

FREQUENTLY ASKED QUESTIONS AND ANSWERS

HOME HEALTH FACE-TO-FACE ENCOUNTERS

GENERAL

Q 1. Medicare has pushed back and delayed the face-to-face encounter policy until the second quarter of 2011, is Ohio Medicaid still scheduled to begin this process on February 1, 2011?

A 1. Yes. Rule 5101:3-1-01 of the Administrative Code is effective February 1, 2011.

Q [Revised] 2. Where can I read Medicare's Frequently Asked Questions?

A 2. The intent of Medicaid's answers to Frequently Asked Questions (FAQs) about home health face-to-face encounters is to be consistent with Medicare's guidance and answers to FAQs about face-to-face encounters mandated by the Patient Protection and Affordable Care Act (PPACA). There is a link on the Centers for Medicare & Medicaid Services, Home Health Agency (HHA) Center's website at <http://www.cms.gov/center/hha.asp>.

Q 3. If my question is not answered by Medicaid's Frequently Asked Questions, where can I send my question?

A 3. Please send any new questions to the Ohio Department of Job & Family Services (ODJFS), Ohio Health Plans, Bureau of Long Term Care Services and Supports' mailbox at BHCS@jfs.ohio.gov.

Q 4. Is there a phone number for an ODJFS complaint line for consumers when they are denied access because the physician, or certain non-physician practitioner (NPP) working with the physician, is not willing or is not timely with completing the face-to-face encounter and/or physician certification of medical necessity?

A 4. Home health agencies should work with physicians to ensure that this does not occur. The Ohio Medicaid Consumer Hotline is 1-800-324-8680 or TTY for the hearing impaired 1-800-292-3572. Hotline

hours are Monday through Friday, 7 a.m. to 8 p.m., and Saturday, 8 a.m. to 5 p.m. It is closed on holidays.

FACE-TO-FACE ENCOUNTER

Q 5. May physicians use their own electronic medical records with drop down menus to select from prepared descriptive language when completing the face-to-face encounter documentation for their consumers? Can the narrative be typed?

A 5. Yes. The regulation requires that the certifying physician document how the encounter supports the consumer's need for home health services. We allow the documentation to be either on the certification or as a signed addendum to it. This allows the sort of flexibility where such documentation could be dictated by the physician to one of his support personnel, or to allow it to be generated by the physician's electronic medical record software.

Q 6. Can a Home Health Agency (HHA) obtain and record verbal orders regarding the required encounter information, which are then sent to the physician for signature?

A 6. No. We believe that a verbal communication by the physician to the HHA regarding the encounter, where the HHA would then document the certification and get the physician to sign it, does not satisfy the statutory mandate that the certifying physician must document the encounter.

Q 7. Can a HHA title a document with a lead-in phrase such as: I had a face-to-face encounter on _____ (date). The clinical findings support home health eligibility because: _____.

A 7. The lead-in phrase is acceptable as long as the physician completes the description of how the clinical findings support the need for home health services, in his or her own words.

Q 8. Can a medical resident conduct the face-to-face encounter?

A 8. No. Only the certifying physician or certain NPPs can perform the face-to-face encounter. Additionally, only Medicare-enrolled and Medicaid-enrolled physicians can certify home health eligibility.

Q [Revised] 9. Is the face-to-face encounter requirement effective only for consumers admitted to home health (i.e. have a new start of care) February 1, 2011 and later for Ohio Medicaid?

A 9. Yes, that is correct. We have interpreted the language in the statute to apply only to initial certifications. The start of care (SOC) date is the same as the SOC on the "485" plan of care which is the first day of billable services.

Q 10. Can you please clarify the hospital physician's role?

A 10. Where the consumer is admitted to home health from acute or post-acute care, we believe that current practice associated with the home health certification would apply to the face-to-face encounter, as well. In most cases, we would expect the same physician to refer the consumer to home health, order the home health services, certify the beneficiary's eligibility to receive Medicaid home health services, and sign the plan of care. It would be this physician who would be responsible for documenting on the certification that he or she, or a NPP working in collaboration with the certifying physician, had a face-to-face encounter with the consumer. However, we recognize that, in some scenarios, one physician performing all of these functions may not always be feasible. An example of such a scenario would be a consumer who is admitted to home health upon hospital discharge.

It is not an uncommon practice for the hospital physician to refer a consumer to home health, initiate orders and a plan of care, and certify the consumer's eligibility for home health services. In the consumer's hospital discharge plan, we would expect the hospital physician to describe the community physician who would be assuming primary care responsibility for the consumer upon discharge. The hospital physician's clinical findings that support the need for home health services may be a signed addendum attached to the JFS 07137, "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" or the plan of care.

Q 11. Would the documentation of the face-to-face encounter in a physician's office visit note that was signed, or a physician's note in the medical record from a face-to-face encounter in the nursing home, suffice if this physician was handing off the consumer to another physician?

A 11. The face-to-face encounter with an attending physician in an office visit or in a nursing home, does not satisfy the requirement unless the attending physician is also the qualifying treating physician who certifies medical necessity. In the consumer's nursing home discharge plan, we would expect the nursing home physician to describe the community physician who would be assuming primary care responsibility for the consumer upon discharge. The nursing home physician's clinical findings that support the need for home health services may be a signed addendum attached to the JFS 07137, "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" or the plan of care.

Q 12. Will documentation of an encounter submitted via an electronic portal and electronic signatures on face-to-face encounter documentation be acceptable?

A 12. Yes. However, it is important to reiterate that the documentation must be part of the certification itself, the plan of care, or a signed addendum to either document.

Q 13. What about consumers that are referred for one time visits for environmental assessment and modifications by therapy that are billed to Medicaid – does this situation require a face-to-face encounter?

A 13. Yes. All Medicaid home health services billed through G-codes including G0151 for physical therapy, G0152 for occupational therapy, and G0153 for speech-language pathology are affected by the face-to-face encounter requirements. ODJFS is in the process of changing waiver policy and rules to address this issue. Once plans are finalized agencies will be apprised of this.

Q [Revised] 14. A consumer started physical therapy prior to February 1, 2011. He starts speech therapy after February 1, 2011 and physical therapy continues. Is a face-to-face encounter documentation required for speech therapy?

A 14. No. In this case, speech therapy (or speech-language pathology) is a new state plan home health service which must be ordered by the physician and documented by an addendum to the plan of care.

Q 15. What about consumers with less than a 3-day hospital stay? Does this situation require a face-to-face encounter?

A 15. Yes. All consumers receiving Medicaid home health services billed through G-codes (G0154 home health nursing, G0156 home health aide, and

the three therapy G-codes) must have a face-to-face encounter and certification of medical necessity. The length of a preceding hospital stay, if there is one, is irrelevant. Please see the answer to Q 34.

Q 16. Please advise who is able to sign/complete the face-to-face encounter documentation? Does it have to be completed and signed by the actual physician?

A 16. According to paragraph (B) of rule 5101:3-12-01 of the Administrative Code: "Home health services are covered only if the qualifying treating physician certifying the need for home health services documents that he or she had a face-to-face encounter with the consumer within the ninety days prior to the home health care start of care date, or within thirty days following the start of care date inclusive of the start of care date. Advanced practice nurses ... in collaboration with the qualifying treating physician, or a physician assistant ... under the supervision of the qualifying treating physician, have the authority to conduct the face-to-face encounter for the purposes of the supervising physician certifying the need for home health services....Only the qualifying treating physician may certify medical necessity." Advanced practice nurses and physician assistants are the two types of non-physician practitioners (NPPs) who may conduct face-to-face encounters in Ohio.

Q 17. Our Medical Director has his own private office, some of his office patients are referred to our agency for skilled services. Is that a problem? Can a hospital physician perform the face-to-face encounter if the hospital owns the HHA to which the patient is referred?

A 17. The physician who documents the face-to-face encounter must be the certifying physician. Per section 42 C.F.R. 424.2(d), the certifying physician may not have a financial relationship as defined in 42 C.F.R. 411.354 with the HHA to which he or she is referring patients. Similarly, a non-physician practitioner performing the face-to-face encounter is subject to the same financial restrictions as the certifying physician.

Q 18 [Revised]. Is there a chance of using the National Association for Home Care (NAHC) form without the homebound statement on it? We have been doing a lot of education with our physicians and are getting them used to this and feel that this would be the easiest route to follow.

A 18. On its own, the NAHC form does not contain adequate and specific certification language to meet the legal requirements of ODJFS. However, because it contains the physician's synthesis of clinical findings that support

the need for home health services, it could be used to document the face-to-face encounter as the signed addendum to the JFS 07137 and/or the plan of care.

Q 19. If a consumer has Medicaid Pending eligibility and is later approved for Medicaid benefits, can we bill without a completed face to face Ohio Medicaid Form?

A 19. No. A face-to-face encounter is required.

Q 61 [New]. We do a lot of Mom/Baby visits for Ohio Medicaid. These are one time only skilled nursing visits. Would these be included under the face-to-face encounter requirement?

A 61. State plan, fee-for-service home health services are covered if provided on a part-time and intermittent basis. This does not include "one time only skilled nursing visits" such as mom/baby visits that you describe. These visits may be covered by Medicaid managed organizations at the discretion of the plan.

CERTIFICATION

Q 20. Will there be an exceptional circumstance whereby an encounter did not occur but the situation was out of the control of the agency (e.g. consumer dies)?

A 20. A reasonable effort must be made to meet the requirements. Certification of medical necessity may not be done without the performance of the face-to-face encounter. If the certification is not completed in a timely manner, a late entry should be used to record the certification in the medical record. The certification must be identified as a "late certification", the current date and time must be entered, and the services must be identified. When late certification is needed due to exceptional circumstances beyond the control of the HHA (e.g. consumer dies before thirtieth day from the start of care date), the certification must be completed as soon as possible. Timely and accurate completion of certification is crucial to support an accurate Medicaid reimbursement system. Incomplete or untimely certifications may result in denial of Medicaid payment when medical records are audited.

Q 21. Can a physician certify a consumer's eligibility and document the face-to-face encounter based on information received from another physician who recently saw the consumer, such as the consumer's attending physician during an acute stay?

A 21. No. The law mandates that either the certifying physician, or certain non-physician practitioners (NPPs) who inform the certifying physician, shall perform the face-to-face encounter. A consumer's encounter with an attending physician during an acute stay does not satisfy the requirement unless the attending physician is also the physician who certifies eligibility. However, certain NPPs in the acute care setting may collaborate with the certifying physician. In such cases, an NPP's encounter with the consumer during an acute or post-acute stay shall satisfy the requirement.

Q 22. If a facility physician completes the encounter documentation and the community physician completes the plan of care, which of the two may bill Medicaid for physician certification?

A 22. Only Medicaid-enrolled or Medicaid Managed Care Plan-contracted physicians who conduct a face-to-face encounter may bill Medicaid or the Medicaid Managed Care Plan for an evaluation and management code associated with a physician visit if one occurred. Unlike Medicare, Ohio Medicaid does not pay for physician supervision of a consumer receiving home health service and for physician certification/recertification when the consumer is not present.

Q 23. Will subsequent episodes be covered if face-to-face encounter requirements are not met timely during the first episode?

A 23. No. The face-to-face encounter requirement is necessary for the initial certification, which is a condition of payment. Without a complete initial certification, there cannot be subsequent episodes.

Q 24. If a consumer has a face-to-face encounter on day 33 after the start of care, will the HHA be denied payment for services provided from day 1 through day 30?

A 24. Yes. If the certification content requirements are not completed within the required time frames, the agency cannot bill.

Q 25. What effect does the face-to-face encounter requirement have on agency practices for meeting Medicaid requirements associated with the plan of care and certification of medical necessity? Can we use the certification form that is printed from our clinical computer system, with all required information, in place of the JFS 07137?

A 25. Long-standing Medicare regulations for Medicare Certified Home Health Agencies have described the distinct content requirements for the plan of care and certification. The Affordable Care Act (ACA) requires the face-to-face encounter as an additional certification requirement. Many providers have implemented the requirements for the plan of care and certification by using one form which meets all the content requirements of both the plan of care and certification. This approach is perfectly acceptable and it will continue to be acceptable. Several years ago, Centers for Medicare and Medicaid Services (CMS) ceased to require that providers use a specific form for the plan of care and/or certification. Providers have the flexibility to implement the content requirements as best makes sense for them.

Medicaid does not require a specific form for the plan of care or a specific form for physician documentation to support the clinical findings used to determine medical necessity. The documentation must include the certifying physician's synthesis of how the consumer's clinical condition, as seen during the face-to-face encounter, supports that the consumer medically needs home health services. This synthesis can be attached as a signed addendum to the JFS 07137 or the plan of care. The required data elements specified in rule 5101-3-12-01 of the Administrative Code and the JFS 07137 include: the name and credentials of the person who conducted the face-to-face encounter, the date of the face-to-face encounter, the certifying physician's signature and credentials with the certification statement, and date of the physician's signature.

Q 26. If the required information is contained in physician documentation, such as a discharge summary from an acute care episode, will this document suffice as the signed addendum to the "485" or plan of care (POC)?

A 26. No. The face-to-face encounter documentation must be included as part of the certification form itself, or as a signed addendum to it. Additionally, it must include the certifying physician's synthesis of how the consumer's clinical condition, as seen during the encounter, supports that

the consumer needs home health services. The physician's synthesis may also be a signed addendum to it.

Q 27. Do both the plan of care and the certification have to be signed by the same physician?

A 27. Prior to 2011, CMS manual guidance required the same physician to sign the certification and the plan of care. Beginning in 2011, CMS and Ohio Medicaid will allow additional flexibility associated with the plan of care when a consumer is admitted to home health from an acute or post-acute setting when the physician may not follow the consumer in the community. We are limited by the law that requires the certifying physician to document that the encounter occurred with him or her, or a permitted NPP. To adopt as much flexibility as the law allows, we will allow physicians who attend to the consumer in acute and post-acute settings to certify the need for home health care based on their face-to-face encounter contact with the consumer (which includes documentation of the face-to-face encounter), initiate the orders (plan of care) for home health services, and "hand off" the consumer to his or her community-based physician to review and sign off on the plan of care. As we described above, we continue to expect that in most cases the same physician will certify, establish and sign the plan of care. But the flexibility exists for home health post-acute consumers if needed.

Q 28. Can the physician document the certification when the physician or hospital physician has the consumer's record in front of him?

A 28. This scenario is acceptable as long as the face-to-face encounter occurs in the specified time frame of 90 days prior to the start of care or 30 days after the start of care and the documentation is completed before billing.

Q 29 [Revised]. Our software has a document for face-to-face encounters embedded in it to meet the Medicare guidelines. It is not the same as the Ohio Medicaid document. Is it possible to use the embedded form? The embedded form is tied to tracking within the software so our clients know when the face-to-face encounter has been returned and it is safe to bill.

If you think there is a possibility that we (our company or our clients) would need to receive some sort of a waiver to use the embedded form, who would be the contact at Medicaid?

A 29. An embedded form could be used for documenting a face-to-face encounter if it contains all the data elements specified in rule 5101:3-12-01 and JFS 07137. Also, the physician documentation as a signed addendum needs to be attached. No waiver process for embedded forms currently exists.

JFS 017137

Q 30. When are the new JFS 07137 instructions going to be posted?

A 30. The JFS 07137 "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" instructions are incorporated into the revised form. The previous instructions that were posted on the ODJFS FORMS website are now obsolete and have been removed.

Q 31. Have the HHA providers been notified? Have the hospital discharge planners been notified?

A 31. Yes. MHTL 3336-11-01 / MAL 574 was distributed to home health agencies and their professional associations, on January 21, 2011. A remittance advice message was posted for applicable providers for both the JFS 07137 and the JFS 02374 "Private Duty Nursing (PDN) Services Request". Hospital discharge planners were not specifically notified. In addition, notification was widely distributed via several e-mail lists maintained by the Bureau of Long Term Care Services and Supports.

Q 32. Has ODJFS educated the physicians?

A 32. MHTL 3336-11-01 / MAL 574 was distributed to the medical associations, applicable physician providers, and other professional groups on January 21, 2011. In addition, notification was widely distributed via several e-mail lists maintained by the Bureau of Long Term Care Services and Supports.

Q 33. With the new face-to-face encounter Medicaid requirement going into effect 2/1/11, please clarify whether this rule applies only to consumers who require skilled services in the home. This is how I am interpreting the form "JFS 07137". Or, does the new ruling apply to non-skilled consumers also? In other words, if we receive a request to see a waiver consumer for home care attendant (HCA) services only, does the face-to-face encounter apply?

A 33. The face-to-face encounter requirements apply to "basic" home health services which any Medicaid consumer may receive. These requirements apply to anyone for whom you are billing the G-codes for home health services (G0154, G0156, G0151, G0152, and G0156).

Q 34. The JFS 07137 has three sections. Sections II and III are both for post-hospital increased home health [and private duty nursing] services. Our providers have physicians who write post-hospital orders for 14 hours or less which don't qualify as increased home health services. Which section of the form should we use?

A 34. In this case use Section I. During the next revision of the JFS 07137 to avoid this confusion, the title of Section I will be amended as follows "BASIC HOME HEALTH SERVICES ~~UNRELATED TO AN INPATIENT HOSPITAL STAY INCLUDING~~ AND INCREASED SERVICES FOR A CONSUMER UNDER AGE TWENTY-ONE".

Q 35. If we attach page one of the JFS 07137 to our plan of care, is that sufficient to meet Medicaid needs?

A 35. No. Attaching page one (which contains Section I) of the JFS 07137 for home health services 14 hours or less per week or for increased services for consumers under age twenty-one together, and the face-to-face encounter documentation and the certifying physician's synthesis of how the consumer's clinical condition, as seen during the encounter, supports that the consumer needs home health services. The JFS 07137 and these documents may be attached as signed addenda to the plan of care. If increased (more than 14 hours up to 28 hours per week) home health services following a qualifying inpatient hospital stay are needed, then an entire form with a signed Section II must be completed in addition to face-to-face encounter and physician documentation.

Q 36. For a home care consumer of 14 hours or less, does ODJFS suggest that we mark the first block and the third block or just one or the other?

A 36. If the home health services are 14 hours or less per week, even if the consumer was post-hospital, the applicable certification is contained in Section I. In Section I, the physician certifying medical necessity for home health services should check the first block. If the physician is certifying medical necessity for increased home health services for a consumer under age twenty-one, then the physician should check the second block. If a face-

to-face encounter was conducted within the timeframe requirements, then the physician should check the third block. Section II is only for increased (more than 14 hours and up to 28 hours per week) home health services following a qualifying inpatient hospital stay.

Q 37. Why does it appear that therapy is included in the rules in the 14 hours of state plan services when Medicare has never counted therapy in any hourly discipline count?

A 37. The face-to-face encounter requirement applies to all five Medicaid home health services, including physical therapy, occupational therapy, and speech-language pathology. When this form is revised, we will expand the clarification offered in the second sentence in Section I on the JFS 07137 which states that "Eight hours of combined home health nursing, home health aide, and skilled therapies can be provided per day."

Q [Revision] 38. We do not do pediatrics, nor the PDN, can we use only the Section II as a 1 sheet form? Can we split the ODJFS form up into 3 separate forms and only send one section to the doctor to complete?

A 38. No. Section I of the JFS 07137 applies to all consumers receiving state plan home health services, not just pediatrics. Section II of the JFS 07137 is longer than one page. Sections II and III do not contain the treating physician's billing number.

Q 39. If we are using the JFS 07137 form, I have questions about the signatures. Name and Credentials of the Person who Conducted the Face-to-face encounter...Does the MD or their designee who actually does the face-to-face encounter need to sign this form, such as the physician who saw them in the hospital or nursing home, or can the physician who is signing the "485" plan of care fill in the name and date of the encounter and then sign as the certifying physician. Should the physician who has the face-to-face encounter sign that section and also sign as the physician certifying.

A 39. Only the qualifying treating physician may sign the certification block. Either the qualifying treating physician or certain non-physician practitioners (in Ohio advanced practice nurses and physician assistants) may perform the face-to-face encounter and complete the face-to-face encounter block. The qualifying treating physician who conducted the face-to-face encounter and is certifying medical necessity may sign both blocks.

Q 40. Is the treating physician's billing number the NPI number?

A 40. The treating physician's billing number is the physician's Medicaid provider number and/or NPI number.

Q 41. On section I of the 07137 in the two locator boxes for signature, credentials, and date of the person completing the face-to-face encounter; If the physician is the one that did the face-to-face encounter, does he/she have to fill out both locator boxes, or since the doctor is the one that did the face-to-face encounter (not an assistant or NP) would that cover the locaters?

A 41. The physician should complete the certifying physician's signature and date boxes, and check the third box above them. The face-to-face encounter box does not require a signature. If any of the other check boxes above are applicable, then they should be checked as well.

Q 42. Is the first part of the form which states it is to be used when services are "unrelated to an inpatient hospital stay" to be used if hospital stay is involved but less than 3 days?

A 42. Yes, use Section I.

Q 43. Do the face-to-face encounter requirements apply to Private Duty Nursing?

A 43. No. Private duty nursing is billed with a T1000 code, not G0154 for home health nursing services.

Q 44. Do independent providers need to have documented face-to-face encounters prior to providing services?

A 44. No. Face-to-face encounter requirements only apply to Medicare Certified Home Health Agencies. Independent providers may not bill G-codes for home health services (G0154, G0156, and the three therapy G-codes). Independent providers are not allowed by rule to provide home health services.

WAIVER

Q 45. Is ODJFS' designated case management agency ready to make sure that consumers have a face-to-face encounter prior to being accepted by a HHA for Medicaid state plan home health services, which includes 14 hour of aide services only?

A 45. No. It is the HHA's responsibility to ensure that a face-to-face encounter has occurred.

Q 46. Has the ODJFS designated case management agency been notified and educated?

A 46. Yes.

Q 47. Is this face-to-face encounter effective for State Plan only? If we have a Waiver only consumer and billing all hours to Waiver, is the face-to-face encounter documentation and certification necessary? If you could remove the state plan hours and have all hours billed to waiver it would alleviate the need for these physician visits. Will Carestar's Case Managers be notified that when developing All Service Plans, an agency may request that State Plan services may not be utilized?

A 47. The face-to-face encounter requirement is not required for waiver services. When state plan home health services are used, the face-to-face encounter requirements apply regardless if the Medicaid consumer is on a waiver or not. The applicable state plan services must be used before similar or "like" waiver services can be delivered or billed. The face-to-face encounter is required for the consumers for whom you are billing the state plan home health services G-codes.

An agency may not request that state plan home health services not be utilized. It is not appropriate for costs to be shifted in this manner.

Q 48. If the consumer has an all service plan (ASP) which lists home health services on it as well as private duty nursing (PDN) and waiver services, does a new admission after 2/1/11 still require the face-to-face encounter and paperwork to be processed? If a case is opened under a waiver (OHC or PASSPORT) and then at a later time adds state plan hours, do we then have to have a face-to-face encounter and the form completed?

A 48. If state plan home health services were not started before February 1, 2011 and no face-to-face encounter occurred, then yes a face-to-face
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encounter and associated certification of medical necessity is required within thirty days of the start of care.

30-DAY TERMINATING SERVICES (DISCHARGING)

Q [Revised] 49. If an agency decides to accept consumers onto care without a preceding face-to-face encounter, can the agency have the consumer sign an acknowledgment that if a face-to-face encounter does not occur within 30 days, they will be discharged. Does this serve as adequate notice of intent to discharge if consumer responsibilities are not met?

A 49. No. As a condition to participate in Medicare, the HHA must coordinate all aspects of the consumer's care needs. The HHA has always been required to coordinate with the consumer's physician to obtain a signed care plan, to update the care plan as needed, and to obtain a completed certification of medical necessity. The face-to-face encounter is now part of that certification requirement. An agency may not transfer liability to the consumer when technical requirements for payment, such as a face-to-face encounter, are not met. It is the agency's responsibility to see that the face-to-face encounter requirement is met, not the consumer's.

Q [Revised] 50. Can we discharge and then reopen the same consumer and/or is there a time limit we must wait before re-engaging a consumer who has not had that face-to-face encounter by that initial day 30?

A 50. No. The consumer has the right to receive a 30-day notice of intent to terminate home health services. What you propose could be perceived as an attempt to circumvent the intent of the Affordable Care Act and could be a practice referable to Medicaid program integrity.

Q [Revised] 51. If within 30 days the Medicaid consumer does not have a face-to-face encounter, HHAs can't bill, so will they be discharging to another agency?

A 51. It is in the best interest of the HHA to develop an internal process to ensure that this does not happen. Medicaid consumers would appreciate that the HHA ensures their continuity of care whenever possible. Before the

consumer is discharged, the consumer must receive a 30-day notice of intent to terminate home health services.

Q 52. Will the next HHA accept a consumer without a documented encounter?

A 52. We cannot predict what the next HHA will do; however, the next agency would have 30 days inclusive of the start of care date to obtain a documented encounter.

Q 60 [New]. We have a patient that is referred to us for weekly medication set ups. The payer source is Medicaid state plan. The patient does not have waiver. We open the case on March 1st and 30 days later on March 31st we still are unable to obtain a face to face encounter for the patient because the patient missed their scheduled doctor appointments. We decide to discharge the patient because we are unable to bill Medicaid. Would we be required to give a 30 day notice on March 31st? This would mean we would continue to provide care from March 31st to April 30th. The first 30 days of care from March 1st to March 31st is not billable because we did not have a face- to-face encounter. If we are still required to give a 30 day notice the care given between March 31st and April 30th would be non-billable as well unless the patient keeps their appointment and we obtain the face to face encounter.

A 60. Yes, you would be required to give a 30-day notice before home health services could be terminated. The 30-day discharge notice requirement applies to Medicaid consumers receiving state plan home health services per rule 5101:3-12-03(C)(2) and to waiver consumers per rule 5101:3-45-10(A)(15), both of the Administrative Code. The discharge notice process is separate from the face-to-face encounter requirement for "basic" state plan home health services. When there is a start of care for "basic" state plan home health services, the face-to-face encounter requirement applies. If a 30-day discharge notice is given to a consumer, and then if services are delivered beyond 30 days and the provider wishes to discharge the consumer, a new 30-day discharge notice is required. In essence, continuing to deliver care for 30 days negates the preceding 30-day discharge notice.

MANAGED CARE

Q 53. Is the face-to-face encounter required for consumers in Medicaid managed care plans?

A 53. Yes. The face-to-face encounter provision applies to all Medicaid home health services.

Q 54. Can you please guide providers to the regulation that states the face-to-face encounter also applies to the Medicaid Managed Care Plans?

A 54. The face-to-face encounter requirements apply to state plan home health services which any Medicaid consumer may receive. That includes both fee-for-service Medicaid and services received through a managed care plan. Nothing in the Affordable Care Act exempts Medicaid managed care consumers from the face-to-face encounter requirement; therefore, Ohio Medicaid must apply this requirement to consumers who receive home health services through managed care plans.

Q 55. At the Medicare level, Medicare Advantage plans are not included in this regulation.

A 55. Since Ohio Medicaid does not administer the Medicare program, it would be inappropriate for this agency to interpret Medicare requirements affecting Medicare Advantage Plans.

CHANGE OF PAYER

Q 56. If the consumer changes to Medicaid from Medicare, is another face-to-face encounter required?

A 56. If the Medicare encounter is within the ninety days prior to the Medicaid home health services start of care date, then it may be used for the initial Medicaid certification if the qualifying treating physician or certain non-physician practitioners (NPPs) conducted the face-to-face encounter.

Q 57. For the dual eligible consumer starting with a Medicare episode that is changed to Medicaid at day 121, does the consumer need a Medicaid face-to-face encounter done?

A 57. According to paragraph (B) of rule 5101:3-12-01 of the Administrative Code, a face-to-face encounter with the consumer must occur within the ninety days prior to the home health care start of care date, or within thirty days following the start of care date inclusive of the start of care date. The face-to-face encounter may have occurred during the Medicare stay.

Q [Revision] 58. Here's a scenario: A consumer has commercial insurance primary and state plan Medicaid secondary. Commercial insurance allows 20 therapy visits/year. The consumer is admitted on 2/1/11 and commercial insurance is billed for the first 20 visits and then Medicaid is billed for subsequent visits. Does a face-to-face encounter certification need to be obtained at the time of the initial admission in February? Or at the time that Medicaid starts to be billed? Or not at all?

A 58. If a face-to-face encounter was done within the prior 90 days, it will satisfy this requirement regardless of the payer source. If none was done during the prior 90 days, a face-to-face encounter and certification of medical necessity must be done within 30 days of the Medicaid admission's start of care.

Q 59. If a consumer, who is receiving on-going home health services, is hospitalized and then discharged to home health services, is this a new start of care requiring the face-to-face encounter?

A 59. After hospital discharge, if the situation qualifies as a resumption of care with the same Health Insurance Prospective Payment System (HIPPS) code, then it is not a new start of care.