



# Home Health Face-to-Face – End Those Denials!

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Ask The Contractor Webinar  
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## Home Health Coverage Resources

- <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf>

### Medicare Benefit Policy Manual Chapter 7 - Home Health Services

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## Face-to-Face (FTF) Encounter

## Home Health Requirements



To be eligible for Medicare home health services, a patient must have Medicare Part A and/or Part B and:



1. Be confined to the home



2. Need skilled services



3. Be under the care of a physician



4. Receive services under a plan of care established and reviewed by a physician



5. Had a face-to-face encounter performed by either:



- a) **Certifying physician** (must be Medicare enrolled)
- b) **Non-physician practitioner (NPP)** 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 home health;
- c) **Physician who cared for the patient** in an acute/post-acute facility during a recent stay and has privileges in that facility

Medicare Benefit Policy Manual; Chapter 7; 30.5.1.1 Face-to-Face Encounter

## FTF Documentation: Important Reminders



**FTF is requirement** for Medicare payment



Missing/incomplete documentation results in  
entire claim being denied



## Face-to-Face When?



Certifying physician must document FTF took place within

- **90 days prior to start of care (SOC),** or
- **30 days after SOC**
  
- **Exceptional** circumstance: Patient death **before** FTF can be performed

## FTF Resource Links



[https://cgsmedicare.com/hhh/education/materials/pdf/hh\\_ftf\\_encounter\\_calendar.pdf](https://cgsmedicare.com/hhh/education/materials/pdf/hh_ftf_encounter_calendar.pdf)

### Home Health Face-To-Face Encounter Calendar

The home health face-to-face (FTF) encounter must occur within 90 days prior to the Start of Care (SOC) or 30 days after the SOC. This tool will assist in assuring the FTF encounter occurs timely. In addition, the following resources are available on the CGS website.

- Home Health Face-to-Face (FTF) Encounter: [http://www.cgsmedicare.com/hhh/coverage/hh\\_coverage\\_guidelines/hh\\_ftf\\_encounter.html](http://www.cgsmedicare.com/hhh/coverage/hh_coverage_guidelines/hh_ftf_encounter.html)
- Home Health Denial Fact Sheet – Denial Reason 5FFTF: [http://www.cgsmedicare.com/hhh/education/materials/pdf/hh\\_5fftf\\_factsheet.pdf](http://www.cgsmedicare.com/hhh/education/materials/pdf/hh_5fftf_factsheet.pdf)


JANUARY			FEBRUARY			MARCH		
90 Days Prior to SOC	SOC Date	30 Days after SOC	90 Days Prior to SOC	SOC Date	30 Days after SOC	90 Days Prior to SOC	SOC Date	30 Days after SOC
10/03	01/01	01/31	11/03	02/01	03/03	12/01	03/01	03/31
10/04	01/02	02/01	11/04	02/02	03/04	12/02	03/02	04/01

## Face-to-Face Why?

FTF must be related to

**primary reason**

for home health admission




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## Documentation of FTF date

Certifying physician must document the date of the FTF encounter before the claim is submitted for billing

– (Medicare Benefit Policy Manual 100-02 Ch. 7; Section 30.5.1)



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## Face-to-Face before Certification



CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 208	Date: April 22, 2015
	<b>Change Request 9119</b>

**B. Policy:** The Affordable Care Act requires that the certifying physician or allowed non-physician provider (NPP) **must have a face-to-face encounter with the beneficiary before they certify the beneficiary's eligibility for the home health benefit.** Regulations require that the encounter occur within 90 days before care begins or up to 30 days after care began. Previous regulations required that documentation of the encounter must include a narrative to explain why the clinical findings of the encounter support that the patient is homebound and in need of skilled services.

## MLN Matters® SE1436

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1436.pdf>

REVISED product from the Medicare Learning Network® (MLN)

- **"Safeguarding Your Medical Identity"** Web-based Training (WBT)

MLN Matters® Number: SE1436	Related Change Request (CR) #: NA
Related CR Release Date: NA	Effective Date: NA
Related CR Transmittal #: NA	Implementation Date: NA

**Certifying Patients for the Medicare Home Health Benefit**

**Example 1**

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**AAA HOSPITAL DISCHARGE SUMMARY  
 -DEPARTMENT OF SURGERY-**

Patient Name: DOE, JANE	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.			

Date of Encounter

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 conservative treatment and has elected to proceed with surgical treatment.

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PAST MEDICAL HISTORY:  
Hypertension, Gout.

PAST SURGICAL HISTORY:  
Hysterectomy.

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 decompensation 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.

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.

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## Supporting Documentation



**HHAs may send information** to the certifying physician:



- Created/generated by HHA
- Other information created/generated by and obtained from the acute/post-acute facility clinicians and staff



The certifying physician may consider and/or use any information sent by the HHA, that has been incorporated into the medical record, as the **basis for certification** of the patient's eligibility for home health services



## Supporting Documentation



**Some examples of supporting documentation to send to physician's medical record:**



- Start of care (SOC) OASIS
- Face-to-face encounter documentation
- Plan of care
- Certification/recertification statement
- Discharge summaries
- History and physical examination (H&P)





## Supporting Documentation



- **Information from the HHA** can be incorporated into the certifying physician's and/or the acute/post-acute care facility's medical record for the patient.
- Information from the HHA incorporated into the physician's medical record **must not conflict** with other medical record entries in certifying physician's and/or the acute/post-acute care facility's medical record for the patient
- Information submitted & incorporated from HHAs **must be received timely** to ensure the certifying physician has all relevant information when making the decision to certify/recertify the patient

## Supporting Documentation



- Documentation created or generated by the HHA must be **signed/dated** by certifying physician to indicate acceptance of documentation into their medical records
- Physician's dated signature must be **on/before the time of claim submission**

## Supporting Documentation



The physician's **sign-off** indicates the physician reviewed, accepted and incorporated the HHA generated documents into the patient's medical record held by the certifying physician (and/or the acute/post acute care facility).

## Supporting Documentation



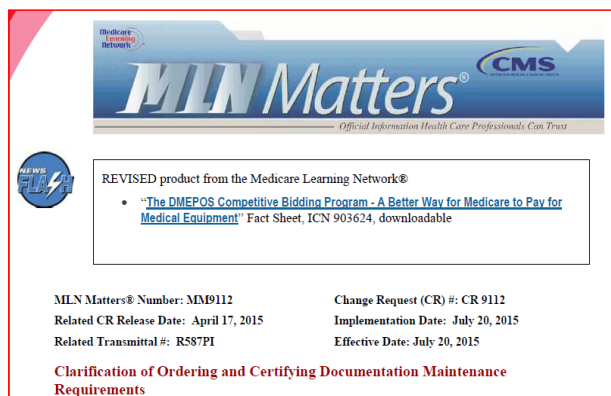
Documentation in the certifying physician's medical record and/or acute/post-acute care facility's medical record:

- **Must** be provided to home health agency (HHA) when requested

Home health agencies should obtain **as much documentation** from the physician's and/or facility's medical records as necessary to assure **eligibility criteria** has been met

## Supporting Documentation

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9112.pdf>



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## Supporting Documentation

**Section 30.5.1.2**, certifying physician and/or acute/post-acute facility medical record (if the patient was directly admitted to home health) for the patient **must contain the actual clinical note for the FTF encounter visit** that demonstrates that the encounter:

- Occurred within required timeframe;
- Was related to primary reason patient requires home health services
- Was performed by an allowed provider type

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## Documentation of FTF



### Patient discharged from acute/post-acute facility directly to home health services

- **Hospitalist** sees patient & **performs FTF encounter**
- **Community physician** will follow patient after discharge and **certifies HH services**
  - HH criteria requires patient to be under care of physician

## FTF with Certification



If the FTF encounter form **also certifies** patient for home health, the hospitalist must identify the community physician who will follow the patient.

(Medicare Benefit Policy Manual 100-02 Ch. 7 Section 30.5.1)

## FTF Documentation: Important Reminders



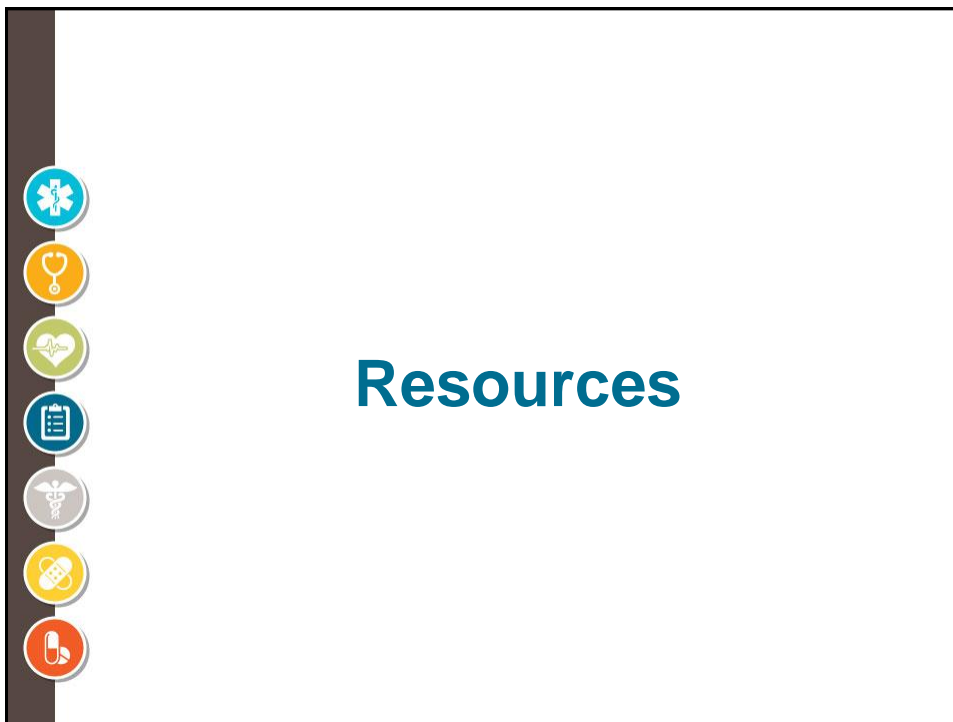
As the billing entity, the home health agency's (HHA's) **responsibilities** include:

- Facilitating and coordinating between patient and physician to ensure FTF occurs timely
- Ensuring all FTF requirements are met
- Ensuring physician's documentation is complete
- Delaying submission of claim until documentation complete

## Common Denials Reasons



- Diagnoses/clinical findings on FTF not related to home care ordered
- No date of FTF encounter
- No actual clinical note
- Certifying physician did not document the date of the face-to-face encounter
- **Not clearly titled** as face-to-face encounter
- Missing, unidentified or undated signatures

A slide titled "Home Health Clinical Resources" in a large blue font. On the left side, there is a vertical column of seven circular icons: a blue circle with a white caduceus, a yellow circle with a white stethoscope, a green circle with a white heart and pulse line, a blue circle with a white clipboard, a grey circle with a white caduceus, a yellow circle with a white bandage, and a red circle with a white pill. The background is white with a dark grey vertical bar on the left.

**Home Health Clinical Resources**

CMS Hospice Benefit Policy Manual (Pub. 100-02, Chapter 7)

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf>

**Medicare Benefit Policy Manual**  
**Chapter 7 - Home Health Services**

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## NEW HH Documentation Checklist Tool

[https://www.cgsmedicare.com/hhh/education/materials/pdf/hh\\_documentation\\_checklist\\_tool.pdf](https://www.cgsmedicare.com/hhh/education/materials/pdf/hh_documentation_checklist_tool.pdf)



### HOME HEALTH

## DOCUMENTATION CHECKLIST TOOL

Face-to-Face Clinical Documentation	
Is a Face-to-Face Encounter note present? • Actual clinical or progress note or discharge summary	<input type="checkbox"/>
Was the Face-to-Face Encounter note performed, signed and dated by an allowed provider type?	<input type="checkbox"/>
Does the Face-to-Face Encounter note indicate the reason for the encounter and was this assessment related to the need for home health services (encounter is for the primary reason for home care)?	<input type="checkbox"/>
Is the Face-to-Face Encounter note dated between 90 days before or 30 days after the start of home health services?	<input type="checkbox"/>
Does the Face-to-Face Encounter note include documentation that substantiates the patient's need for skilled services and homebound status? (see below for homebound criteria/skilled service need)	<input type="checkbox"/>
Is there any HHA additional documentation incorporated into the certifying physician's medical record? Please note any incorporation of documentation must be corroborated by the submitted clinical/medical documentation (when supporting homebound criteria and/or skilled service need for the referral to homecare).	<input type="checkbox"/>


### HOME HEALTH

## DOCUMENTATION CHECKLIST TOOL



Homebound Requirement	
Criteria One	Criteria Two
Does the physician/facility documentation indicate that the patient requires a: • Mobility assist device or • Special transportation or • Assistance of another person to leave the home or • Has a condition that leaving home is medically contraindicated	Does the physician/facility documentation support: • The patient has a normal inability to leave the home <b>AND</b> • Requires a considerable and taxing effort to leave the home
Does the patient meet Criteria One and Criteria Two?	
If Criteria One or Criteria Two not met:	
Do any of the HHA generated assessments (e.g. OASIS, initial skilled therapy, and/or nurse assessments) provide additional support for the homebound status and/or need for skilled services for the referral to homecare? If applicable please make sure these documents are signed, dated and incorporated by the certifying physician.	

## HOME HEALTH DOCUMENTATION CHECKLIST TOOL




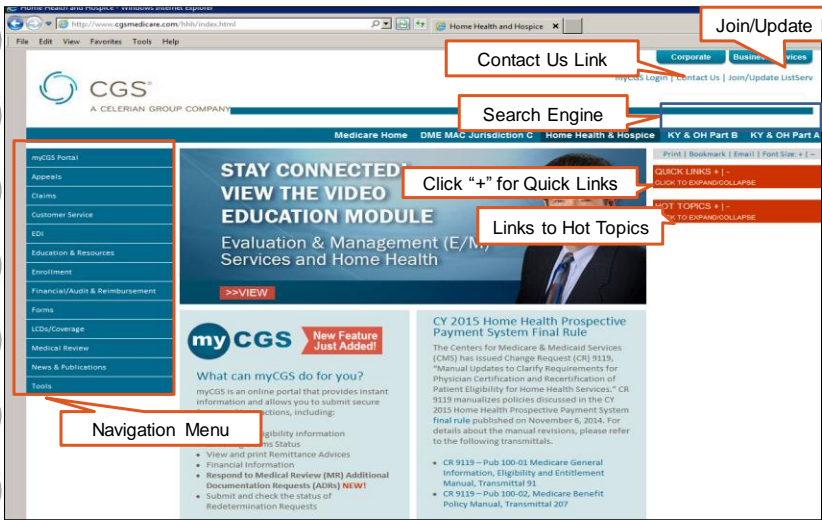
Plan of Care	
Does the Plan of Care contain:	
<ul style="list-style-type: none"> <li>Diagnoses</li> <li>Mental status</li> <li>Types of services, supplies, and equipment required</li> <li>Frequency of the visits</li> <li>Prognosis</li> </ul>	<ul style="list-style-type: none"> <li>Rehabilitation potential</li> <li>Functional limitations</li> <li>Activities permitted</li> <li>Nutritional requirements</li> <li>Medications and treatments</li> </ul>
	<ul style="list-style-type: none"> <li>Safety measures to protect against injury</li> <li>Instructions for timely discharge or referral; and</li> <li>Any additional items the HHA or physician chooses to include</li> </ul>

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## CGS HH&H Website

<http://www.cgsmedicare.com/hhh/index.html>





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### Education & Resources

Our overall goal is to provide our customers with effective, on time, focused education that is easily accessible, understandable, and provides the best fit for their learning needs and challenging schedule. CGS offers a variety of educational resources to keep you informed about Medicare guidelines, including:

- The Advisory Group assists CGS in the creation, implementation, and review of provider education strategies and efforts.
- Upcoming Calendar of Events includes webinars, Ask-the-Contractor Teleconferences (ACTs), and replays of live presentations.
- CMS Educational Resources provides access to Centers for Medicare & Medicaid Services (CMS) website resources, including transmittals (i.e. Change Requests) as well as Medicare Learning Network (MLN) articles, products catalog, and more.
- Educational Materials page allows quick access to a variety of CGS educational resources, including general, billing and clinical Quick Resource Center, Intermediary Standard System (ISS) Guide, and claims filing instructions and much more.
- Frequently Asked Questions (FAQs) provides answers related to a variety of topics. FAQs are reviewed/updated each quarter to ensure all questions are answered.
- The New Provider Resources Center provides step-by-step guides through five steps to help you get familiar with the CGS and CMS websites and resources.

**Education & Resources: CMS Educational Resources, Educational Materials, FAQs**

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## CGS HH&H Website: News & Publications

<http://www.cgsmedicare.com/hhh/pubs/index.html>

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## Home Health Coverage Resources

<https://www.cgsmedicare.com/hhh/education/index.html>

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## Home Health Coverage Resources

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<h1 style="margin: 0;">HOME HEALTH DENIAL FACT SHEET</h1>	<p><b>Denial Reason 5HC01:</b>                  Missing/Incomplete/Untimely Face-to-Face Encounter</p>
<p><b>What is the face-to-face encounter?</b></p>	<p>As part of the certification, a face-to-face (FTF) encounter with the patient must be performed by the certifying physician, a physician who cared for the patient in the acute or post-acute care facility (with privileges) or an allowed non-physician practitioner (NPP). Information about NPPs who are allowed to perform the encounter are provided in the Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7) section 30.5.1.1 (<a href="https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf">https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf</a>).</p>
<p><b>What is the timeframe for</b></p>	<p>The FTF must occur within 90 days prior to the start of care (SOC) or 30 days after the SOC. The</p>

## Home Health Coverage Resources

[https://www.cgsmedicare.com/hhh/coverage/hh\\_coverage\\_guidelines/hh\\_ftf\\_encounter.html](https://www.cgsmedicare.com/hhh/coverage/hh_coverage_guidelines/hh_ftf_encounter.html)



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**Questions?**

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Option 2: Electronic Data Interchange (EDI)  
Option 3: Provider Enrollment  
Option 4: Overpayment Recovery (OPR)

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