

Part B Insider (Multispecialty) Coding Alert

Face-to-face Rule: New CMS Clarification May Help With Your Documentation When Certifying A Patient's Home Health Eligibility

Physician staff can prepare the face-to-face documentation, CMS says in new Q&A.

With the April 1 deadline for the physician face-to-face encounter for home care certification already in the rearview mirror, physicians and home care providers are getting desperate to get into compliance with the burdensome regulation. Now some information has come from CMS that may help physicians with their documentation woes.

Background: Under the new FFE requirement finalized in the 2011 PPS final rule published in the Nov. 17 Federal Register, certifying physicians must see the home care patient 90 days prior to start of care or 30 days after care begins for the reason the patient is requiring home care. And the certifying physician must document the encounter as part of the certification itself or as a signed addendum to it. The documentation must include the date when the encounter occurred and a brief narrative that describes how the clinical findings of the encounter support the patient's homebound status and need for skilled services. HHAs and hospices can't bill for the patients if the FFE isn't performed.

New clarification: Although many medical practices were sweating the additional time and burden that this rule would put on their doctors, CMS may have just offered an olive branch. Physicians can merely sign off on the F2F documentation their "support staff" prepares for them, says a new question-and-answer posted by CMS on its website. "A physician's own support staff can help the physician draft the face-to-face encounter documentation narrative in a number of ways," CMS says in the Q&A.

The agency lists examples of how that might work. "The support staff can extract the narrative from the physician's own medical record documentation of the encounter," CMS says in Q&A #10482. Or "the support staff can generate the narrative from the physician's electronic medical record software."

Another option: "The certifying physician can dictate the narrative to the physician's support staff," CMS says. Hospital discharge planners can fulfill this support staff role too, CMS said in a Q&A posted last month (Q&A #10414).

In fact, the definition of support staff is pretty wide. "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," CMS says in a separate Q&A (#10484).

But the definition doesn't stretch to home health agency employees. "The HHA staff cannot draft the narrative documentation for the physician to sign," CMS says in the Q&A. "This would violate the statutory requirement."

CMS also offered an example of what the F2F narrative should look like: "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," CMS gives as an example in Q&A #10480.

Note: A link to the full set of F2F Q&As is at www.cms.gov/center/hha.asp.