Face to Face:
The Biggest Challenge of the 2015 Home Health Certification Requirements

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F2F FINAL RULE 2015 Update

Final Decision: We are finalizing our proposal to eliminate the face-to-face encounter narrative as part of the certification of patient eligibility for the Medicare home health benefit, effective for episodes beginning on or after January 1, 2015. The certifying physician will still be required to certify that a face-to-face patient encounter, which is related to the primary reason the patient requires home health services, occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care and was performed by a physician or allowed non-physician practitioner as defined in §424.22(a)(1)(v)(A), and to document the date of the encounter as part of the certification of eligibility.
For instances where the physician is ordering skilled nursing visits for management and evaluation of the patient's care plan, the physician will still be required to include a brief narrative that describes the clinical justification of this need as part of the certification/recertification of eligibility as outlined in §424.22(a)(1)(i) and §424.22(b)(2).

In determining whether the patient is or was eligible to receive services under the Medicare home health benefit at the start of care, we will require documentation in the certifying physician's medical records and/or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) to be used as the basis for certification of home health eligibility. We will require the documentation to be provided upon request to the home health agency, review entities, and/or CMS. Criteria for patient eligibility are described at §424.22(a)(1) and §424.22(b).

HHAs should obtain as much documentation from the certifying physician’s medical records and/or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) as they deem necessary to assure themselves that the Medicare home health patient eligibility criteria have been met and must be able to provide it to CMS and its review entities upon request. 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.

Therefore, in order to determine when documentation of a patient’s face-to-face encounter is required under sections 1814(a)(2)(C) and 1835 (a)(2)(A) of the Act, we proposed to clarify that the face-to-face encounter requirement is applicable for certifications (not recertifications), rather than initial episodes. A certification (versus recertification) is considered to be any time that a new SOC OASIS is completed to initiate care.
Certification Requirements: Who Can Perform a Face-to-Face Encounter
According to 42 CFR 424.22(a)(1)(v)(A), the face-to-face encounter can be performed by:

- The certifying physician;
- The physician who cared for the patient in an acute or post-acute care facility (from which the patient was directly admitted to home health);
- A nurse practitioner or a clinical nurse specialist who is working in collaboration with the certifying physician or the acute/post-acute care physician; or
- A certified nurse midwife or physician assistant under the supervision of the certifying physician or the acute/post-acute care physician.

According to 42 CFR 424.22(d)(2), the face-to-face encounter cannot be performed by any physician or allowed NPP (listed above) who has a financial relationship with the HHA.

Certification Requirements: Supporting Documentation

Documentation in the certifying physician’s medical records and/or the acute/post-acute care facility’s medical records (if the patient was directly admitted to home health) shall be used as the basis for certification of home health eligibility. 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.

According to the regulations at 42 CFR 424.22(c), Certifying physicians and acute/post-acute care facilities must provide, upon request, the medical record documentation that supports the certification of patient eligibility for the Medicare home health benefit to the home health agency, review entities, and/or CMS. Certifying physicians who show patterns of non-compliance with this requirement, including those physicians whose records are inadequate or incomplete for this purpose, may be subject to increased reviews, such as provider-specific probe reviews.
Information from the HHA, such as the patient’s comprehensive assessment, 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 must be corroborated by other medical record entries and align with the time period in which services were rendered.

The certifying physician must review and sign off on anything incorporated into the patient's medical record that is used to support the certification of patient eligibility (that is, agree with the material by signing and dating the entry).

The certifying physician’s and/or the acute/post-acute care facility’s medical record 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; and

Homebound status.

The certifying physician’s and/or the acute/post-acute care facility’s medical record for the patient must contain the actual clinical note for the face-to-face encounter visit that demonstrates that the encounter:

1. Occurred within the required timeframe;
2. Was related to the primary reason the patient requires home health services; and
3. Was performed by an allowed provider type.

This information can be found most often in, but is not limited to, clinical and progress notes and discharge summaries.

Please review the following examples included at the end of this article:

Discharge Summary;
Progress Note;
Progress Note and Problem List; or
Discharge Summary and Comprehensive Assessment.
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Make sure that you are clear...... IF the agency supplements the visit note or discharge summary with additional information from the comprehensive assessment to support homebound status and the need for skilled services, this must be sent to the physician to sign and date, making it a part of the medical record of the patient.

Lastly, please understand that the home health agency MUST obtain the visit note and/or discharge summary and this document MUST contain the first three criteria: 1) a visit date that falls in the required timeframe for the F2F; 2) the reason for the visit is related to the primary reason for homecare; and 3) the visit was performed by an allowed provider type.

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**2015 FINAL HH Regulation**

**Question:** What happens if the face-to-face encounter is completed during the 90-day period prior to the start of care (SOC) and then the patient’s condition changes?

- **Answer:** In situations when a physician 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 start of care (SOC), the certifying physician or an allowed non-physician practitioner (NPP) must see the patient again within 30 days after admission. Specifically, if a patient saw the certifying physician or NPP within the 90 days prior to SOC, 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.
In the Calendar Year (CY) 2012 Home Health (HH) Prospective Payment System (PPS) proposed rule published on July 12, 2011, CMS proposed their intent to provide clarification to the Benefit Policy Manual language regarding the definition of "confined to the home". In the CY 2012 HH PPS final rule published on November 4, 2011 (FR 76 68599-68600), CMS finalized that proposal. In order to clarify the definition, CMS is amending its policy manual as follows:

### Homebound Definition

For purposes of the statute, an individual shall be considered “confined to the home” (homebound) if the following two criteria are met:

**Criteria-One:**
The patient must either:
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. If the patient meets one of the Criteria-One conditions, then the patient must ALSO meet two additional requirements defined in Criteria-Two below.

**Criteria-Two:**
There must exist a normal inability to leave home;
AND
Leaving home must require a considerable and taxing effort.
Example 3 - Part 1 of 2

Progress Notes:
Patient: Bright, John
DOB: 12/13/1965
Address: 22 Maple Lane, Townwood, MD 21241

Subjective:
Preceding list:

Objective:

Plan:

Follow Up:

Example 3 - Part 2 of 2

Problem List:

*Note: The problem list is provided for illustrative purposes only and is not intended to represent actual patient information.

*The problem list may be updated or deleted as necessary.

*An entry here indicates that the patient is being monitored for potential complications.

*Please refer to the problem list for all relevant information.

*Note: The problem list is provided for illustrative purposes only and is not intended to represent actual patient information.

*The problem list may be updated or deleted as necessary.

*An entry here indicates that the patient is being monitored for potential complications.

*Please refer to the problem list for all relevant information.
### Example 4 – Part 1 of 2

**AAA HOSPITAL DISCHARGE SUMMARY**

**Department of Surgery**

#### Discharge Details

- **Date of Discharge**: 3/1/2015
- **Discharge Diagnosis**: Left lower extremity
- **Discharge Summary**: Left lower extremity

#### Medical History

- **History of Present Illness**: 75 y/o male who presents with left lower extremity discomfort for 4 weeks. Has been treated by his primary care physician for the past three months with no improvement. On examination, there is tenderness to palpation and swelling of the left lower extremity. No discharge is noted as the leg has been treated for the past three months. No discharge is noted as the leg has been treated for the past three months.

#### Current Medications

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
- **Discharge Instructions**: Continue current medications. Discharge criteria include:
  - No evidence of infection or cellulitis
  - Methicillin-resistant Staphylococcus aureus (MRSA) screening negative

**Signature:**

Signed: ___________ Date: 3/1/2015

Electronically signed by: ___________ Date: 3/1/2015

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### Example 4 – Part 2 of 2

**General Home Health Agency**

**Discharge from Comprehensive Assessment (DCA-A)**

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>John Smith</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPI Reference Number</td>
<td>01234567</td>
</tr>
</tbody>
</table>

**ASA Status**: Continued

**Discharge Criteria**: Continue current medications. Discharge criteria include:

- No evidence of infection or cellulitis
- Methicillin-resistant Staphylococcus aureus (MRSA) screening negative

**Signature:**

Signed: ___________ Date: 3/1/2015

Electronically signed by: ___________ Date: 3/1/2015

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**Notes:**
- **Discharge Instructions**: Continue current medications. Discharge criteria include:
  - No evidence of infection or cellulitis
  - Methicillin-resistant Staphylococcus aureus (MRSA) screening negative

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1. Know upon referral that you will be able to obtain the Face to Face
2. Request Physician Office Visit Note or Discharge Summary with signed referral order
3. Develop narratives based on the Comprehensive Assessment of the Patient to support:
   a) Why the patient needs home health
   b) Why the patient meets homebound status criteria
4. Send Narratives to physician for signature
5. Must be returned signed and dated prior to billing the final claim for the episode

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Questions

Faculty Contact Info

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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.

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.

Transcribed by: A.M 02/17/2014
Electronically signed by: John A. Doe, M.D. 02/17/2014 17:52
Progress Notes

Patient: Smith, Jane
DOB: 04/13/1941
Address: 1714 Main Street, Plano TX 15432

Subjective:
CC:
1. Wound on left heel.

HPI:
Pt is here for evaluation of wound on left heel. Patient reports her daughter noticed the wound on patient’s heel when she was washing her feet. Patient states she has difficulty with reaching her feet and her daughter will sometimes clean them for her. She reports she uses a shoe horn to put on her shoes.

ROS:

General:
No weight change, no fever, no weakness, no fatigue.

Cardiology:
No chest pain, no palpitations, no dizziness, no shortness of breath.

Skin:
Wound on left lower heel, no pain.

Medical History: HTN, hyperlipidemia, hypothyroidism, DJD.

Medications: zolpidem 10 mg tablet 1 tab once a day (at bedtime), Diovan HCl 12.5 mg-320 mg tablet 1 tab once a day, Lipitor 10 mg tablet 1 tab once a day.

Allergies: NKDA

Objective:

Vitals: Temp 96.8, BP 156/86, HR 81, RR 19, Wt 225, Ht 5’4”

Examination: General appearance pleasant. HEENT normal. Heart rate regular rate and rhythm, lungs clear, BS present, pulses 2+ bilaterally radial and pedal. Diminished pinprick sensation on bilateral lower extremities from toes to knees. Left heel wound measures 3 cm by 2 cm and 0.4 cm deep. Wound bed is red, without slough. Minimal amount of yellow drainage noted on removed bandage.

Assessment:
1. Open wound left heel

Plan:
1. **OPEN WOUND** Begin hydrocolloid with silver dressing changes. Minimal weight bear on left leg with a surgical boot on left foot. Begin home health for wound care, family teaching on wound care, and patient education on signs and symptoms of infection. The patient is now homebound due to minimal weight bearing on left foot and restrictions on walking to promote wound healing, she is currently using a wheelchair. Short-term nursing is needed for wound care, monitor for signs of infection, and education on wound care for family to perform dressing changes.

Follow Up: Return office visit in 2 weeks

Provider: John Doe, M.D.
Patient: Smith, Jane  DOB: 04/13/1941  Date: 05/03/2013

Electronically signed by John Doe, M.D. on 05/03/2013 at 10:15 AM

Sign off status: Completed

Meets the requirements for documenting:
(1) the need for skilled services; (2) why 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.
Progress Notes
Patient: Rogers, Buck
DOB: 08/13/1925
Address: 234 Happy Lane, Teamwork, MD 12345

Provider: Jane Doe, M.D.
Date: 09/01/2014
Allowed provider type

Subjective:
CC:
Weakness

HPI:
Pt was hospitalized 2 weeks ago for pneumonia. He was treated with IV antibiotics for 5 days and discharged on oral antibiotics for 10 days. His caregiver is present with him for the visit. The patient reports that his appetite has been decreased since the hospitalization and he has noticed increasing weakness and difficulty walking. The patient has lost 2 lbs. since his last visit. He has stayed in bed for most of the time since his hospitalization. He used a wheelchair to move from the front of the office building to the exam room. The patient has not needed a wheel chair previously. The patient denies any fever, chills, cough, rhinorrhea, sore throat, ear pain, difficulty drinking liquids, nausea, vomiting or diarrhea.

ROS:
General:
2 lb weight change, positive for weakness, positive for fatigue.
Pulmonary: As per the HPI
Cardiology:
No chest pain, no palpitations, no dizziness, no shortness of breath.

Medical History: HTN; hyperlipidemia; Diabetes Mellitus

Medications: ASA 325 mg once a day, Diovan HCl 12.5 mg-320 mg tablet 1 tab once a day, Lipitor 10 mg tablet 1 tab once a day. Metformin 1000 mg once a day.

Allergies: NKDA

Objective:
Vitals: Temp 98.6, BP 120/80, HR 71, RR 12, Wt 200, Ht 5’9” pulse ox 99% on room air
Examination: The patient is awake and alert and in no acute distress. He is in a wheelchair. HEENT: Pupils do not react to light. Heart rate regular rate and rhythm, lungs clear, BS present, Extremities: pulses 2+ bilaterally radial and pedal. Diminished pinprick sensation on bilateral lower extremities from toes to knees ; Muscle Strength 3/5 in all 4 extremities(normal 5/5). The patient’s get up and go test was 35 seconds(normal <10

Assessment:
1. Muscle Weakness secondary to deconditioning due to pneumonia

Plan:
1. Prior to the patient’s hospitalization for pneumonia, the patient could ambulate in his residence with assistance and was able to rise from a chair without difficulty. The patient requires a home health PT program for gait training and increasing muscle strength to restore the patient’s ability to walk in his residence.

Follow Up: Return office visit in 6 weeks.

Provider: Jane Doe, M.D.
Electronically signed by Jane Doe, M.D. on 09/02/2014 at 10:15 AM
Sign off status: Completed

Meets the requirements for documenting: (1) the need for skilled services; and (2) that the encounter was related to the primary reason the patient requires home health services.

Please see problem list (Part 2 of 2) for homebound status.
Problem List*

Patient: Rogers, Buck
DOB: 08/13/1925
Address: 234 Happy Lane, Teamwork, MD 12345

401.1  HTN - 1999
272.2  Hyperlipidemia -1999
250.5  Diabetes Mellitus  with ophthalmic manifestations -2000
369.22 Blindness - 2002 (requires caregiver assistance in order to leave the home)
482.31  Pneumonia- Streptococcus- 2014

In conjunction with the progress note, this meets the requirements for documenting why the patient was/is confined to the home (homebound).

*A problem list would not be acceptable by itself to demonstrate skilled need and/or homebound status.
Smith, John 00000124 04-14-2014
Patient Name Med Rec No. Admit Date
Physician: Sam Bone, M.D.
Dictated By: Sam Bone, M.D.

ADMISSION DIAGNOSIS:
Left knee osteoarthritis.

DISCHARGE DIAGNOSIS:
Left knee osteoarthritis.

CONSULTATIONS:
1. Physical Therapy
2. Occupational Therapy

PROCEDURES:
04/14/2014: Left knee arthroplasty.

HISTORY OF PRESENT ILLNESS:
Mr. Smith is 70 y.o. male who presents with left knee osteoarthritis for 10 years. Over the past three years the pain has steadily increased. It was initially controlled by ibuprofen and steroid injections. In the last year he has required ibuprofen and Percocet to ambulate and this treatment has been unsuccessful in relieving pain for the last 6 months. His ambulation has been limited by pain and he has pain at night that interrupts sleep. Workup did show reduction in the left knee joint space. He has failed conservative treatment and has elected to proceed with surgical treatment.

PAST MEDICAL HISTORY:
Hypertension

PAST SURGICAL HISTORY:
Inguinal hernia repair

DISCHARGE MEDICATIONS:
Colace 100 mg daily, Percocet 5/325 every 4 hours as needed for pain, Lisinopril 10 mg daily, Lovenox 30mg sq every 12hours for 6 more days.

DISCHARGE CONDITION:
Upon discharge Mr. Smith is stable status post left total knee replacement and has made good progress with his therapies and rehabilitation. Mr. Smith is to be discharged to home with home health services, physical therapy and nursing visits, ordered. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decompensation and teaching of Lovenox injections.

PATIENT INSTRUCTION:
The patient is discharged to home in the care of his wife. Diet is regular. Activity, weight bear as tolerated left lower extremity. 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. Bone in two weeks.

Transcribed by: A.M 04/18/2014
Electronically signed by: Sam Bone, M.D. 04/18/2014 18:31

Meets the requirements for documenting: (1) the need for skilled services; and (2) that the encounter was related to the primary reason the patient requires home health services.

Please see OASIS (Part 2 of 2) for homebound status.
Patient Name: John Smith  
HH Record Number: 4433225

**ADL/IADLs continued**

**(M1845) Toileting Hygiene:** Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.

- **0** - Able to manage toileting hygiene and clothing management without assistance.
- **X** 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.
- **☐** 2 - Someone must help the patient to maintain toileting hygiene and/or adjust clothing.
- **☐** 3 - Patient depends entirely upon another person to maintain toileting hygiene.

**Comments:** Patient requires clothes to be laid out on bed. He is able to dress himself from a seated position at foot of bed.

**(M1850) Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

- **☐** 0 - Able to independently transfer.
- **X** 1 - Able to transfer with minimal human assistance or with use of an assistive device.
- **☐** 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.
- **☐** 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
- **☐** 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
- **☐** 5 - Bedfast, unable to transfer and is unable to turn and position self.

**Comments:** Patient requires one-arm assistance to transfer from bed to chair.

**(M1860) Ambulation/Locomotion:** Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- **☐** 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
- **☐** 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- **X** 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- **☐** 3 - Able to walk only with the supervision or assistance of another person at all times.
- **☐** 4 - Chairfast, unable to ambulate but is able to wheel self independently.
5 - Chairfast, unable to ambulate and is unable to wheel self.

6 - Bedfast, unable to ambulate or be up in a chair.

Comments: Pt. with a shuffling gait and frequently trips while ambulating. Pt. requires a wheeled walker and requires frequent cueing to remind him to not shuffle when he walks and to look up to avoid environmental hazards. Unable to go up and down stairs without his daughter assisting him. Daughter states that patient needs 24/7 supervision and is only able to leave his home for doctor appointments and only when she and her husband assist him. Patient is an increased fall risk because of inability to safely navigate stairs, uneven sidewalks and curbs.

In conjunction with the discharge summary, this meets the requirements for documenting why the patient was/is confined to the home (homebound).

Signed and dated by certifying physician indicating review and incorporation into the patient’s medical record.