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Home Health Coding and OASIS Expert

Face-To-Face: Will Your F2F Burden Grow in 2015?

Good news: New F2F documentation doesn't always require a new F2F visit.

The 2015 home health prospective payment system final rule's removal of the physician narrative portion of the F2F drew a largely positive response from home health agencies, but another detail may result in more legwork for you.

Old way: In its 2011 PPS final rule, the **Centers for Medicare &Medicaid Services** explained that Medicare required F2Fs only for certifications not recertifications. In later regulatory guidance, CMS detailed that it required F2Fs for "initial episodes" only. That means when an agency discharged a patient with goals met, but then readmitted the patient within 60 days, Medicare did not require a new F2F for the second episode.

New way: Now, "the face-to-face encounter requirement is applicable for certifications (not recertifications), rather than initial episodes," CMS says in the 2015 rule published in the Nov. 6, 2014, Federal Register. In other words, when an episode requires a new OASIS Start of Care assessment, it's a certification that requires F2F, CMS explains in the rule. That's true even if the second episode occurs within 60 days of the first one, and even if it's considered a "subsequent" episode for PPS billing purposes.

Why? Many episodes that occur within 60 days of a previous one are due to a hospitalization of the patient and have a different reason for home care, CMS notes in the rule.

"Equating a certification with any time a SOC OASIS is completed to initiate care will further encourage physician accountability in certifying a patient's eligibility for the Medicare home health benefit and in establishing and overseeing the patient's plan of care," CMS says.

Rule Takes Aim At Frequent Fliers

This change affects episodes that start after a partial episode payment (PEP) episode too, CMS explains. But the provision really "was intended to mostly respond to instances of patients being discharged after the end of a 60-day episode of care and then readmitted without a 60-day gap in care before the start of the next episode," CMS says in the final rule. "For claims processing purposes (to categorize episodes into 'early' versus 'late' for case-mix adjustment), these episodes are considered subsequent episodes rather than initial episodes of care."

Result: This change could translate into an additional 800,000 F2Fs per year, CMS says in the rule.

"The switch from initial to certification episodes will be a big deal," foresees clinical consultant Judy Adams with **Adams Home Care Consulting** in Asheville, N.C. "It will mean obtaining face-to-face documentation more frequently."

"It is difficult for HHAs to get this documentation from the physicians at all," Adams tells Eli. "To have to have more of them will add significantly to the agency's workload requesting them, tracking them, reviewing them and trying to get the forms edited. Many HHAs have had to assign a staff member specifically to obtaining and reviewing F2F documentation."

Take note: Keep in mind that the patient who is in the hospital over the end of the episode who has to have a new start of care will need new F2F documentation as well something that wasn't required in 2014, says **Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C, HCS-O**, consultant and principal of **Selman-Holman & Associates** and **CoDR Coding Done Right** in Denton, Texas.

Bottom line: "This is another element that more than likely will not make physicians very happy more paper work," Adams emphasizes.

Impact Will Vary Depending On Practices

While CMS concedes that it will require more F2F documentation under this rule, the impact may not be as great as you think. For one, new F2F documentation doesn't necessarily mean a new F2F visit. A qualifying F2F visit may occur up to 90 days before an episode starts. "Depending on when the face-to-face encounter occurred, the face-to-face encounter from the PEP episode could be used for the new certification as long as it was performed within the required timeframe and is still related to the primary reason the patient requires home health services," the agency points out in the rule.

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