

Home Health:
Audit Denials?
Non-affirmations?
Coming Face to
Face with your FTF
Operational Issues

HOW TO ENSURE
COMPLIANCE AND PAYMENT

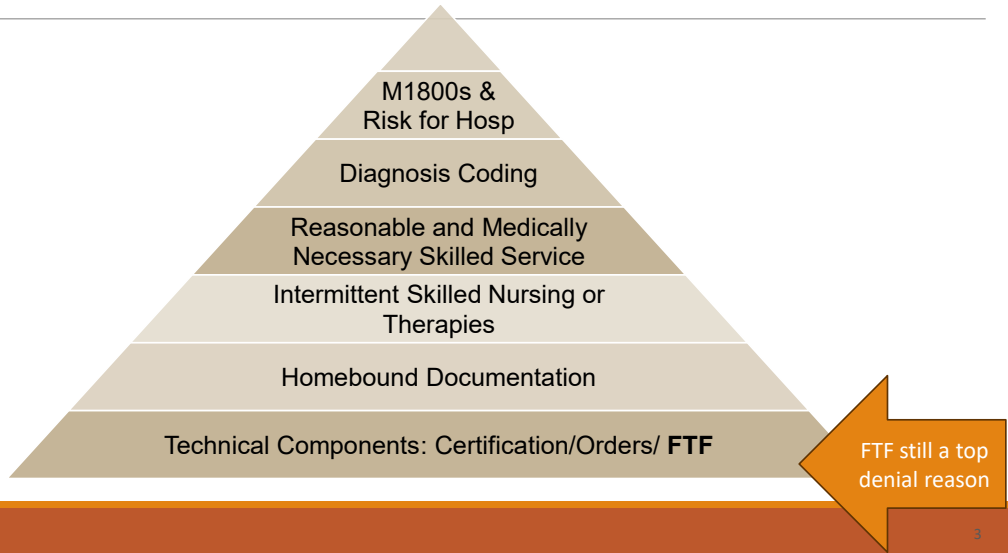


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Why still all this focus on the FTF?
TOP DENIAL and non-affirmation!
and we all have a part of Compliance!

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Medical Review Hierarchy



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The Technicals



Timeframe – Up to 90 days back and 30 days after admission (BUT- does this REALLY work??!!)



Who– Physicians, NPs or PAs



Where- in facility (hospital, SNF/PAC, ER) or provider’s office

ALSO: Telehealth by AUDIO and VIDEO can be used as FTF in patient’s home through 12/31/27

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Two community physicians!?! No problem!

- ❑ Did the patient see another community provider for the focus of care, but the PCP will follow for home health?
 - ❑ If the two providers are in the **same practice**- there is **no further collaboration**/handoff required
 - ❑ As a best practice, we recommend noting these providers are in the same practice.
 - ❑ If the two providers are **NOT affiliated**- the HHA (or providers) **must document a handoff/collaboration**
 - ❑ The HHA can do this for the providers
 - ❑ MACs concurred simple as including the name of the provider who performed the FTF in the FTF certification statement, with the date of the visit
 - ❑ MACs also noted that a care coordination note, by the HHA stating that they provided the information of the FTF to the certifying provider would also be acceptable

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The Necessities

The visit must have actively treated (not just a dx in a laundry list) the same problem that the home health is now going to treat

- Should be addressed in the “assessment” or “plan” sort of narrative documentation
- May be related to a medical diagnosis or may be related to a change in function- but must be tied back to a medical problem (why is the patient now weak)

The issue should be serious enough that it requires the follow up skill by a nurse or therapist- defined by Medicare in Chapter 7

- <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf>

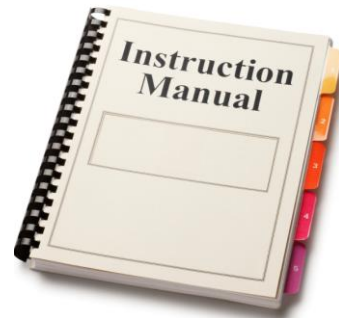
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The Mythbuster: Chapter 7!

Chapter 7 of the Medicare Benefit Policy manual is the Conditions for Payment

- Describes the Medicare Home Health benefit
- Defines what Medicare pays for, under what circumstances
- Rules are only for Medicare patients (or other payers that adopt the Medicare coverage rules)
- Used upon payment audits

- Different than the Conditions of Participation
 - Survey/Quality standards
 - Applicable to all patients/all payers



<https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/home-health-agency-center>

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What Medicare Pays for...

Nursing to assess and teach for a month when changes in condition /meds /treatment	Nursing to provide care to a COMPLEX wound or high risk wound	Medications per IV, IM or treatments like catheter change	Psych nursing when changes in treatment in last three weeks
Therapies when change in function, setting or caregiver warrants	AND- the patient is "homebound" (Medicare and Medicare Advantage)	AND- has an ordering provider in the community willing to follow	AND- the focus of care in the home was actively treated in the FTF documentation

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The “no-go’s”

M62.81 Muscle Weakness Generalized
R26.89 Abnormality of gait and mobility
M54.5 Low back pain
R26.81 Unsteadiness on feet
R53.1 Weakness
R26.9 Unspec abnormalities of gait and mobility
R29.6 Repeated falls
R26.2 Difficulty in walking not elsewhere classified
M19.90 Unspecified osteoarthritis
Z48.89 Encounter for other specified surgical aftercare

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How Does Face to Face (FTF) Fit in Here?

- Technical and supports medical necessity!
- The FTF is the physician or NPP encounter- which reflects some of the clinical indications of why the patient needs home health
 - May discuss the increased s/s of CHF, COPD, Diabetes, other conditions
 - May discuss pain or new conditions
 - May discuss decreased function, falls, etc.
- The assessing clinician has the opportunity to provide more details to be incorporated into the FTF documentation
 - Details of lung sounds, level of exertion causing dyspnea, blood sugars
 - Details of wounds, pain assessments, medication compliance and understanding, side effects, etc.
 - Details of new risk for falls, inability to care for self due to declines
 - Included on 485 and when signed by certifying clinician, becomes doctor record for FTF

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Not Necessary-

The visit doesn't need to mention home health, nursing or therapies

The visit doesn't need to mention homebound

BUT- the story in the visit note should support

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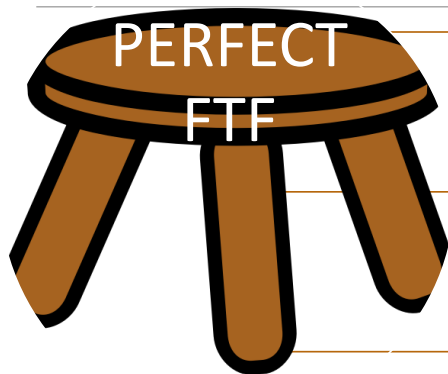
FTF Process: Choose the Right Note



- ❑ Marketing/Intake- Ensure proper documentation is obtained from ordering provider
- ❑ Clinical in office/leadership weighs in
- Choose the “best” documentation available related to reason for home health
 - In a facility? Just needs to be a physician, NP, PA, CNS
 - Community admission? Needs to be documentation of visit by same provider who will be certifying
 - MUST be for same reason as referral- Home Health is a continuation
 - Must be within last 90 days (although closer is more supportive)
 - If using “telehealth”- MUST state audio and video and be prior to 10/1/25
- ❑ HAND-OFF to admitting clinician clearly re: which note is FTF, what is focus
- ❑ ADMITTING Clinician- we MUST document to the focus of the FTF visit note FIRST- and THEN can elaborate on any other needs you have found
 - Example CHF at physician visit- but nurse finds a wound

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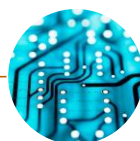
Three-Legged Table- All Supports Each Other



Hospital or
Dr visit note



Agency's Focus
on Admission



Correct
ICD10 CODE

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Focus of Care Admission Narrative



- Document Strategy:
- WHAT is paying the bill PER the FTF?
 - "Admitted for assessment following a CHF exacerbation" or "Admitted post hospitalization for assessment of recurrent UTI"
 - THEN add in anything else you assess and see the need for – including the complicating factors such as DM, dementia
 - LASTLY, make note of any new findings that were not mentioned in the H&P – such as skin tears, wounds, etc
 - INCLUDE the details- what type of wound? Specific etiology, location, etc

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What Do We Do Now?

- Patient referred to the agency for a wound, but the only FTF visit note does not mention the wound
 - Inquire if other documentation that includes wound
 - Schedule a visit with the physician so they can assess the wound in a FTF visit
 - New in 2026- schedule a mobile doc or wound doc to get the focus of care for wound!
 - Two different community providers are allowed!
 - Re-review the FTF- and look at what was ACTIVELY TREATED and see if HH can be provided for the primary issue during that note
 - Clarify with referring Dr to ensure orders
 - Handoff clarity to admission RN to ensure she documents the focus is what is on FTF, and the wound is not first issue documented/focused on

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What Do We Do Now?

- Patient referred for therapy, but recent H&P was all about CHF exacerbation? Or Cancer?
 - Due to PDGM, we can't typically use a "therapy diagnosis" like we used to- such as "Weakness" or "Abnormality of gait"
 - Medical diagnoses (such as CHF exacerbation, COPD, Cancer) are allowed and SHOULD be used for therapy
- If the medical diagnoses doesn't make sense for therapy, may need to:
 - Clarify with Dr if nurse care is also needed to reflect the FTF reason
 - Schedule a visit

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What About Re-certification?

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What do you need at Recertification?

- No face to face is needed at recertification.
 - This is only mandated at the start of care
 - NOTE: if you are audited for a recertification episode, you must still include the FTF encounter, as well as the initial certification to show initial eligibility, along with the current recertification
- Homebound must still be supported in medical record
- Medical necessity must still be supported
 - If Medicare/MA plan, be sure to reflect how the patient meets these criteria from Chapter 7

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Recertification Support



30-day Episode and Recertification Review

- 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 so, the agency must determine coverage by considering the following:

Nursing:

- Is there still a "hands-on" skill that the patient needs?
 - Ongoing skilled wound care
 - Vitamin B12 or other IM injections
 - IV medication administration
 - Foley catheter changes
- 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)

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 with the professional assessment and adjustments of plan of care? (not repetitive each visit)**
 - Note: Due to Jimmo vs Sebelius 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?
- 4.) Prior to new 30-day episode- ask "Is the focus of care going to remain the same? Any new co-morbidities to add to the claim?"
 - a. "No new focus or diagnoses"- will carry over codes from past comprehensive assessment/coding
 - b. If a new focus, ask "Was this related to a major decline not expected in the POC?" If yes, do SCIC. If no, proceed to change diagnoses to reflect the focus of care

Recertification for Nursing Need

- Is there still a "hands-on" skill that the patient needs?
 - Ongoing skilled wound care
 - Vitamin B12 or other IM injections
 - IV medication administration
 - Foley catheter changes
- For ongoing assessment or teaching:
 - Has there been a **medication or treatment order change in last three weeks?**
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Recertification for Therapies

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Not Just at Recert!

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Next Steps...



Review your own FTF processes for compliance. Include who obtains info, who identifies and documents the FTF and how is this focus provided to the admitting clinician.




Perform a focused audit on 10 FTF, comparing the visit note date and focus with our certification date and focus of care. Also note who performed and if community referral, ensuring that it is the same provider.




Educate and modify process as needed! Education for sales, referrals, intake and team in the field.

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BONUS TOOL!

Simplified Home Health FTF Compliance Checklist



✓

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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Questions?



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