Home Health Certifying Physician Documentation

Hello, I'm Charles Canaan, senior provider education consultant with Palmetto GBA.

Today we're going to talk about the certified physician's role in Home Health.

Now Palmetto GBA advocates the Health Information Supply Chain concept, and that's a concept that takes many entities to work together to have a successful product.

In this case our successful product is a Home Health record that meets the billing requirements and documentation requirements. It takes physicians, nurses, therapists, social workers, home health aides, coders, billers and compliance people to make the supply chain effective.

So today we're going to talk about the front end of this process. We're going to talk about the physician's role. Whether we're talking pre-claim review, a records request from a Medicare contractor or a regular ADR, the physician's documentation is key to the Home Health agency getting their reimbursement.

So what we're going to do, we're going to being with an overview of the Home health benefit, then we'll focus on the face-to-face encounter documentation. We will touch on the plan of care, certification and recertification, then we will finish by talking about care plan oversight.

Medicare Requirements

When someone is looking to be a part of the Home Health benefits, there are things that have to be in place. A person receiving the Home Health benefits needs to be someone who needs to be someone not sick enough that they need to be in a facility but is too sick to be in outpatient service. So they're in a little space right in the middle. The individual has to be confined to the home. We also call that "homebound." So when you're confined to the home, that means leaving the house is very difficult. It's either exhausting, taxing, needing someone to help you — it's just not easy to get around.

The other piece of the Home Health benefit is the patient has to be under the care of a physician, which is what we're going to talk about today.

A plan of care has to be established by that physician in collaboration with the Home Health agency to make sure all the beneficiary's needs are met, and the person has to be in need of some type of skilled services that require a healthcare professional as opposed to a layperson to complete.

The patient also has to have a face-to-face encounter.

What is a face-to-face encounter? That's a very interesting story. So let's go back in history and tell you how that came about to be.

If you go back before the Affordable Care Act, individuals being at home—we're talking your Home Health, hospice, durable medical equipment — patients were referred to those services, and many of them were not seen by a physician. So there were times when there were individuals were not appropriate for that benefit.

So the Affordable Care Act enacted a rule that all of these patients had to have some type of face-to-face encounter by a physician to verify their eligibility for that service.

So for the Home Health benefit, the individual has to see a physician either 90 days before Home Health services start, or within the first 30 days of start of care of the Home Health benefit.

The reason the person is seen by the physician needs to line up to the reason that they need Home Health service.

That physician can be a physician; it can be a non-physician practitioner, also. Remember, the intent of the face-to-face encounter is to validate that the person is eligible for homebound services, needs skilled care, and Home Health is the appropriate service for them.

"Certification" — what does that mean?

The certified physician has to certify that the patient meets the requirements that we have just discussed. So they have to have a need for skilled care. Skilled care means skilled nursing, physical therapy or occupational therapy for the initial service. Now, they can have supplemental services, such as Home Health aides, social work or occupational therapy if needed. But nursing PT or speech-language pathology has to be the primary need.

The person has to be confined to the home, so the certifying physician is certifying that's the case. The certifying physician also does sign the plan of care that is put together separately in collaboration with himself or herself and the Home Health agency.

A physician — we have said that name several times. What does that name "physician" in this case?

The physician can be someone who saw this person while they were in a hospital or in a post-acute facility such as a skilled nursing facility. Or it can be a physician that saw them in an outpatient office.

A non-physician practitioner can also perform the face-to-face encounter, and those that meet that requirement are a nurse practitioner, a clinical nurse specialist, a certified midwife, or a physician's assistant.

This needs to be somebody (when we're talking about our non-physician practitioners) that has a working relationship with that primary physician. It cannot be an independent practitioner that was just hired for the sole source to do the face-to-face.

Who Performs the F2F?

So if the face-to-face is completed by one of these physicians other than the certified physician, the certified physical needs to acknowledge that he knows the face-to-face was done.

He or she could just cosign that document, acknowledging that he knows the face-to-face was done by, for example, the hospitalist or a non-physician practitioner. This is called "handing off." You can have more than one physician involved in the Home Health process. If another physician starts off

the process: let's say the hospitalist begins by doing the face-to-face and ordering the Home Health services, the patient's primary physician (or we call up the immunity physician) will take over, generally speaking, sign the plan of care, and continue to follow that person throughout their Home Health services.

So, a full review:

- A face-to-face encounter can be performed by a certified physician, or can be performed by another physician in a facility such as a hospital or a subacute facility. So you can have plenty of physicians involved in this process.
- Remember that the non-physician practitioner has to be in collaboration with that primary physician.
- Don't forget, there has to be a partnership. The partnership has to be with that nurse practitioner, that physician assistant, and that primary physician.
- So when you are turning in your records for review it has to be obvious that these partnerships and handoffs have taken place.

Some people put that as part of their plan of care (and we will discuss ways to make sure you do that in later videos) but it is key to show that communication between the hospitalist or the non-physician practitioner and the primary physician. Because the certified physician at the end of the day is the one who is responsible for the patient's care.

What is an Encounter?

We've said the word "encounter" several times. What does the word "encounter" actually mean?

This is a problem-oriented document, which means it has the reason the person needs medical care. So basically a history, a summary or physical exam, or physical finding, and a plan – the person needs skilled nursing, what-have-you. Those are the elements that are required when we say "encounter."

Now the Methods Matter article SE 14-36 has four examples of what face-to-face counters may look like. So there are several different versions depending on whether the patient did see the physician. And remember, this encounter has to be related to the reason the person is receiving Home Health services.

Those who have been with Home Health for a while, you're used to seeing the good old face-to-face form that started back in 2011. That form is no longer a requirement, but a lot of agencies still like to use it. If you are using that face-to-face form, that is good supplemental information, but does not meet the requirement by itself.

You still have to provide the actual visit where they were in the hospital or they were in the doctor's office, or that Home Health claim will not be payable.

To reiterate: the form by itself, that just fills in the blank, is not acceptable by itself.

Inadequate Documentation

- Diagnosis alone, such as osteoarthritis
- Recent procedures alone, such as total knee replacement
- Recent injuries alone, such as hip fracture
- Statement, "Taxing effort to leave home" without specific clinical findings to indicate what makes the beneficiary homebound
- "Gait abnormality" without specific clinical findings
- "Weakness" without specific clinical findings

Some other sources or denials or lack of payment have come from poor documentation. The diagnosis by itself does not support somebody need Home Health services.

For example, I want to admit someone to Home Health because they have high blood pressure. This person's probably had high blood pressure for 20 years, why do they need Home Health today? So we're looking at the change of the person's baseline. So you need to have symptoms described.

So, I have high blood pressure, my head is hurting, I'm fainting, I'm dizzy – that is the type of documentation that is needed to tell the story.

A surgical procedure by itself does not support Home Health services. Now the natural description of the outcome will help you out.

I had a knee replaced. As a result of that, I cannot bear weight on that leg, I'm in a lot of pain, I need crutches. You have to have those details at the end to justify the Home Health services.

Simply regurgitating regulation, saying, "My person has a taxing effort, it is difficult to leave home." You have to tie that to a medical reason. Regulations say illness or injury is why you need Home Health services. If you're painting the picture that this is just an older person who's slowing down because they're just getting older, that claim would not be payable.

If the person has an abnormality of gait, that was the common diagnosis in ICD-9. What does "abnormality" mean? Be specific. Does that person have a Parkinsonian shuffle? Does that person need to lean against a wall? Is that person stumbling a couple of feet then falling? Just give us a little more details.

And "weakness." Weakness as evidenced by what? Weakness is a good start, but we need to know what weakness means. Does "weakness" mean they can walk five feet and can't breathe? That's good. But "weakness" by itself is not going to be payable.

Points of Focus

To put this in a nutshell, acute symptoms versus chronic disease—that's probably the most important point I need you to take away from this little session.

Most people are going to have a chronic condition, probably about 95 percent of them. What is going on with that person that they need Home health today? What symptoms are different from that baseline? If you are communicating that you are 95 miles down the road and most of your work will be done.

Now the Home Health agency may give you several documents to sign off on, and you may wonder, why are they sending me all these sheets of paper?

I will tell you why. The Home Health Agency does an assessment of a person in their home, so they are going to see some things that you will not see while they were in the hospital, or while you saw this person while they were in your office. So they will have information related to the person's living environment, such as steps, stairs, things like that. How far it is from their bed to the bathroom? Fifty feet, and they can only walk 10 of those feet, things like that.

So they will have a few extra details from their natural assessments, and they may send those documents to you to sign off on to help support the Home Health benefit. So don't be offended, they're not trying to tell you need to do your job right, they just have extra information because they're just doing and in-home assessment, and they're just giving information just to give a more complete picture.

The certified physician just needs to sign off on those documents and you should incorporate those into your natural records and send a copy back to the Home Health agency so they can submit them for their record being reviewed.

Plan of Care (POC)

The next piece of documentation involving the physician is the plan of care.

A plan of care is a list of orders, mediations, and basically the treatment plan for that patient. This is put together in collaboration with the physician in the Home Health agency. This has to be done every 60 days, and it needs to be signed before the agency can bill. So you may feel that this agency keeps badgering me about this document, and they're going to continue to do that because if that document is not signed by the certifying physician, that agency cannot get their reimbursement.

So it's very important that when they send those documents to you, that you sign them, date them, and return them as soon as possible. A signature without a date is invalid. If you sign it and don't put a date on it, they're going to send it back to put a date on it.

Recertification

Now if a patient is being recertified — meaning that they are going to continue on a Home Health benefit for another 60 days — recertification requires and extra statement. We just need a statement that says this person is expected to need skilled services for **x** amount of time. That is something they're also going to ask you about. It can be in days, weeks, but it has to be a quantifiable time frame. You cannot say "until the patient gets better," or "until they die," or "until they're discharged." You need something that is quantifiable.

That is something they are going to ask you for in every recertification. Please make sure you cooperate with agency and provide that information to them. This is something that has to have your signature on it, so some people are putting it on the plan of care, so that the document you're naturally signing. Some people are putting it on the order to continue services. However you and the agency want to work that out, that's up to the two of you, but it does have to be documented that this patient will need skilled services for at least one more episode.

If you're summarizing this information for medical necessity, we did a focus group that tried to put this in a nutshell. The focus group consisting of Physicians and Home Health providers came up with four questions:

Four Questions

- What are the structural impairments?
- What are the functional impairments?
- What are the activity limitations?
- What is the nurse/therapist going to do about it?

Structures and Functions

1. Body structures are anatomical parts of the body such as organs, limbs and their components
2. Body functions are physiological functions of body systems (including psychological functions)
3. Impairments are problems in body functions or structure such as a significant deviation or loss

Structural impairment — you will most likely see this with wounds. Those decubitus ulcers, diabetic ulcers are going to be classic examples of structural impairment.

Functional impairment — is physiological in nature. That's going to be a change in their cardiovascular system, respiratory system, what-have-you.

Now all of your patients may not have a structural impairment but they should all have a functional impairment because a Home Health agency is trying to remedy some type of symptoms. So whatever that symptom is, the body system related to that should be where your functional impairment is.

Activity Limitations — This is where you support the homebound services in your need for your therapists.

Your patient has some type of need that needs to be fixed. The easy way to measure that is to look at what they do day to day. They have to try to walk to the bathroom, they have to feed themselves, dress themselves, so just explaining what tasks they cannot do meets this requirement.

It's very easy to do because it's very visual and also has a beginning and an end. You will easily be able to tell if somebody buttons up all the buttons on their shirt, or take a walk from the bed to the bathroom. So you have met that requirement by having a measurable problem, and you have a measurable solution.

Going back to what I said in the beginning: you're going to have an acute flare-up of a chronic problem. So those activity limitations are going to be a perfect way to tell that story.

My person has had congestive heart failure for ten years. Normally they can walk about 500 feet before they get tired, after the flare-up they can only walk 10 feet. It's the perfect way to tell that story. Think of before and after. Before I had this problem flare-up I was here, since it's flared up, I can only go this far. The perfect way to justify Home Health Services.

Here are some examples based on the different function of systems.

Functions of the Cardiovascular System

- Experiences angina even at rest
- Experiences angina with minimal activity
- Poor endurance, experiences SOB with minimal activity
- Experiences SOB at rest
- Able to ambulate only short distances (20 feet or less) before experiencing SOB, angina
- Fluctuations of blood pressure

What is the difference from this person's baseline? They're tired when they're just walking a couple of feet. They're having shortness of breath just sitting watching TV. (Unless their football team is losing, but that doesn't count). Shortness of breath: they can only walk around the corner, only walk to the bathroom and then they get tired. These are things that are very measurable, and when this person's symptoms are resolved, you can document how they can walk faster, or that shortness of breath isn't there anymore. The perfect way to justify the need for service, and it gives you a recipe to show how Home Health Services are affected.

Functions of the Respiratory System

Respiratory Symptoms are going to be very similar. It's going to reference a person who has shortness of breath. You can also look at how many words they can say before becoming fatigued or before they run out of breath.

Functions of the Musculoskeletal System

- Medical restrictions on activity due to (partial/non) weight-bearing status.
- Activity restricted due to pain
- New pathological fracture (osteoporosis) with severe pain and limited mobility

Musculoskeletal issues: how far can the person walk? Can the person bear weight? Is it painful for them to walk? Are they walking with bad balance? Do they need crutches? Do they have to lean on a person? Do they have to lean on a wall? These are very simple things to describe.

Functions of the Endocrine System

- Unstable blood sugar levels, experiences severe fluctuations
- Requires assist or assistive device due to neuropathy/paresthesia in LES
- Activity restrictions due to diminished sensation/circulation in LES. Patient vulnerable to blisters, other breakdowns on feet when ambulating > 100 feet.

Your diabetes patient. There are a whole lot of folks out there who are going to need Home Health for diabetes. You need to tell a story about what those symptoms are that need to be remedied. If the person's blood sugars are going up and down, up and down, your documentation just needs a history of some of those reasons.

If the person has trouble giving their insulin, explain why. If the person has bad vision, they can't see those little lines on the syringe, perfect reason to have Home Health give the insulin. If the person has Parkinson's, and their hand is shaky, they can't manage the syringe. The person has as stroke. Again, there are various reasons why a person cannot give their insulin or their blood sugar is out of control. Just tell that story, and the person will meet eligibility.

Activity Limitations

- Able to ambulate only short distances (20 feet or less)
- Cannot transfer from bed to chair
- Cannot dress oneself
- Cannot feed oneself

Activity Limitations — Once again, these are things that are naturally assessed by the Home Health agency, so they may ask you to sign that comprehensive assessment. They naturally do an assessment on the person's ability dress, to feed themselves, transfer and ambulate. Between the agency documentation and the physician's documentation, we expect to see those activities this individual cannot perform.

Face-To-Face Articles

We do have a plethora of education on our website that we would like you to take advantage of. We have many articles on the Palmetto GBA website. Make sure you are on the side that says Medicare, and you will see it's broken down by Part A, Part B and Home Health. You would go to Home Health, and we have several tabs that are beneficial.

There is a pre-claim review tab that has information. There's a face-to-face tab by itself that shows great information. We have articles, and we also have a video which talks about some tips on how to

document. It's on YouTube. It's about five minutes long, so it's a very quick video for new staff or for refreshers on documenting medical necessity for the Home Health patient.

We also have a checklist that we have put together for the Home Health agencies, but it's great for the physician to use also to learn what is expected of these documents, and also as a QI-type thing. Did I mention why they need skilled services? Did I mention symptoms related to homebound? Things like that. That's also an excellent tool we recommend you use.

Resources

The pre-claim review section also has many references. The User's Guide has information on what is being looked for on a pre-claim review. It also has several checklists there. So that is also a good resource.

We have general resources that relate to pre-claim review also. Some of them are CMS Frequently Asked Questions. We have information on our website about that, so please take advantage of those resources.

Care Plan Oversight (CPO) Services

We're now going to talk about Care Plan Oversight (CPO) services.

Care plan oversight is when a physician can bill for reviewing the care plan for these individuals. A Care Plan Oversight does apply to Home Health and Hospice patients. The rules are exactly the same. If you deal with Hospice you can also use these same guidelines.

The point of Care Plan Oversight is these individuals in the home have a multidisciplinary care plan, meaning you have several disciplines involved: nursing, social work, therapy, what-have-you. And a physician needs to oversee these to make sure the results are what we desire them to be.

The way to bill this is through the:

HCPCS Codes

- G0179: MD recertification HHA patient
- G0180: MD certification HHA patient (new certification or start of care)

Dates of Service

How to bill these services: you use the date of service that you are signing that certification document: generally, the plan of care. So whatever date that is, it needs to be the same date that you submit on the claim to bill.

The same physician that is a certified position needs to be the same physician NPI that uses the claim to bill.

You have to make sure you are relating your billing to the time frame of the person being seen. A 60-day episode — January to February for example — cannot bill care plan oversight for some time back in November. It has to be related to the 60-day episode during that timeframe.

Medical Records for these Services Must Indicate

- The physician spent 30 minutes or more for countable care-planning activities
- The specific service furnished, including the date and length of time

Care plan oversight is a time code, so as you know, time code, it has to have time. We're looking at 30 minutes of managing the person's case. This is what they call a non-patient code, because the patient is not going to be there in the office. It's your review of records, and things along that line. Now, we are only talking about physician time, so nursing staff time in the physician's office that is involved, that does not count. Any type of filing, xeroxing records, that does not count.

You have to make sure you do document your time. Like I say, time codes have to have a time. Just don't overstep that. It's easy to forget.

Non-Physician Practitioners

Now, non-physician practitioners can perform the actual care plan oversight. This will function the same way physicians, nurse practitioners and PAs do incident, too, so it's the same exact process. You guys should be familiar with that. So basically your non-physician practitioner does record reviews and collaborates with the physician and conference on the person's needs. So it has to be collaborative effort. The nurse practitioner cannot do it himself or herself without the primary physician being involved. And remember, the NPI used is going to be the certified physician. If you try to bill the NPI of the nurse practitioner or the PA, that is incorrect.

Facility Discharge

- The work included in hospital discharge day management (codes 99238 – 99239) and discharge from observation (code 99217) is not countable toward the 30 minutes per month required for work on the same day as discharge but only for these services separately documented as occurring after the patient is actually physically discharged from the hospital

If you are working with somebody who has been discharged from a facility — an inpatient facility, a nursing home, observation, anything like that — you cannot use the same documentation for the inpatient facility discharge and care plan oversight. You have to have documentation that shows these with two separate actions.

Services That Can't Be Billed

Things that you cannot bill are going to be situations such as something that is naturally covered by a global period. What is a "global period?" When an individual has a procedure, the fee schedule — basically how the physician gets paid for that procedure — has a global period: 0 days, 30 days, 90 days, where all services connected to that procedure are wrapped up in that surgical procedure

billing. So if you have a procedure that is a global period of 30 days, then if you try to do something with care plan oversight during that time, it's going to reject because it is falling during that global period. So please keep an eye on the fee schedule. Make sure you know what the global period is so you can bill correctly.

Services Not Countable

- Time associated with discussions with the patient, his or her family or friends, to adjust medication or treatment
- Time spent by staff getting or filing charts
- Travel time
- Physician's time spent telephoning prescriptions into the pharmacy unless the telephone conversation involves discussions of pharmaceutical therapies

There are a few things you can't count that I've already mentioned: Xeroxing, driving from point A to point B, things that are not actually related to the record are things you cannot bill for plan of care oversight.

CPO References

We have the references on this slide just so you can have a point of view to make sure you're billing it right in the documentation requirements.

Conclusion

So we've gone over a lot in this little time period. We've talked about certified physicians, and his role in the Home Health

We talked about the face-to-face requirement. We've talked about recertification. We've talked about care plan oversight.

If you follow the recommendations on this video you will have a successful endeavor in the face-to-face world. It does take a little bit of coordination between the agency and the physician's office.

So again, going back to the Health Information Supply Chain — everybody has to coordinate, everybody has to work together to make sure this documentation is complete for the Home Health agency to bill.

But I feel confident you guys can do it. You have great information. I know you guys all want the beneficiary to receive the services that he or she should receive. Because that's what it's all about — we all want to see the beneficiary get taken care of.

And always remember, Medicare ends in "I Care." We care too. I know that's kind of corny, but you know what I mean. Everybody wants the person to receive the proper services and we want the agencies and physicians to be paid in full.

I’m Charles Canaan with Palmetto GBA. Thanks for watching.