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Face-to-Face Encounter Requirements

When Did the F2F Start?

Medicare began requiring a home health F2F in 2011 as the result of the Affordable Care Act (ACA). The intent of the F2F was to reduce fraud, waste, and abuse.

When the F2F was first initiated in 2011, agencies were required to document the F2F encounter on a specific form. Many agencies and clinicians remain unaware that requirement was eliminated by CMS in 2015 and they continue to submit F2F encounter forms as documentation. Since 2015 the actual provider visit note is used for the F2F and can be supplemented by other documentation signed and dated by the certifying provider.

Where Can You Find the Guidance for the F2F Requirements?

Medicare Benefit Policy Manual (cms.gov)

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

Medicare Benefit Policy Manual
Chapter 7 – Home Health Services

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(Rev. 11447, 06-06-22)

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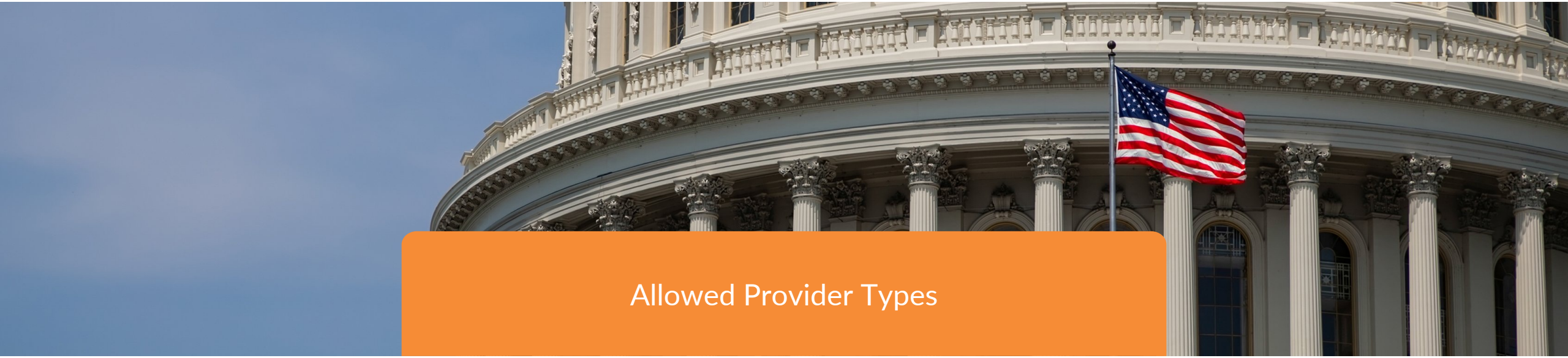
Medicare Benefit Policy Manual
Chapter 7 – Home Health Services

Face-to-Face Encounter 30.5.1.1

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01-11-21)



Allowed Provider Types

As part of the certification of patient eligibility for the Medicare home health benefit, a face-to-face encounter with the patient must be performed by:

- The certifying physician or allowed practitioner himself or herself,
- A physician or allowed practitioner 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 home health) or an allowed non-physician practitioner (NPP).

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NPP's Who Are Allowed to Perform the Encounter Are:

- A nurse practitioner or a 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 facility from which the patient was directly admitted to home health;
- A certified nurse midwife, as authorized by State Law, 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 home health;
- A 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 home health.

NPPs performing the encounter are subject to the same financial restrictions with the HHA as the certifying physician, as described in 42 CFR 424.22(d).

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Plans of Care and Certifying/ Recertifying Patient Eligibility:

In addition to a physician, **section 3708 of the CARES Act allows a Medicare-eligible home health patient to be under the care of a nurse practitioner, clinical nurse specialist, or physician assistant who is working in accordance with state law.**

These physicians/practitioners can:

- Order home health services;
- Establish and periodically review a plan of care for home health services (e.g., sign the plan of care);
- Certify and re-certify that the patient is eligible for Medicare home health services.

The changes, effective March 1, 2020, provide the flexibility needed for more timely initiation of services for home health patients, while allowing providers and patients to practice social distancing. Specifically, for Medicare, these changes are effective for Medicare claims with a 'claim through date' on or after March 1, 2020. **This provision has been made permanent beyond the COVID-19 public health emergency and is codified in the regulations at 42 CFR 409.43.**

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Timeframe Requirements

- The encounter must occur no more than **90 days prior** to the home health start of care date or **within 30 days** after the start of care.
- In situations when a physician or allowed practitioner orders home health care for the patient based on a new condition that was not evident during a visit within the 90 days prior to the start of care, the physician or an allowed NPP must see the patient again within 30 days after admission. Specifically, if a patient saw the physician or NPP within the 90 days prior to the start of care, another encounter would be needed if the patient's condition had changed to the extent that standards of practice would indicate that the physician or a non=physician practitioner should examine the patient in order to establish an effective treatment plan.

Exceptional Circumstances

When a home health patient dies shortly after admission, before the face-to-face encounter occurs, if the contractor determines a good faith effort existed on the part of the HHA to facilitate/coordinate the encounter and if all other certification requirements are met, the certification is deemed to be complete.

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Telehealth

The face-to-face encounter can be performed via a telehealth service, in an **approved originating site.** An originating site is considered to be the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in a rural health professional shortage area or in a country outside of a Metropolitan Statistical Area.

The provider must use an **interactive audio and video** telecommunications system that permits real-time communication between the distant site and the patient at home.

The Originating Sites Authorized by Law Are:

- The office of a physician or practitioner
- Hospitals
- Critical Access Hospitals (CAH)
- Rural Health Clinics (RHC)
- Federally Qualified Health Centers (FQHC)
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites)
- Skilled Nursing Facilities (SNF)
- Community Mental Health Centers (CMHC)

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Medicare Telehealth and Telecommunications Technology

Home Health Agencies (HHAs) can provide more services to beneficiaries using telecommunications technology within the 30-day period of care, as long as it's part of the patient's plan of care and does not replace needed in-person visits as ordered on the plan of care. We acknowledge that the use of such technology may result in changes to the frequency or types of in-person visits outlined on existing or new plans of care. Telecommunications technology can include, for example: remote patient monitoring; telephone calls (audio only and TTY); and two-way audio-video technology that allows for real-time interaction between the clinician and patient. This provision is permanent beyond the COVID-19 PHE. Home health services furnished using telecommunication systems are required to be included on the home health claim beginning July 1, 2023.

The required face-to-face encounter for home health can be conducted via telehealth (i.e., 2-way audio-video telecommunications technology that allows for real-time interaction between the physician/allowed practitioner and the patient) when the patient is at home. After the PHE ends, the Consolidated Appropriations Acts, 2023 provides for an extension for the flexibility to **allow the home to be an originating site through December 31, 2024.**

30.5.1.2 Supporting Documentation Requirements

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01-11-21)

As of January 1, 2015, documentation in the certifying physician or allowed practitioner's medical records and/or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) **will be used as the basis upon which patient eligibility for the Medicare home health benefit will be determined.**

Documentation from the certifying physician or allowed practitioner's medical records and/or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) used to support the certification of home health eligibility must be provided, upon request, to the home health agency, review entities, and/or the Centers for Medicare and Medicaid Services (CMS). In turn, an HHA must be able to provide, upon request, the supporting documentation that substantiates the eligibility for the Medicare home health benefit to review entities and/or CMS. 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.

The certifying physician or allowed practitioner and/or the acute/post-acute care facility medical record (if the patient was directly admitted to home health) for the patient must contain information that justifies the referral for Medicare home health services. This includes documentation that substantiates the patient's:

- Need for the skilled services
- Homebound status

30.5.1.2 Supporting Documentation Requirements

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The certifying physician or allowed practitioner and/or the acute/post-acute care facility medical record (if the patient was directly admitted to home health) for the patient must contain the **actual clinical note** for the face-to-face encounter visit that demonstrates that the encounter:

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

This information can be found most often in clinical and progress notes and discharge summaries. While the **face-to-face encounter** must be related to the primary reason for home health services, the patient's skilled need and homebound status can be substantiated through an examination of all submitted medical record documentation from the certifying physician, or allowed practitioner, acute/post-acute care facility, and/or HHA (see below). The synthesis of progress notes, diagnostic findings, medications, nursing notes, etc., helps to create a longitudinal clinical picture of the patient's health status.

Supporting the F2F Encounter Note

Information from the HHA, such as the **plan of care** required per 42 CFR 409.43 and the initial and/or comprehensive assessment of the patient required per 42 CFR 484.55, can be incorporated into the certifying physician or allowed practitioner's medical record for the patient and **used to support the patient's homebound status and need for skilled care.** However, this information must be corroborated by other medical record entities in the certifying physician or allowed practitioner's and/or the acute/post-acute care facility's medical record for the patient. This means that the appropriately incorporated HHA information, along with the certifying physician or allowed practitioner's and/or the acute/post-acute care facility's medical record, creates a clinically consistent picture that the patient is eligible for Medicare home health services.

Certifying Physician Incorporating Supporting Documentation into Their Medical Record

The certifying physician or allowed practitioner **demonstrates the incorporation of the HHA information into his/her medical record for the patient by signing and dating the material.** One incorporated, the documentation from the HHA, in conjunction with the certifying physician or allowed practitioner and/or acute/post-acute care facility documentation, must substantiate the patient's eligibility for home health services.

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Community Referral Versus Facility Referral

If you have a community referral:

- A physician or allowed non-physician provider can complete the F2F encounter. It must be signed by the same physician or provider.

If you have an acute or post-acute care facility referral:

- The facility physician or allowed provider can complete the F2F encounter visit. The SOC and POC may be signed by the same person OR the certifying provider must acknowledge that they have properly reviewed the encounter.

The Certifying Provider can Acknowledge the F2F by Doing One of These

- Include the F2F date on the plan of care.
- Obtain a separate attestation from the certifying physician attesting to the F2F date.
- The certifying physician's date co-signature on the actual F2F encounter note.

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Face to Face Issues Found During ADR Review:

- Face to Face encounter was not within the required time frame (90 days prior or within 30 days)
- The primary reason for home health was not addressed in the F2F visit note.
- The F2F encounter was not signed and dated by the provider.
- The F2F was not performed by the certifying physician or acute/post-acute providers/allowed provider.
- Face to Face submitted was not an actual patient visit by the provider.
- Skilled needs was not documented on the encounter and no supplemental documentation to support this.
- The certifying physician didn't document the date of the encounter as part of the certification.
- The date documented by the certifying physician did not match the F2F encounter submitted
- Homebound not documented in the encounter and not supported in supplemental documentation.
- F2F encounter was done telehealth but was not provided with audio and video.

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Top Denial Reason for the Face to Face

1. The F2F encounter was not related to the primary reason for home health (can't just record a history of that diagnosis, it must be addressed in the actual provider visit note).
2. The F2F note was missing.
3. The F2F encounter was untimely and/or the certifying provider did not document the date of the encounter.

Face to Face Denials

- The F2F is a condition of payment for Medicare.
- F2F Denial = Whole Claimed Denied = No Money
- Hard to appeal and win

Tips

- Don't have your Plan of Care signed prior to having a valid F2F.
- Don't bill your episode prior to having a F2F that is valid and meets all requirements.

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Thank You

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References:

Home Health Denial Fact Sheet: Denial Reason 5HC01: Missing/Incomplete/Untimely Face-to-Face Encounter (Home Health & Hospice) (cgsmedicare.com)

Home Health Face-to-Face Checklist (palmettogba.com)

Medicare Claims Processing Manual (cms.gov)