Recertification/30-day Review

PROVIDERINSIGHTS

1.) Does the patient still have needs for nursing or therapy related to unmet goals? If yes, continue to #2- if no, discharge from care, unless payer will pay for non-skilled care only.
2.) Is this a payer who requires authorization? If yes, proceed to seek orders and authorization. If "no"- proceed to #3.
3.) Is this a traditional Medicare patient? If yes, the agency must determine coverage by considering homebound status, and the following:

Nursing:

- A. Is there still a "hands-on" skill below that the patient needs? If yes= Covered service for recertification, If no= Go to "B"
    - Ongoing skilled wound care such as wound vac, packing, full thickness wound
    - Vitamin B12 or other IM injections with appropriate diagnoses to support
    - IV medication administration
    - Foley/suprapubic catheter changes
- B. For ongoing assessment or teaching:
    - Has there been a **medication or treatment order change** in **last three weeks?**
    - Has there been a new or exacerbated condition in last three weeks (requiring medication or treatment changes)
    - If yes to one of above, covered services for recertification. If no- consider DC from nursing/ca

Therapies:

- Are there still skilled modalities, such as ultrasound, that the patient needs?
- Are the other manual modalities (therapeutic exercises, gait training, ADL training, balance work) **advancing/changing with the professional assessment and adjustments of plan of care? (not repetitive each visit)**
    - Note: Due to Jimmo vs Sebalius case, we do not need to see improvement to qualify for home health- but it is NOT considered to take skills of therapist to simply perform repetitive modalities that could be taught to non- therapist
- Has there been a change in setting? Caregiver? Function?
- Is it reasonable to meet goals?

Simplified Home Health FTF Compliance Checklist

PROVIDERINSIGHTS

Confirm a Valid FTF Encounter

- [ ] Ensure there is a **Face-to-Face (FTF) encounter** within the last **90 days**, completed by: MD, DO, NP, PA, or DPM (when appropriate)
- [ ] If the FTF is from a community provider, confirm that **same provider** is signing the **home health plan of care** (POC).
  - [ ] The HH agency will have to **show collaboration** if two different providers/practices

Select and Label the Best Supporting Document

- [ ] Choose a document (H&P, office note, progress note, or discharge summary) that clearly shows:
  - [ ] A **skilled need** (e.g., wound care, catheter change, IV/IM meds)
  - [ ] A **change in condition** or **treatment warranting assessment by a nurse**
  - [ ] A **change in function warranting skilled therapies**
- [ ] Confirm the **clinical team supports** this skilled need.
- [ ] **Label** the selected document in the EMR as the **official FTF encounter**.
- [ ] **Provide admitting clinician with FTF documentation and clear direction of the focus of care.**

Ensure Alignment in Admission & POC

- [ ] Admitting clinician must document:
  - [ ] The **focus of care** (matching the FTF)
  - [ ] The patient's **homebound status** at the start of their narrative
- [ ] In the POC, include:
  - [ ] The statement: *"I certify that a face-to-face encounter was completed on [MM/DD/YYYY]."*
  - [ ] The clinician's **narrative** as *"FTF Corroboration"*

Compliance & Quality Made Easy

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