the need for home services. Examples of additional documentation may include: facility therapy notes, social work or discharge planning records, history and physicals, and other clinical progress notes.

**TIP:** 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 incorporated into the certifying physician medical records. This can be demonstrated by the physician signing and dating the documentation supplied by the HHA; however, the findings of the HHA must be corroborated by the other medical record entries from the physician and/or facility. (Refer to CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 7, Section 30.5.1.2 for additional specific information relating to this topic).

3. The physician from the acute/post-acute care setting is certifying the patient’s eligibility for the home health benefit and completing the face-to-face encounter, but will not be following the patient after discharge, and there is no documentation of the community physician who will be following the patient after discharge. In this situation, the certifying physician must identify the community physician who will be following the patient after discharge. Per CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 7, Section 30.5.1.2, “One of the criteria that must be met for a patient to be considered eligible for the home health benefit is that the patient must be under the care of a physician. Otherwise, the certification is not valid.”

**TIP:** If the facility physician or a hospitalist is providing the certification of the five required elements, confirm that the community physician is identified by the certifying physician. If missing, it should be investigated whether the certifying physician will continue to care for the patient in the community. If not, the certifying physician should make an addendum to their documentation with the name of the community physician.

4. The HHA is not providing the certification and face-to-face encounter documentation from the start of care (SOC) episode when the claim under review is a recertification claim. The Medical Review department is responsible for determining whether the patient was eligible to receive services under the Medicare home health benefit at the start of care, so it is critical that this documentation is supplied, regardless of what certification/recertification claim it is.
TIP: Supply all of the documentation relating to the certification requirements and the face-to-face encounter for the start of care episode even on claims that apply to a recertification period. It is helpful to include the SOC plan of care with the recertification document. This document often helps support the physician certified the first four elements.

5. The recertification does not include an estimate by the physician of how much longer the skilled services will be required. This estimate must be specifically stated and will not be inferred by the Medical Review staff from the certification dates on the plan of care, or the frequency/duration of the orders.

TIP: The HHA should review all recertification forms for the estimate of how much longer the skilled services will be required; if missing, obtain documented clarification from the physician before the services are billed to Medicare.

It is our goal that supplying this early feedback to providers will assist them in preparing for the probe and educate record requests as well as review their current protocols to ensure they are in compliance with the current Medicare requirements pertaining to certification and face-to-face documentation.
Thanks for Attending!
Feel free to contact us with any questions.
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