How to Save Face with the Face-to-Face

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SESSION EVALUATIONS

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STEPS TO COMPLETE YOUR EVALUATION
WILL BE SHOWN AT THE CLOSE OF THIS SESSION

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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 & recertification
  1. Need for the skilled services
  2. Homebound status
  3. Occurred within the required timeframe
  4. Was related to primary reason the patient requires HH services
  5. Was performed by an allowed provider type

F2F Background

The requirements differ for eligibility certification & recertification; however, if requirements for certification are not met, then claims for subsequent episodes of care, which require a recertification, will be non-covered – even if the requirements for recertification are met.
<table>
<thead>
<tr>
<th>F2F Background</th>
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</thead>
<tbody>
<tr>
<td>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. This was originally accomplished with a F2F form.</td>
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<thead>
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<th>F2F Background</th>
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<tbody>
<tr>
<td>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 &amp; recertification have been met.</td>
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F2F Background

• Agency must be able to provide documentation to CMS and its review entities upon request.

• Per the regulations at 42 CFR 424.22(c), if the documentation used as the basis for the certification of eligibility is not sufficient to demonstrate that the patient is or was eligible to receive services under the Medicare HH benefit, payment will not be rendered for HH services provided.

F2F Background

• Many roadblocks along the way, especially with physician cooperation

• Denials ensued
So, Changes Were Made

- In 2015 CMS 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 and eliminated the narrative requirement as part of F2F document.
- Documentation must become part of the patient’s 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 F2F form and simply submit that form to the physician for a signature and expect that 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 F2F documentation was one of the top reasons for denials (5FFTF)
- 1,377 claims were reviewed between July 1 & Dec 31, 2013
- 765 claims were denied for insufficient F2F documentation – 80%

Major Documentation Errors

The most common error is insufficient documentation of clinical findings by the Physician/Non-Physician Practitioner (NPP) to show:

- The encounter was related to the primary reason for home care
- How the patient’s condition supports the patient’s homebound status; or
- How the patient’s condition supports the need for skilled services
New Guidance on F2F Documentation

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

Helpful Tips

1. The actual clinical note for the F2F encounter visit (such as progress note or facility’s discharge summary) is to be submitted by the HHA when responding to all ADRs.

2. The F2F attestation form that was commonly used prior to 2015 with a brief clinical narrative is no longer required and is not sufficient.
Helpful Tips

3. Include in your submitted documentation any recent acute/post-acute care facility therapy notes, social work or discharge planning records, history & physicals, and other clinical progress notes.

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

Helpful Tips

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

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

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

Discharge Summary

Discharge Condition
Upon discharge Mrs. Doe is stable status post right total knee replacement and has made good progress with her therapy & rehabilitation.

Mrs. Doe is to be discharged to 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 decompensation or adverse events from the new Coumadin medical regimen.
Progress Notes

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

Problem List:

- I10 HTN 1992
- E78.5 Hyperlipidemia 1995
- E11.39 DM with ophthalmic manifestations 2003
- H54.0 Blindness 2007
(requires a caregiver assistance in order to leave home)

Comprehensive Assessment Example

Discharge Condition:

M1850 “5” - Chairfast, unable to ambulate and is unable to wheel self.
M1860 “6” – Bedfast, unable to ambulate or be up in a chair

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

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

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;

Non-Physician Practitioner (NPP)

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.
Non-Physician Practitioner (NPP)

- 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.

Specific Documentation Guidelines

- The certifying physician must document that the F2F visit took place, regardless of who performed the encounter.
- If the F2F encounter was not performed by the certifying physician, the NPP or physician who cared for the patient and performed the F2F must provide the F2F record of the F2F encounter to the certifying physician.
Specific Documentation Guidelines

- NPPs performing a F2F encounter in an acute/post-acute facility must inform the physician they are collaborating with, or under the supervision of, so that physician can inform the certifying physician of the clinical findings of the F2F.

- The certifying physician cannot merely co-sign the encounter documentation if performed by an NPP. He or she must complete/sign the form or a staff member from his or her office may complete the form from the physician’s encounter notes, which certifying physician would then sign.

Specific Documentation Guidelines

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

1. The date of F2F encounter, and
2. Clinical findings to support that the encounter is related to the primary reason for home care, the patient is homebound, and in need of Medicare covered HH services.
Homebound Status

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

- Clarifies definition of patient being “confined to home”
- Reflects definition in Social Security Act (Section 1835(a))
- Removes vague terms to ensure clear & specific definition
- Not a change in homebound definition
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 & taxing effort. Absences from home for health care treatment (including adult day care) or religious services are allowed, and do not negate the beneficiary’s homebound status.
### Insufficient Homebound Examples

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

### Acceptable Homebound Examples

**From clinician admit notes:**

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.”
Acceptable Homebound Examples

From clinician admit notes:

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.”

Acceptable Homebound Examples

From clinician admit notes:

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

From clinician admit notes:

4. “Status post right total hip replacement. Needs physical therapy to restore ability to walk without assistance. Homebound temporarily due to requiring a walker, inability to negotiate uneven surfaces and stairs, inability to walk greater than 5-10 feet before needing to rest.”

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.
Probe & Educate

CMS is conducting pre-payment reviews of HH claims for episodes beginning on or after Aug 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 new patient certification requirements.

Second round of review began in December 2016.
Criteria for Probe & Educate

5 key criteria must be found somewhere within the “complete” medical record. The reviewed medical record will include not only home care provider’s documentation but also primary physician’s office notes & 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 primary reason for HH
5. Encounter was performed by an allowed provider type
Probe & Educate Process

• Intermediary will request & 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 number 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.

Probe & Educate Process

• It’s critical that when your agency starts auditing charts, that you focus on all aspects of documentation and not just on F2F documentation.

• Don’t delay – respond promptly to ADRs.

• QA charts completely before submission.

• Provide everything at one time.
Probe & Educate Process

• If episode requested is a recertification, be sure to include the original documentation from SOC that warranted the F2F.
• Don’t use sticky notes or highlighters to mark pages. Use an index page.

Probe & Educate Review Change

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

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

- Don’t ignore or procrastinate on responding to Probe. Check DDE system often.
- Mitigate damages. Leave no page unturned. Scrutinize every part of the record, not just the F2F.
- Chances are you will receive all five requests at one time – send all documentation at the same time.
- Send with return receipt request.
- DON’T MAKE THEM DIG FOR DOCUMENTATION! Point out everything clearly. Use cover sheet & index.
- If 2 or more of the 5 records reviewed fail to meet the required standard, more will be requested & probe will deepen.
Early Results

The types of denials so far:

- Certification
- Homebound
- Therapy not reasonable & necessary

Some details about certification denials:

- F2F documentation is missing, incomplete, untimely
- Primary reason – medical documentation does not support need for homecare or the homebound eligibility criteria
- The 5 certification elements are not signed off by the certifying physician
Early Results

More details about certification denials:

• If claim is a recertification claim, initial documentation of F2F is not provided (including initial plan of care)
• Documentation of the actual F2F encounter was not provided (physician office note or discharge summary)

<table>
<thead>
<tr>
<th>Denial Reason</th>
<th>Certification Issues – 57%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• F2F missing/invalid - 51%</td>
</tr>
<tr>
<td></td>
<td>• Untimely POC - 2%</td>
</tr>
<tr>
<td></td>
<td>• POC/Certification not signed - 2%</td>
</tr>
<tr>
<td></td>
<td>• Missing certification - 2%</td>
</tr>
<tr>
<td></td>
<td>• Recertification estimate missing - 1%</td>
</tr>
<tr>
<td></td>
<td>• Initial certification missing/invalid - 1%</td>
</tr>
<tr>
<td>#2 Denial Reason</td>
<td>No Response to ADR – 30%</td>
</tr>
<tr>
<td>#3 Denial Reason</td>
<td>Medical Necessity of Therapy Services – 13%</td>
</tr>
</tbody>
</table>
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 & return to HH during the 60-day episode
30.5.2 Physician Recertifications

- Must be conducted between days 56-60 of the episode
- Recertification should occur at the time the plan of care is reviewed, and must be signed & dated by the physician who reviews the plan of care

Recertifications

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

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

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

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

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

SESSION EVALUATIONS

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STEP 2: Select “Take Survey” - Located at the Bottom of Screen

STEP 3: Complete Each of the 9 Questions to Receive CEUs

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Connected Home Living partners see a reduction in readmission rates, greater patient satisfaction and increased referrals. Our integration of Remote Care Coordinators and intuitive telehealth support your ability to achieve a premiere position in the market place. We provide 24/7 live monitoring and meaningful patient engagement, managing alerts, data and resources so that your staff can focus upon clinical interventions.

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