CareForum 2022

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Face-to-face encounter documentation: Guidance for withstanding medical review scrutiny

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Today's speaker

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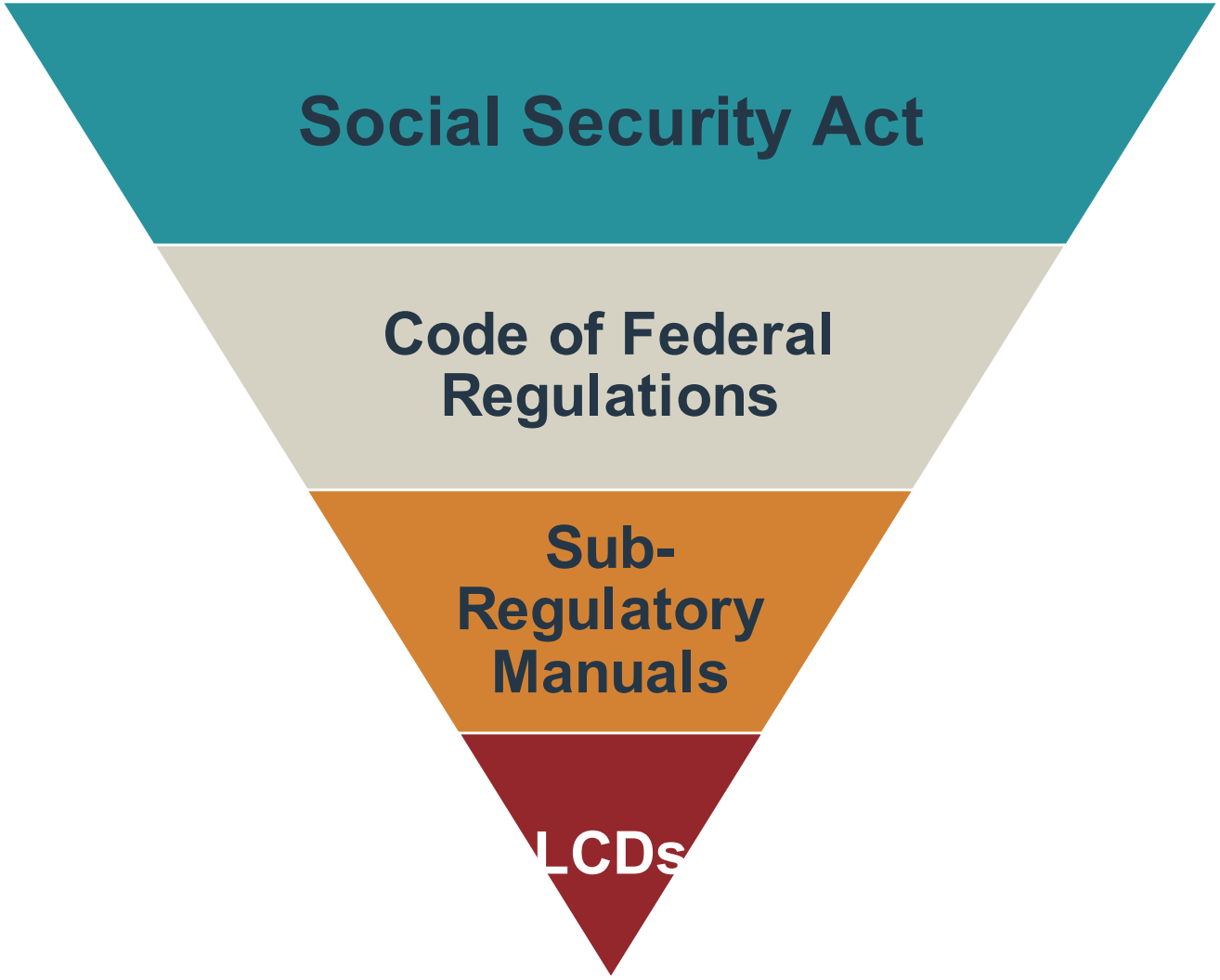
Why we're still here talking about F2F

- The winding road of home health F2F rulemaking and interpretation
  - 2011 – rules for both home health and hospice imposed
  - 2013 – more than $200MM in HH claims denied for F2F issues
  - 2015 – HH F2F rules change but no end to the confusion
  - 2022 – 7 years later and F2F is a leading denial reason for HH
- For hospice, the story is simpler
  - 2011 rules have essentially remained the same
  - Now, however, more emphasis is being placed on the adequacy of the F2F visit as a source of information for the certifying physician
- The most important thing to remember – when the F2F fails, all the services associated with the requirement also fail
- When does the 60-day self-reporting rule come into play?

Authoritative guidance for F2F questions

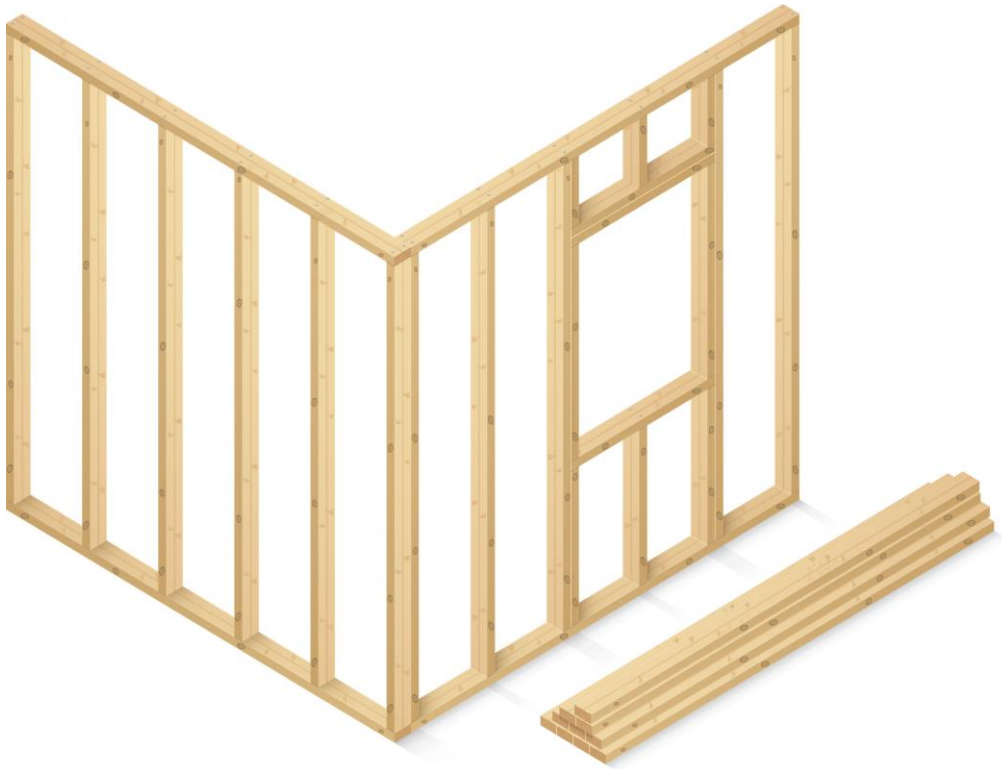
- The actual language of the regulation is the governing authority
  - For HH 42 CFR § 424.22
  - For Hospice 42 CFR § 418.22
- Next in line are the coverage provisions in the IOMs – Medicare Benefit Policy and Program Integrity Manuals
  - For HH Chapter 7 and Chapter 6 of the PIM
  - For Hospice Chapter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



Home health F2F

What you need to know

F2F encounter framework



- Chapter 6 of the Program Integrity Manual — Section 6.2.1
  - –Without a valid encounter and certification at the SOC, there can be no service reimbursement for any certification period in a series
  - –This is where the 60-day self-reporting rule comes in
- Medicaid — partially funded by the federal government and requires a F2F and most states follow the federal rules
- Medicare Advantage plans have discretion regarding their F2F requirement

HH F2F – 42 CFR § 424.22

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

HH F2F – 42 CFR § 424.22

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

A new hurdle — the 2020 regulatory addition

42 CFR § 424.22 (a)(1)(v)

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

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

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

Chapter 7 guidance

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

Chapter 7 cont.

- If the inpatient physician certifies eligibility "**but will not be following the patient after discharge**" then he/she must identify the community physician or allowed practitioner who will be following the patient after discharge

- It is "not acceptable" for HHAs to wait until the end of a 60-day certification period to obtain a completed certification of eligibility

- All of the references to NPPs or allowed practitioners who perform the encounter and/or certify eligibility indicate that they must be working in accordance with state law
  - The newest addition to Chapter 7 (3/25/22 – CR 12615) goes a step further
  - "Individual states have varying requirements for conditions of practice which decide whether a practitioner may work independently without a written collaborative agreement or supervision from a physician, or whether general or direct supervision and collaboration is required. **However, a CNS and NP must work in collaboration with a physician even if state laws governing collaboration don't exist.**"

Chapter 7 – new conditions and exceptions

- When HH is ordered based on a new condition that was not evident during a prior visit within the 90 days preceding HH, the patient must be seen again within 30 days by the certifying physician or practitioner

- This is merely a confirmation of the fact that the reason for HH must be consistent with the F2F

- When a HH patient dies before the F2F can be performed, as long as the agency can demonstrate a good faith effort to facilitate the encounter, the certification will be deemed to be complete

F2F supporting documentation

- The physician, NPP or facility record must contain information that justifies the referral. This includes:
  - The patient's skilled home health need,
  - The patient's homebound status

- The F2F encounter must contain the "actual clinical note"

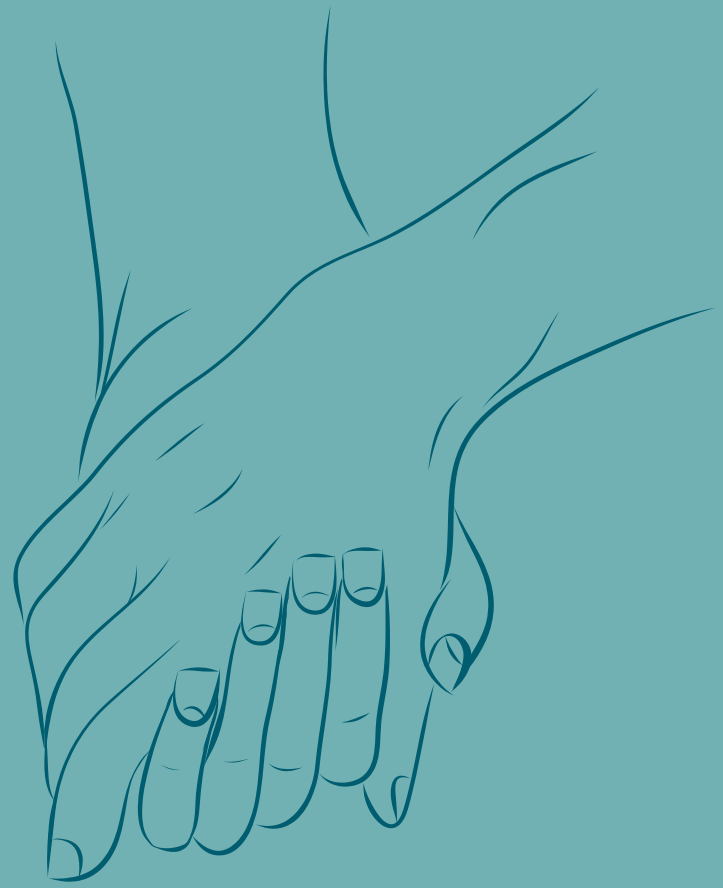
- Information from the agency's record can be incorporated into the physician/facility record and used to establish eligibility
  - The POC should have a longitudinal description of homebound status
  - The POC is required to establish the skilled care need as a condition of payment at 42 CFR § 409.43
  - The incorporation of the agency's information is demonstrated by the physician or practitioner's signature on the document

Certification signature exception

- Both Chapter 7 and Chapter 4 of the Medicare Entitlement Manual – as updated in 2021 — allow for alternate signatures on a HH Plan of Care that would include a certification of eligibility

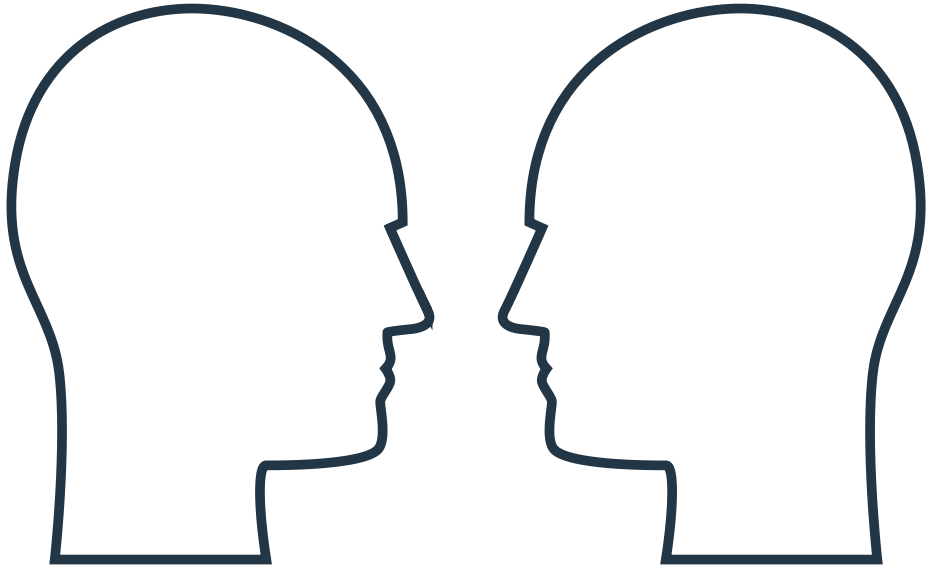
- Not surprisingly, the 2021 additions to Chapter 7 are different from the exceptions earlier noted in Chapter 4 and updated in 2021
  - Chapter 7 establishes that the alternate must be from the same group practice, but Chapter 4 is silent on this
  - Chapter 7 says that the physician or practitioner who performed the required F2F encounter must sign the certification of eligibility, unless the patient is directly admitted to HH from an acute or PAC stay, but Chapter 4 is silent on this

Hospice F2F
What you need to know



Hospice F2F encounters

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



Hospice F2F per 42 CFR § 418.22

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

Interpretive guidance from Chapter 9

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

Chapter 9 guidance cont.

CHAPTER 9

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

What you should do

Home health F2F tips

F2F encounters — inpatient settings

- Inpatient is defined to include services provided in a hospital or other institutional setting when the patient comes “directly” to home health
  - Relates to the facility setting only
  - Encounters in the ED or hospital observation stays can be used for F2F as “inpatient” encounters
  - Make sure that the documentation being used shows evidence of a true clinical encounter between the qualified provider and patient
- Within an “inpatient” setting, the encounter can be performed by a person – “with privileges”
- “With privileges” and “directly” are not defined in the regulatory guidance

Outpatient encounters

- When the encounter is an outpatient encounter, the person who performs the F2F must also certify
- Make sure that the encounter is related to the primary reason for HH
  - This does not require a matching diagnosis
  - The more time between an outpatient encounter and the HH referral, the less likely the reason for HH will be clear and defensible
  - **Example:** F2F visit a month ago when HH referral is due to a more recent fall with injury
  - **Example:** Pre-op notes for joint replacement where the HH skilled need is aftercare

Homebound status documentation

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

Myths	Facts
• The inpatient record being used for the encounter must be signed by the certifying physician if they are different from the inpatient provider	This is only true when the inpatient provider is certifying
• F2F encounters performed by allowed practitioners must be signed by the supervising physician	There is no home health regulation that requires this
• If the F2F encounter document does not specifically address homebound status, it cannot be used	The requirement is that the physician or facility record must establish homebound status – broader than just the isolated F2F encounter
• The primary diagnosis on the F2F needs to match the primary diagnosis on the patient's SOC Plan of Care	There is no regulation that requires diagnosis matching
• The certification must include the name of the performing provider	There is no regulation that requires the certifying provider to identify the individual who performed the encounter by name – only the date is required

Curing common F2F gaps

Each of the most common gaps can be rectified by process improvements – acquiring and validating the F2F at intake

- Encounter is timely but unrelated to the reason for home health services
- Encounter is not timely
- Record does not show evidence of an actual provider/patient visit
- Encounter performed by someone other than a physician/allowed practitioner
- Encounter is an outpatient service with a physician who is not certifying
- Encounter is signed by someone other than the performing provider

Agencies should establish an admission review process that compares the F2F with the “primary” skilled need with measurement of the other criteria

Curing common F2F gaps

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

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

What you should do
Hospice F2F tips

Hospice F2F tips

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

Identifying and addressing hospice F2F gaps

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

Wrap up

- F2F gaps are the most prevalent sources of payment denial for home health and an increasing technical pitfall for hospice

- The key to success is to ‘get it right the first time’ by controlling the process

- When faced with a denial based on the insufficiency of the F2F, appeal
  - Reviewers are not always right
  - Use gaps in the available guidance to your advantage
  - The appeal can forestall the self-reporting requirement if there is doubt

- Work toward a goal of making all key staff members F2F experts

Thank you.

Contact:

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