Codify
BY AAPC

Health Information Compliance Alert

Home Health Regulations: Make Note of When F2F is Necessary

Don't let your patient's hospital stay torpedo your claim for his entire episode.

You might find the new face-to-face requirements confusing, but don't let that put your reimbursement at stake.

The Centers for Medicare & Medicaid Services will be changing its guidance on F2F physician encounter requirements for patients who are in the hospital at the time of recert, according to a new clarification from Home Health & Hospice Medicare Administrative Contractors **NHIC and National Government Services.**

"This notice appears to be yet another reversal by CMS on when a new F2F is required for home health," says Judy Adams with Adams Home Care Consulting in Asheville, N.C. The F2F requirement "is being continually subjected to a more stringent interpretation."

In question-and-answer 11 of a Q&A document CMS revised in February, a home health agency asked "must home health agencies secure new face-to-face encounters/documentation for billing starts of care when current patients were transferred to the hospital and remained in the hospital over day 60/61?"

Old answer: "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," CMS replied at the time.

New answer: Now the agency is changing its tune, NHIC and NGS say in the clarification. "CMS recently clarified that this is required for all initial episodes or start of care (SOC) episodes," the MACs say. "This is a change from instructions CMS has in their question and answer document (Answer 11) regarding the HH FTF. They will be updating the questions and answers soon."

HHAs may not realize that an F2F is required in these scenarios, the MACs offer:

1. A patient is receiving HH services but is hospitalized on day 60 (the last day of one episode) and day 61 (the first day of the next episode of continuous care). When services resume following this hospitalization, the Medicare Claims Processing Manual, requires the new episode be billed as a new SOC claim. This will require a new F2F encounter document.

2. A HH patient is hospitalized and is discharged on day 60 or day 61. If the HHA performs a Resumption of Care (ROC) assessment that changes the Health Insurance Prospective Payment System (HIPPS) code from a recertification assessment performed in the last five days of the previous episode, this must be reported as a SOC assessment prior to submission to the state agency. This is a new SOC. A F2F is required.

3. A beneficiary may be admitted to the hospital in the first days of an episode prior to delivery of services in the new episode. This is handled the same as the discharge on day 60 or 61 above. The episode will be considered a SOC if the HIPPS code is different from the recertification assessment performed in the last five days of the previous episode.

4. A HH patient changes insurance from Medicare Advantage to Medicare fee-for-service. The claim for Medicare fee-for-service will be a SOC claim and a F2F is required.

F2F Change Drags at Agencies' Shoulders

This new clarification is bound to confuse and more heavily burden providers, experts say. "The [Medicare] payment

system identifies what is called an initial episode that is an episode that is the first episode in a sequence of sequential episodes," explains Chicago-based regulatory consultant **Rebecca Friedman Zuber.** "An initial episode only occurs when there has been at least a 60-day break in home health services between the end of the last episode and the beginning of the current episode," she says.

This guidance is contradictory to instructions CMS has posted in the past regarding SOC episodes with less than a 60-day time span between billing cycles, points out consultant **Pam Warmack with Clinic Connections** in Ruston, La.

"As with everything related to F2F, it appears that CMS has decided to make the requirement as difficult as possible," Zuber laments. "It seems to me to be well within their range of flexibility to go with the initial episode interpretation here." The statutory language doesn't specify which type of SOC requires the F2F, she maintains.

Denial tool: Requiring a new F2F "just because the patient was still in the hospital on day 62" doesn't seem to add any value to the F2F requirement, Zuber tells Eli. "It would be so refreshing for them to find a way to work with this requirement that would add value to the benefit rather than just providing them with a hook to disallow episodes."

Remember, "if the F2F is not accepted, the HHA cannot be paid for any of the services provided on the initial and any subsequent episodes based on that SOC," Adams explains.

Warmack says she's not surprised to see this clarification that tightens up the requirements. "F2F documentation has become the monster in the bedroom closet for home health providers," she notes. "All my clients are receiving denials based on the documentation on these forms. What is so discouraging is that one audit body interprets them one way and the next another."

Note: NHIC's clarification is at www.medicarenhic.com/providers/articles/HHF2FArticle0829.pdf.CMS's list of 51 F2F Q&As is at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/Home-Health-Questions-Answers.pdf.