

Home Health Face-to-Face Encounter Question & Answers

Question 1: Will requirements be met if a community physician certifies a patient and completes a plan of care when a face-to-face encounter was conducted and documented appropriately on a discharge summary or referral that is conducted by a resident who is not enrolled in Medicare?

Answer 1: Yes, a resident who is not Medicare-enrolled can perform the face-to-face encounter, but only under the supervision of a teaching physician who has privileges at the acute or post-acute facility. Because the physician performing the face-to-face encounter in an acute or post-acute facility must have admitting privileges, it is only acceptable for a resident to perform the face-to-face encounter in an acute or post-acute facility and inform the certifying physician through their supervising teaching physician who has such privileges. However, it is the certifying physician who must document the face-to-face encounter. The certifying physician has the discretion of whether or not to sign that discharge summary or communication documentation, indicating that it is to serve as the certifying physician's face-to-face documentation. It is allowable for the certifying physician to use the discharge summary or referral as documentation of the face-to-face encounter if:

- The discharge summary or referral meets all the documentation requirements for face-to-face documentation; and
- The discharge summary or referral, which is serving as the face-to-face documentation, is clearly titled and dated as such; and
- The certifying physician signs and dates the discharge summary or referral, demonstrating that the certifying physician received that information from the teaching physician supervising the resident who performed the face-to-face encounter, and that the certifying physician is using that discharge summary or referral as his or her documentation of the face-to-face encounter.

Question 2: Is care provided in an emergency room considered to be acute facility care for purposes of face-to-face encounters (i.e. can a certifying physician use an ER physician's documentation to meet the certification and plan of care requirements)?

Answer 2: Yes, assuming it meets the face-to-face requirements described in our regulations, and that it is the certifying physician who ultimately documents the face-to-face encounter and signs the documentation. The certifying physician has the discretion of whether or not to sign that discharge summary or communication documentation, indicating that it is to serve as the certifying physician's face-to-face documentation. It is allowable for the certifying physician to use the ER physician's documentation as documentation of the face-to-face encounter:

- If that ER physician's documentation meets all the documentation requirements for face-to-face documentation; and
- The ER physician's documentation, which is serving as the face-to-face documentation, is clearly titled and dated as such; and

- The certifying physician signs and dates the ER physician’s documentation, demonstrating that the certifying physician received that information from the physician who performed the face-to-face encounter, and that the certifying physician is using that ER physician’s documentation as his or her documentation of the face-to-face encounter.

Question 3: Is care provided while a patient is being held for observation for several days considered to be acute facility care for purposes of face-to-face encounters (i.e. may the certifying physician use the observation physician’s documentation to meet the certification and plan of care requirements)?

Answer 3: Yes, assuming it meets the face-to-face requirements described in our regulations, and that it is the certifying physician who ultimately documents the face-to-face encounter and signs the documentation. The physician who performs the face-to-face encounter must have privileges at the acute or post-acute facility. The certifying physician has the discretion of whether or not to sign that discharge summary or communication documentation, indicating that it is to serve as the certifying physician’s face-to-face documentation. It is allowable for the certifying physician to use the observation physician’s documentation as documentation of the face-to-face encounter:

- If that observation physician’s documentation meets all the documentation requirements for face-to-face documentation; and
- The observation physician’s documentation, which is serving as the face-to-face documentation, is clearly titled and dated as such; and
- The certifying physician signs and dates the observation physician’s documentation, demonstrating that the certifying physician received that information from the physician who performed the face-to-face encounter, and that the certifying physician is using that observation physician’s documentation as his or her documentation of the face-to-face encounter.

Question 4: What do the regulatory words “separate and distinct” mean in practical application?

Answer 4: In practical application, “separate and distinct” addresses the need for the face-to-face documentation, whether it is included on the certification itself or if it exists as a separate addendum to the certification, to be clearly titled and as such be easily recognizable as documentation of the face-to-face encounter.

Question 5: If an agency accepts face-to-face encounter documentation in the form of a discharge summary or referral that includes all of the required elements, would that meet the separate and distinct criteria?

Answer 5: The regulatory language reads that “the documentation of the face-to-face encounter must be a separate and distinct section of, or an addendum to, the certification, and must be clearly titled, dated and signed by the certifying physician.” The discharge summary or referral must be that of the NPP working in collaboration with the certifying physician or the physician

who cared for the patient in the acute or post-acute facility and has privileges at that facility. The certifying physician has the discretion of whether or not to sign that discharge summary or communication documentation, indicating that it is to serve as the certifying physician's face-to-face documentation. By using the discharge summary (which is not on the certification itself), the certifying physician would title, sign, and date the discharge summary and include the documentation as an addendum to the certification. It is allowable for the certifying physician to use the discharge summary as documentation of the face-to-face encounter if:

- The discharge summary meets all the documentation requirements for face-to-face documentation; and
- The discharge summary, which is serving as the face-to-face documentation, is clearly titled and dated as such; and
- The certifying physician signs and dates the discharge summary, demonstrating that the certifying physician received that information from the allowed NPP or physician who performed the face-to-face encounter, and that the certifying physician is using that discharge summary as his or her documentation of the face-to-face encounter.

Question 6: May the physician who conducts the face-to-face encounter provide documentation of the required elements on a variety of records (e.g. some elements on the discharge summary, other elements on the clinical visit note)? If yes, what are the signature requirements?

In other words: May the communication from the physician who cared for the patient in an acute or post-acute facility who has privileges or the allowed NPP upon which the community physician bases the face-to-face encounter documentation and certification include notes from multiple encounters that took place during the acute stay, or must the communication be from a single encounter that occurred during the stay?

Answer 6: CMS does not require a specific form, or format for the communication or documentation of the face-to-face encounter from the non-physician practitioner (NPP) collaborating with the certifying physician, or the physician who cared for the patient in the acute or post-acute setting. The Affordable Care Act and our HH PPS rulemaking (specifically our CFR language) speak to an encounter and the clinical findings of that encounter. The clinical findings that support the eligibility of the patient for home health must be reflective of the patient's condition upon discharge. If the physician who cared for the patient in the acute or post-acute facility chooses to use documentation that is compiled from the patient's medical record (e.g. a discharge summary) to inform the certifying physician of how the clinical findings of the face-to-face encounter support Medicare home health eligibility for that patient, the compiled documentation must be reflective of the clinical findings of that face-to-face encounter as observed by that physician caring for the patient in the acute or post-acute facility, thus serving as that physician's communication to the certifying physician. Further, if the certifying physician chooses to use the encounter documentation from the informing physician or NPP as his or her documentation of the face-to-face encounter, the certifying physician must sign and date the documentation, demonstrating that the certifying physician received that information from the physician who performed the face-to-face encounter, and that the certifying physician is using that discharge summary or documentation as his or her documentation of the face-to-face encounter.

Question 7: If the communication from the allowed NPP or physician who cared for the patient in an acute or post-acute facility who has privileges is in the form of a discharge summary or referral, must that physician or NPP that conducted the encounter create and sign the communication document?

Answer 7: CMS does not require that the communication from the NPP who is collaborating with the certifying physician, or the physician who attended to the patient in an acute or post-acute facility, be signed. The certifying physician has the discretion of whether or not to sign that discharge summary or communication documentation, indicating that it is to serve as the certifying physician's face-to-face documentation. As such, it is allowable for the certifying physician to use the discharge summary as documentation of the face-to-face encounter:

- If that discharge summary or communication documentation meets all the documentation requirements for face-to-face documentation; and
- The discharge summary or communication documentation, which is serving as the face-to-face documentation, is clearly titled and dated as such; and
- The certifying physician signs and dates the discharge summary or communication documentation, demonstrating that the certifying physician received that information from the allowed NPP or physician who performed the face-to-face encounter, and that the certifying physician is using that discharge summary or communication documentation as his or her documentation of the face-to-face encounter.

Question 8: If it is permissible for a person other than the physician/NPP in the acute or post-acute facility, such as a discharge planner, to create the communications (e.g. referral/discharge summary), must the allowed NPP or acute physician performing the encounter sign it?

Answer 8: The certifying physician's support staff may assist the certifying physician in obtaining documentation information from the allowed NPP or physician who cared for the patient in an acute or post-acute facility who performed the encounter, or that NPP/physician's support staff (including discharge planners). Physician support staff is staff who works with or for the physician on a regular basis, and, as part of their job duties regularly perform documentation, take dictation from the physician, and/or extract from the physician's medical records to support the physician in a variety of ways. Hospital discharge planners may also assist the informing acute or post-acute physician who performed the face-to-face by compiling the discharge summary, which may be used as documentation by the certifying physician. The communication of the face-to-face encounter must be from the physician who cared for the patient in the acute or post-acute facility and has privileges at the acute or post acute facility, or the NPP who is collaborating with the certifying physician. Again, CMS does not require that the communication from the NPP who is collaborating with the certifying physician or the physician who attended to the patient in an acute or post-acute facility, be signed.

Question 9: May an NPP who works under the direction of the acute or post-acute care facility physician conduct a face-to-face encounter or must NPPs work for the community physician who does the certification?

Answer 9: An NPP who works under the direction of the acute physician may conduct the face-to-face encounter and inform the certifying physician. CMS only requires that NPPs performing the face-to-face encounter work in collaboration with the certifying physician to inform the certifying physician of the NPP's findings from the encounter.

Question 10: Must home health agencies secure new face-to-face encounters/documentation for billing starts of care which are required when current patients that were transferred to the hospital remain in the hospital over day 60/61?

Answer 10: Assuming there is not a 60-day gap between episodes, this would not be considered an initial episode, and thus, would not require a face-to-face encounter and documentation.

Question 11: Must certification statements include all of the text as appeared on the 485? If not, what content is required?

Answer 11: To clarify, CMS does not require a form for face-to-face documentation. CMS does not require that the certification, which includes the face-to-face documentation, be in a specific format or on a specific form. A physician who is enrolled as a Medicare provider must certify the patient's eligibility for the benefit. The physician must certify that:

1. The home health services are or were needed because the patient is or was confined to the home as defined earlier in this article.
2. The patient needs or needed skilled services on an intermittent basis.
3. A plan of care has been established and is periodically reviewed by a physician.
4. The services are or were furnished while the patient is or was under the care of a physician.

Prior to initially certifying the home health patient's eligibility, the Affordable Care Act of 2010 requires that the certifying physician must document the face-to-face encounter. The face-to-face documentation must reflect the experience of the certifying physician, allowed NPP, or for patients admitted to home health immediately after an acute or post-acute stay, the physician who cared for the patient in that acute or post-acute facility and who has privileges at the facility, with the patient.

In the case of patients admitted to home health following an acute or post-acute stay, a CMS-485 form signed by the community physician who assumes oversight of the patient's home health care with an addendum containing the face-to-face encounter documentation requirements signed by a physician who cared for the patient in an acute or post-acute setting satisfies the documentation requirements is allowable (assuming all content requirements of the certification and face-to-face documentation are otherwise met).

Question 12: What action must agencies take to address realignment of the 13th and 19th therapy visits when patients have late (beyond day 30) face-to-face encounters, resulting in retroactive changes to start of care dates?

Answer 12: Because the therapy visits provided before the new start of care date (post-face-to-face completion) are not covered by Medicare, those visits do not count towards the Medicare-covered visit count for assessment timing. As was discussed in the CY 2012 final rule, only Medicare-covered visits are to be considered and counted. HHAs should track both Medicare-covered and non-covered therapy visits to keep count of the appropriate number of Medicare-covered therapy visits in these situations.

Question 13: Please define the “physician support staff” who can assist the physician in drafting the narrative.

Answer 13: Physician support staff are those staff who work with or for the physician on a regular basis, and, as part of their job duties regularly perform documentation, take dictation from the physician, and/or extract from the physician's medical records to support the physician in a variety of ways. Hospital discharge planners may also assist the informing acute or post-acute physician who performed the face-to-face by compiling the discharge summary, which may be used as documentation by the certifying physician.

Question 14: Can an NPP’s encounters with a patient while the patient was in hospital satisfy the encounter?

Answer 14: Yes. Certain NPPs in the acute care setting may collaborate with the certifying physician. Qualified NPPs include a Nurse Practitioner or Clinical Nurse Specialist (as those terms are defined in §1861(aa)(5) of the Social Security Act), who is working in collaboration with the physician in accordance with State law, a certified nurse-midwife (as defined in §1861(gg) of the Social Security Act, as authorized by State law), or a Physician Assistant (as defined in §1861(aa)(5) of the Social Security Act), under the supervision of the physician. In such cases, an NPP’s encounter with the patient during an acute or post-acute stay may satisfy the requirement.

Question 15: If an HHA were to receive a complete certification for home health services and the face-to-face documentation, whether part of the certification form or as an addendum, was not clearly titled, would it be allowable for the HHA to add a title to such documentation so that it would then be clearly titled?

Answer 15: The face-to-face documentation must be that of the certifying physician, must be clearly titled and dated, and signed by the certifying physician, and cannot be altered/changed by the HHA in any way. Prior to billing, a home health agency should ensure that all certifications are complete, to include face-to-face documentation that has been clearly titled and dated, and signed by the certifying physician.

Question 16: Is it allowable for a home health agency to provide a certifying physician and his or her office support staff, a completed “sample” face-to-face encounter documentation to use as a guide for how to complete actual face-to-face documentation?

Answer 16: To clarify, CMS does not require a form for face-to-face documentation. CMS does not require that the certification, which includes the face-to-face documentation, be in a specific format or on a specific form. Rather, CMS requires that the content requirements of the face-to-face documentation are met. The face-to-face documentation must reflect the certifying physician’s, allowed non-physician practitioner’s, or for patients admitted to home health immediately after an acute or post-acute stay the physician who cared for the patient in that acute or post-acute facility and who has privileges at the facility, experience with the patient. A home health agency providing physicians with sample face-to-face documentation as a guide to what would be considered acceptable face-to-face documentation to assist them in preparing their particular face-to-face documentation for a patient, would be allowable. The home health agency cannot provide the specifics of a certain patient’s face-to-face encounter in a document, call it a “sample”, with the expectation, possibility, or probability that the physician would have all the information he or she would need to document the face-to-face for that particular individual and thus simply sign it as the official face-to-face documentation.

Question 17: Can any physician inform the certifying physician regarding his or her experiences with the patient as the face-to-face encounter?

Answer 17: No. Only an allowed NPP, the certifying physician or a physician who cared for the patient in an acute or post-acute facility may inform the certifying physician regarding his or her face-to-face encounter with the patient.

Question 18: Where HHAs use the 485 form to meet both the certification and plan of care requirements, can one physician sign the 485 and another physician sign the face-to-face documentation?

Answer 18: In the case of patients admitted to home health following an acute or post-acute stay, a CMS-485 form signed by the community physician who assumes oversight of the patient’s home health care with an addendum containing the face-to-face encounter documentation requirements signed by a physician who cared for the patient in an acute or post-acute setting satisfies the documentation requirements is allowable (assuming all content requirements of the certification and face-to-face documentation are otherwise met).

Question 19: How would the NPP or the physician who cared for the patient in an acute or post-acute setting inform the certifying physician regarding their encounters with the patient?

Answer 19: In the case of a patient admitted to home health after an acute stay, CMS expects that in most cases, a patient’s hospital discharge summary would contain the information needed to satisfy the documentation requirement. If so, the discharge summary can be signed by the certifying physician and attached to the certification as an addendum. The certifying physician’s support staff may assist the certifying physician in obtaining documentation information from the practitioner who performed the encounter, or the practitioner’s support staff (including discharge

planners). Emails, phone calls and other information exchanges are acceptable. For example, in cases where the patient's hospital discharge summary is lacking enough clinical detail for the certifying physician to complete the documentation, a phone call or email exchange between the certifying physician or his or her support staff and the hospital physician or his or her support staff could resolve the information gaps.

Question 20: Does the certifying physician need to also sign the documentation completed by the hospital physician who cared for the patient?

Answer 20: Yes. The certifying physician must document that the face-to-face encounter took place and therefore must sign and date the encounter documentation from the hospital physician who cared for the patient, if he/she chooses to utilize it as the encounter documentation.

Question 21: If the hospital discharge summary contains all of the needed content, can the certifying physician just attach it to the certification and have it serve as the face-to-face documentation?

Answer 21: It is allowable for the certifying physician to use the discharge summary, compiled from the allowed acute or post-acute practitioner's medical record, as documentation of the face-to-face encounter:

- If that discharge summary meets all the documentation requirements for face-to-face documentation; and
- The discharge summary, which is serving as the face-to-face documentation, is clearly titled and dated as such; and
- The certifying physician signs and dates the discharge summary, demonstrating that the certifying physician received that information from the practitioner who performed the face-to-face encounter, and that the certifying physician is using that discharge summary as his or her documentation of the face-to-face encounter.

Question 22: Can the hospital, post-acute facility or certifying physician develop forms for the face-to-face encounter that utilize checkboxes?

Answer 22: It depends. We would not allow a form created by the HHA, which contained only checkboxes for the certifying physician to check off, to satisfy the requirement. The documentation must include the physician's assessment as to how the clinical condition of the patient, as seen during the encounter, supports homebound status and need for skilled services. We have provided physicians the flexibility to generate the documentation from their electronic medical record entries concerning the patient. The physician's own medical record entries would contain the physician's assessment of the patient's condition as seen during the encounter. We also allow the physician's support staff to extract documentation from the physician's medical records entries for the physician's signature. We accept documentation which was generated and/or extracted from a physician's medical record by the physician's support staff, assuming it contains all the required content, regardless of what format it is in. As long as it comes from the certifying physician, checkboxes either generated from a physician's electronic health records, or more simply created and used by a physician for documentation purposes, are allowable.

Question 23: Can you please clarify the hospitalist's role?

Answer 23: The statute requires that the certifying physician must document that the face-to-face encounter occurred with himself or herself, certain non-physician practitioners (NPPs), or the physician who cared for the patient in an acute or post-acute facility who informs the certifying physician. Where the patient is admitted to home health from acute or post-acute care, the acute or post-acute physician may refer the patient to home health, order the home health services, certify the beneficiary's eligibility to receive Medicare home health services, and sign the plan of care. This physician would be responsible for documenting on the certification that he or she, or a NPP working in collaboration with the certifying physician, had a face-to-face encounter with the patient. However, we recognize that, in some scenarios, one physician performing all of these functions may not always be feasible. An example of such a scenario would be a patient who is admitted to home health upon hospital discharge. While we would still expect that in most cases, a patient's primary care physician would be the physician who refers and orders home health services, documents the face-to-face encounter, certifies eligibility and signs the plan of care, there are valid circumstances where this is not feasible for the post-acute patient. For example, some post-acute home health patients have no primary care physician. In other cases, the physician who cared for the patient in an acute or post-acute facility and who has privileges at the facility assumes primary responsibility for the patient's care during the acute stay, and may (or may not) follow the patient for a period of time post-acute. In circumstances such as these, it is not uncommon practice for the physician who cared for the patient in an acute or post-acute facility and who has privileges at the facility to refer a patient to home health, initiate orders and a plan of care, and certify the patient's eligibility for home health services. In the patient's hospital discharge summary, we would expect the physician who cared for the patient in an acute or post-acute facility and who has privileges at the facility to identify the community physician who would be assuming primary care responsibility for the patient upon discharge. Another allowable scenario is one in which the physician who cared for the patient in the acute or post-acute facility and who has privileges at the facility performs the face-to-face encounter and informs the certifying physician of the findings of the encounter. We also believe that with growing prevalence of NPPs in the acute and post-acute care settings, NPPs may increasingly collaborate with the community certifying physician regarding the NPP's encounter with the patient in the acute and post-acute settings.

Question 24: Do both the plan of care and the certification have to be signed by the same physician?

Answer 24: Prior to Calendar Year 2011, CMS manual guidance required the same physician to sign the certification and the plan of care. Beginning in Calendar Year 2011, CMS allowed additional flexibility associated with the plan of care when a patient is admitted to home health from an acute or post-acute setting. For such patients, many asked that CMS allow the contact between the physician who attended to the patient during an acute or post-acute stay to satisfy the encounter requirement, even when the physician may not follow the patient in the community. These commenters asked CMS to allow such physicians to inform the community certifying physician as the law allows non-physician practitioners (NPPs) to do. We are limited by the law that requires the certifying physician to document that the encounter occurred with himself or herself, a permitted NPP, or the physician who cared for the patient in an acute or

post-acute facility. To adopt as much flexibility as the law allows, we allow physicians who care for the patient in acute and post-acute facilities to certify the need for home health care based on their face-to-face contact with the patient (which includes documentation of the face-to-face encounter), initiate the orders (plan of care) 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. As we described above we continue to expect that in most cases the same physician will certify, establish and sign the plan of care. But the flexibility exists for home health post-acute patients if needed. In the case of patients admitted to home health following an acute or post-acute stay, a CMS-485 form signed by the community physician who assumes oversight of the patient’s home health care with an addendum containing the face-to-face encounter documentation requirements signed by a physician who cared for the patient in an acute or post-acute setting satisfies the documentation requirements (assuming all content requirements of the certification and face-to-face documentation are otherwise met).

Question 25: Can the physician document the certification when the physician or hospitalist has the patient’s record in front of him?

Answer 25: Yes. As long as the face-to-face encounter occurs in the specified timeframe of 90 days prior to the start of care or 30 days after the start of care and the documentation is completed before billing, this scenario is acceptable.

Question 26: The final rule requires that the certifying physician documents how the clinical findings of the face-to-face encounter support home health eligibility. The rule references homebound status and skilled need. Is the documentation of the clinical findings sufficient?

Answer 26: The documentation must include how the patient’s clinical condition, as seen during the encounter, supports that the patient is homebound and needs skilled services.

Question 27: Can the HHA title a document with a lead-in phrase such as: “I had a face-to-face encounter on _____(date). The clinical findings support home health eligibility because:”

Answer 27: The lead-in phrase is acceptable as long as the physician completes the description of how the clinical findings support homebound status and the need for skilled services, in his or her own words.

Question 28: Is the face-to-face required for patients in Medicare Advantage plans?

Answer 28: No, the face-to-face provision applies only to Medicare fee for service.

Question 29: Is the face-to-face encounter requirement effective only for patients' initial home health certification?

Answer 29: Yes, that is correct. We have interpreted the language in the statute to apply only to certifications and not recertifications.

Question 30: Will documentation of an encounter submitted via an electronic portal and electronic signatures on face-to-face encounter documentation be acceptable?

Answer 30: Yes, that is fine. However, it is important to reiterate that the documentation of the face-to-face patient encounter must be a separate and distinct section of, or an addendum to, the certification, and must be clearly titled, dated and signed by the certifying physician.

Question 31: Can a physician performing the face-to-face encounter bill Medicare for the visit?

Answer 31: We would expect most of the time that the physician visit which satisfies the face-to-face encounter requirement would include medically necessary physician services for which the physician can bill Medicare.

Question 32: Can a hospital physician perform the face-to-face encounter if the hospital owns the HHA to which the patient is referred?

Answer 32: The physician who documents the face-to-face encounter must be the certifying physician. Per section 424.22(d), the certifying physician may not have a financial relationship as defined in 411.351 with the HHA to which he or she is referring patients. Similarly, a physician who cared for the patient in an acute or post-acute facility or a non-physician practitioner (NPP) performing the face-to-face encounter is subject to the same financial restrictions as the certifying physician.

Question 33: If all other eligibility criteria are met, do Medicare regulations allow a home health agency to provide services only to beneficiaries whose face-to-face encounter occurred during the first time frame (within 90 days prior to the start of home health care) and to deny/postpone admission to those patients whose encounter may occur during the second time frame (30 days after the start of care)?

Answer 33: CMS has no regulation that would force an HHA to admit a patient under the above described circumstances, although CMS would expect HHAs NOT to adopt such admission practices. Rather, we would expect the HHA to coordinate with the patient and physician to ensure that a timely encounter occurs. We are not overly concerned that this is an access risk because we believe most patients will have had an encounter within the 90 days prior to start of care for the following reasons:

- Physicians provided CMS with comments that geriatric patients see their physicians at least once every 3 months, typically

- An OIG study in 2001 (before the surge of HH fraud) showed that about 89% of HH patients see their physicians every month
- Half of home health patients are admitted to home health from an acute setting. Our implementation approach allows the acute attending physician's encounter with the patient to satisfy the face-to-face encounter requirement, to the extent allowed in the law.

And, finally, there is an abundance of HHAs. MedPAC reports that 99% of Medicare beneficiaries reside in an area served by at least 2 HHAs.

Question 34: In the event that the encounter does not occur within the 90 prior/30 day subsequent period, can an HHA discharge the individual from care or charge for any services the beneficiary wishes to receive beginning with day 31?

Answer 34: The certification, which now requires documentation of a face-to-face encounter, is a technical requirement for payment. In the case where the face-to-face encounter requirement is not met, an HHA cannot hold a patient financially liable for services provided. Failure to meet a technical condition for payment is not one of the criteria where an HHA can hold a patient financially liable.

Once a patient is admitted, an HHA cannot abruptly discharge a patient unless the patient is properly notified and there is a valid reason for discharge. While there may be scenarios where failure to meet the face-to-face encounter requirement would result in a valid HHA discharge, CMS expects the HHA to facilitate and coordinate efforts of the patient and physician to ensure that the face-to-face encounter occurs timely. It is important to note:

- As a condition to participate in Medicare, the HHA must coordinate all aspects of the HH patient's care needs
- The HHA has always been required to coordinate with the patient's physician to obtain a signed care plan, to update the care plan as needed, and to obtain a completed certification. The face-to-face encounter is an additional certification content requirement, and we expect the HHA to coordinate with the physician and patient to ensure compliance.

Question 35: What effect does the face-to-face requirement have on agency practices for meeting Medicare requirements associated with the plan of care and certification?

Answer 35: It is important to note that the Affordable Care Act did not change the longstanding mandate that a physician must certify a patient's eligibility for the home health benefit. The law has added the encounter and documentation as an additional requirement associated with the certification. Long-standing Medicare regulations have described the distinct content requirements for the plan of care and certification. Many providers have implemented the requirements for the plan of care and certification by using one form which meets all the content requirements of both the plan of care and certification. This approach is perfectly acceptable and it will continue to be acceptable. Several years ago, CMS ceased to require that providers use a specific form for the plan of care and/or certification. Providers have the flexibility to implement the content requirements as best makes sense for them.

Question 36: Can a resident conduct the face-to-face encounter?

Answer 36: The certifying physician, allowed NPPs, or, for patients admitted to home health immediately after an acute or post-acute stay, the physician who cared for the patient in the acute or post-acute facility and who has privileges at the facility, can perform the face-to-face encounter. Because residents do not have privileges, if a resident is not the certifying physician and is performing the face-to-face encounter, the resident must inform the certifying physician of the encounter through the supervising teaching physician who must have such privileges. Only Medicare-enrolled physicians can certify home health eligibility, per the Affordable Care Act.

Question 37: May physicians use their own electronic medical records with drop down menus to select from prepared descriptive language when completing the face-to-face encounter documentation for their patients? Can the narrative be typed?

Answer 37: Yes. The regulation requires that the certifying physician document how the encounter supports the patient's homebound status and need for skilled services. We allow the documentation to be either on the certification or as a signed addendum to it. This allows the sort of flexibility where such documentation could be dictated by the physician to one of his support personnel, or to allow it to be generated by the physician's electronic medical record software. Such is common practice for physicians to document their patient encounters.

Question 38: Can an HHA obtain and record verbal orders regarding the required encounter information, which are then sent to the physician for signature?

Answer 38: No. We believe that a verbal communication by the physician to the HHA regarding the encounter, where the HHA would then document the certification and get the physician to sign it, does not satisfy the statutory mandate that the certifying physician must document the encounter.

Question 39: If a facility physician completes the encounter documentation and the community physician completes the plan of care, which of the two may bill Medicare for physician certification?

Answer 39: The physician who certifies may bill Medicare for physician certification.

Question 40: Will there be an exceptional circumstance whereby an encounter did not occur but the situation was out of the control of the agency (e.g. patient dies, changes physicians, moves, etc.)?

Answer 40: The face-to-face encounter is an additional content requirement associated with the certification. Agencies should deal with the above described situations as they always have when such occur prior to obtaining a completed, signed certification. Refer to Section 10.11, Chapter 7, Pub. 100-02.

Question 41: Since the HHABN Option Box 1 does not apply, do Option Box 2 (discontinue services for agency business reasons) or Option Box 3 (no physician orders) apply?

Answer 41: The HHABN, Form CMS-R-296, has been approved by the Office of Management and Budget (OMB) to provide limitation of liability protections to Original Medicare beneficiaries receiving home health services under section 1862(a)(1)(A) of the Act for care that CMS or its contractors determines is not reasonable and necessary under Medicare; section 1862(a)(9) of the Act, for custodial care; section 1862(g)(1)(A) of the Act, for care when the beneficiary is not homebound; and section 1862(g)(1)(B) of the Act, for care provided to a beneficiary who is not in need of skilled nursing care. The HHABN must not be used to transfer liability to the beneficiary when technical requirements for payment, such as a face-to-face encounter, are not met. The HHABN is not approved for this use. A beneficiary is not financially liable if the certification is incomplete.

Question 42: What happens if the certification isn't documented before a patient is discharged? In other words, should a discharge be "held"?

Answer 42: We are assuming the question relates to short stay patients. The HHA should treat this scenario as they always have when the patient's care plan goals have been met but the certification is not yet complete.

Question 43: Will subsequent episodes be covered if face-to-face requirements are not met timely during the first episode?

Answer 43: The face-to-face encounter requirement is necessary for the initial certification, which is a condition of payment. Without a complete initial certification, there cannot be subsequent episodes.

Question 44: Could you please give an example of the physician's narrative on the face-to-face documentation?

Answer 44: The certifying physician's face-to-face description should be a brief narrative describing the patient's clinical condition and how the patient's condition supports homebound status and the need for skilled services.

For example:

"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 decomposition or adverse events from the new COPD medical regimen."

Question 45: When can the HHABN Option 2 be used if a patient fails to have a face-to-face encounter with the certifying physician?

Answer 45: HHABN Option 2 must be used if an HHA has initiated home health services and chooses to terminate services for administrative reasons such as lack of a face-to-face encounter.

HHABN Option 2 is a change of care notice and has no bearing on financial liability. The HHA is required to provide the specific reason on the HHABN that termination is due to the failure to meet the face-to-face encounter requirements. If possible, the HHA should provide the notice in advance of the termination date so that the beneficiary has an opportunity to work with the HHA and his/her physician in their complying with this requirement. HHAs do not issue the Notice of Medicare Provider Noncoverage (Expedited Determination notice), CMS 10123, before care is terminated under these circumstances. HHAs should recognize that they are responsible for providing information to Medicare beneficiaries prior to the start of care about the extent to which Medicare may pay for services and thereafter prior to a change in payment status under the Patient Bill of Rights set out in 42 CFR 484.10(e).

Question 46: Can the documentation requirements for the home health face-to-face encounter be satisfied in scenarios where the certifying physician's support staff completes the face-to-face documentation as either part of or as an addendum to the certification, based on information from the patient's medical record and the certifying physician reviews and signs? Can existing medical records (such as a discharge summary) be attached to the certification and meet the face-to-face documentation requirements?

Answer 46: The statute requires that the certifying physician document the encounter as part of the certification. A physician's own support staff can help the physician draft the face-to-face encounter documentation narrative in a number of ways which include but are not limited to: the certifying physician can dictate the narrative to the physician's support staff, the support staff can extract the narrative from the physician's own medical record documentation of the encounter, or the support staff can generate the narrative from the physician's electronic medical record software. Such are examples of common practice for physicians to document their patient encounters, and all would meet the statutory requirement that the certifying physician must document the encounter as part of the certification. We would expect that because this same information is often present on the discharge summary and/or physician orders for home health services, the face-to-face encounter documentation narrative may satisfy multiple purposes.

A physician's orders for home health services or an acute or post-acute discharge summary can be used to satisfy the face-to-face documentation narrative, if they reflect the clinical condition of the patient as seen during the encounter, they are compiled from the informing physician's medical record by a discharge planner, the physician or the physician's support personnel, and they meet the requirements listed below.

Whether the face-to-face documentation is on the certification form itself or is an addendum to it, it must be separate and distinct. It must also include the following: 1) the patient's name; 2) date of the encounter; 3) how the patient's clinical condition as seen during the encounter supports homebound status and the need for skilled services; 4) the certifying physician's signature (original signature, a faxed copy, copy of original document with signature or electronic signature - but not stamped signature); and 5) date of the certifying physician's signature.

Question 47: How many signatures are needed for the face-to-face documentation?

Answer 47: One physician signature suffices if the face-to-face encounter documentation is co-located with the physician's certification of eligibility. Otherwise, if the face-to-face documentation is attached as an addendum to the certification (a separate document), the face-to-face documentation and certification each require a signature by the certifying physician. Electronic signatures are acceptable.

Question 48: Can a home health agency Medical Director or physician perform the face-to-face encounter?

Answer 48: The HHA Medical Director or physician must not have a financial relationship with the HHA, as defined in 42 CFR 411.354, unless exceptions to the referral prohibition defined in §1877 of the Social Security Act apply.

Question 49: Can someone separately draft the face-to-face narrative if the certifying physician performs the encounter?

Answer 49: Yes, under certain conditions. We allow certifying physicians the flexibility to generate the face-to-face encounter documentation from their electronic medical record entries regarding the patient and we allow the physician's support staff to extract the documentation from the physician's medical record entries for the physician to sign. In the case of patients admitted to home health from the hospital, hospital discharge planners who have access to the medical record entries of the physician who attended to the patient during the hospital stay may extract the documentation. However, because the ACA provision requires the certifying physician to document the encounter, the law does not allow a home health agency to draft the documentation for the physician to sign.

Question 50: If the face-to-face does not occur within 30 days after the start of care (SOC), but it does occur, for example, on the 35th day, how should OASIS data be collected and submitted?

Answer 50: If the face-to-face encounter does not occur within the 90 days prior to the SOC, or within 30 days after the SOC, then the Medicare home health eligibility criteria have not been met and the episode is not covered or billable as a Medicare home health episode. Assuming all other Medicare eligibility criteria are met, the face-to-face encounter (occurring on day 35 in the given scenario) would represent a pay source change to the Medicare home health benefit. Longstanding guidance in Section 80 of Chapter 10 of the Medicare Claims Processing Manual states that in certain instances, a new start of care OASIS assessment can be generated that reflects a SOC date equal to the start of the beneficiary's change to Medicare FFS. A prior OASIS can be used to generate the new SOC OASIS. The manual allows for this OASIS completion flexibility in targeted situations, to meet both Medicare billing and eligibility rules. A late face-to-face encounter is another of these targeted situations which justifies OASIS

completion flexibility. Specifically, where a face-to-face encounter did not occur within the 90 days prior to the SOC or within 30 days after the SOC, a provider may use an existing OASIS assessment to generate another OASIS with a reported SOC date equal to the first visit date after all Medicare HH eligibility criteria are met. If multiple OASIS assessments exist, the data from the assessment conducted closest to the date of Medicare eligibility should be used. This could be a SOC, ROC, or Follow-up Assessment type. In this scenario, the date when all Medicare eligibility was met would be 30 days prior to the F2F encounter (with the F2F encounter date counted as day 1). The (M0090) Date Assessment Completed should be reported as the actual date the new OASIS assessment is being generated, even if no visit is provided on that date. Timing warnings from the OASIS state system may be generated based on the difference between the SOC date and the date the assessment was completed (> 5 days), but these warnings may be unavoidable in these situations and can be disregarded. Based on the new certification period range, it may be necessary to change the response originally reported for (M0110) Episode Timing, and/or (M2200) Therapy Need, to exclude therapy visits provided before the date of eligibility. Medicare will not pay for services provided before the date on which all Medicare HH eligibility have been met, which in the scenario described would refer to any services provided in the first five days of care. If the original OASIS assessment had already been submitted to the State, it should be deleted, and the newly generated SOC OASIS assessment (with modified M0030/M0090 dates, M0110, M2200, etc.) submitted. All assessments should be maintained in the agency clinical record, with documentation explaining the situation.

Example:

- Agency provides first skilled visit **January 1st**
- Face-to-Face encounter occurs **February 4th** (Day 35)
- Date when all Medicare eligibility was established **January 6th** (30 days prior to the F2F encounter, with F2F encounter date counted as "day 1")
- Non-covered visit period (**January 1st-5th**)
- (M0030) SOC Date on generated OASIS (The date of the first visit on or after **January 6th**)
- (M0090) Date Assessment Completed on generated OASIS (The actual date new assessment is generated – on or after the **February 4th** F2F encounter.)

Question 51: Can you expand on Section 30.1 of the Ch. 7 Home Health Benefit Policy manual which appears to suggest that the face-to-face documentation may be signed by another physician authorized by the attending physician in his/her absence?

Answer 51: Statute requires that the qualifying face-to-face encounter is performed by the certifying physician, one of the allowed non-physician practitioners (NPPs), or the physician who attended to the patient in an acute or post-acute facility. Our regulations at 42 CFR 481.22 say:

§ 424.22 Requirements for home health services. (a) (2) *Timing and signature.* The certification of need for home health services must be obtained at the time the plan of care is established or as soon thereafter as possible and must be signed and dated by the physician who establishes the plan.

As we have stated in Q&A #10296, we will allow physicians who attend to the patient in acute and post-acute settings to certify the need for home health care based on their face-to-face contact with the patient (which includes documentation of the face-to-face encounter), initiate the orders (plan of care) 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. As we described above we continue to expect that in most cases the same physician will certify, establish and sign the plan of care. However, the flexibility exists for home health acute and/or post-acute patients if needed. We believe that some of the confusion exists because some agencies use a single form for the plan of care/certification. We do not dictate what form(s) an agency uses, so long as the statute, our regulations, and the associated requirements are met. Again, qualifying face-to-face encounters must be made by either the certifying physician (physician who signs the certification), one of the allowed NPPs, or the physician who cared for the patient in an acute or post-acute facility. In the area of the manual that you refer to, we are talking about the attending physician who has signed the certification and the plan of care. For the attending physician to be able to sign the certification he/she must have been the physician who documented the face-to-face encounter. It should be noted that in the case of patients admitted to home health following an acute or post-acute stay, a CMS-485 form signed by the community physician who assumes oversight of the patient's home health care with an addendum containing the face-to-face encounter documentation requirements signed by a physician who cared for the patient in an acute or post-acute setting satisfies the documentation requirements (assuming all content requirements of the certification and face-to-face documentation are otherwise met).