Texas Association for Home Care & Hospice
Leading ★ Advancing ★ Advocating

56th Annual Meeting

Thursday, August 28, 2025

1:30pm-2:30pm

5a. From Intake to Approval: Mastering Home Health Acceptance, Face to Face Compliance and Denial Prevention

Presented by:

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Navigating Home Health Acceptance To Service

Ensuring Compliance, Timely Care, and Preventing Denials under CoP §484.105

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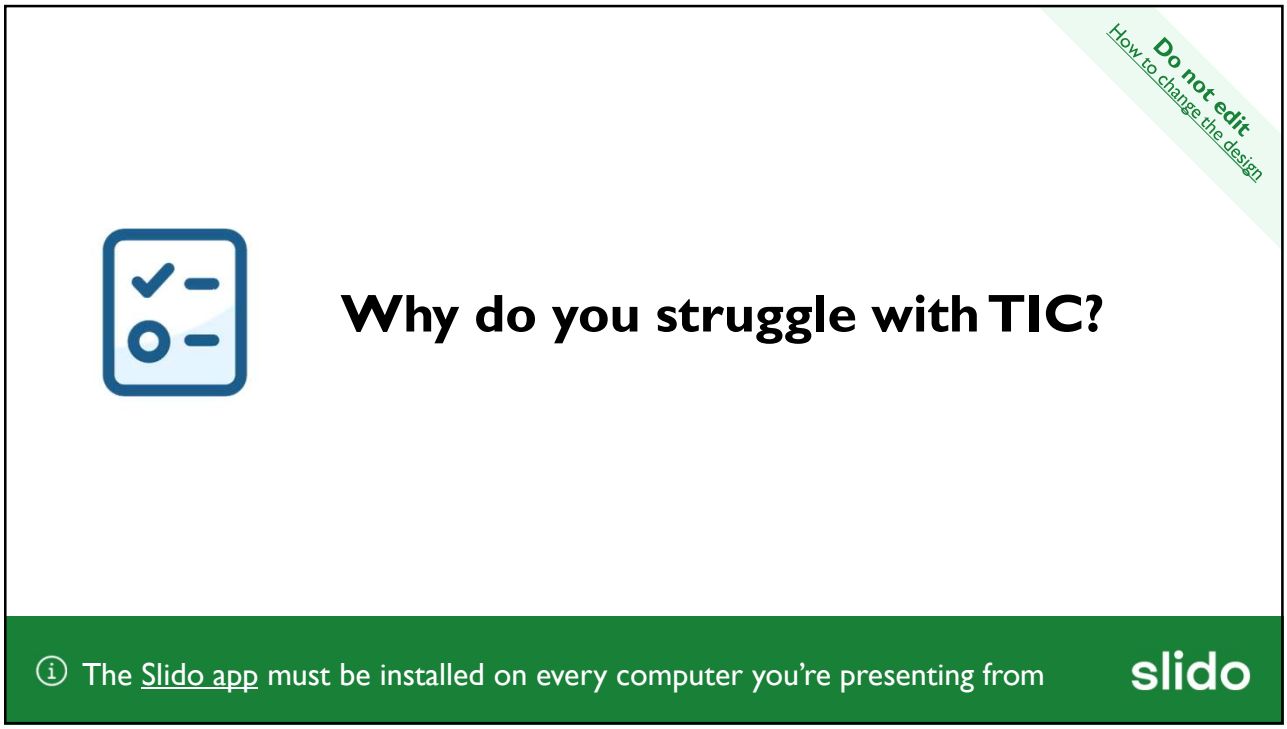
1

Agenda

1. Introduction & Foundation
2. The Critical Need for Speed
3. The Gateway of Care
4. Fortifying Your Revenue Cycle
5. Continuous Improvement

2


Do not edit
How to change the design
Why do you struggle with TIC?
The Slido app must be installed on every computer you're presenting from
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3


The Foundation

4

Definition

- This CoP is the bedrock of your agency's operations. It mandates that you must:
  - Timely initiation of care in home health is when the start or resumption of care occurs on the date specified by the physician, or within two days of the referral date or inpatient discharge date. The Centers for Medicare & Medicaid Services (CMS) requires that initial home health visits occur within 48 hours of the referral or the patient's return home.
  - Timely access to home health care is important for reducing costs and adverse outcomes for patients. Some reasons for delays in home health care include patient avoidance and care postponement.
  - The Agency for Healthcare Research and Quality says that timeliness of care is a practice's ability to provide care quickly after recognizing a need. Timely care can lead to better patient health outcomes and engagement.

5

CMS Process Measure

Type	Measure Title	Posted on Care Compare	NQF Status	Risk Adjusted	Measure Description	Numerator	Denominator	Measure-specific Exclusions	OASIS-E Item(s) Used
Process - Timely Care	Timely Initiation of Care*	Yes	Not endorsed	No	Percentage of home health quality episodes in which the start or resumption of care date was on the physician-ordered SOC/ROC date (if provided), otherwise was within 2 days of the referral date or inpatient discharge date, whichever is later.	Number of home health quality episodes in which the start or resumption of care date was on the physician-ordered SOC/ROC date (if provided), otherwise was within 2 days of the referral date or inpatient discharge date.	Number of home health quality episodes ending with discharge, death, or transfer to inpatient facility during the reporting period, other than those covered by generic or measure-specific exclusions.	None	(M0102) Date of Physician-ordered Start of Care (M0104) Date of Referral (M0030) Start of Care Date (M0032) Resumption of Care Date (M1000) Inpatient Facility discharge (M1005) Inpatient Discharge Date (M0100) Reason for Assessment

6

The High Stakes of Home Health

35%

of post-hospital patients fail to receive home health care within the critical first week.

This delay leaves the most vulnerable patients without essential support during a high-risk transition period.

41%

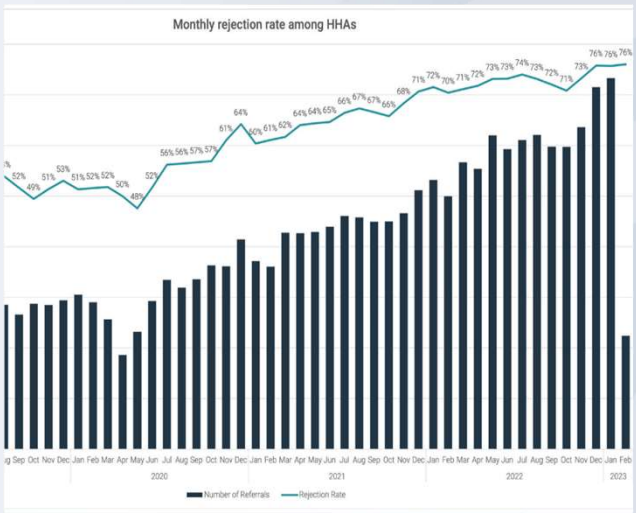
Higher Mortality Rate

Patients who don't receive timely home health care face a significantly higher risk of death compared to those who do.

7

Referral Rejection Rates

- Home Healthcare News-July 2023 stated patient complexity in home health and rejection rates reach an all time high.
- Shifting to a value-based model
- Specifically, 76% of patients being referred to home health care were not being accepted as of December 2022. That number was up from 54% in 2019.



8

By the Numbers

- Of 48,497 episodes, 16,251 (33.5%) had a start-of-care nursing visit >2 days after discharge.
  - These episodes had 26.4% higher rates of 30-day re-hospitalizations and ED visits as compared with episodes with timely visits.
- Increased odds of this time frame were associated with being black or Hispanic and having solely Medicaid insurance.
- Odds were highest for patients discharged on Fridays, Saturdays, and Mondays.

https://www.sciencedirect.com/science/article/abs/pii/S1525861021003017#:~:text=Of%2048%2C497%20episodes%2C%2016%2C251%20(33.5,Fridays%2C%20Saturdays%2C%20and%20Mondays

9

By The Numbers

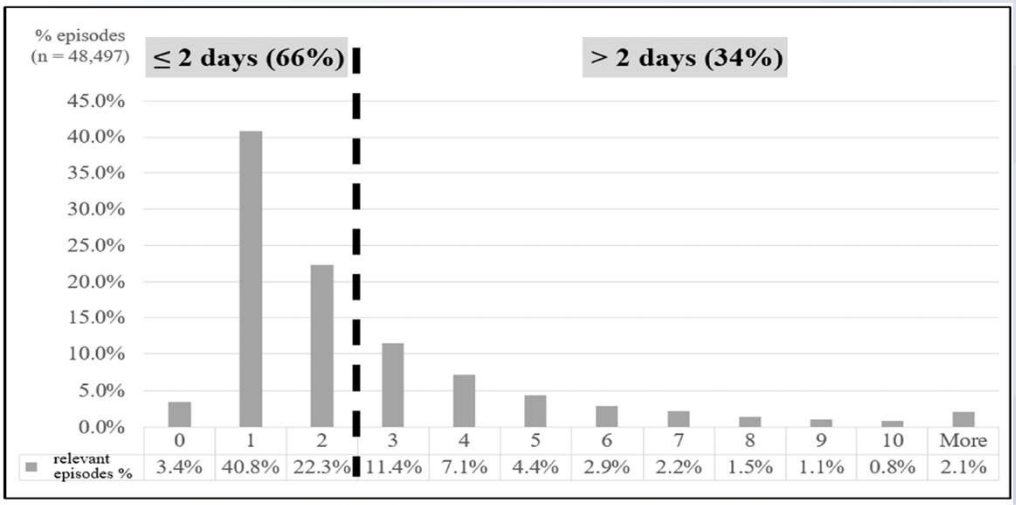


Figure 1. Days between hospital discharge to homecare first nursing visit

10

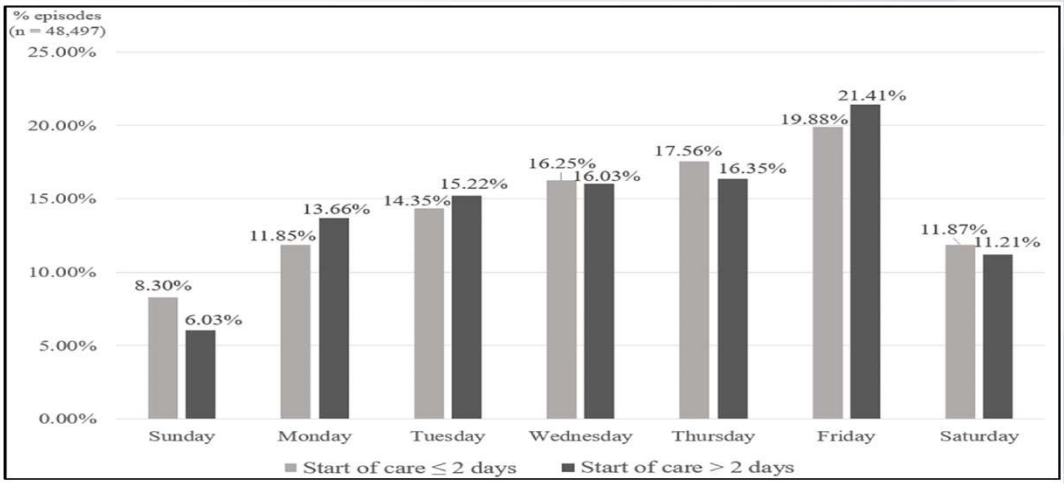
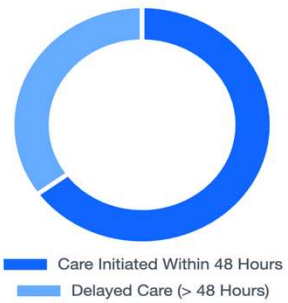


Figure 2. The proportion of hospital discharges between start-of-care ≤ 2 days group and a start-of-care > 2 days group by day of week

11

The Race Against the 48 Hour Clock

National Average: Timely Initiation of Care



Why Timeliness Matters

The first 48 hours post-discharge are critical. Timely care initiation allows clinicians to address issues before they escalate into emergencies.

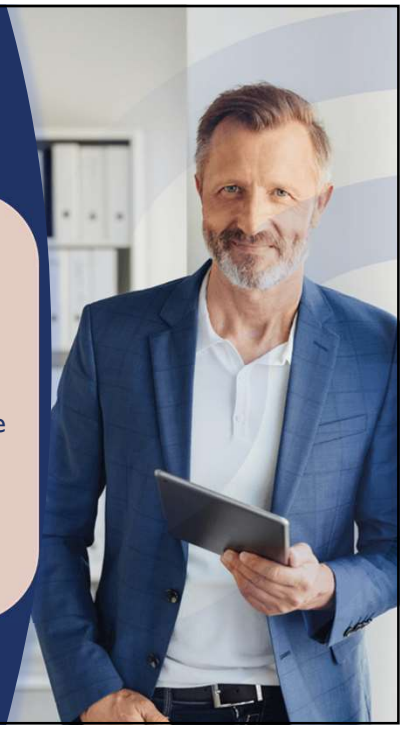
- ✓ **Reduces Rehospitalizations:** Early intervention prevents complications. Up to 70% of rehospitalizations occur in the first two weeks.
- ✓ **Improves Patient Outcomes:** Immediate medication reconciliation and patient education lead to better health.
- ✓ **Ensures Compliance:** Meeting this measure is a major focus for state surveyors and a reflection of your agency's quality.

12

High Cost of Delays in Care

Delays in starting home health care are linked to significant negative outcomes.

- A 2024 analysis by the Partnership for Quality Home Healthcare found:
  - In 2022, nearly 35% of Medicare patients referred to home health after a hospital stay did not receive services within 7 days.
  - Patients who did not receive timely home health had a 41% higher mortality rate.
- Research shows up to 70% rehospitalizations from home health occur within the first two weeks of the episode. Early intervention is key to preventing this.



13

Home Health Referrals Among MA Members

Following acute hospitalization, members with discharge orders to receive home health services between January 2021 and October 2022 were identified in a medical claims database consisting of MA beneficiaries. HH treated group consisted of 2115 discharges, and untreated group consisted of 761 discharges.. The treated group experienced lower mortality at 30 days (2% vs 3%), 90 days (8% vs 10%), 180 days (11% vs 14%). The untreated group also experienced higher readmissions at 30 days (13% vs 10%), 90 days (24% vs 16%), and 180 days (33% vs 24%)

Conclusion-MA members referred to HH after acute hospitalization who did not receive home health services had higher mortality.

AJMC July 2024- https://doi.org/10.37765/ajmc.2024.89579

14

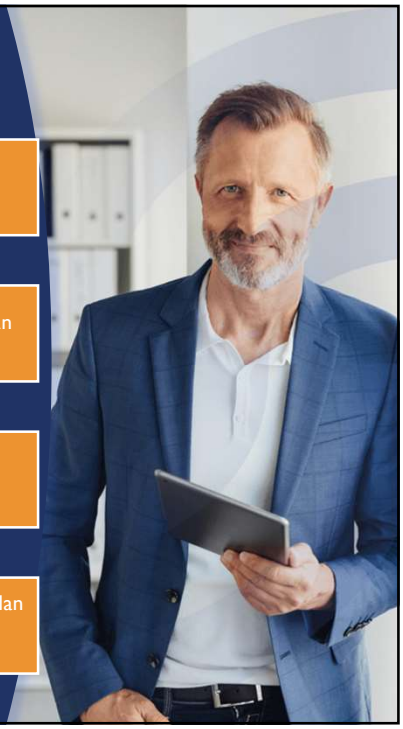
Takeaway Points

Following acute hospitalization, MA members with orders to receive home health may not ultimately receive these services for member- and health care system related reasons.

Common reasons for unfulfilled home health referrals include member refusal of service and an inability to contact or locate the member,

Among those with Dc orders to receive HH, those who did not receive service experienced significantly higher mortality at 30, 90 and 180 days.

Because the referring hospital physicians believe that their members will receive HH and may plan their DC accordingly, it is important to address gaps in understanding, anticipate barriers to service, and strengthen communication between inpatient teams and HH agencies.



15

Conditions of Participation

16

Conditions of Participation §484.105

Would require HHAs to develop, implement, and maintain an acceptance-to-service policy that is applied consistently to each prospective patient referred for home health care.

The policy must address, at minimum, the following criteria related to the HHA's capacity to provide patient care:

- The anticipated needs of the referred prospective patient.
- The HHA's case load and case mix.
- The HHA's staffing levels.
- The skills and competencies of the HHA staff.

HHAs will be required to make specified information available to the public that is reviewed whenever services are changed, and no less often than annually.

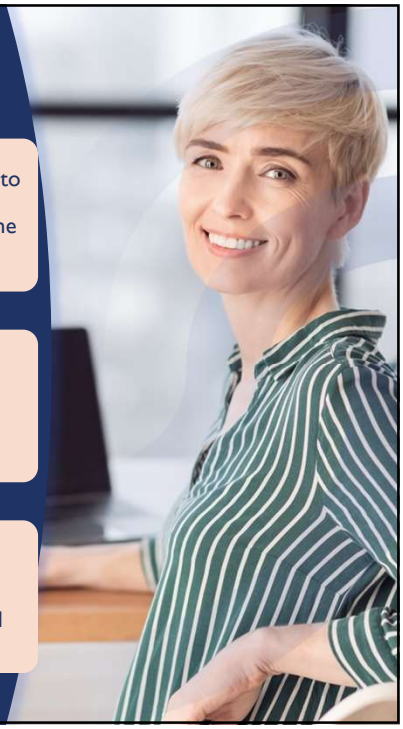
17

Conditions of Participation §484.105

At a minimum, this policy would need to address the agency's capacity to provide patient care, the anticipated needs of the referred prospective patient, the agency's caseload and case mix, agency staffing levels, and the skills and competencies of the agency staff.

Agencies would also need to make information available to the public about geographic coverage areas, types of specialty services, service duration, and service frequency to make it easier for patients and caregivers to select an appropriate agency and avoid delays in care.

HHAs will be required to include information regarding the HHA's caseload and case mix (that is, the volume and complexity of the patients currently receiving care from the HHA), anticipated needs of the referred prospective patient, the HHA's current staffing levels, and the skills and competencies of the HHA staff.



18

Conditions of Participation §484.105

- This CoP is the bedrock of your agency's operations. It mandates that you must:
  - Organize, manage, and administer resources to meet every patient's needs.
  - Attain and maintain the highest practicable functional capacity for each patient.
  - Provide services in accordance with the plan of care.
  - Ensure administrative and supervisory functions are not delegated and that services under arrangement are monitored and controlled.
  - Must disclose service area, specialty services, and client/team members ratio.

19

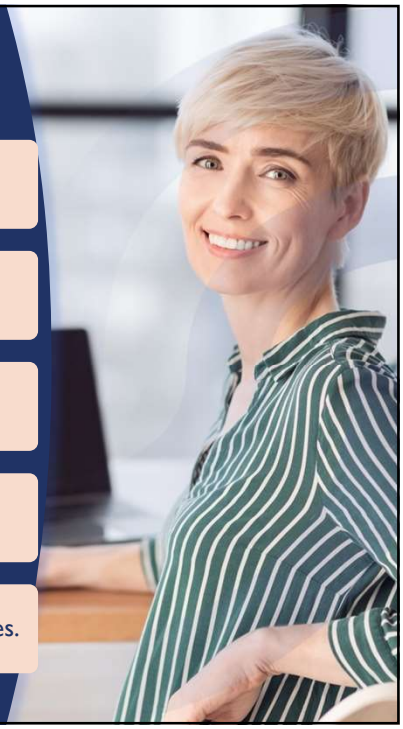
The Core Mandate

- Your agency must have a clear, written policy for accepting patients that aligns your resources with patient needs to provide safe, effective, and timely care.
  - Criteria for acceptance (clinical and administrative eligibility).
  - A statement ensuring patients are accepted only when you can adequately meet their medical, nursing, and social needs.
  - Process of evaluating referrals for acceptance or denial.

20

Compliance and Monitoring

- Training to all staff
- Regularly audit referral acceptance decision and patient outcomes.
- Intake Coordinator? Sales/marketing team?
- Will be important for intake to know about staffing/competency challenges
- QAPI may end up doing a PIP if you have poor referral/intake outcomes.



21

Case Study: The Acceptance Decision

78 YO Male, post hospitalization for CHF exacerbation. Needs SN for teaching and cardiac assessment. Lives in rural area at edge of your service area.

Non-Compliant

- The intake coordinator accepts the patient without checking nurse availability. The scheduler discovers no nurse is available to see the patient for 4 days.
- Result: Violation of timely initiation of care, increased risk of rehospitalizations, and potential for a compliant survey.

Compliant

- The intake coordinator reviews the referral, notes the rural location, and consults the clinical manager. The manager confirms a nurse with cardiac experience is available for a SOC visit the next day.
- Result: Compliant with CoPs, good patient care, and reduced risk of adverse events.

22

Face to Face Encounter

23

🏠 Laying the Foundation: The CMS Face-to-Face Requirement

Focus on the Purpose/Intent:
Confirm the patient's eligibility for home health services.

Medicare Requirement:
A valid Face-to-Face encounter is mandatory to qualify for Medicare-covered home health care.

- 🕒 **Timing**: Encounter must occur **within 90 days before** or **30 days after** the **start of care (SOC)**
- 👨‍⚕️ **Who Can Perform**:
- Physician
- Nurse Practitioner (NP)
- Physician Assistant (PA)
- Certified Nurse Specialist (CNS)
- Certified Nurse Midwife (CNM)
  (All must be working in collaboration with the certifying physician)

24

Provider Documentation must Include:

Qualifying criteria for home health benefit must be met in Encounter note.

- Confirmation the patient was seen
- Relevant **clinical findings** (e.g., history of present illness, physical exam, chief complaint)
- Clear **support for homebound status**
- Justification for need of **skilled services** (SN, PT, ST)

The certifying provider must support why now and why in the home.
(F2F Encounter note)

Remember:

- Only the patient's provider can diagnose the patient. Codes cannot be assigned per clinician documentation only.

25

What a compliant Face-to-face encounter is:

- **Confirms a face-to-face visit occurred** — typically this includes **chief complaint**, **history of present illness**, and/or **physical exam**
- Clearly supports that **home health is the appropriate level of care** (justifies need for SN, PT, ST or ongoing OT)
- Explains why patient needs care in the home **right now** (wound, unstable BP, weights, or blood sugar, falls, new medications, recent ED trip/hospitalization)
- Demonstrates why the patient is **homebound**, with specific findings such as:
  - Shortness of breath (SOB)
  - Generalized weakness
  - Edema
  - Cognitive impairment/confusion
  - History of repeated falls
  - Gait abnormality requiring assist to leave home

26

What a compliant Face-to-face encounter is NOT

⚠ **Face-to-Face Attestation Form ≠ Valid Face to Face**

- The **Attestation Form is a supplement — not a substitute** for a valid provider note
- A **referral alone is not enough** — the **provider's documentation must align** with the reason for home health
- If the Encounter note shows **no clinical need** (e.g., stable vitals, no impairments, no med changes), but the order requests home care — it **raises compliance and payment risk**
- Example:
  - Patient/family reports falls or confusion
  - PCP sends latest note + order
  - Note lacks evidence of functional decline or skilled need

27

How to identify and document the true Focus of Care

Before building a plan of care, start with the cornerstone—verifying the Face-to-Face encounter to meet CMS requirements.

- **Review Referral Documentation**
  - Physician referral, F2F
- **Conduct Thorough Initial Assessment**
  - Functional status, Clinical Conditions
- **Determine Skilled Needs**
  - Wound care, PT/ST/OT, med mgt.
- **Prioritize FOC with most Complex need**
- **FOC is captured in clinician narrative and POC**
  - Measurable interventions and goals, physician orders

28

Putting It All Together

Review it Twice, Send it Once!

Face to Face Encounter

For all SOCs, the patient must be seen by an authorized provider in a Face-to-Face Encounter that addresses the primary diagnosis (agency's main stated focus of care) within 90 days prior to the SOC or within 30 days after.

The F2F encounter note must be attached to the patient's chart.

Plan of Care

The primary diagnosis at SOC, ROC, Recert, and Other Follow-up OASIS timepoints must be in one of the twelve PDGM Primary Clinical Groups.

Must support the Primary Diagnosis and include Interventions/goals identified in Oasis and F2F

Focus of Care Diagnosis

The assessing clinician must document the Focus of Care Diagnosis for all ordered disciplines at SOC, ROC, Recert, and Other Follow-up OASIS timepoints.

This stated focus of care must be assessed during a F2F Encounter within the allowed timeframes at SOC.

29

🎯 Success in Action: Solutions that Prevent Denials & Survey Hits

Knowledge = Payment Power

Keep it simple. Don't overcomplicate.

✅ **Face-to-Face & OASIS = Episode Authorization**

If requirements aren't met —**at risk for no payment.**

🔍 Make sure your team understands:

- The **Face-to-Face rule**
- How **OASIS** impacts episodic payment
- The Oasis AND Plan of Care must align with the Face to Face
- All three elements must support the Primary Diagnosis on the POC

30

Blueprint for Responsibility-

Clearly define each role to keep the project — and patient care — on solid ground.

Physician/NPP	Intake/CI Manager	Clinician	Coders
Complete F2F visit within required timeframe	Obtain and verify compliant signed F2F documentation	Verify F2F visit completion. Review F2F for condition and diagnosis requiring home health	Review F2F to confirm primary diagnosis/skilled need for home health
Document clinical findings supporting skilled home health services	Coordinate with clinical team to address missing or incomplete F2F	Document SOC clinical findings supporting skilled services related to F2F	Ensure diagnosis aligns stated Focus of care
Certify patient's homebound status	Track and resolve F2F issues	Notify clinical manager if needed services are not addressed in F2F	Assign primary diagnosis per PDGM
Maintain ongoing communication and collaboration with the home health agency	Upload F2F to EMR		Notify clinical team of documentation, F2F, or non-PDGM diagnosis discrepancies

31

🛠 Strengthen Your Workflow for Payment Success

- **Implement hard stops** at critical workflow points
- 📅 **Review issues weekly** with Finance & Leadership
- 🔁 **Own the process** — assign clear ownership for each step
- ✅ **Strong intake process** backed by a **strong clinical manager**
- 🔍 **Clear accountability** across providers, staff, and clinicians
- ⚠️ **Monitor OASIS validation errors** — who's tracking trends?
- 🔎 **QAPI team**: Identify care gaps and address ADR risks
- 💵 **Financial team**: Report on down pays, short pays, LUPAs, outliers, and denials

32

Steer Clear of These F2F Documentation Pitfalls

Prevent cracks in your compliance foundation by avoiding common Face-to-Face errors.

- Wounds with unknown, unconfirmed, or varied etiologies
- Missing, unidentified, or invalid F2F Encounter note
- Discrepancy between diagnoses treated in F2F versus focus of care identified on the OASIS/POC
- F2F encounter note does not include a diagnosis in one of the twelve PDGM groups
- Referral today for SN/PT due to weakness and falls but last PCP appt was last month and not related to weakness or falls

33

Examples of good and bad F2F (CVA)

HPI Comments
Details:
78 y.o patient is here today for hospital f/u 01/31 DX:Stroke,HTN, requesting home health to help with a ADL's at home.

Review of Systems
Status of ROS: 10 or more systems reviewed and unremarkable except as noted in history and below

No documentation of residuals from stroke requiring home health's assist

Documentation of CVA with residual of left sided weakness and expressive aphasia

Assessment & Plan

Seizure disorder (HCC)
- Patient has a known history of seizure disorder is typically managed on Vimpat and Depakene; however family felt she was too lethargic with Vimpat and they stopped the medication 3 days ago.
- Now presents with seizures; patient had seizure activity at home and witnessed seizure in the ED. Received Ativan. CT head no acute intracranial process.
- Neurology consulted -received Keppra in the ED and is to continue Depakene -dose adjusted.
- Continue seizure precautions, orders as per neurology, n.p.o. as is postictal, resume p.o. intake when more awake and alert.

Stage 3b chronic kidney disease (HCC)
- Creatinine at baseline. Will monitor renal function

History of cerebrovascular accident (CVA) with residual deficit
- Left-sided weakness and expressive aphasia. Patient is slow to respond but is able to communicate basic needs.
- Will resume in the a.m. aspirin and statin.

Essential hypertension

34

Example of good and bad F2F (weakness, unsteady gait)

13. Frequent falls

Clinical Notes: Pt. will continue to use assistive device and safe technique with transfers.
Pt to follow up with ordered physical therapy services

Referral To:Physical Medicine
Reason:Referral for Physical Therapy Evaluation and Treatment due to frequent falls, gait stability and balance. Therapy Exercises 2 x a week x 6 weeks.

No documentation of diagnosis causing frequent falls, gait instability and unsteady balance

Documentation that gait instability is related to bilateral knee OA

7. Gait instability

Referral To: [redacted] Home Health
Reason:HH referral for physical therapy due to bilateral knee OA with gait instability, pt is using a walker. To prevent falls, gait training and strengthening | RMC doc

35

Recent Face-to-Face Clarifications-Win for US!

In summary, per CFR §424.22:

- **A clinical nurse specialist can perform the FTF if recognized as a provider in their state.**
- **A community provider may conduct the FTF if not the certifying provider, as long as collaboration is documented.**
- **The FTF doesn't need to come from the last facility of discharge; for example, a hospital record can be used even if the patient was discharged from a SNF.**

36

Ways this will help TODAY

🔄 **Expanded Options for Face-to-Face Encounters**

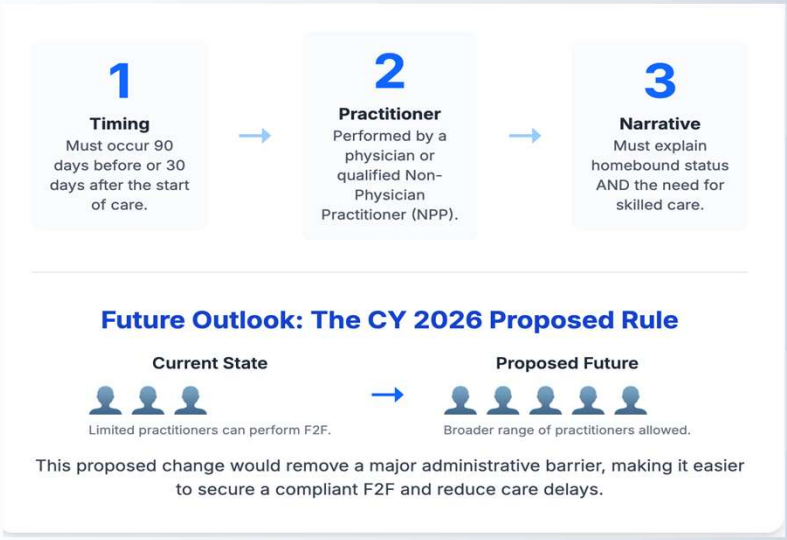
- **Certified Nurse Specialists (CNS)** are now eligible to perform the Face-to-Face encounter
- Increases flexibility while maintaining compliance

- 🤝 **Collaborative Referrals: PCP + Specialist**
- For **community referrals**, if the **PCP has not seen the patient**, but a **specialist initiates the referral**:
  - PCP may sign the Face-to-Face as long as collaboration with the specialist is documented
  - This reflects best practice for coordinated, patient-centered care

- **Hospital-to-Home Transition Support**:
- When **home care need is related to an acute condition**, and the patient is discharged to a SNF due to weakness:
  - The hospital discharge summary can serve as supporting documentation for the home health referral
  - Ensures continuity of care and supports compliance

37

FTF: The Gateway to Payment



38

PALMETTO GBA:
Published 05/08/2025

Home Health: Who Can Perform a Face-to-Face Encounter?

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

- **The certifying physician or a physician, with privileges, who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health**
- **The certifying nurse practitioner, certifying clinical nurse specialist, or a nurse practitioner or clinical nurse specialist who is working in accordance with state law and in collaboration with a physician or in collaboration with an acute or post-acute care physician with privileges who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health**

If a beneficiary was admitted from home and the certifying provider and the face-to-face performing provider are different:

- **A community provider can perform the face-to-face even if they are not the certifying provider**
- **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 face-to-face**
- **No evidence of collaboration is required if it can be determined that the certifying provider and the provider who performed the face-to-face are from the same practice**

Reference: Code of Federal Regulations, Section 424.22 Requirements for home health

39

AI for the Intake Process

40

Operational Efficiency

- Referral to Admission Automation
  - Referral review to ensure patient's align with agency criteria and goals.
  - Auto population of patient information into EHR and dashboards for ease of patient management, to reduce data entry errors.
- Route Optimization for Caregivers: Smart Scheduling
  - AI-driven tools can optimize travel routes for caregivers, reducing travel time and costs, and improving time spent with patients.
- Predictive Staffing
  - AI can forecast demand for services based on historical data, patient acuity, and seasonal trends, ensuring optimal staffing levels
- Streamlined Scheduling:
  - AI-powered scheduling systems can automatically adjust based on real-time changes in patient needs or staff availability, reducing manual effort.

41

Governance-Key Pillars

- **HIPAA Compliance and Beyond:** Adherence to the Health Insurance Portability and Accountability Act (HIPAA) is the baseline. This includes ensuring all data is encrypted, access is strictly controlled, and Business Associate Agreements (BAAs) are in place with all third-party AI vendors.
- **Informed Consent and Data Transparency:** Patients and their families must be provided with clear, understandable information about what data is being collected, how it will be used by the AI system, and with whom it will be shared. Consent should be an ongoing conversation, not a one-time checkbox.
- **Data Minimization and Purpose Limitation:** Only the data necessary for the specific function of the AI tool should be collected. The purpose for which the data is used should be clearly defined and adhered to.

42

Algorithmic Accountability and Fairness

- Bias Detection and Mitigation: AI models must be rigorously tested for biases related to race, gender, socioeconomic status, and other demographic factors. Regular audits and the use of diverse and representative datasets are essential to mitigate these risks.
- **Transparency and Explainability:** "Black box" AI systems, where the decision-making process is opaque, are not suitable for high-stakes environments like healthcare. The reasoning behind an AI's recommendation or action should be understandable to clinicians, patients, and their families.
- **Independent Validation and Efficacy:** Before deployment, home health AI tools should undergo independent validation to ensure their safety and effectiveness. This includes real-world testing in diverse home care settings.

43

Clear Lines of Accountability and Liability

When an AI system is involved in a clinical decision that results in harm, determining responsibility can be challenging. A clear framework for accountability is crucial.

- **Shared Responsibility Model:** Liability should be distributed among all stakeholders, including the AI developer, the home health agency that deploys the technology, the clinicians who use it, and in some cases, the patient or their caregiver who interacts with it.
- **Human-in-the-Loop Oversight:** For critical clinical decisions, a qualified human healthcare professional must remain in the loop to review and override AI-driven recommendations. The AI should be viewed as a tool to augment, not replace, human judgment.
- **Regulatory Oversight:** Government agencies, such as the Food and Drug Administration (FDA) for medical devices and the Office for Civil Rights (OCR) for HIPAA enforcement, must have clear authority and guidelines for regulating home health AI products.

44

Lifecycle Approach to Governance

Governance is not a one-time task but an ongoing process that extends throughout the entire lifecycle of an AI system.

- **Pre-deployment Assessment:** Rigorous evaluation of an AI tool's safety, efficacy, and ethical implications before it is introduced into a home health setting.
- **Continuous Monitoring and Post-Market Surveillance:** Ongoing monitoring of the AI's performance in real-world conditions to detect any unforeseen issues, biases, or safety concerns.
- **Regular Audits and Updates:** Periodic audits of AI systems and their governance frameworks to ensure they remain effective and aligned with evolving best practices and regulations.

45

46

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47