



Face-to-face encounter documentation in home health & hospice



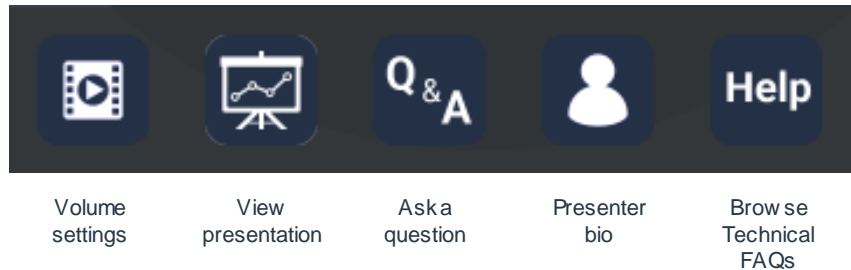
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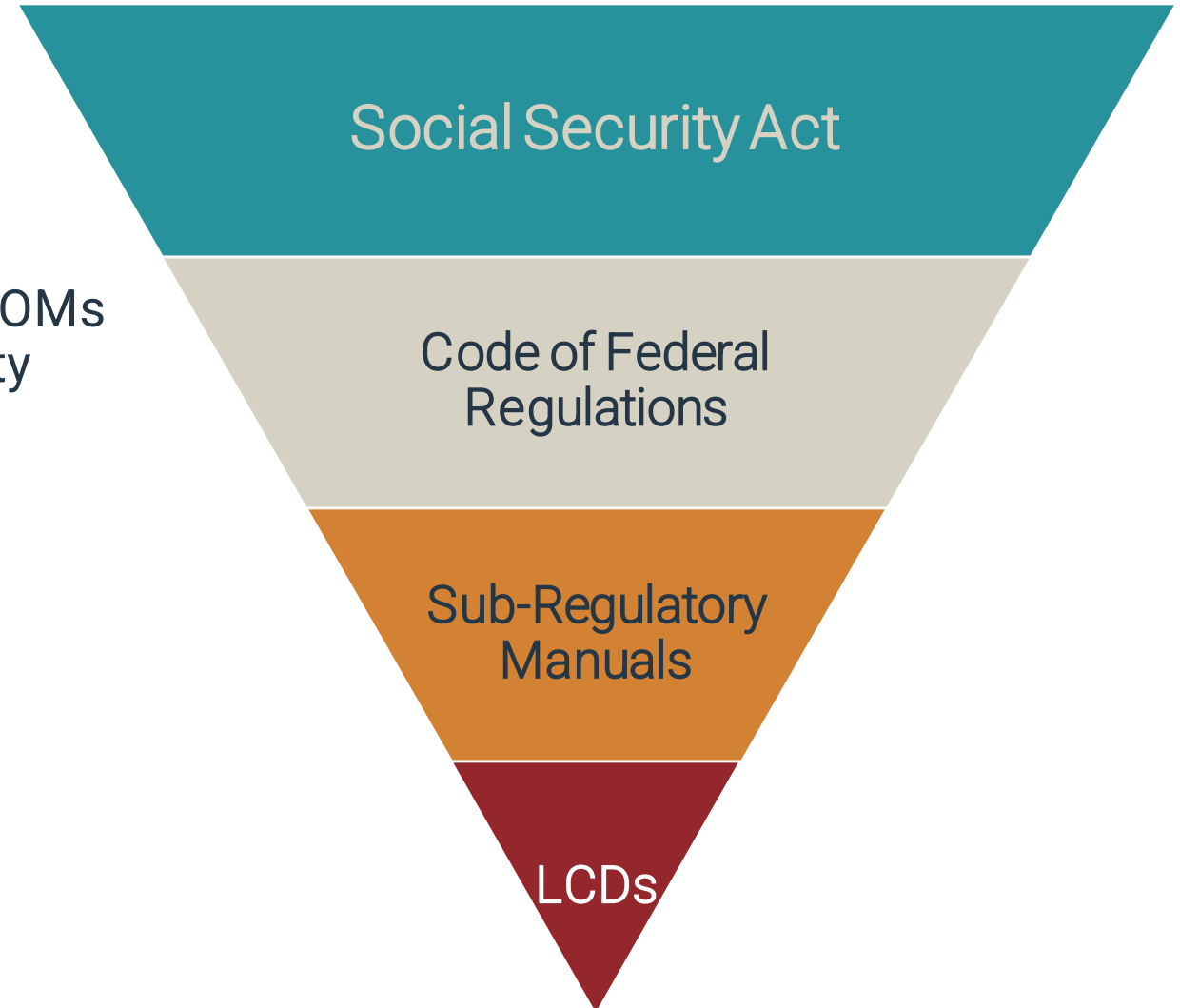
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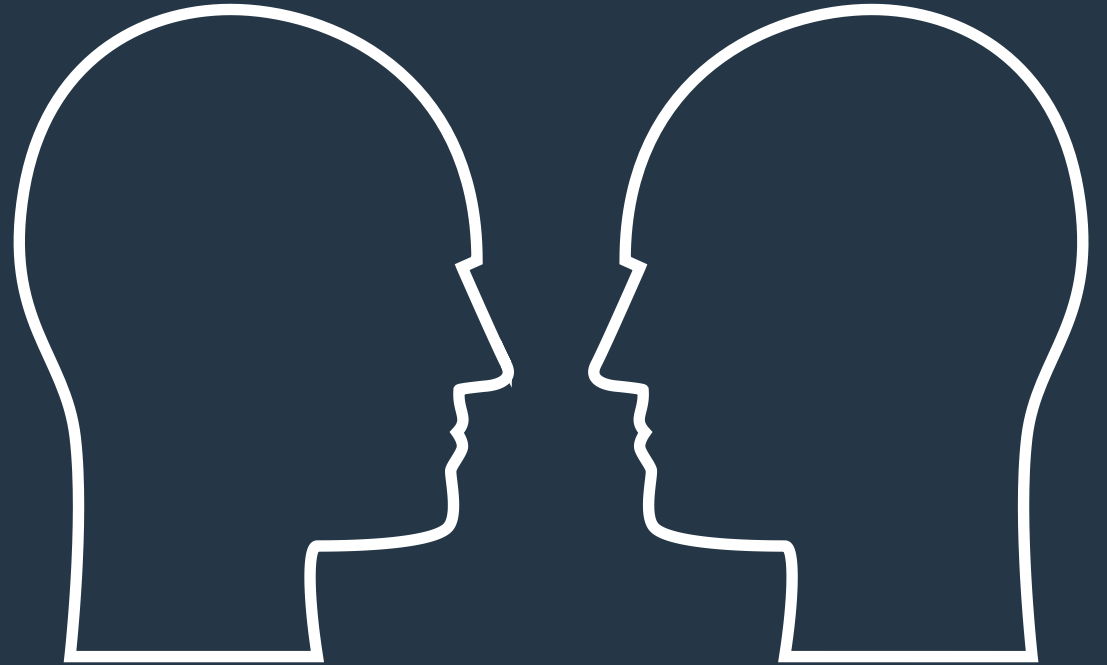
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Authoritative guidance for face-to-face (F2F) questions

- The actual language of the regulation is the governing authority
 - For HH 42 CFR § 424.22
 - For Hospice 42 CFR § 418.22
- Next in line are the coverage provisions in the IOMs – Medicare Benefit Policy and Program Integrity Manuals
 - For HH Chapter 7 and Chapter 6 of the PIM
 - For Hospice Chapter 9
- Following are Local Coverage Determinations
 - No LCDs for home health
 - Palmetto and NGS LCDs for hospice terminal illness certifications which are related to F2F
- There are inconsistencies!



Home health F2F encounter rules



F2F encounter framework

- Chapter 6 of the Program Integrity Manual –Section 6.2.1
 - Without a valid encounter and certification at the start of care, there can be no service reimbursement for any certification period in a series
- Medicaid – partially funded by the federal government and requires a F2F
- Medicare Advantage plans have discretion regarding their F2F requirement



HH F2F – 42 CFR § 424.22

- The F2F encounter must relate to the primary reason the patient requires home health services
- The encounter must be timely and within the 121-day window
- The encounter date must be documented “as part of the certification”
- The encounter must be performed by:
 - The **certifying physician** or a physician, with privileges, who cared for the patient in an inpatient facility from which the patient was directly admitted to home health,
 - The **certifying NP, CNS** or an NP or CNS working in collaboration with a physician, with privileges, who cared for the patient in an acute or post-acute facility from which the patient was directly admitted to home health,
 - A **certified nurse midwife**, under the supervision of a physician, including physicians with privileges who cared for the patient in an acute or post-acute setting,
 - The **certifying PA** or a PA under the supervision of a physician, with privileges, who cared for the patient in an acute or post-acute facility from which the patient was directly admitted to home health

HH F2F – 42 CFR § 424.22

- The encounter may occur through telehealth in compliance with Section 1834(m) of the Social Security Act subject to the restrictions contained there
 - Don't confuse this with the § 1135 Waiver during the PHE
- The F2F must be performed by the certifying physician or allowed practitioner unless the encounter is performed by:
 - A certified nurse midwife under the supervision of a physician, or
 - A physician, PA, NP, or CNS, with privileges, who cared for the patient in the acute or post-acute facility from which the patient was directly admitted to home health and who is different from the certifying physician or practitioner
- The certification must be obtained at the time the plan of care is established or as soon thereafter as possible and must be signed/dated by the physician or allowed practitioner who establishes the plan of care

A new hurdle – the 2020 regulatory addition

42 CFR § 424.22 (a)(1)(v)

(C) The face-to-face encounter must be performed by the certifying physician or allowed practitioner unless the encounter is performed by:

(1) A certified nurse midwife as described in paragraph (a)(1)(v)(A)(4) of this section

(2) A physician, physician assistant, nurse practitioner, or clinical nurse specialist with privileges who cared for the patient in the acute or post-acute facility from which the patient was directly admitted to home health and who is different from the certifying practitioner



Chapter 7 guidance

- A F2F encounter must be associated with every start of care assessment
- The certifying physician or allowed practitioner must document the encounter date
- From the manual:
 - A certification (versus recertification) is considered to be anytime that a start of care OASIS is completed to initiate care. In such instances, a physician or allowed practitioner must certify (attest) that:
 - a face-to-face encounter occurred no more than 90 days prior to or within 30 days after the start of the home health care, was related to the primary reason the patient requires home health services, and was performed by a physician or non-physician practitioner.
 - The certifying physician or allowed practitioner “must also document the date of the encounter”
- This guidance is inconsistent with the language of the regulation

Chapter 7 cont.

- If the inpatient physician certifies eligibility “but will not be following the patient after discharge” then they must identify the community physician or allowed practitioner who will be following the patient after discharge
- It is “not acceptable” for HHAs to wait until the end of a 60-day certification period to obtain a completed certification of eligibility
- All references to NPPs or allowed practitioners who perform the encounter and/or certify eligibility indicate that they must be working in accordance with state law
 - The newest addition to Chapter 7 (3/25/22 – CR 12615) goes a step further
 - “Individual states have varying requirements for conditions of practice which decide whether a practitioner may work independently without a written collaborative agreement or supervision from a physician, or whether general or direct supervision and collaboration is required. However, a CNS and NP must work in collaboration with a physician even if state laws governing collaboration don’t exist.”

Chapter 7 – new conditions and exceptions

- When home health is ordered based on a new condition that was not evident during a prior visit within the 90 days preceding home health, the patient must be seen again within 30 days by the certifying physician or practitioner
- This is merely a confirmation of the fact that the reason for home health must be consistent with the F2F
- When a home health patient dies before the F2F can be performed, as long as the agency can demonstrate a good faith effort to facilitate the encounter, the certification will be deemed to be complete

F2F supporting documentation

- The physician, NPP, or facility record must contain information that justifies the referral. This includes:
 - The patient's skilled home health need,
 - The patient's homebound status
- The F2F encounter must contain the "actual clinical note"
- Information from the agency's record can be incorporated into the physician/facility record and used to establish eligibility
 - The plan of care should have a longitudinal description of homebound status
 - The plan of care is required to establish the skilled care need as a condition of payment at 42 CFR § 409.43
 - The incorporation of the agency's information is demonstrated by the physician or practitioner's signature on the document



Certification signature exception

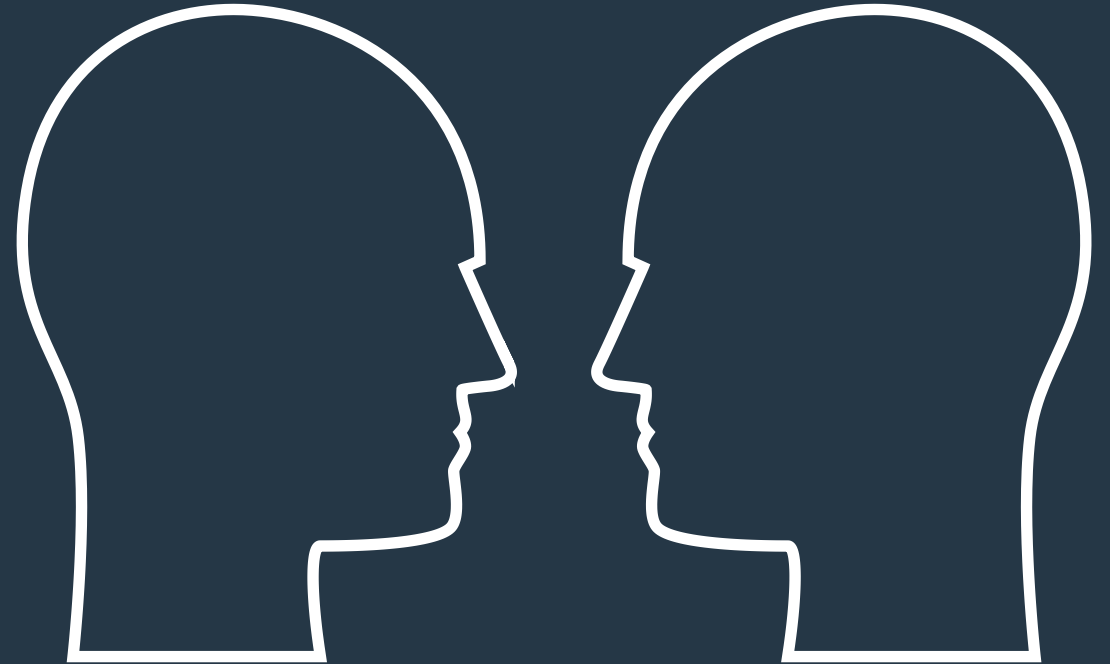
- Both Chapter 7 and Chapter 4 of the Medicare Entitlement Manual – as updated in 2021 – allow for alternate signatures on a home health plan of care that would include a certification of eligibility
- Not surprisingly, the 2021 additions to Chapter 7 are different from the exceptions earlier noted in Chapter 4 and updated in 2021
 - Chapter 7 establishes that the alternate must be from the same group practice, but Chapter 4 is silent on this
 - Chapter 7 says that the physician or practitioner who performed the required F2F encounter must sign the certification of eligibility, unless the patient is directly admitted to home health from an acute or PAC stay, but Chapter 4 is silent on this

A teal-tinted photograph showing a woman in the foreground smiling and holding the hand of an elderly person. The woman's face is partially visible on the left, and her hands are clasped around the elderly person's hand. The elderly person's face is blurred in the background on the right. The overall mood is warm and supportive.

Hospice F2F encounter rules

Hospice F2F encounters

- Hospices are obligated to obtain a F2F encounter that will establish the reasons why a patient continues to be eligible starting with the 3rd benefit period
- The encounter is performed by a hospice employed NP or a hospice physician
- Encounters can be performed within the 30-day period prior to the beginning of the benefit period
- Hospice encounters are considered to be administrative costs of the hospice



Hospice F2F per 42 CFR § 418.22

- A hospice physician or NP must have an encounter with each patient whose total stay across all hospices is anticipated to reach the 3rd benefit period
- The encounter must occur prior to but no more than 30 days before the applicable benefit period to gather clinical findings and determine continued eligibility
- During a PHE, the encounter may occur via a telecommunications technology
- Subsequent certification is based on the physician's judgment concerning the normal course of the patient's illness
 - The F2F encounter information is intended to inform this judgment

Interpretive guidance from Chapter 9

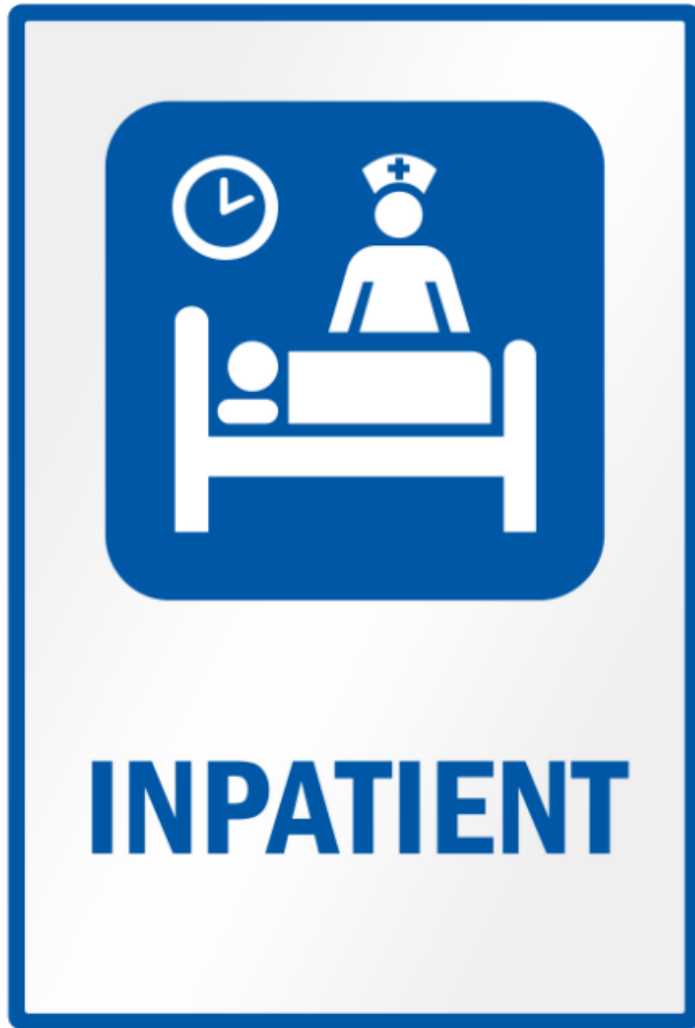
- Failure to conduct a timely F2F encounter results in a failure to meet the recertification of terminal illness
- When this happens, the patient ceases to be eligible for hospice
- Encounters can be considered timely if they occur on the first day of the certification period to which they apply
- A physician or NP who performs the encounter must attest in writing as to the encounter and its date, and the attestation must be part of the recertification form
- When the person performing the encounter is not certifying, the attestation must also confirm that the results of the encounter were provided to the certifying physician

Chapter 9 guidance cont.

- NPs who perform encounters must be employed by the hospice
- Physicians can be either employed by or under contract
- Attending physicians cannot perform encounters
- There are emergency exceptions to the timing rules:
 - Weekend admissions
 - When CMS data/eligibility systems are down
 - When the patient dies within 2 days
 - Missing or invalid encounters render the required certification incomplete
 - When the encounter is untimely, the patient would be discharged from the Medicare benefit but retained as a patient for which the hospice has financial liability
 - When the encounter is performed, the patient can then be readmitted

Home health F2F tips

F2F encounters – inpatient settings



- Inpatient is defined to include services provided in a hospital or other institutional setting when the patient comes “directly” to home health
 - Has no bearing on the patient’s inpatient status relative to PDGM case mix
 - Relates to the facility setting only
 - Encounters in the ED or hospital observation stays can be used for F2F as “inpatient” encounters
 - Necessary for providers to understand the dichotomy between F2F and PDGM requirements
- Within an “inpatient” setting, the encounter can be performed by a person – “with privileges”
- “With privileges” and “directly” are not defined in the regulatory guidance

Outpatient encounters

- When the encounter is an outpatient encounter, the person who performs the F2F must also certify
- The more time between an outpatient encounter and the home health referral, the less likely the reason for home health will be clear and defensible
 - Example: F2F visit a month ago when home health referral is due to a more recent fall with injury
 - Example: Pre-op notes for joint replacement where the home health skilled need is aftercare
- The initial reason for the outpatient visit and the home health skilled need do not need to be the identical, however
 - Example: Visit for HTN med follow up where significant diabetic foot ulcer is discovered

Homebound status documentation

- The regulations require that the physician or facility record, including those used for the F2F encounter, establish homebound status
- Records other than the encounter can be used to demonstrate homebound status
 - Add a longitudinal description of why the patient is homebound to the plan of care
 - Remember that the plan of care is one of the certifying practitioner's own records
 - When homebound status is addressed in the plan of care, even if the F2F documentation doesn't address it, the requirement will be met

Myths

vs.

Facts

- The inpatient record being used for the encounter must be signed by the certifying physician if they are different from the inpatient provider

This is only true when the inpatient provider is certifying

- F2F encounters performed by allowed practitioners must be signed by the supervising physician

There is no home health regulation that requires this

- If the F2F encounter document does not specifically address homebound status, it cannot be used

The requirement is that the physician or facility record must establish homebound status – broader than just the isolated F2F encounter

- The primary diagnosis on the F2F needs to match the primary diagnosis on the patient's SOC Plan of Care

There is no regulation that requires diagnosis matching

- The certification must include the name of the performing provider

There is no regulation that requires the certifying provider to identify the individual who performed the encounter by name – only the date is required

Curing common F2F gaps

- Each of the five most common gaps can be rectified by process improvements – acquiring and validating the F2F at intake
 - Encounter is timely but unrelated to the reason for home health services
 - Encounter is not timely
 - Record does not show evidence of an actual provider/patient visit
 - Encounter performed by someone other than a physician/allowed practitioner
 - Encounter is an outpatient service with a physician who is not certifying
 - Encounter is signed by someone other than the performing provider
- Agencies should establish an admission review process that compares the F2F with the “primary” skilled need with measurement of the other criteria

Curing common F2F gaps

Each of the following gaps can be reviewed with attention to the content on the plan of care

- Encounter date is not provided in conjunction with the certification
- The certification is missing, incomplete, or unsigned/undated
- F2F certification is provided but the underlying encounter record is missing



Hospice F2F tips



Hospice F2F tips

- Remember what the F2F is intended to do – establish ongoing terminal status before the certification narrative is written
- Use the relevant LCD and train staff on what things are important to document
- The later the benefit period, the more important the F2F to eligibility
 - Use end-stage signs and functional measures – PPS, FAST, Karnofsky, NYHA
 - For dementia diseases with slower end-stage trajectories, also other factors
- Always document the F2F visit as a formal clinical visit that is signed/dated

Identifying and addressing hospice F2F gaps

- F2F does not clearly support ongoing terminal status
- Physician copies the F2F findings for the narrative
 - Negates the attestation as to original authorship
- New patient is in an advanced benefit period – F2F is not done or is late
 - Renders the patient ineligible until the F2F is done
 - Services become the hospice's liability as patient is DC'd from Medicare benefit
 - Services cannot be charged to the patient due to the hospice's failure to comply
- Hospice physician ignores the F2F findings to defend ongoing terminal status



Wrap up

- F2F gaps are the most prevalent sources of payment denial
- The key to success is to 'get it right the first time' by controlling the process
- When faced with a denial based on the insufficiency of the F2F, appeal
 - Reviewers are not always right
 - Use gaps in the available guidance to your advantage
- Work toward a goal of making all key staff members F2F experts

Questions

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A scenic landscape photograph of a sunset over a mountain range. The sun is low on the horizon, creating a bright yellow and orange glow that transitions into a deep blue and purple sky. The mountains are silhouetted against the colorful sky, with some peaks catching the light of the setting sun. The overall mood is serene and hopeful.

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