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FAQ

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

Written by
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Face-to-face encounter documentation continues to be the top reason for claim denials by Medicare and Medicaid review contractors, and recent changes to face-to-face rules by CMS make it more important than ever for agencies to review and understand documentation standards.

Renowned compliance and policy expert, Sharon Harder, President of C3 Advisors, recently presented an important webinar that equipped home health and hospice organizations with face-to-face documentation standards that can withstand medical review scrutiny. This webinar is now available to watch on-demand.

Home Health

Diagnosis and encounters

Q: Does the primary reason for the encounter need to be the same as the primary reason the patient requires home health services? For example, if the primary reason that the patient requires home health was discovered during an encounter that began for another reason, is this still acceptable?

A: According to 42 CFR § 424.22, the face-to-face (F2F) encounter must be related to the "primary reason the patient requires home health." This stops short of saying that the initial reason for the encounter must also be related. Thus, information about the patient that is discovered during the encounter, whether or not that information formed the initial basis for the encounter, would be sufficient to meet the requirement.

An example of this concept could be as follows: A patient with both hypertension and diabetes sees his primary care physician (PCP) for a quarterly checkup in advance of a prescription renewal for his hypertension meds. During the visit, it is discovered that the patient has a new stage 2 diabetic foot ulcer for which home health wound care services are needed. Even though the initial reason for the encounter was something different, the fact that the diabetic ulcer was found during the encounter qualifies it (for purposes of the F2F) for a start of care (SOC) with a primary diagnosis related to the wound.

On the other hand, if the encounter documentation mentions only the diabetes diagnosis as part of the patient's personal medical history (PMH), without mention of the foot ulcer, that would likely not qualify

the physician visit for purposes of determining the patient's eligibility. In that case, another physician encounter to address and diagnose the foot ulcer as well as the need for home health would be necessary.

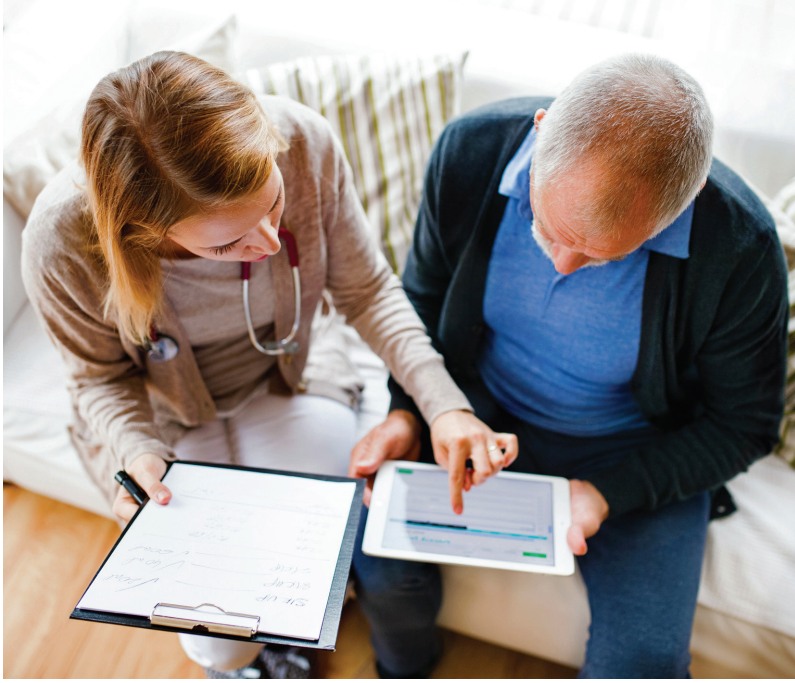
Regarding inpatient encounters, be careful with the documents that you select to serve as the F2F. For example, an admission history and physical examination (H&P) may show evidence of a clinical encounter but may not support later clinical findings that specifically relate to the patient's need for home health. A classic example is the patient who goes to the ER with symptoms that could be suggestive of several different problems. The H&P mentions only the symptoms without specifically associating them with a condition that is later diagnosed for the first time. In this case, the H&P as the F2F could fail on the technicality that the inpatient stay is confirmed but the reason for the stay is not.

Q: How closely does the F2F need to match the referring diagnosis? For example, if a patient has a PCP appointment to manage diabetes, but later, the caregiver calls to report a new diabetic foot ulcer, can the prior visit focused on diabetic care be used for the home health wound care, given that the ulcer is related to the patient's diabetes?

A: No. The home health focus of care, which is the wound, was not evident at the time of the PCP visit even though its underlying chronic cause was. Without the presence of the wound being mentioned in the physician note, the relationship between the physician visit and the home health skilled need is not proven.

Q: Can a claim be denied for payment on the basis that the diagnosis on the F2F does not match the home health primary diagnosis?

A: Neither the regulation nor the sub-regulatory guidance establishes the need for the diagnoses to



match between the encounter and the plan of care (POC). Moreover, CMS addressed this issue when it stated in the 2011 Home Health Final Rule that there was no intent that "those who enforce the provision would take such a literal interpretation to look for a cause-and-effect relationship between a diagnosis on the physician's claim and the diagnosis on the home health claim." This issue seemed to come up during Pre-Claim Review and has resurfaced with the Review Choice Demonstration (RCD). When agencies are confronted with denials or non-affirmations related to diagnosis matching, the point should be argued either through a conversation with an RCD supervisor or in the case of a claim denial, through appeal.

Q: If the primary diagnosis is aftercare following a joint replacement, should we use the actual surgical note for the F2F, or will the pre-op physician encounter suffice?

A: In this scenario, the primary reason for home health services is the joint replacement, which would not have happened during the pre-op exam. Thus, that documentation will not suffice for the F2F, and the post-op or procedure note should be used instead.

Q: If we admit a patient with a primary diagnosis of dementia, can the related diagnosis be listed on the encounter under Past Medical History? Or does it have to state that dementia is an active diagnosis?

A: The reason for home health must be based on a patient's current (rather than past) condition. Usually dementia does not resolve; however, if it is not the focus of the encounter, and is listed as a past problem, then the F2F would likely fail for lack of the required relationship with the home health skilled need.

Denials and F2F timing

Q: If, as a result of an Additional Development Request (ADR), the Medicare Administrative Contractor (MAC) denies a claim based on the F2F encounter, can the denial be appealed?

A: Yes, as long as the agency has a good argument for why the F2F encounter documentation is valid. In fact, you should always appeal a denial unless there is clear and irrefutable information in the record that supports the denial.

The denial code will most likely be 5FF2F, which states that "the physician certification was invalid since the required face to face was invalid/untimely/missing." The granular error information will tell you more specifically about the rationale for the denial and its regulatory basis. This information will enable you to make a more convincing argument in favor of payment. Just be sure in the text of the appeal to point out specifically why the reviewer's conclusion was incorrect.

Q: When is a F2F encounter considered late?

A: There are two scenarios in which the encounter could be considered "late", and therefore, invalid. The first is when the encounter occurs on a date that is beyond the 30th day following the SOC, keeping in mind that the SOC is considered Day 0. The second is when the encounter is performed within the 30-day period following the SOC but after the patient was discharged and no longer under the care of the home health team.

Telehealth encounters

Q: Under what circumstances are remote encounters permissible for the conduct of home health F2F encounters?

A: When the public health emergency (PHE) was declared, CMS imposed § 1135 Waivers, one of which addressed home health F2F encounters. It noted that encounters could be conducted through telehealth applications or other remote services utilizing both audio and video capabilities. The permissibility of using telehealth for home health F2F encounters is limited to the duration of the PHE; however, when the PHE is lifted, the site restrictions that apply to telehealth services will be reimposed. This will eliminate the ability of a physician or allowed practitioner to conduct a telehealth visit with the patient while the patient is at home.

Encounter documentation

Q: Is the inclusion of vital signs a necessary component of F2F encounter documentation?

A: No. There is no requirement to list the patient's vital signs on the F2F. In fact, some documents that CMS has specifically pointed out as being acceptable forms of documentation (for example, a Discharge Summary) would not have this information. The only requirement is that the relationship between the encounter and the patient's skilled home health need must be clearly established.

Q: If a patient is admitted directly from an inpatient stay, is the agency permitted to still use another record, such as the last physician progress note, in lieu of inpatient documentation?

A: Yes. You can use any documentation that meets the standard in terms of its origins and timing. There is no regulatory requirement that an agency must use inpatient documentation even though the patient may be coming from an inpatient stay.

Q: If the F2F was performed after the SOC, does the date of the encounter still need to be included on the POC?

A: Irrespective of when the encounter is performed, the physician must still document the date of the encounter.

Q: What are the most common documents used for F2F encounter documentation?

A: When patients are coming from an inpatient stay, the most common encounters are captured in the form of:

- The inpatient discharge summary
- An inpatient progress note for an encounter performed by a qualifying physician or practitioner
- An inpatient history & physical (H&P)
- Surgical procedure or post-op notes

When a patient is coming from a community referral, the acceptable form of the F2F note is the physician or practitioner progress note.

Certification and signing

Q: Is certifying the same as signing the POC?

A: No. When a physician or allowed practitioner provides a certification, it is a statement that confirms the patient's eligibility for home health services. The certification statement is different than the orders for service that also appear on the POC. In the absence of the certification of the patient's eligibility, there can be no services.

Q: Can nurse practitioners (NP) and physician assistants (PA) still certify eligibility and sign the POC?

A: Generally, yes, as long as applicable state regulations permit the practice. This change came about from the CARES Act that was passed in March 2020 and it is permanent; however, your state must also permit the practice. Remember that when there is a difference between a federal and state regulation, the more stringent of the two would apply. Thus, if your state does not allow the practice, these practitioners would not be able to certify eligibility and sign the POC.

Q: For a patient who has not had an inpatient stay before directly proceeding to home health, can the NP perform the F2F encounter while the physician signs the POC?

A: No. Unless the patient is coming from an inpatient stay where the inpatient documentation is being used for the F2F or the F2F was performed by a nurse midwife, the individual who performs and signs the F2F must also certify eligibility and sign the POC. This was the regulatory change that was added in 2020.

Inpatient setting

Q: Is an assisted living facility or a supportive living facility considered an inpatient setting for purposes of the F2F?

A: No. Only short-stay acute care hospitals, skilled nursing facilities, inpatient rehabilitation facilities, long-term care hospitals and critical access hospitals would be considered inpatient settings.

Hospice

Q: For hospice, does the NP who performs the F2F need to be a company employee, or can the hospice use an independent contractor for this purpose?

A: The NP performing the hospice F2F encounter must be a hospice employee.

Q: Many hospice patients have the hospice medical director as their designated attending physician. Does this mean that the hospice physician, who is also serving as the patient's attending physician, is precluded from performing the F2F?

A: No. In that instance, the physician would be considered the hospice physician with that privilege. The prohibition refers to attending physicians who are not a part of the hospice team.

Q: If a hospice patient needs to be discharged in the event of a failure to timely conduct the F2F, does the hospice also have to file a revocation?

A: If the hospice fails to perform the F2F in a timely manner, the patient is no longer eligible for the Medicare benefit, which means that the hospice would be obligated to discharge the patient from Medicare only; this means that it would be a pay-source change but not a true discharge. The patient's care would be, until the F2F error is cured, the hospice's liability.

Q: Must hospice patients be homebound?

A: There is no homebound status requirement for hospice.

About the author

Sharon Harder has over three decades of executive management experience in the healthcare industry and recently authored the book, ***Face to Face Answers, 2022*** (a comprehensive guide to home health and hospice face-to-face requirements). Sharon is the former Vice President of Finance and Administration for the Healthcare Financial Management Association (HFMA) and the former Chief Financial Officer for Help and Home, Inc. Currently, as President of C3 Advisors, LLC, Sharon helps clients develop the strategic vision required to improve their profitability and competitive position in the rapidly transforming healthcare marketplace.

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