Eli's Rehab Report

Home Health Therapy Documentation: Avoid HIPPS And F2F Denials With Airtight Documentation

Therapy-targeted medical review can land you in hot water.

You need to check that the physician who recommended therapy for your patients has made the face-to-face documentation airtight to validate and justify the services your agency provides. Otherwise, your home health claims are at risk for denials.

Palmetto GBA performed a service-specific prepay targeted medical review on claims with 2CGK* and 1BGP* HIPPS codes from May to July 2013, the Home Health & Hospice Medicare Administrative Contractor says in an article on its website. Palmetto set the edits for four regions within its territory. The HIPPS codes represent high-therapy episodes, experts note (see box on page 94 for specifics on those codes).

Palmetto may have been fishing for therapy denials, but the vast majority of the denials reviewers made were not for that reason. "What is most interesting is the fact that the actual (ADR) review is for high therapy ... yet the majority of denials are for F2F," observes clinical consultant **Lynda Laff** with **Laff Associates** in Hilton Head Island, S.C.

In its analysis of the edit results, Palmetto breaks out the denials by region and HIPPS code. The region and code with the lowest denials was 38 percent in the Gulf Coast (AL, FL, GA and MS) region for 2CGK. The highest denial rate was tied at 80 percent in the Midwest (IL, IN and OH) for 2CGK and the Southwest (AR, LA, NM, OK and TX) also for 2CGK. Most regions' denial rates were in the 50s or 60s for both codes.

Among the denied claims, F2F was by far the most common reason for denial. In one region it accounted for 100 percent of the denials. Two regions saw F2F denial percentages in the 50s, two in the 70s and three in the 80s, Palmetto reports.

Important: "In the process of medical review, they are reviewing not only for reasonable and necessary skilled care," Laff points out. "They review for homebound status, signed MD orders, compliance with MD orders and F2F."

"Thus, F2F has produced the lion's share of denials," Laff concludes.

"When they get the record in their hands for review, they look at everything and are not concerned only about the therapy," agrees consultant Pam Warmack with Clinic Connections in Ruston, La. "A home care provider has to ensure the medical records can pass any level of scrutiny rather than focusing on one aspect of care."

The results of this edit square with what home health agencies and consultants have been reporting from the field. "F2F denials are staying very high, especially from PGBA," says Judy Adams with Adams Home Care Consulting in Asheville, N.C.

"Every ADR my clients have received from PGBA in the past six months or so have all been part of this probe," Warmack adds.

F2F Compliance Bedevils HHAs

The obstacles agencies face in complying with F2F requirements are extremely challenging. Usually, the denial stems from the physician's narrative, not whether the encounter occurs 90 days before or 30 days after the home health start of care.

"The documentation of the encounter must include a brief narrative, composed by the certifying physician, describing

how the patient's clinical condition as observed during that encounter supports the patient's homebound status and need for skilled services," Palmetto says in the article.

"Agencies are really struggling to get physicians to understand the type of information that needs to be included in the narrative," Adams says. And that is frustrating since it's the agency's reimbursement, not the physician's, that hinges on the correct documentation.

For example: "We are seeing denials with the reasons being that the physicians are documenting only diagnoses, and expecting that to explain the patient's need for the referral to home care and often for homebound as well," reports Warmack. **The Centers for Medicare & Medicaid Services**' F2F guidance reads that "there must be a narrative explanation of why the patient required the encounter and how the information justifies or validates the need for home health services."

Bottom line: "Diagnoses alone do not fulfill this requirement," Warmack stresses.

HHAs Must Step Up To The Plate

HHAs have contributed to the problem as well by not requiring compliant F2F narratives until recently. "Most agencies only worked on getting the F2F signed without clearly recognizing the clinical findings specificity and homebound status documentation necessary," Laff laments.

Physicians feel that since their too-brief, vague, or otherwise insufficient F2F statements have worked fine for more than two years, why do they need to be changed now? Thus, agencies are meeting "resistance from physicians to tighten their narratives and correct forms that are not meeting the expected documentation content," Adams relates.

And some agencies haven't been too picky about securing F2F documentation at all. They "have not clearly understood the ramifications of admitting patients without an adequate F2F and then trying to make sure the F2F is completed within the first 30 days of service," Laff says. "Many have continued to provide services after the first 30 days without a valid F2F, not realizing that all visits made for every day after day 30 up to the date when a valid F2F is signed will be denied."

Those types of practices will have to change as MACs and other Medicare contractors continue to crack down on F2F documentation.