CMS Probe & Educate - F2F in spotlight!

CMS is conducting pre-payment reviews of home health claims for episodes that began on or after August 1, 2015. The purpose of this Probe and Educate process is to ensure that HHAs understand and are compliant with new patient certification requirements to include the F2F encounter requirements. CMS will direct Home Heath MACs to select a sample of 5 claims for pre-payment review from each HHA within their jurisdiction.

What will the review be based on?

The Medicare review contractors will review the certification documentation for any episode initiated with the completion of a start-of-care OASIS assessment. The Medicare review contractor shall determine whether the supporting documentation addresses the **five eligibility criteria:**

1. Homebound
2. Skilled Care
3. Plan of Care
4. Under Physician Care
5. Face-to-Face Encounter

What does the F2F requirement entail?

- Final rule eliminates the requirement of a face-to-face encounter narrative as part of the certification of patient eligibility for home health services
- Home Health Eligibility and payment will be determined from the certifying physician's medical record and/or acute/post-acute care facility's medical records (if the patient was directly admitted to home health) not the F2F Form
- Information in the medical record should confirm that a F2F encounter was related to the primary reason for home care services & performed either by the certifying physician, an acute/post-acute care physician or allowed NPP
- The F2F encounter must occur in the required time frame - no more than 90 days prior to the home health start of care date or within 30 days after the start of care
- The certifying physician 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 need for skilled services and homebound status.

To learn more read the recently issued MLN article SE1524.

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What issues have been reported and how to resolve them?

- When medical documentation is requested, providers fail to submit the actual F2F encounter note from the medical record. To avoid denial of HH services, providers must ensure they submit all medical records including the actual clinical notes from F2F encounter
- To stay in compliance with certification and F2F encounter requirements, agencies need to submit the entire medical record and not just F2F encounter narrative.

What medical records are required?

It is imperative that all documents are thoroughly checked for accuracy and compliance prior to submission!

- CMS recommends obtaining as much documentation from the certifying physician to prove patient eligibility for home health benefit
- It is highly recommended that HHAs obtain medical record evidence of eligibility at the time of referral AND prior to billing
- Information from the HHA, such as the initial and/or comprehensive assessment of the patient required per 42 CFR 484.55, can be incorporated into the certifying physician'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 entries in the certifying physician's and/or the acute/post-acute care facility's medical record for the patient.
- Sources of documentation that may assist in defining the patient's need for skilled services and homebound status include:
    - Physician/approved NPP clinical and progress notes
    - Inpatient History & Physical
    - Inpatient Plan of Care
    - Discharge Summary (from referring entity)
    - Discharge Plan (from referring entity)
    - Case Management and Discharge Planner documentation from Inpatient Facility

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To summarize, in case of a review, ensure all paperwork is completely reviewed for accuracy including:

- All pages correspond to the appropriate patient
- Patient name on each page
- The correct DOS for all materials
- Provider Enrollment, Chain and Ownership System - PECOS Validation for all physicians involved in the patient's care for all dates of service in the episode
- Clear and correct dates and signatures. If not, it is recommended to have the document attested or have a signature log for physicians and clinicians.
- If paper charting then ensure all charting be in black ink
- Documentation supports patient's need for skilled services
- Homebound status is identified and comprehensible (as per CMS guidelines)
- All of the eligibility criteria are met for initial and recertification
- For Recertification, certifying physician's statement which must indicate the continuing need for services and estimate how much longer the services will be required
- The referring physician identified the community physician that would be monitoring the patient care
- For Recertification, original F2F encounter documentation is included
- ADR is placed on top of the medical record.

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