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Our Panel

Host

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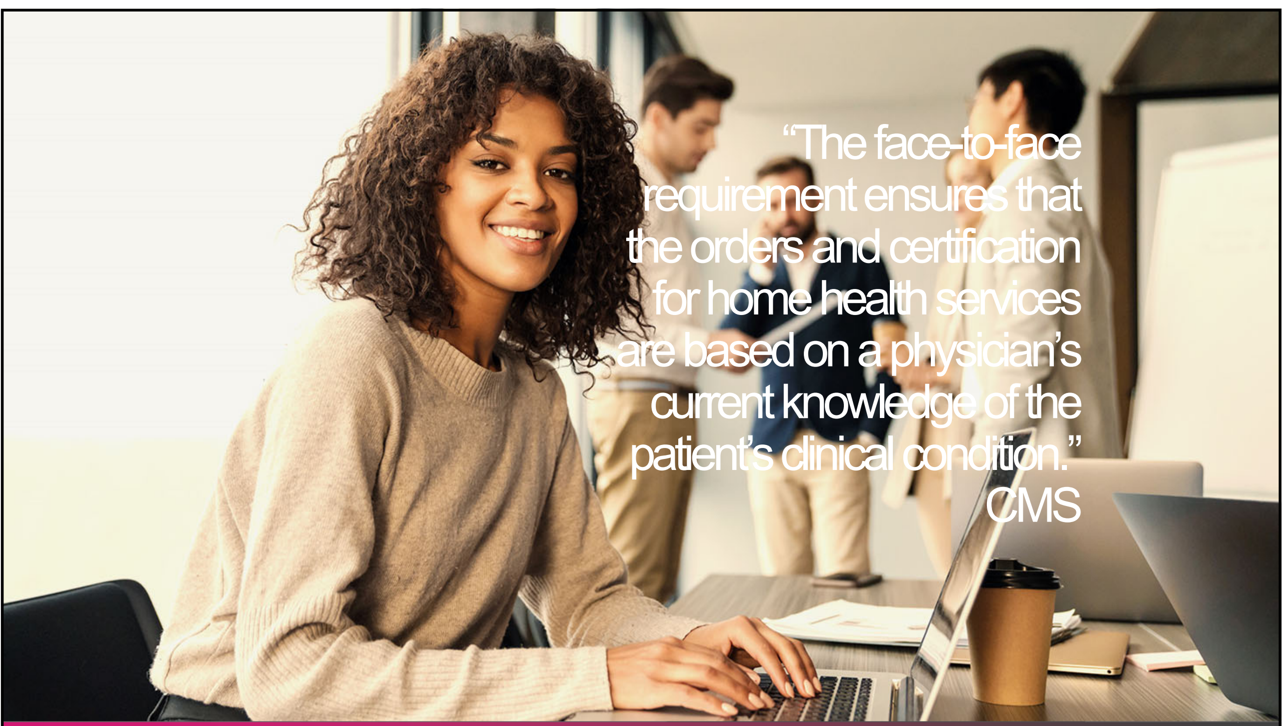

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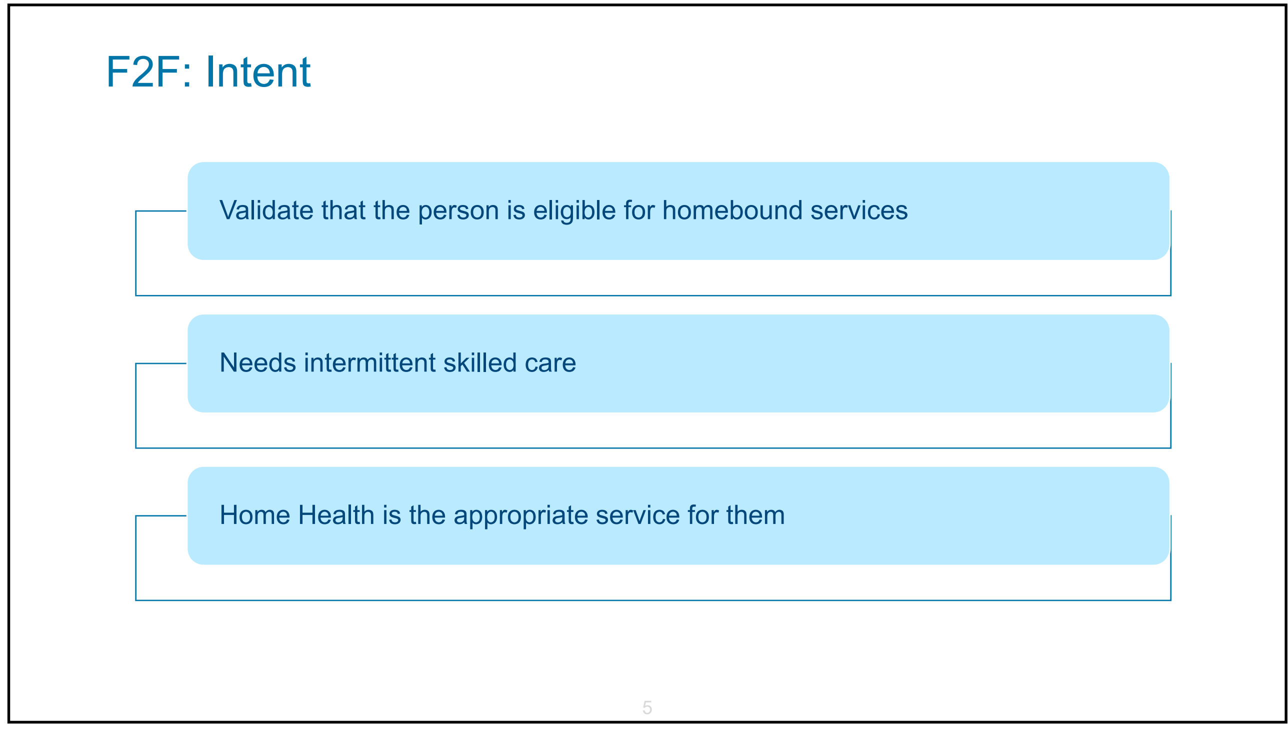

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Face-to-Face

Mandated by the Affordable Care Act (ACA)
A condition of payment

Episode 1 SOC requires F2F → All → Subsequent → Episodes → Until → Discharge → Depend on that F2F at SOC

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As the Rule Reads Now

- A face-to-face patient encounter, which is related to the primary reason the patient requires home health services, occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care and was performed by physician or non-physician practitioner defined in paragraph (a)(1)(v)(A) of this section. The certifying physician or certifying allowed practitioner must also document the date of the encounter as part of the certification.

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As the Rule Reads Now

(A) The face-to-face encounter must be performed by one of the following:

- (*1*) A physician (as defined at § 484.2 of this chapter).
- (*2*) A nurse practitioner (as defined at § 484.2 of this chapter).
- (*3*) A clinical nurse specialist (as defined at § 484.2 of this chapter).
- (*4*) A physician assistant (as defined at § 484.2 of this chapter).
- (*5*) A certified nurse-midwife (as defined in section 1861(gg) of the Act) as authorized by State law.

(B) The face-to-face patient encounter may occur through telehealth, in compliance with section 1834(m) of the Act and subject to the list of payable Medicare telehealth services established by the applicable physician fee schedule regulation.

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F2F: Requirements

1. Timely (90 days prior or within 30 days of the SOC)
2. Performed by an allowed provider
3. Related to the primary reason services are rendered
4. F2F evidence of homebound status and medical necessity

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F2F: Timing

- **When** was the F2F visit performed?
  - Date visit occurred (90 days prior or within 30 days of the SOC)
  - Not when the provider signed the encounter

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Date of Signature vs. Date of Encounter

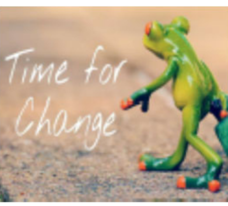
- Question: If the progress notes are signed on the date of visit, do you still need M.D. to date if the date of visit is on note?
- Answer: *For the purposes of HH there isn't a requirement that the rendering provider sign AND date their note. If there is no date with the signature, it must be evident when that encounter occurred in order to determine the timeliness of that visit.*

Source: PGBA, November 20, 2020

The documentation must be clearly titled and dated and the documentation must be signed by the [physician/provider]. 424.22

Performed by an Allowed Provider

Current Language	***Removed Language***
Face-to-face encounter must be performed by one of the following: a physician, a nurse practitioner, a clinical nurse specialist, or a physician assistant as defined at 42 CFR 484.2; or a certified nurse-midwife as defined in section 1861(gg))	A physician, physician assistant, nurse practitioner, or clinical nurse specialist ***with privileges*** who cared for the patient in ***the acute or post-acute facility*** from which the patient was ***directly admitted*** to home health and who is different from the certifying practitioner.



F2F: Who?

F2F

- Physician
- Nurse practitioner
- Physician Assistant
- Clinical Nurse Specialist
- Certified Nurse Midwife

Certification

- Physician
- Nurse practitioner
- Physician Assistant
- Clinical Nurse Specialist
- Certified Nurse Midwife

Can be same or different
Can be in facility or in community
"Provider performing face-to-face encounter has firsthand information of the patient's primary reason for needing home health services and also is the most appropriate (that is, the most knowledgeable) provider to complete the face-to-face encounter."

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What the MACs are looking for…

- CMS's expectation that the F2F provider must:

1. Have firsthand knowledge of the patient's primary reason for home health
2. Be the clinically appropriate provider

   Not the *ophthalmologist* for the orthopedic patient.

- Must communicate the clinical findings of that face-to-face encounter to the certifying physician/NPP.

What PGBA and CGS said before the final rule: Evidence *of collaboration* must be included in the documentation which verifies that prior to the certification, the certifying provider collaborated with the provider who performed the F2F.

This is NOT a requirement according to the current rule.

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Conundrum: Patient Transfers from Hospital to SNF

- Could the MAC determine that the SNF provider encounter documentation should have been used instead of the acute facility provider?
- What is the primary diagnosis?
- Can you support that the acute facility provider has firsthand knowledge?

"Provider performing face-to-face encounter has firsthand information of the patient's primary reason for needing home health services and also is the most appropriate (that is, the most knowledgeable) provider to complete the face-to-face encounter."

Certification

- The certifying physician must document that he or she, or an allowed non-physician practitioner has had a face-to-face encounter with the patient.
- Example Certification Statement:

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 01/11/2026 and the encounter was related to the primary reason for home health care.*

How do you show the certifying practitioner knows that the F2F practitioner has firsthand knowledge?

- "Must communicate the clinical findings of that face-to-face encounter to the certifying physician/NPP." 409.22
- Provide a copy of the F2F to the certifying practitioner. "Copy of F2F encounter documentation provided for your records."
- Enter the date of the encounter into the certification statement.
- Write a synopsis: The patient is homebound because…The patient had a F2F encounter with an approved provider on [date] and the primary diagnosis of rheumatoid arthritis was discussed.
- The patient has diabetes, and the focus of care is diabetic polyneuropathy.

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F2F Requirements Not Met

- Face to Face encounter document missing
- Face to Face encounter was not within the required time-frame
- Encounter was not related to the primary reason for home health
- Encounter was not performed by an allowed provider
- Certifying Provider did not document the date of the encounter
- Missing attestation

Most common denial reason

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F2F: What is included

- **What** constitutes a valid F2F visit note?
- **Elements of a comprehensive assessment**
  - Subjective information provided by patient/caregiver
  - Vital signs
  - ***Physical exam/Assessment/Review of systems***
  - ***Diagnoses***
  - Plan/Orders
  - Example: SOAP note
- Choose wisely
  - History & Physical (H&P) vs Discharge Summary vs Summary of Discharge
  - Preoperative note vs Operative note vs Post-operative note

Encounter Related to Home Health Services

- How does the encounter relate to the need for home health services?
  - **Requires clinical oversight**
  - **Referral documents** – diagnosis that drives request for services
  - **Historical diagnoses** not acceptable unless exacerbated
  - **F2F encounter** – details are in the note
    - Symptomatology (e.g., elevated blood pressures, respiratory issues, mobility declines, etc.)
    - Acute exacerbations of chronic conditions
    - New diagnoses
    - Medication changes to manage acute exacerbations or new-onset conditions

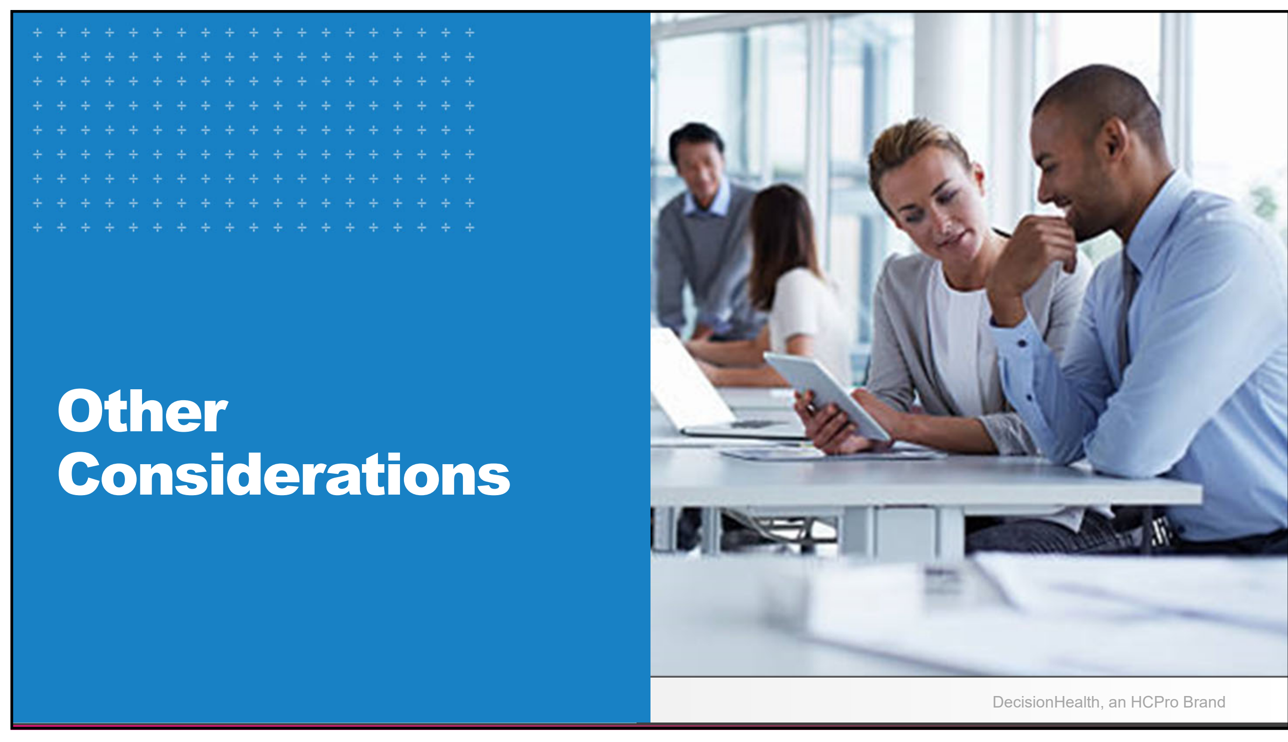
Encounter Related to Home Health Services

- Coding prior to obtaining a F2F encounter will likely result in inefficiencies:
  - Auditing issues
  - Increased administrative burden due to the need for recoding the chart
  - May require patient to visit provider after SOC (within 30 days)

Encounter was related to the primary reason that home health services were needed

- Diagnosis ***codes*** are not required to be on the face-to-face documentation and do not exactly have to match the primary diagnosis for which the patient is receiving home health services.
- Rather, the face-to-face documentation has to sufficiently demonstrate that the encounter was related to the primary reason that home health services were needed (42 CFR 424.22(a)(1)(v)).

- How is this significant?
- Physician documents/discusses ulcer on the right foot and also documented DMT2. The physician places L97.509 next to the ulcer and E11.9 next to the DM.
- I code E11.621 and L97.519 (and hopefully more specifically)



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F2F: Points of View

- Virtual F2F encounters extended until December 31, 2027!
- F2F means the encounter must be visual and audio.

The face-to-face patient encounter may occur through telehealth, in compliance with Section 1834(m) of the Act and subject to the list of payable Medicare telehealth services established by the applicable physician fee schedule regulation.

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Telehealth Explained

- The Medicare telehealth limitations related to originating site and geographic location primarily apply to providers who may bill Medicare directly for telehealth services.
  - Home health agencies do not bill Medicare for telehealth visits and, therefore, are not the entities to which these limitations directly apply.
- Prior to the COVID-19 Public Health Emergency (PHE), telehealth was used infrequently due to restrictive Medicare requirements, including limits on where the patient could be located and who could receive telehealth services. During the PHE, these requirements were temporarily relaxed, allowing beneficiaries to receive telehealth services in their own homes. Those flexibilities significantly expanded telehealth use.

Telehealth Explained

- As a result, physicians and certain non-physician practitioners may bill Medicare for valid telehealth visits with patients. Home health is impacted only indirectly. When a telehealth visit meets Medicare requirements and is payable to the billing provider, an audio-visual telehealth face-to-face (FTF) encounter may be used to support home health eligibility, just as an in-person visit would.
- However, if a telehealth visit does not meet Medicare's telehealth requirements and is not payable, it cannot be used to satisfy face-to-face requirements for home health.
- This is why home health agencies are not specifically referenced in most telehealth regulations—the rules are fundamentally tied to Medicare payment for the provider furnishing the visit, not to home health services themselves.

F2F Pitfalls

An auditor cannot accept what they cannot read!!

Denial Risks

- Encounter visit note missing or incomplete
  - Obtain complete F2F encounter note from provider
    - Ensure all pages of the encounter are present
- Invalid signatures (avoid relying on fax stamped dates)
  - Encounter signed by someone other than the author of the note
  - Encounter with incomplete/illegible signature and/or date
    - Ensure electronic signatures are validated
  - Unsigned encounters
  - Stamped signatures
  - Encounter signed by Resident without attending co-signature

F2F Pitfalls

- F2F encounter occurs after the SOC and Plan of Care is signed/dated before F2F visit
  - Verify the plan of care is not signed/dated until after the F2F encounter occurs, OR;
  - Obtain a separate attestation from the certifying provider detailing the required certification statement
    - *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 nonphysician practitioner on XX/XX/XXX and the encounter was related to the primary reason for home health care.*
- Reliance on the ability to obtain F2F encounter within the hospital system's EMR
- Don't forget to incorporate supporting documentation to link the F2F to the primary reason for home health services if not clear for an auditor

Strategies to Mitigate F2F Denials

- Start at Intake
  - Provide comprehensive training on the necessary elements of F2F
  - Educate intake staff on F2F process and requirement
    - Explain the 'why'
  - Create a checklist of requirements to ensure all required elements are met
  - Conduct regular refresher training sessions to keep intake staff updated on any changes
- Clinical oversight of the F2F encounter
  - To validate F2F encounter aligns with the primary reason home health services are being rendered (primary diagnosis code aligns)
- Incorporate supporting documentation to meet F2F requirements
  - Homebound status
  - Need for skilled care

References

- https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-B/
- https://www.federalregister.gov/documents/2025/12/02/2025-21767/
- CMS – Medicare Benefit Policy Manual (Chapter 7). Medicare Benefit Policy Manual (cms.gov)
- CMS – Medicare Home Health Face-to-Face Requirement.
- CGS – Home Health Face-to-Face Encounter Calendar. Home Health Face-To-Face Encounter Calendar (cgsmedicare.com)
- CGS – HH&H FAQs: Home Health Face-to-Face (FTF) Encounters. J15 HH&H FAQs (cgsmedicare.com)
- COVID-19. Home Health Agencies: CMS Flexibilities to Fight COVID-19
- https://dominoapps.palmettogba.com/palmetto/providers.nsf/files/Home_Health_Face_to_Face_Checklist.pdf/$FILE/Home_Health_Face_to_Face_Checklist.pdf
- 424.507(b) Conditions for payment of claims for covered home health and hospice

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February Scenario

POC Scenario: An 84-year-old male was hospitalized for COPD exacerbation. Patient is O2-dependent and has nebulizer treatments every 4-6 hours. The patient's other comorbidities include hypertension that is well managed with medication, Type 2 diabetes with a sliding scale of Humalog, and Lantus 20 U daily. Patient also has hypothyroidism, hyperlipidemia, and anxiety. The RN case manager has admitted the patient to home health and is now preparing the plan of care for this patient.

What conditions should be considered when establishing goals and interventions on the POC based on industry best practices?

February Scenario Answer

The patient was hospitalized for COPD, so you would address this as it is the primary reason for home health.

The patient also has diabetes, is taking medications, and is on oxygen.

Medication mistakes are the number one reason patients are hospitalized. Oral medication administration is expected to show improvement during the quality episode.

Diabetes can cause a lot of complications, so it is important to monitor for these and ensure the patient understands the possible complications.

Oxygen requires precaution education. Oxygen is flammable and can cause a fire if not used properly.

March Scenario

F2F Scenario: A patient referral was sent to the home health agency from community physician, Dr. Jones. Intake reviews the F2F and notices that NP Sarah Poppleton completed the F2F visit and there is no visit note from Dr. Jones in the past 90 days. Intake reviews the medical practice that Dr. Jones works in and determines the NP works in collaboration with Dr. Jones. Intake is unsure if they can accept the patient's referral unless they get the patient in to have a visit with Dr. Jones.

What is the most recent clarification/guidance regarding the home health Face-to-Face that would clarify what is allowed in this situation?

A. Telehealth is allowed for face-to-face encounters.
B. The Face-to-Face date must be noted in the certification statement.
C. The Face-to-Face may be conducted by a different physician/provider in the same practice as the certifying physician/provider with firsthand information of the patient.
D. The physician or allowed provider who completed the Face-to-Face must be the certifying physician.

Product Spotlight

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May 19th through 21st in Orlando, Florida

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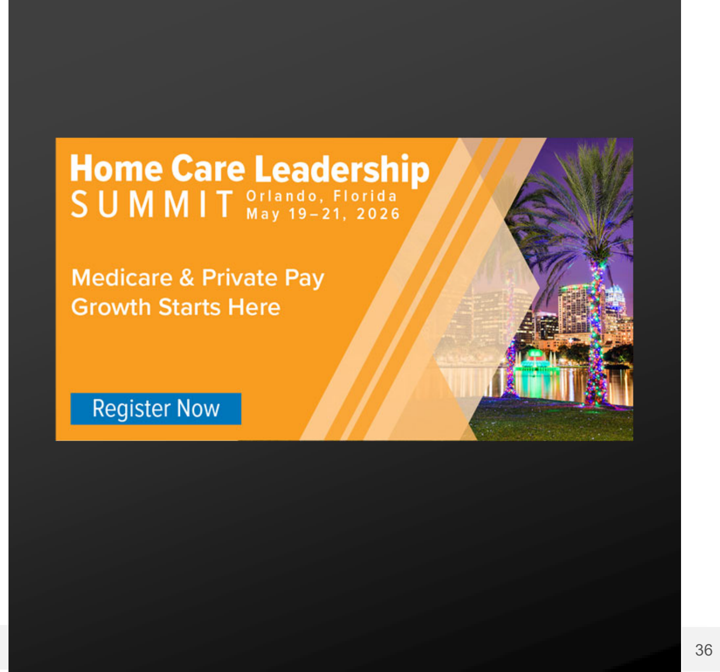

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What's new with AHCC

AHCC Credential Holders Survey:

- Open now: https://www.surveymonkey.com/r/8DR9ZQK

AHCC Networking call March 31

- Join us to meet fellow members and work through scenarios.

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