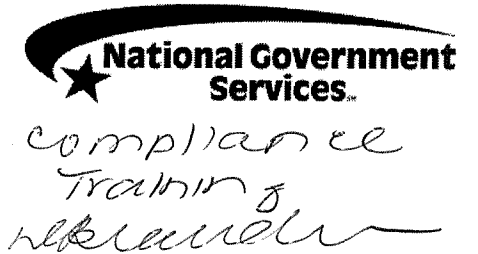




Master
Presentation
5/27/14



Face-to-Face Encounters



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Today's Presenter

- Shelly Bernardini RN, CPHM
 - Home Health Clinical Consultant
 - Provider Outreach & Education

Disclaimer

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Acronyms

CFR – Code of Federal Regulations

CHF – Congestive heart failure

CMS – Centers for Medicare & Medicaid Services

COPD – Chronic obstructive pulmonary disease

CR – Change Request

ED – Emergency department

FTF – Face-to-face

HH – Home health

HHA – Home health agency

HIPPS – Health insurance prospective payment system

IOM – Internet-Only Manual

MD – Medical doctor

Acronyms

MLN – Medicare Learning Network

MU – Medicare University

NPP – Nonphysician practitioner

OASIS – Outcome and Assessment Information Set

PT – Physical therapy

ROM – Range of motion

SOB – Shortness of breath

SOC – Start of care

Agenda/Objectives

- To assist HHAs & hospitals with Medicare home health care regulations for the FTF encounter, including:
 - Certifying physician requirements
 - Homebound status documentation requirements
 - Documenting the need for skilled service requirements
 - Telehealth
 - Examples of acceptable/unacceptable encounters
 - FTF encounter & HH resources

Face-to-Face Encounter

- The FTF encounter is a condition for payment for patients with Medicare fee-for-service & may not be required for patients with Medicare Advantage plans
- HHAs **cannot** bill for their services without a completed FTF encounter document
- HHAs must ensure the FTF is completed correctly prior to submitting a claim, which often times means repeatedly requesting that the certifying physician add or correct information on the FTF
 - ***HHA Helpful Hint:*** *In an effort to avoid repeated corrections to certifications and FTF encounter documents, share all educational materials with the physicians and facilities that frequently utilize your HHA.*

Certifying Physicians

- The Affordable Care Act requires a **certifying** physician to document that either a physician or NPP has had a FTF encounter with patient for **all start of care episodes**
 - Allowed NPP
 - Physician assistant
 - Clinical nurse specialist
 - Nurse practitioner
 - Certified nurse midwife

Reminder: *Because residents do not have privileges, if a resident is performing the FTF encounter, he/she must inform the certifying physician of the encounter through the supervising teaching physician who must have such privileges.*

Certifying Physician Regulations

- Certifying physician or NPP cannot have financial relationship with home health agency unless it meets one of exceptions in 42CFR411.355-42CFR411.357
- Certifying physician has to be a Medicare-enrolled physician

Timing Requirements

- Timing requirements for “in-person” encounter:
 - Up to **90 days prior** to the start of care
 - If the visit was for the same diagnosis/condition that now requires HH services
 - Within **30 days after** the SOC
 - For the diagnosis/condition that requires the HH services

Timing Requirement Exceptions

- Exception to timing requirement
 - When the patient dies shortly after admission to home health
 - If there was a good faith effort to facilitate/coordinate the encounter, and
 - All other certification requirements are met

Document Requirements

- Titled as “Face-To-Face”
- Name of patient
- Date of encounter
- What type of HH services are being requested
- **Clinical information to support need for skilled nursing and/or therapy services***
- **Clinical information to support homebound status***
- Dated signature of certifying physician

Reminder: There must be **TWO (2)** dates on the form... one is the date that the encounter occurred and the other is the date that the physician signed the document. The two dates may be the same, or they may be different.

Document Requirements

- The CMS IOM Publication 100-02, *Medicare Benefit Policy Manual* states that documentation must include a brief narrative that “describes how the patients clinical condition as seen during the encounter supports the patients homebound status and need for skilled services”.
- Documentation must include clinical findings that support the need for the following eligibility requirements:
 - Homebound status
 - Skilled services

Reminder: *The Face-to-Face Encounter is a condition for payment for patients with Medicare fee-for-service & may not be required for patients with Medicare Advantage plans*

Homebound Status - “Confined to the Home” Definition

- 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
- **He/she must also meet both of the additional requirements below:**
 - There must exist a normal inability to leave home
 - Leaving home must require a considerable and taxing effort

Documenting the Need for Homebound Status

- **The homebound status of the patient must include a brief narrative that:**
 - Includes information about the injury/illness & the type of supportive device/assistance required
 - Explains in detail what about the patients current condition makes leaving home medically contraindicated
 - Details exactly what about the requested services or illnesses qualify the patient as homebound
 - Offer clinical information (beyond a list of recent diagnoses, injury, or procedure) that is individual and specific to the patient explaining why it is a considerable and taxing effort for the patient to leave his/her home

Documenting the Need for Skilled Home Health Services

- The Face-to-Face Encounter document should include a brief narrative detailing the patients need **for any/all skilled services requested** (including PT/OT/SLP/MSW).
 - Distinguish exactly what services are going to be provided by the skilled professional in the patients home
 - Explain why a skilled professional is required to provide the home health care services requested
 - Disclose clinical information beyond a list of recent diagnoses, injury, or procedure that is individual and specific to the patient
 - Clarify why the findings from this individual patient FTF encounter support the medical necessity of the services ordered

Skilled Nursing Services

- Skilled nursing services must be reasonable and necessary for the treatment of the patients illness/injury. Skilled nursing services can be, but are not limited to:
 - Teaching/training
 - Observe/assess
 - Complex care plan management
 - Administration of certain medications
 - Tube feedings
 - Wound care, catheters and ostomy care
 - Nasogastric and tracheostomy aspiration/care
 - Psychiatric evaluation and therapy
 - Rehabilitation nursing
- **Reference:** MLN article SE1405

Skilled Therapy Services (PT/OT/ SLP)

- Assuming all other eligibility and coverage requirements are met, **one of the following three conditions must be met** for therapy services to be covered:
 1. The skills of a qualified therapist are need to restore patient function
 2. The skills of a qualified therapist are needed to design or establish a maintenance program
 3. The skills of a qualified therapist (not an assistant) are needed to perform maintenance therapy
- **Reference:** MLN article SE1405

Face-to-Face Encounter – Home Health Certification Requirement

- “... Medicare allows a physician who attended to the patient in an acute or post-acute setting, but does not follow the patient in the community (such as a hospitalist) to **certify the need for home health** care based on their contact with the patient and **establish and sign the POC**. The acute/post-acute physician would then “hand off” the patient’s care to his or her community based physician **to review and sign off on the plan of care.**”

Face-to-Face Encounter – Home Health Certification Requirement

- “...the physician who attended to the patient in an acute or post-acute setting (such as a hospitalist) to certify the need for home health care based on their contact with the patient, initiate the orders for home health services, and “hand off” the patient to his or her community-based physician to review and sign off on the plan of care”

Face-to-Face Encounter Document Reminders

- **HHAs may add:**
 - Title “Face-to-Face Encounter” to a document if documentation that is received from an acute or post-acute setting is not titled as such (example: Discharge Summary)
 - Date the documentation is received from an acute or post-acute setting if the FTF encounter received is signed but the signature is not dated

***This only applies to FTF Encounter documents.
HHAs are not allowed to alter the FTF documentation in any other way.***

Face-to-Face Encounter Document Reminders

- Must include when (actual date) the physician or NPP saw the patient on the Face-to-Face Encounter document. *(If NPP provides encounter, a certifying physician must countersign the document. As per CMS IOM Publication 100-02 , Chapter 7, Section 30.5.1.1)*
- Can be a part of the certification form itself, or an addendum to the certification. *(**IMPORTANT:** When utilizing an addendum for the Face-to-Face Encounter, the certification and the Face-to-Face Encounter document each require a dated certifying physician signature. It must also contain the required information about the patients homebound status and need for skilled nursing and/or therapy services)*

Face-to-Face Encounter Document Reminders

- Blanket CMS statements (*“leaving home is a taxing effort”*) should be avoided.
- Check box documentation should include an area for a written narrative that is required to support the need for the home health skilled services being requested (***As per CMS IOM Publication 100-02 , Chapter 7, Section 30.5.1.1 “Encounter Documentation Requirements...must include the date...and a brief narrative...” Also review SE1405 for narrative requirements.***)
- Double check all documents for dates/signatures & all required information prior to submission to the HHA.

Start of Care Claims

An FTF encounter is required for all HHA initial episodes/SOC claims. This includes:

- **When the HH patient is hospitalized on day 60 and 61**
 - When HH resumes, it will have to be billed as new SOC so new FTF is needed
- **When the HH patient is hospitalized and discharged on day 60 or 61**
 - If resumption of care assessment changes HIPPS code from a recertification assessment performed in last 5 days of prior episode, this must be reported as SOC assessment and FTF is needed

Start of Care Claims

An FTF encounter is required for all HHA initial episodes/SOC claims. This includes:

- When the current HH patient is recertified for another episode but is hospitalized before the first visit of this subsequent episode occurs**
 - If HIPPS code on return to home care is different than HIPPS code obtained during recertification assessment in last 5 days of previous episode, then claim has to be entered as new SOC and new FTF is needed
- When the HH patient's insurance changes from Medicare Advantage to Medicare fee-for-service**
 - Although patient has been receiving HH services, it is an SOC claim and FTF is needed

Late Face-to-Face Encounter

- Generate another OASIS with reported SOC date equal to first visit date after all Medicare home health eligibility criteria are met
 - If multiple OASIS assessments exist, use data from OASIS conducted closest to date of Medicare eligibility
 - Similar to the actions needed when a patient switches from Medicare Advantage to Medicare fee-for-service
 - CMS Home Health Face-To-Face Q&A Document (3/1/2013)
 - Question #51

Late Face-to-Face Example

- Jane D receives the **first skilled visit** from HHA on **1/1/13**. Patient has not had a **recent visit** with her doctor. She schedules an appointment and sees her doctor on **2/4/13**. This is day 35.
 - This is beyond 30-day requirement for FTF encounter
- Determine date of eligibility:
 - Date of encounter is day 1 (Face-To-Face) (2/4/13)
 - Count back 30 days... that is first day all Medicare eligibility requirements are met (1/6/13)
 - LATE FTF EXAMPLE CONTINUED ON NEXT SLIDE...

Late Face-to-Face Example

- 1/1/13-1/5/13 are noncovered days
- This will require a new OASIS with SOC date of January 7 (M0030)
 - January 7 was first visit date and so is new SOC
- The date the OASIS was actually generated (M0090) should be on or after the February 4 FTF encounter
 - Nurse completes new OASIS for this patient on February 7

Face-to-Face Tele-Health Regulation

- Tele-Health services may be used at one of several specified authorized originating sites if the beneficiary is from a rural area where there is a health professional shortage or they reside outside of a metropolitan statistical area
- Authorized originating sites include:
 - Office of a physician or practitioner
 - Hospital
 - Critical access hospital
 - Rural health clinic
 - Federally qualified health center
 - Hospital-based dialysis center
 - Skilled nursing facility
 - Community mental health center

Example of an *Acceptable* Face-to-Face Encounter

FACE-TO-FACE ENCOUNTER

Patient name- James Doe

Date of encounter- February 19, 2013

Face-To-Face Certification - *“I attest that I or an allowed NPP working with me had a face-to-face visit with this patient on the date above.”*

Clinical Condition- Diagnoses: *Acute Emphysema/Chronic Obstructive Pulmonary Disease. Patient has become increasingly short of breath with activity, weakness and decreasing oxygen saturation levels over the last 3 weeks resulting in her becoming wheelchair bound, requiring 2 assist for transferring, thus causing homebound status. Nursing services are needed for skilled assessment and education. Physical & Occupational Therapy evaluations are ordered.*

Certification to support the need for skilled services & homebound status- *“I certify that this patient is homebound and requires intermittent skilled nursing and/or physical/Occupation/Speech-Language Pathology services. He/she is under my care and the plan of care is periodically reviewed by a physician.”*

Dated Signature- Electronically signed by William Smith MD on 2/22/13

Example of an *Acceptable* Face-to-Face Encounter

Primary Care Office Visit Progress Note: (FACE-TO-FACE)-

4/2/13 James Doe visits today because of worsening bilateral knee pain. The patient has had an orthopedic evaluation for severe osteoarthritis but is not a candidate for surgery at this time due to his worsening pulmonary disease. He has been taking the prescribed nonsteroidal anti-inflammatory medication without relief and continues to have difficulty with ambulation and climbing stairs. (5 steps into/out of house and 8 to bedroom) Balance is worsening and he presents today due to a fall last evening on the steps to get into the house that resulted in some minor abrasions and bruising to the right hip and knee (x-rays without fracture). Patient requires physical therapy and occupational therapy evaluations and requires an assistive device for safety with all ambulation. PT/OT to determine most appropriate device. This patient is declared homebound due to recent falls secondary to severe debilitating chronic osteoarthritis causing an unsteady gait, and need for assistive device when ambulating. Referral to ABC HH sent. Electronically signed by M. Jones MD on 4/2/13.

***Certification statement on the Plan of Care also signed by Dr. M. Jones**

Example of an *Acceptable* Face-to-Face Encounter

FACE-TO-FACE

- I (or an allowed NPP) had a face-to-face encounter with Jane Doe on March 8, 2013.
- **Clinical information:** I am treating this patient for coronary artery disease and congestive heart failure following coronary stent placement. The patient requires rest when walking >20 feet due to severe fatigue and shortness of breath. Balance is poor-requiring use of a walker. She is homebound due to these issues. Home health nursing is needed for observation, assessment and education about new medications and physical/occupation therapy evaluations for gait training and assistive devices for activities of daily living.
- **Certification statement:** *"I certify that this patient is homebound and requires intermittent skilled nursing and/or physical/Occupational Therapy. He/she is under my care and the plan of care is periodically reviewed by a physician."*
- **Date & Signature:** Electrically signed by Charles Williams MD on March 13, 2013

Example of an *Acceptable* Face-to-Face Encounter

Discharge Note (FACE-TO-FACE ENCOUNTER)

Added by HHA

Dr. Jones,

- I treated Ms. Doe in the Emergency Department of Community General Hospital on 2/28/13 after she suffered a fall in her home. She was accompanied by her daughter who states this is her second fall in <30d. X-rays of her left hip and shoulder are normal but there is significant bruising and abrasions. She is alert & oriented to person and place. Disoriented to time with short-term memory loss noted. Breath sounds clear, no cough. Abdomen soft with active bowel sounds. All pulses present. No pedal edema noted. **Patient is legally blind and requires assistance to leave home.** A PT evaluation was done as well as gait training with a cane. Patient is very hesitant to use a cane. The patient will benefit from additional gait training for safety. Need for a cane and blindness results in her being homebound. I provided a referral to ABC Home Health for continued PT. I informed the home health agency that you will be the physician approving the plan of care.
- (From Dr. Williams)
- Electronically signed by N. Jones MD 3/13/13

Example of an *Acceptable* Face-to-Face Encounter

FACE-TO-FACE

Patient: Jane Doe

Date of encounter: January 11, 2013

The above named patient requires nursing service assessments and PT/OT evaluations because of pneumonia/COPD exacerbation resulting in increased shortness of breath, severe weakness, cough and decreased oxygen saturation levels. Diabetic patient with elevated glucose levels secondary to steroid medications will now require insulin injections & diabetic education. She is currently homebound with a new walker for her unsteady gait and requires training and education with her assistive device and insulin therapy.

- Certification statement: *"I attest that I had a face-to-face encounter with the above patient on the date noted above."*

Electronically signed by Dr. James Smith

Received on January 15, 2013

Added by HHA

Example of an *Acceptable* Face-to-Face Encounter

FACE-TO-FACE ENCOUNTER

Patient: John Smith

Date of encounter: September 4, 2013

Clinical information: Nursing services are required for this 42 year old wheelchair bound paraplegic male patient to include wound care of infected stage 4 sacral decubitus ulcer. Prescription medication for dressing change requirements provided. Dressing to be changed 3x/day.

- **Homebound Status:** This wheelchair bound patient remains homebound
- **Certification statement:** *"I attest that I had a face-to-face encounter with the above patient on the date noted above."*

Signed electronically by A. Jones MD on 9/9/13

Example of an Unacceptable Face-to-Face Encounter

Date of encounter- January 21, 2013

Patient name- Jane Doe

Clinical condition-Pernicious anemia, chronic bronchitis.
Requires nursing services for vitamin B12 injections and assessment and education about her illnesses

Homebound status- unable to drive

- Certification statement- *"I attest that I had a face-to-face encounter with the above patient on the date noted above."*

Electronically signed by N. Jacobs MD on 1/23/13

Example of an Unacceptable Face-to-Face Encounter

FACE-TO-FACE ENCOUNTER

Date of encounter: March 28, 2013

Patient name: Jane Doe

Clinical condition: Diabetes, Hypertension

Homebound status: Taxing effort to leave home

- Certification statement: *“I attest that I had a face-to-face encounter with the above patient on the date noted above.”*

Electronically signature by M Davis MD on April 4, 2013

Example of an Unacceptable Face-to-Face Encounter

FACE-TO-FACE ENCOUNTER

Patient Name-Jane Doe

Clinical Condition-total knee replacement 7/30/13

Homebound status-requires assistance of 1 and a walker -
status post total knee replacement surgery

Electronically signed by Dr. W. Moore. 8/1/2013

Resources & References

- <http://www.NGS Medicare.com>
 - Face-to-Face Encounter Educational Quality Tool and Checklist Guide for Physicians Certifying Home Health
 - MLN Matters article SE1038
- www.cms.gov/Home-Health-Agency-HHA-Center
 - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 7, Section 30.5.1.1
 - CR 8444
 - CMS Home Health Face-to-face Encounter Questions & Answers (3/1/13)
 - <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/Home-Health-Questions-Answers.pdf>

National Government Services Website

The screenshot shows the top navigation bar of the National Government Services website. The logo on the left reads "National Government Services." with a star icon. To the right of the logo is a search bar with the text "Site Search" and "Enter Keyword(s)", a dropdown menu with "HHH" selected, and a "Search" button. Further right are links for "Home", "FAQs", and "Contact Us". Below the search bar is a horizontal navigation menu with the following items: "CLAIMS", "EDUCATION & TRAINING", "ENROLLMENT", "MEDICAL POLICY CENTER", "PUBLICATIONS", "RESOURCES", and "REVIEW PROCESS". The "RESOURCES" item is highlighted with a black box. A dropdown menu is open under "RESOURCES", listing the following items: "Acronym Search", "CMS Links", "Connex", "Contact Us", "Forms", "Provider Satisfaction Survey", "Production Alerts", "Other Medicare Contacts", "Self-Service Center", and "Tools And Materials". An arrow points from the "Tools And Materials" item in the dropdown menu to the text in the list on the left.

- Home Health Resources & Tools
 - (Top of Home Screen) Resources
 - Tools and Materials
 - Claims, billing and payment information
 - Coverage and documentation information
 - Home Health job aids
 - Self-help tools

National Government Services Website

Home | FAQs | Contact Us

Site Search Enter Keyword(s) HHH Search Advanced Search

▶ CLAIMS ▶ **EDUCATION & TRAINING** ▶ ENROLLMENT ▶ MEDICAL POLICY CENTER ▶ PUBLICATIONS ▶ RESOURCES ▶ REVIEW PROCESS

- EDUCATION & TRAINING
 - Medicare University
 - New Provider Center
 - POE Advisory Group
 - Policy Education
 - Training Events Calendar
 - Training Summaries

- Medicare University

- <http://www.MedicareUniversity.com>

- Interactive online system available 24/7

- Educational opportunities available

- Computer-based training courses





- Teleconferences, webinars, live seminars/face-to-face training

- Self-report attendance

CMS Website

CMS.gov

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Outreach and
Education

- <http://www.CMS.gov>
 - Medicare
 - Provider Type
 - Home Health Agency

Medicare.gov Website

- <http://www.medicare.gov>

- A great resource for beneficiaries and their families: housing information on providers, hospitals, plans & suppliers, home health agencies, coverage & home health compare!

The screenshot shows the Medicare.gov website interface. At the top, there are links for 'Español', 'A A A', 'Email', and 'Print'. On the right, there are links for 'About Us', 'FAQ', 'Glossary', 'CMS.gov', and 'MyMedicare.gov Login'. A search bar is located on the right side with the placeholder text 'type search terms here' and a 'Search' button. Below the search bar, the 'Medicare.gov' logo is displayed, followed by the tagline 'The Official U.S. Government Site for Medicare'. A horizontal navigation menu contains several categories: 'Sign Up / Change Plans', 'Your Medicare Costs', 'What Medicare Covers', 'Drug Coverage (Part D)', 'Supplements & Other Insurance', 'Claims & Appeals', 'Manage Your Health', and 'Forms, Help, & Resources'. The main content area features a large banner with the question 'Is my test, item, or service covered?' and a search input field with a 'Go' button. Below the banner, there are two buttons: 'Find health & drug plans' and 'Apply for Medicare'. To the right of these buttons is a 'MyMedicare.gov login' link. Further down, there are three promotional banners: 'Live in a Durable Medical Equipment Competitive Bidding Program area?' with a 'Find a Medicare-contract supplier' link; 'Need to know more about the Durable Medical Equipment Competitive Bidding Program?' with a 'Learn more' link; and 'Your Medicare Summary Notice just got easier to understand.' with a 'Learn more' link. At the bottom, there are three more sections: 'Address change/Medicare card issue?' with a dropdown menu and a 'Go' button; 'Information for my situation' with a dropdown menu and a 'Go' button; and 'Find someone to talk to' with a dropdown menu and a 'Go' button.



Thank You!

