Home Health Face-to-Face Changes 2015

Compliance Strategies to Retain Revenue

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DECISIONHEALTH

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Objectives

- Understand the new Home Health Face-to-Face requirements effective January 1, 2015 as published in the Federal Register
- Understand the importance of securing adequate physician documentation now that the Face-to-Face physician narrative requirement has been removed
- Build strong physician documentation exchange processes that promote timely securing of information
- Ensure physician Face-to-Face Encounter documentation stands up to auditor scrutiny
- Steps to take when physician documentation received does not establish home health eligibility (homebound status and skilled need)

CMS Awards New Region 5 RAC Contract, but now on hold!

- **January 14, 2015** – Due to a post-award protest filed at the Government Accountability Office (GAO), CMS has delayed the commencement of work under the national DMEPOS/HH&H, Region 5, Recovery Audit contract
- **December 30, 2014** – CMS has awarded the Region 5 Recovery Audit contract to Connolly, LLC. The purpose of this contract will be to support the Centers for Medicare & Medicaid Services (CMS) in completing this mission through the identification and correction of improper payments for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), and home health/hospice (HH/H) claims

F2F Denials Still a Problem!

72% Claims Denied Face-to Face Requirements not met

Palmetto GBA Home Health and Hospice

Home Health Medical Review Top Denial Reason: October-December 2014

32X Denials: There were a total of 3,989 claims denied for 32X bill types				
Rank	**Denial Code**	**Denial Description**	**# Claims**	**% Claims Denied**
1	5FF2F	Face-to-Face Requirements Not Met	3,813	72.1

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FACE-TO-FACE CHANGES EXPLAINED

The Reality

CMS removes the physician narrative requirement in exchange for physician documentation from the prior setting of care which demonstrates the patient was eligible for Medicare Home Health services.

*"Final Decision: **We are finalizing our proposal to eliminate the face-to-face encounter narrative** as part of the certification of patient eligibility for the Medicare home health benefit, effective for episodes beginning on or after January 1, 2015. The certifying physician will still be required to certify that a face-to-face patient encounter, which is related to the primary reason the patient requires home health services, occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care and was performed by a physician or allowed non-physician practitioner as defined in Sec. 424.22(a)(1)(v)(A), and to document the date of the encounter as part of the certification of eligibility."* 2015 PPS Final Rule Quote

Physician Documentation Explained in the Final Rule

"Again, we want to remind certifying physicians and acute/post-acute care facilities of their responsibility to provide the medical record documentation that supports the certification of patient eligibility for the Medicare home health benefit. Certifying physicians who show patterns of non-compliance with this requirement, including those physicians whose records are inadequate or incomplete for this purpose, may be subject to increased reviews, such as through provider-specific probe reviews." 2015 PPS Final Rule Quote

Physician F2F Communication Now Permissible in the Final Rule

"It is permissible for the HHA to communicate with and provide information to the certifying physician about the patient's homebound status and need for skilled care and for the certifying physician to incorporate this information into his or her medical record for the patient. The certifying physician must review and sign off on anything incorporated it into his or her medical record for the patient that is used to support his/her certification/re-certification of patient eligibility for the home health benefit."

2015 PPS Final Rule Quote

Physician F2F Communication Now Permissible in the Final Rule

*"**In addition, any information from the HHA** (including the comprehensive assessment) that is incorporated into the certifying physician's and/or the acute/post- acute care facility's medical record for the patient (if the patient was directly admitted to home health) and used to support the certification of patient eligibility for the home health benefit, **must corroborate the certifying physician's** and/or the acute/post-acute care facility's **own documentation/medical record entries**, including the diagnoses and the patient's condition reported on the comprehensive assessment."* 2015 PPS Final Rule Quote

Non-covered physician claims when eligibility not met

"Final Decision: Physician claims for certification/recertification of eligibility for home health services (G0180 and G0179, respectively) will not be covered if the HHA claim itself was non-covered because the certification/recertification of eligibility was not complete or because there was insufficient documentation to support that the patient was eligible for the Medicare home health benefit."
2015 PPS Final Rule Quote

F2F Timing Clarified

"Final Decision: In order to determine when documentation of a patient's face-to-face encounter is required under sections 1814(a)(2)(C) and 1835 (a)(2)(A) of the Act, we are clarifying that the face-to-face encounter requirement is applicable for certifications (not re-certifications), rather than initial episodes. A certification (versus recertification) is considered to be any time that a new Start of Care OASIS is completed to initiate care." 2015 PPS Final Rule Quote

Exception to the Rule: Narrative Still Required - M & E

"For instances where the physician orders skilled nursing visits for management and evaluation of the patient's care plan, the certifying physician must include a brief narrative that describes the clinical justification of this need and the narrative must be located immediately before the physician's signature. If the narrative exists as an addendum to the certification form, in addition to the physician's signature on the certification form, the physician must sign immediately after the narrative in the addendum." 2015 PPS Final Rule Quote

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THE FINAL WORD

HHA's still feel the pinch as CMS clearly delineates in the final rule that the HHA will be hit in the pocket book for physician documentation that does not measure up!

*"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 home health benefit, **payment will not be rendered for home health services provided**."*

2015 PPS Final Rule Quote

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Considerations in light of changes

- Revisions or institution of processes relative to physician documentation procurement
- Revisions to current forms…is this even necessary???
- Education on the changes to physicians, referral sources, internal staff
- Q/A process revisions to ensure physician documentation stands up to auditor scrutiny

Are the changes better or worse?

- Many are divided over whether the removal of the physician narrative requirement is better or worse in light of relying on physician documentation from the inpatient/outpatient care setting
- Can the prior setting physician documentation adequately explain homebound status and skilled need requirements to prevent F2F denials?
- The risk still falls to the Home Health agency to now get prior setting physician documentation and then to ensure that it meeting criteria for reimbursement or continue to fight 72% and higher F2F denial trends.

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SECURING PHYSICIAN DOCUMENTATION

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Physician Documentation is more important than ever

The challenge of securing physician documentation in a timely manner is not a new problem for the majority of home health agencies.

- Physician documentation has always been critical to accurate, specific coding
- Face-to-Face Encounter rules now add more reasons to shore up your physician documentation procurement processes
- But HHA's know obtaining physician documentation can be a difficult and cumbersome process

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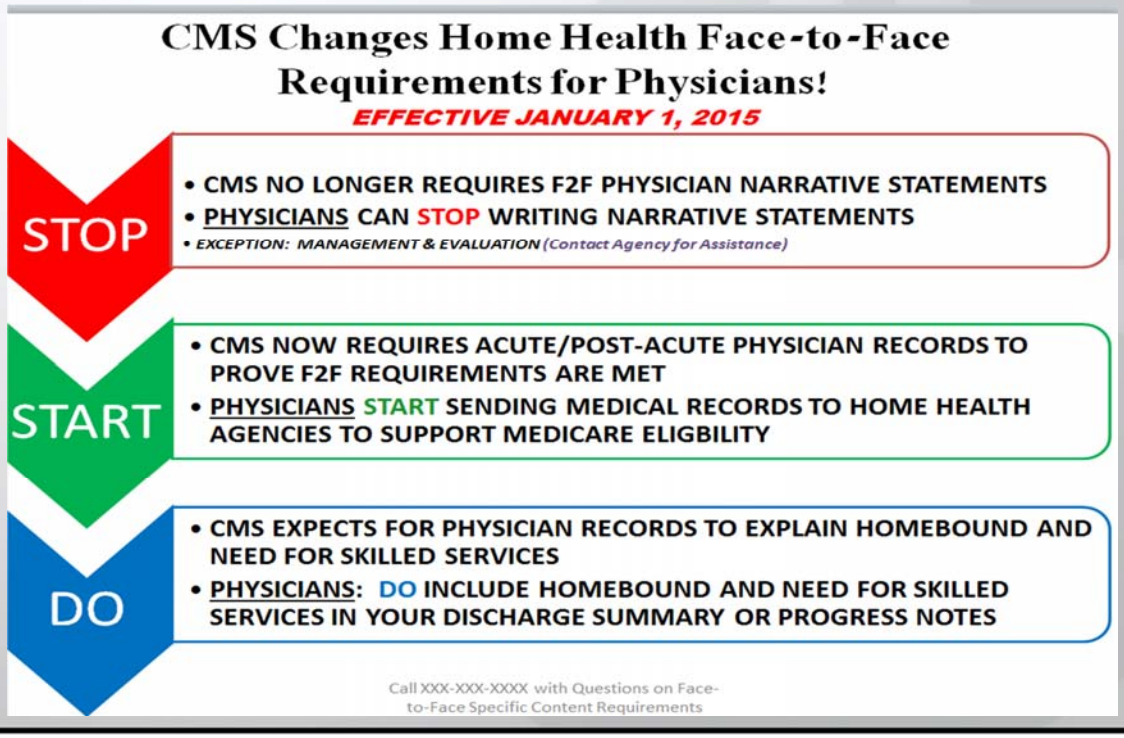
Agencies not routinely obtaining physician records

- If your agency has not been routinely securing physician documentation then now is the time to set up formal processes necessary to meet the new Face-to-Face requirements
- Involve intake, medical records, marketing teams in the process design
- Create one page education flyers summarizing the Face-to-Face changes to physicians/referral sources
- Ensure hospital discharge planners/case management staff are also aware of physician documentation requirements
- Streamline referral forms/processes to include the new Face-to-Face requirements
- Explore the possibility of gaining IT access to affiliated hospital systems to retrieve inpatient physician documentation

Agencies routinely receiving physician records

- Agencies that have routinely been requesting and receiving physician documentation will adjust to the new Face-to-Face requirements more readily, but should still look for ways to improve the process
- Create one page education flyers summarizing the Face-to-Face changes to physicians/referral sources
- Ensure hospital discharge planners/case management staff are also aware of physician documentation requirements
- Streamline referral forms/processes to include the new Face-to-Face requirements
- Explore the possibility of gaining IT access to affiliated hospital systems to retrieve inpatient physician documentation

Example of Education Flyer



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Marketers can help obtain Physician Documentation

- Ensure your marketing team members are experts on the F2F changes
- Hone in on the specific skills of the marketing team to ensure the referral information they solicit also contains ***rich*** physician documentation
- Marketing teams on the ground can make or break your physician documentation procurement processes

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What if the Physician will not supply documentation/records?

- HHA's have reported that some physician's do not provide physician documentation and records
- Many HHA's fear this practice will continue despite the new requirements
- The final rule clearly mandates that physicians must provide this documentation to HHA's *(may want to provide the MD a copy of the final rule quote)*
- Remember if the documentation is insufficient to support eligibility=no payment for the HHA

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AUDITING PHYSICIAN DOCUMENTATION

Does it Pass?

HHA's must ensure that they have trained reviewers versed in the Medicare Eligibility requirements as well as physician documentation abstraction.

- Getting physician documentation is the first step
- Auditing the inpatient/prior setting physician records to ensure that eligibility is met is next essential step to prevent continued claims denials by MAC's and RAC's
- It is not enough to just receive physician documentation and file it away without checking it out

Reviewer Training Aides

- New Training Aides are available to assist reviewers understand Medicare eligibility and changes to F2F requirements
  - MLN Connects National Provider Call Web Page: http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html
  - Contains PDF Power Point, Audio, and 5 PDF examples of acceptable F2F physician documentation from various settings

Reviewer Training Aides

MLN Matters® Number: SE1436

- Gives Medicare-enrolled providers an overview of the Medicare home health services benefit, including patient eligibility requirements and certification/recertification requirements of covered Medicare home health services.
- 14 pages long and basically summarizes the MLN Connects National Provider Call

Reviewer Training Aides

- Home Health Physician Face-to-Face Video by Palmetto: http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Jurisdiction-11-Home-Health-and-Hospice~9C6RXN6560
  - 4 minute physician training video that covers 4 questions the physician should answer:
    - What is the structural impairment?
    - What is the functional impairment?
    - What is the activity limitation?
    - What do the skills of a nurse or therapist address in the specific structural or functional impairment and activity limitations you have identified when answering the first 3 questions?

Eligibility Review—MD Must Certify

1. The patient needs intermittent skilled nursing care, physical therapy, and/or speech language pathology services;

2. The patient is confined to the home or homebound;

3. A plan of care has been established and will be periodically reviewed by a physician; and

4. Services will be furnished while the individual is under the care of a physician.

CMS "Confined to Home" Refresher

- Confined to the home – Describe why the patient is homebound. An individual is considered "confined to the home" if **both** of the following **two criteria** are met:
  - Criteria 1--The patient must either:
    - Because of illness or injury, need supportive devices such as crutches, canes, wheelchairs, and walkers; special transportation; or another person's help to leave his or her residence, **OR**
    - Have a condition such that leaving his or her home is medically contraindicated
  - Criteria 2--There must exist:
    - A normal inability to leave home; **AND**
    - Exertion of a considerable and taxing effort needed to leave the home

Who can perform the F2F Encounter?

- The certifying physician,
- The physician who cares for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health,
- A nurse practitioner or clinical nurse specialist who is working in collaboration with the certifying physician or the acute/post-acute care physician, or
- A certified nurse midwife or physician assistant under the supervision of a certifying physician or the acute/post-acute care physician.
- Per the regulations, the face-to-face encounter cannot be performed by any physician or allowed NPP listed above who has a financial relationship with the home health agency.

5 Elements Needed In Physician Supportive Documentation

- Number 1 — The need for skilled services,
- Number 2 — Documentation that substantiates the patient's homebound status,
- Number 3 — The face-to-face encounter occurred in the required timeframe,
- Number 4 — The note is related to the primary reason that the patient requires home health services, and
- Number 5 — The note, the face-to-face encounter, has been performed by an allowed provider type.

The Certification Statement Is Still Needed

- The CMS MLN Connects provider call examples from December do not contain certification statements
- The certifying physician will still be required to certify that a face-to-face patient encounter took place per the 2015 final rule as part of patient eligibility certification

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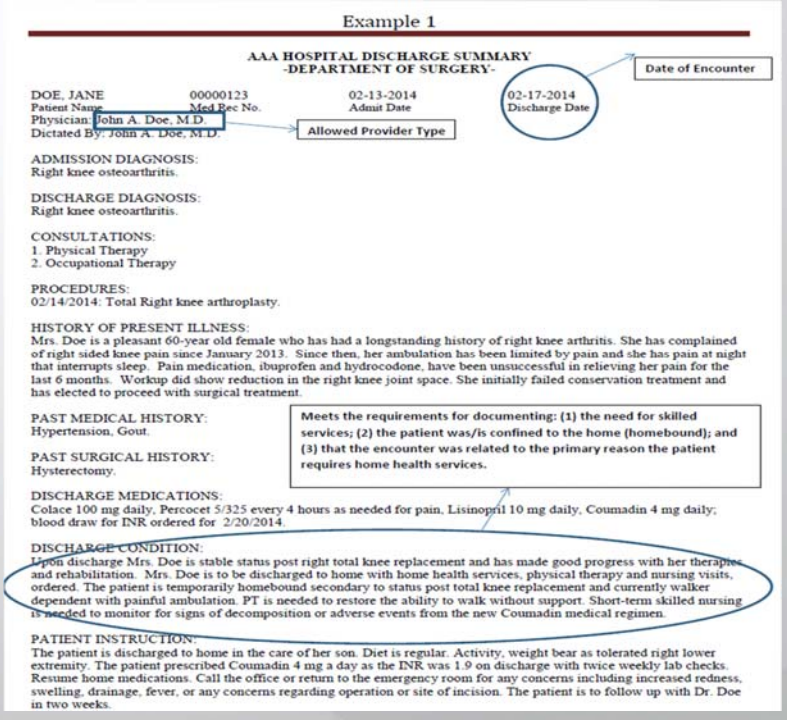
Discharge Summary Example



Example 1

AAA HOSPITAL DISCHARGE SUMMARY
-DEPARTMENT OF SURGERY-

Date of Encounter

DOE, JANE
Patient Name
00000123
Med Rec No.
02-13-2014
Admit Date
02-17-2014
Discharge Date
Physician: John A. Doe, M.D.
Dictated By: John A. Doe, M.D.

Allowed Provider Type

ADMISSION DIAGNOSIS:
Right knee osteoarthritis.

DISCHARGE DIAGNOSIS:
Right knee osteoarthritis.

CONSULTATIONS:
1. Physical Therapy
2. Occupational Therapy

PROCEDURES:
02/14/2014: Total Right knee arthroplasty.

HISTORY OF PRESENT ILLNESS:
Mrs. Doe is a pleasant 60-year old female who has had a longstanding history of right knee arthritis. She has complained of right sided knee pain since January 2013. Since then, her ambulation has been limited by pain and she has pain at night that interrupts sleep. Pain medication, ibuprofen and hydrocodone, have been unsuccessful in relieving her pain for the last 6 months. Workup did show reduction in the right knee joint space. She initially failed conservation treatment and has elected to proceed with surgical treatment.

PAST MEDICAL HISTORY:
Hypertension, Gout.

PAST SURGICAL HISTORY:
Hysterectomy.

Meets the requirements for documenting: (1) the need for skilled services; (2) the patient was/is confined to the home (homebound); and (3) that the encounter was related to the primary reason the patient requires home health services.

DISCHARGE MEDICATIONS:
Colace 100 mg daily, Percocet 5/325 every 4 hours as needed for pain, Lisinopril 10 mg daily, Coumadin 4 mg daily; blood draw for INR ordered for 2/20/2014.

DISCHARGE CONDITION:
Upon discharge Mrs. Doe is stable status post right total knee replacement and has made good progress with her therapies and rehabilitation. Mrs. Doe is to be discharged to home with home health services, physical therapy and nursing visits, ordered. The patient is temporarily homebound secondary to status post total knee replacement 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 signs of decomposition or adverse events from the new Coumadin medical regimen.

PATIENT INSTRUCTION:
The patient is discharged to home in the care of her son. Diet is regular. Activity, weight bear as tolerated right lower extremity. The patient prescribed Coumadin 4 mg a day as the INR was 1.9 on discharge with twice weekly lab checks. Resume home medications. Call the office or return to the emergency room for any concerns including increased redness, swelling, drainage, fever, or any concerns regarding operation or site of incision. The patient is to follow up with Dr. Doe in two weeks.

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Progress Note Example

Example 2

Progress Notes

Patient: Smith, Jane
DOB: 04/13/1941
Address: 1714 Main Street, Plano TX 15432

Provider: John Doe, M.D.
Date: 05/03/2013

Allowed Provider Type

Date of Encounter

Subjective:
CC:
1. Wound on left heel.
HPI:
Pt is here for evaluation of wound on left heel. Patient reports her daughter noticed the wound on patient's heel when she was washing her feet. Patient states she has difficulty with reaching her feet and her daughter will sometimes clean them for her. She reports she uses a shoe horn to put on her shoes.
ROS:
General:
No weight change, no fever, no weakness, no fatigue.
Cardiology:
No chest pain, no palpitations, no dizziness, no shortness of breath.
Skin:
Wound on left lower heel, no pain.

Medical History: HTN, hyperlipidemia, hypothyroidism, DJD.

Medications: zolpidem 10 mg tablet 1 tab(s) once a day (at bedtime), Diovan HCl 12.5 mg-320 mg tablet 1 tab(s) once a day, Lipitor 10 mg tablet 1 tab(s) once a day.

Allergies: NKDA

Objective:
Vitals: Temp 96.8, BP 156/86, HR 81, RR 19, Wt 225, Ht 5'4"
Examination: General appearance pleasant. HEENT normal. Heart rate regular rate and rhythm, lungs clear, BS present, pulses 2+ bilaterally radial and pedal. Diminished pinprick sensation on bilateral lower extremities from toes to knees. Left heel wound measures 3 cm by 2 cm and 0.4 cm deep. Wound bed is red, without slough. Minimal amount of yellow drainage noted on removed bandage.

Assessment:
1. Open wound left heel

Plan:
1. **OPEN WOUND** Begin hydrocolloid with silver dressing changes. Minimal weight bear on left leg with a surgical boot on left foot. Begin home health for wound care, family teaching on wound care, and patient education on signs and symptoms of infection. The patient is now homebound due to minimal weight bearing on left foot and restrictions on walking to promote wound healing, she is currently using a wheelchair. Short-term nursing is needed for wound care, monitor for signs of infection, and education on wound care for family to perform dressing changes.

Follow Up: Return office visit in 2 weeks.

Provider: John Doe, M.D.
Patient: Smith, Jane **DOB:** 04/13/1941 **Date:** 05/03/2013
Electronically signed by John Doe, M.D. on 05/03/2013 at 10:15 AM
Sign off status: Completed

Meets the requirements for documenting: (1) the need for skilled services; (2) why the patient was/is confined to the home (homebound); and (3) that the encounter was related to the primary reason the patient requires home health services.

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Requirements on Different Pages

Page 1 Progress Note

Objective:
Vitals: Temp 98.6, BP 120/80, HR 71, RR 12, Wt 200, Ht 5'9" pulse ox 99% on room air
Examination: The patient is awake and alert and in no acute distress. He is in a wheelchair. HEENT: Pupils do not react to light. Heart rate regular rate and rhythm, lungs clear, BS present, Extremities: pulses 2+ bilaterally radial and pedal. Diminished pinprick sensation on bilateral lower extremities from toes to knees ; Muscle Strength 3/5 in all 4 extremities(normal 5/5). The patient's get up and to test was 35 seconds(normal <10)

Assessment:
1. Muscle Weakness secondary to deconditioning due to pneumonia

Plan:
1. Prior to the patient's hospitalization for pneumonia, the patient could ambulate in his residence with assistance and was able to rise from a chair without difficulty. The patient requires a home health PT program for gait training and increasing muscle strength to restore the patient's ability to walk in his residence.

Follow Up: Return office visit in 6 weeks.

Provider: Jane Doe, M.D.
Electronically signed by Jane Doe, M.D. on 09/02/2014 at 10:15 AM
Sign off status: Completed

Meets the requirements for documenting: (1) the need for skilled services; and (2) that the encounter was related to the primary reason the patient requires home health services.

Please see problem list (Part 2 of 2) for homebound status.

Page 2 Problem List

Problem List*

Patient: Rogers, Buck
DOB: 08/13/1925
Address: 234 Happy Lane, Teamwork, MD 12345

401.1 HTN - 1999
272.2 Hyperlipidemia -1999
250.5 Diabetes Mellitus with ophthalmic manifestations -2000
369.22 Blindness - 2002 (requires a caregiver assistance in order to leave the home)
482.31 Pneumonia- Streptococcus- 2014

In conjunction with the progress note, this meets the requirements for documenting why the patient was/is confined to the home (homebound).

*A problem list would not be acceptable by itself to demonstrate skilled need and/or homebound status.

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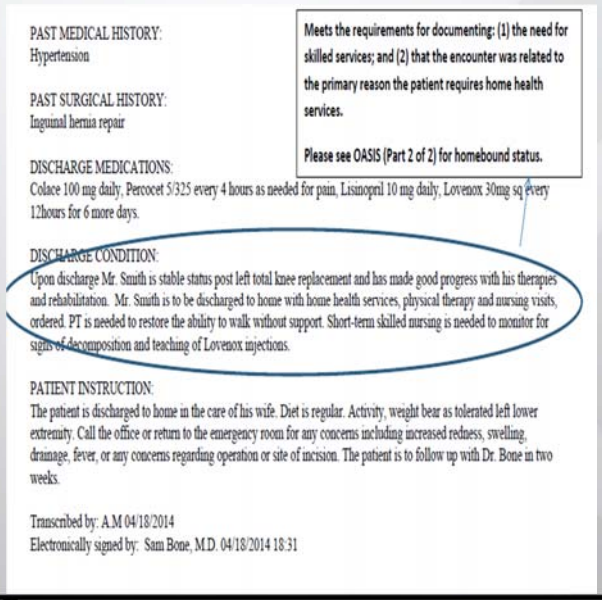
Comprehensive Assessment Example

Discharge Summary



PAST MEDICAL HISTORY:
Hypertension

PAST SURGICAL HISTORY:
Inguinal hernia repair

DISCHARGE MEDICATIONS:
Colace 100 mg daily, Percocet 5/325 every 4 hours as needed for pain, Lisinopril 10 mg daily, Lovenox 30mg sq every 12hours for 6 more days.

DISCHARGE CONDITION:
Upon discharge Mr. Smith is stable status post left total knee replacement and has made good progress with his therapies and rehabilitation. Mr. Smith is to be discharged to home with home health services, physical therapy and nursing visits, ordered. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decomposition and teaching of Lovenox injections.

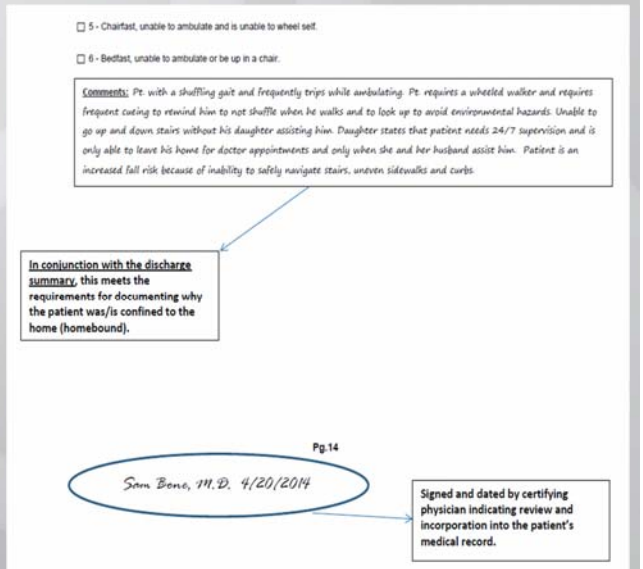
PATIENT INSTRUCTION:
The patient is discharged to home in the care of his wife. Diet is regular. Activity, weight bear as tolerated left lower extremity. Call the office or return to the emergency room for any concerns including increased redness, swelling, drainage, fever, or any concerns regarding operation or site of incision. The patient is to follow up with Dr. Bone in two weeks.

Transcribed by: A.M 04/18/2014
Electronically signed by: Sam Bone, M.D. 04/18/2014 18:31

Meets the requirements for documenting: (1) the need for skilled services; and (2) that the encounter was related to the primary reason the patient requires home health services.

Please see OASIS (Part 2 of 2) for homebound status.

OASIS Excerpt-MD Signed



☐ 5 - Chairfast, unable to ambulate and is unable to wheel self.

☐ 6 - Bedfast, unable to ambulate or be up in a chair.

Comments: Pt. with a shuffling gait and frequently trips while ambulating. Pt. requires a wheeled walker and requires frequent cueing to remind him to not shuffle when he walks and to look up to avoid environmental hazards. Unable to go up and down stairs without his daughter assisting him. Daughter states that patient needs 24/7 supervision and is only able to leave his home for doctor appointments and only when she and her husband assist him. Patient is an increased fall risk because of inability to safely navigate stairs, uneven sidewalks and curbs.

In conjunction with the discharge summary, this meets the requirements for documenting why the patient was/is confined to the home (homebound).

Pg.14

Sam Bone, M.D. 4/20/2014

Signed and dated by certifying physician indicating review and incorporation into the patient's medical record.

Does this Pass Homebound and Need for Skilled Services/5 Elements?

- Home/Discharge Assessment Excerpt:

"At D/C patient has physical/cognitive deficits identified by PT/OT/ST: No. Patient has deficits identified by any member of the health care team: No. Primary diagnosis <principal problem not specified>. ADL's: *blank.* Equipment Needed: *blank*. Date of Face-to-Face Encounter Visit 1/12/15, Electronically signed, John Doe, MD, 1/12/15."

No!

- Note is not related to primary reason for home health services (primary dx not completed on EHR)
- Note is missing homebound reason
- Note is missing need for skilled services
- Note is missing a certification statement

Let's try another—does it pass?

"Discharge date: 1/9/15. Discharge Today @1300PM. DC Dx: Hyperglycemia without ketosis. Patient Care Plan Goals: Increase knowledge of disease/disorder/condition, Medication compliance. Home with home health services. F/U appt. in 1 week with PCP. Electronically signed, John Quick, MD, 1/9/15."

No!

- Note is missing homebound reason
- Note is missing need for skilled services (skills of nurse or therapist not listed)
- Note is missing a certification statement

Last one—does it pass?

"Date of Face-to-Face Encounter Visit: 1/13/15. Primary Dx and reason for home care referral: clinical findings to support the need for home care services: deconditioning and decline in the ability to safely ambulate, disease process education and management, medication monitoring. Homebound status: limited mobility, unable to ambulate safely without 1 person total asst due to falls with injury in recent past due increased weakness, requires 2.5 L O2 continuously. Electronically signed, Jane Doe, MD 1/13/15."

Almost, but not quite!

- Note is missing need for skilled services (skills of nurse or therapist not listed)
- Note is missing a certification statement

Physician Training

- Physician training is vital to successful compliance with the 2015 F2F rules!
- Focus education for physicians on 2 points: adding specific homebound and skilled need statements to existing discharge summary/progress note dispositions
- Use the CMS d/c summary and progress note examples
- Keep it simple and focused!

Physician Training Tool Example

CMS Changes Home Health Face-to-Face Requirements for Physicians!

EFFECTIVE JANUARY 1, 2015

CMS Examples of acceptable homebound and/or need for skilled services physician documentation taken from discharge summaries/progress notes:

EXAMPLE #1
Upon discharge Mrs. Doe is stable status post right total knee replacement and has made good progress with her therapies and rehabilitation. Mrs. Doe is to be discharged to home with home health services, physical therapy and nursing visits, ordered. The patient is temporarily homebound secondary to status post total knee replacement 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 signs of decomposition or adverse events from the new Coumadin medical regimen.

EXAMPLE #2
Plan: 1. **OPEN WOUND** Begin hydrocolloid with silver dressing changes. Minimal weight bear on left leg with a surgical boot on left foot. Begin home health for wound care, family teaching on wound care, and patient education on signs and symptoms of infection. The patient is now homebound due to minimal weight bearing on left foot and restrictions on walking to promote wound healing, she is currently using a wheelchair. Short-term nursing is needed for wound care, monitor for signs of infection, and education on wound care for family to perform dressing changes.

EXAMPLE #3
Plan: 1. Prior to the patient's hospitalization for pneumonia, the patient could ambulate in his residence with assistance and was able to rise from a chair without difficulty. The patient requires a home health PT program for gait training and increasing muscle strength to restore the patient's ability to walk in his residence. Problem list: Blindness - 2002 (requires a caregiver assistance in order to leave the home)

EXAMPLE #4
DISCHARGE CONDITION: Upon discharge Mr. Smith is stable status post left total knee replacement and has made good progress with his therapies and rehabilitation. Mr. Smith is to be discharged to home with home health services, physical therapy and nursing visits, ordered. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decomposition and teaching of Lovenox injections.

Source: CMS MLN Connects™ National Provider Call - Certifying Patients for the Medicare Home Health Benefit (December 16, 2014)

Home Health

WHAT TO DO WHEN PHYSICIAN DOCUMENTATION DOES NOT SUPPORT ELIGIBILITY

Physician Documentation Alone is Lacking

- So your F2F reviewer has checked the available physician documentation supplied and the 5 elements are not met
- The good news is that agencies now have options to get the missing elements that were not available under the old rules
- The agency can send excerpts of the comprehensive assessment for missing elements to MD for review, signature, and incorporation into his record (see OASIS example on slide 35)
- The agency can also communicate additional information to the physician on the patient's homebound status and need for skilled services and obtain the MD signature/date that he incorporated into his medical record

Physician F2F Communication Form

Home Health Face-to-Face Physician Communication Form

In accordance with the 2015 Home Health PPS Final Rule: "It is permissible for the HHA to communicate with and provide information to the certifying physician about the patient's homebound status and need for skilled care and for the certifying physician to incorporate this information into his or her medical record for the patient."

Patient Name:
Patient Date of Birth:
Encounter Date:
MD/Allowed Provider Name:

Additional Information to Certifying Physician

Homebound Status:

Need for Skilled Care:

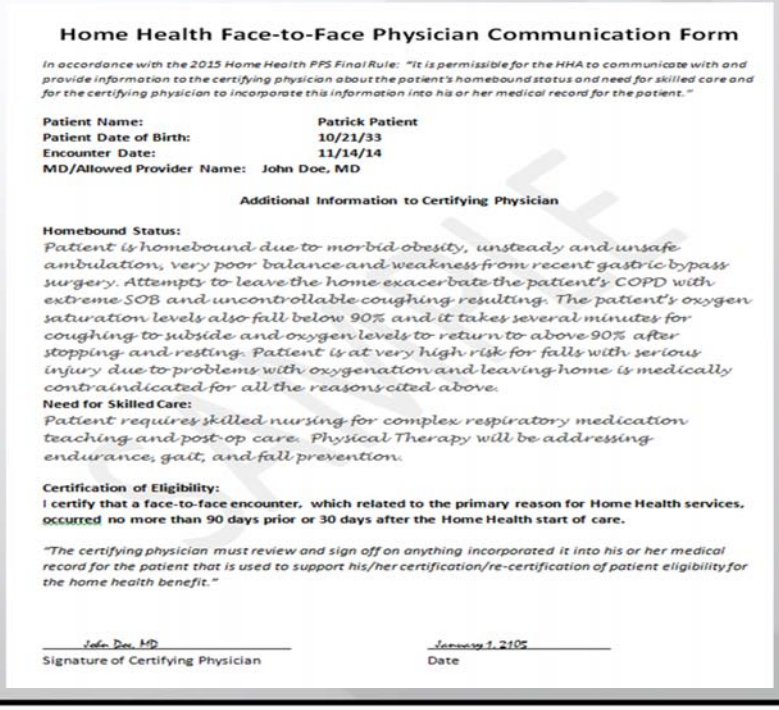
Certification of Eligibility:

I certify that a face-to-face encounter, which related to the primary reason for Home Health services, occurred no more than 90 days prior or 30 days after the Home Health start of care.

"The certifying physician must review and sign off on anything incorporated it into his or her medical record for the patient that is used to support his/her certification/re-certification of patient eligibility for the home health benefit."

Signature of Certifying Physician _____ Date _____

Physician F2F Communication Example



Home Health Face-to-Face Physician Communication Form

In accordance with the 2015 Home Health PPS Final Rule: "It is permissible for the HHA to communicate with and provide information to the certifying physician about the patient's homebound status and need for skilled care and for the certifying physician to incorporate this information into his or her medical record for the patient."

Patient Name: Patrick Patient
Patient Date of Birth: 10/21/33
Encounter Date: 11/14/14
MD/Allowed Provider Name: John Doe, MD

Additional Information to Certifying Physician

Homebound Status:
Patient is homebound due to morbid obesity, unsteady and unsafe ambulation, very poor balance and weakness from recent gastric bypass surgery. Attempts to leave the home exacerbate the patient's COPD with extreme SOB and uncontrollable coughing resulting. The patient's oxygen saturation levels also fall below 90% and it takes several minutes for coughing to subside and oxygen levels to return to above 90% after stopping and resting. Patient is at very high risk for falls with serious injury due to problems with oxygenation and leaving home is medically contraindicated for all the reasons cited above.

Need for Skilled Care:
Patient requires skilled nursing for complex respiratory medication teaching and post-op care. Physical Therapy will be addressing endurance, gait, and fall prevention.

Certification of Eligibility:
I certify that a face-to-face encounter, which related to the primary reason for Home Health services, occurred no more than 90 days prior or 30 days after the Home Health start of care.

"The certifying physician must review and sign off on anything incorporated it into his or her medical record for the patient that is used to support his/her certification/re-certification of patient eligibility for the home health benefit."

John Doe, MD — Signature of Certifying Physician
January 1, 2015 — Date

Completing F2F Communication Forms on Admission

- Some agencies have begun to complete F2F communication-style forms on SOC as a routine practice
- This increases specific documentation communication on homebound and the need for skilled services between both the HHA and certifying MD (and in their records)-- ensuring it is adequately captured every time
- Work on the front end can pay off later on the back end

Placing Communication Notes on 485

- CMS does not mandate where to place the communication to physician regarding homebound status or need for skilled services by the HHA
- Caution placing communication on all 485's as a standard practice. Remember the certifying MD can be an acute care physician that does not review/sign the 485. Many times the community physician or PCP signs the 485, but was not the physician who performed the F2F encounter
- Be careful to send additional information to the certifying physician or risk denials!

Can the HHA just complete the entire F2F form for the MD and have him sign it?

- Caution against this approach based on the final rule quote (full quote on slide 10)
- ***"In addition, any information from the HHA… must corroborate the certifying physician's… own documentation/medical record entries…"***
- Final rule stipulates the physician's own records must corroborate the HHA's information—both sides participate

Another Common Question

- ***Can the certifying physician just keep writing out F2F forms with narratives/all 5 elements, and not change to the new F2F requirements?***
  - The Final Rule does not specifically comment on this exact scenario
  - Consider the following to prevent denials:
    - CMS removed the narrative requirement, but now requires that the physician medical record support eligibility under the 2015 PPS Final Rule
    - Securing physician documentation from the prior setting of care to support eligibility may prevent F2F denials (depending on content) when the certifying physician submits an older F2F form

Final Thoughts

- Ensure that your agency staff understand the Face-to-Face changes effective January 1, 2015 and share the changes with physicians and referral sources
- Ensure that physician documentation procurement processes are solid in your agency
- Ensure that you have a strong QA process in place that will check physician documentation to make sure it meets eligibility requirements (including homebound status and need for skilled care) *before you bill*
- If physician documentation does not meet Face-to-Face requirements, then communicate to physician the specific homebound and skill needs of your patient and have the certifying MD sign/incorporate the additional information into his record

References

- 2015 PPS Home Health Final Rule
- CMS MLN Connects™ National Provider Call - Certifying Patients for the Medicare Home Health Benefit (December 16, 2014)
- CMS Internet Only Manual (IOM), Medicare Benefit Policy Manual, Chapter 7

Questions

Contact Information

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