corridor

Face-to-Face & Clinician Focus of Care Best Practices

Exclusively for Corridor Clients

Lea Stratton, HCS-D, COS-C, HCS-H

Education Manager

Insights | Expertise | Results

Objectives

Define the F2F and its requirements

Discuss clinician documentation practices

Identify Face-to-Face challenges

Examine Corridor's Face-to-Face Best Practice Approach

Face-to-Face Requirements

The initial SOC certification must include documentation that an allowed physician, or non-physician, had a face-to-face encounter with the patient

The encounter must be related to the ***primary reason for home care admission***

Key focus of today's conversation

Face-to-Face Requirements

Who can complete the F2F?

- Certifying physician
- Physician who cared for patient in an acute or post-acute facility
- Qualified non-physician practitioner (NPP) including nurse practitioners, physician's assistant, certified nurse midwives, or clinical nurse specialist
  - Must be in collaboration with an acute or post-acute care physician, with privileges and cared for the patient in the acute or post-acute facility ; OR
  - Under the supervision of the certifying physician or under supervision of an acute or post acute care physician who has privileges and cared for the patient in the acute or post-acute facility

42 CFR 424.22(a)(1)(v)(A)

Face-to-Face Requirements

When does the F2F need to be completed?

- 90 days prior to the SOC OR 30 days after
  - If the F2F encounter occurred within 90 days of the SOC but is not related to the primary reason for home health, the NPP or certifying physician must have a F2F encounter within 30 days after the SOC
    - This cannot just be an addendum; the guidance states a **NEW F2F** must be completed within 30 days after the SOC
      (*Medicare Policy Manual 30.5.1.1 Face-to-Face Encounter*)

Face-to-Face Requirements

- **Signatures and dates:**
  - The F2F must be dated (the date of the encounter) and signed by the provider
  - If hospitalist completed the F2F but will not be the certifying physician/practitioner there needs to be documentation by the certifying practitioner of the F2F encounter date

I certify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized services on this plan of care and will periodically review the plan. The patient had a face-to-face encounter with a physician or an allowed non-physician practitioner on 11/01/2020 and the encounter was related to the primary reason for home health care.

Face-to-Face Requirements

What needs to be documented in the F2F?

- Documentation supporting the reason for a home health referral
- Need for skilled services
- Homebound status
- Documentation must include the actual clinical note for the F2F encounter visit that demonstrates that an encounter occurred:
  - Within the required timeframe
  - Was related to the primary reason for home health services; and
  - Was performed by an allowed provider type
- Agencies can support the patient's homebound status and need for skilled care, but it must be corroborated with the other medical record entries in the certifying physician's and/or the acute/post-acute care facility's medical record for the patient and **signed and dated** by the physician to indicate acceptance into their medical record.

Face-to-Face Supporting Documentation

Face-to-Face encounter documentation is often contained within:

- Discharge Summaries
- Clinical notes
- Progress notes
- Admit summary, part of the OASIS, therapy eval notes, nurse's notes that support the certification and signed off by the physician and incorporated into the physician or acute/post-acute facilities medical record

(https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/se1436.pdf)

Face-to-Face Supporting Documentation

EXAMPLE 1:
PT progress note helps support that patient is confined to the home:
Home health agency physical therapy progress note documents patient is non-weight bearing on right leg and requires use of a two-handed device to walk alone on a level surface, and requires assistance to negotiate stairs or steps or uneven surfaces. The home health agency assessment with progress notes has been signed by the community orthopedic certifying physician.

EXAMPLE 2*:*
SN notes help to identify the need for skilled services:
Nursing notes states that the patient is significantly deconditioned, as a result of recent pneumonia, and requires the use of a walker to ambulate from chair to bathroom with frequent stops to rest. The home health agency skilled nursing note has been signed by the certifying physician.

https://palmettogba.com/palmetto/jmhhh.nsf/DIDC/ATBM2D3066~Home%20Health~Face-to-Face

Understanding the Face-to-Face

Progress Notes
Patient: Smith, Jane
DOB: 04/13/1941
Address: 1714 Main Street, Plano TX 15432

Provider: John Doe, M.D.
Date: 05/03/2013

Allowed Provider Type

Date of Encounter

Subjective:
CC:
1. Wound on left heel.
HPI:
Pt is here for evaluation of wound on left heel. Patient reports her daughter noticed the wound on patient's heel when she was washing her feet. Patient states she has difficulty with reaching her feet and her daughter will sometimes clean them for her. She reports she uses a shoe horn to put on her shoes.
ROS:
General_____:
No weight change, no fever, no weakness, no fatigue.
Cardiology_____:
No chest pain, no palpitations, no dizziness, no shortness of breath.
Skin ____:
Wound on left lower heel, no pain.

Medical History: HTN, hyperlipidemia, hypothryroidism, DJD.

Medications: zolpidem 10 mg tablet 1 tab once a day (at bedtime), Diovan HCl 12.5 mg-320 mg tablet 1 tab once a day, Lipitor 10 mg tablet 1 tab once a day.

Allergies: NKDA

Objective:
Vitals: Temp 96.8, BP 156/86, HR 81, RR 19, Wt 225, Ht 5'4"
Examination: General appearance pleasant. HEENT normal. Heart rate regular rate and rhythm, lungs clear, BS present, pulses 2+ bilaterally radial and pedal. Diminished pinprick sensation on bilateral lower extremities from toes to knees. Left heel wound measures 3 cm by 2 cm and 0.4 cm deep. Wound bed is red, without slough. Minimal amount of yellow drainage noted on removed bandage.

Assessment:
1. Open wound left heel

Plan:
1. **OPEN WOUND** Begin hydrocolloid with silver dressing changes. Minimal weight bear on left leg with a surgical boot on left foot. Begin home health for wound care, family teaching on wound care, and patient education on signs and symptoms of infection. The patient is now homebound due to minimal weight bearing on left foot and restrictions on walking to promote wound healing, she is currently using a wheelchair. Short-term nursing is needed for wound care, monitor for signs of infection, and education on wound care for family to perform dressing changes.

Follow Up: Return office visit in 2 weeks

Provider: John Doe, M.D.
Patient: Smith, Jane **DOB**: 04/13/1941 **Date**: 05/03/2013
Electronically signed by John Doe, M.D. on 05/03/2013 at 10:15 AM
Sign off status: Completed

Meets the requirements for documenting: (1) the need for skilled services; (2) why the patient was/is confined to the home (homebound); and (3) that the encounter was related to the primary reason the patient requires home health services.

https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/se1436.pdf

Challenges

- Unclear focus of care documentation from clinician SOC
  - Often see a list of past medical history or vague documentation such as medication management.
- Clinician does not know reason for home health and documents separate focus of care statement
  - Has to be a condition that was ***treated (addressed)*** either in the inpatient or post acute facility OR community setting prior to admission
- Clinician misunderstands the impact of the F2F encounter
- Clinician doesn't know what to do if the F2F encounter is different from his/her SOC assessment

Challenges

- Dual diagnosis coding/RCD challenges
  - Provide additional documentation as a F2F addendum to support dual diagnosis codes if needed
  - For example: F2F is related to patients' diagnosis of dementia. Patient's referral documents also confirm a diagnosis of hypothyroidism. Per coding guidelines, there is an assumed relationship between hypothyroidism and dementia therefore per coding guidelines the hypothyroid code is required to be coded prior to the dementia coding.
  -
    - Attach referral with documented hypothyroidism and submit as F2F addendum to support dual diagnosis codes
    - Provide coding guidelines to reviewers- often lack of knowledge surrounding coding guidelines on the reviewers' part
    - Ensure interventions in POC that address the code in the primary location on the POC

What's the Impact?

- Increased denial risk if F2F does not align with initial primary diagnosis
- Non-affirmations for states in Review Choice Demonstration
- Increased turnaround time if needing to query when clinician's FOC does not align with F2F
- Increase demand in resources (e.g., managers having to resolve queries or clean up/fix things that could be prevented)

Corridor Best Practice to Ensure Alignment

Clinician Focus of Care (FOC) Statement: clinician's need to clearly define their focus of care

- It should be the chief reason the patient is receiving home care and the diagnosis most related to the current home health Plan of Care
- Having a list of conditions or past medical history will lead to increased queries
- Recommend the clinician's focus of care is documented in a consistent area for all assessments
- In the rare instance there is more than one focus of care that meets the criteria for primary, per OASIS guidance it is the clinician determines which condition will be their focus of care

Corridor Best Practice to Ensure Alignment

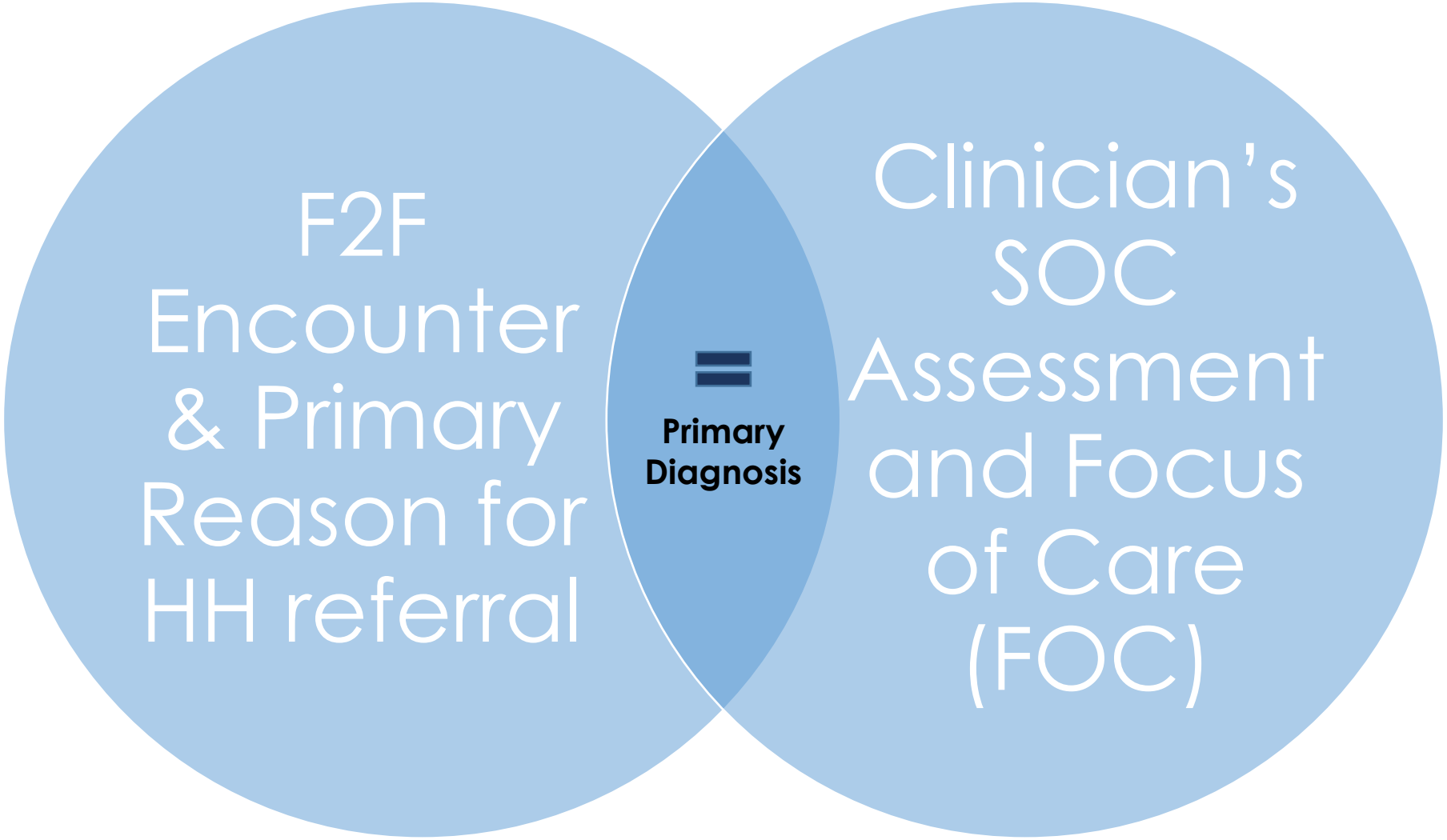
Labeled Face-to-Face (F2F): labeling the F2F removed any ambiguity or assumptions on what is used as the F2F for your agency.

- (F2F) encounter note uploaded into current admission
- Encounter must occur within 90 days of SOC date or 30 days after
- Corridor is not responsible for verifying that the agency identified F2F meets all compliance pieces -It is the responsibility of the agency. Corridor focuses on the diagnoses addressed within the encounter to determine the potential focus of care.

Corridor Best Practice to Ensure Alignment

- Clinician reads the F2F ***prior*** to making home visit
  - Could also be the agency has process in place where either intake/branch manager/assigned individual has responsibility to communicate primary focus of care that is addressed on F2F encounter to admitting clinician to ensure alignment
- Clinician clearly documents FOC statement indicating the primary diagnosis requiring home health
- Know when to contact physician for new F2F

F2F Encounter Must Align With Clinician's SOC Assessment/FOC



Query If…

- No F2F is present
- There are no diagnoses that overlap between the F2F and the FOC statement
- The diagnoses on the F2F are resolved
- The Primary diagnosis is non-acceptable as primary under PDGM
- The FOC is unclear
- There is more than one FOC documented and addressed in F2F. Per OASIS guidance it is the clinician who determines which condition will require the most intensive services.

Examples/Scenarios

Assessment and Plan:
This female with a history of ESRD, prior TIA, IDDM 2 presents for generalized weakness, poor appetite, cough, dyspnea, chest pain

ASSESSMENT:
Acute respiratory failure 2/2 Viral PNA
Influenza A infection, viral pneumonia
RLE swelling; ecchymotic lesion lower medial thigh
Elevated D-dimer -CTA negative for PE
ESRD on HD, missed dialysis 2/2 weakness
IDDM2 with hyperglycemia
Hyperkalemia 2/2 ESRD with missed dialysis
Hyponatremia, mild
Elevated troponin, elevated BNP 2/2 ESRD with missed dialysis -no overt evidence of CHF exacerbation

New and/or exacerbated conditions treated during encounter

CHRONIC conditions
HTN, stable
Dyslipidemia

These are chronic stable conditions and would not be considered addressed

Examples/Scenarios

HPI

History of Present Illness

Date of Encounter: 02/27/23
Time of Encounter: 18:29
Supervising Provider:
Chief complaint HPI: Left great toe cellulitis
History of Present Illness:

gentleman who presented to the ER secondary to fever and nonhealing wound to the left great toe. He is diabetic and does not recall the trauma but does state that he has been dealing with the wound for approximately two weeks. He has been cleaning it and wrapping it at home. Today, he started experiencing fevers and chills and decided to come to the ER for evaluation. He denies any other symptomatology. His CRP was found to be 110 during his workup in the ER. His left foot x-ray showing degenerative changes at the great toe metatarsophalangeal joint without fracture or dislocation. No definitied erosive changes. Patient will be admitted at this time for IV antibiotic therapy and MRI evaluation to rule out underlying osteomyelitis.

New and/or exacerbated conditions treated during encounter

Past Medical/Surgical History

Medical His

Diabetes (Medical) E11.9
HTN (hypertension) (Medical) I10
Hyperlipidemia (Medical) E78.5

These are chronic stable conditions and would not be considered addressed

What's in it for me

- Decrease in number of queries to agency
- Improved turnaround time of record
- Less documentation corrections needed by clinicians
- Decrease demand in office employees time if F2F, clinician documentation of FOC and coding all align.
- No delay in agency payment as it relates to primary diagnosis
- Increase in affirmation rates for agencies in Review Choice Demonstration

What's In It For Me?

- Decrease in number of queries to agency
- Improved turnaround time of record
- Less documentation corrections needed by clinicians
- Decrease demand in office employees time if F2F, clinician documentation of FOC and coding all align
- No delay in agency payment as it relates to primary diagnosis
- Increase in affirmation rates for agencies in Review Choice Demonstration

Resources

- https://palmettogba.com/palmetto/jmhhh.nsf/DID/BXUJBY2653
- https://palmettogba.com/palmetto/jmhhh.nsf/DIDC/ATBM2D3066~Home%20Health~Face-to-Face
- SE 1436- Certifying Patients for the Medicare Home Health Benefit https://www.hhs.gov/guidance/document/certifying-patients-medicare-home-health-benefit
- CMS IOM Publication 100-02- Chapter 7, Section 30.5.1 & Section 30.5.1.2 - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf


Any
Questions