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

Winter Conference
Wednesday, February 18, 2026
2:00pm-3:15pm

3a. Home Health Medical Review & The New F2F Clarification

Presented by:

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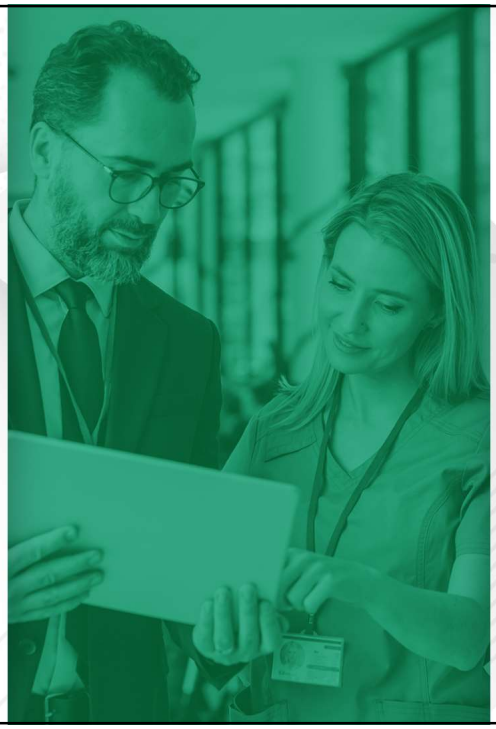
3a. Home Health Medical Review & The New F2F Clarification



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Melinda A. Gaboury, COS-C
Chief Executive Officer

Melinda A. Gaboury, with more than 33 years in home care, has over 23 years of executive speaking and educating experience, including extensive day to day interaction with home care and hospice professionals. She routinely conducts Home Care and Hospice Reimbursement Workshops and speaks at state association meetings throughout the country. Melinda has profound experience in Medicare PDGM training, billing, collections, case-mix calculations, chart reviews and due diligence. UPIC, RA, ADR & TPE appeals with all Medicare MACs have become the forefront of Melinda's current impact on the industry. She is currently serving as Chair of the The Alliance/HHFMA Advisory Board and Work Group and is serving on the board of the Home Care Association of Florida and the Tennessee Association for Home Care. Melinda is also the author of the Home Health OASIS Guide to OASIS-E1 and Home Health Billing Answers, 2025.

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Home Health Medical Review

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Levels of Medical Review

- Post-payment Additional Development Requests (ADR) by Medicare MAC
- Recovery Audit Contractor (RAC)
- Unified Program Integrity Contractor (UPIC)
- Supplemental Medical Review Contractor (SMRC)
- Targeted Probe & Educate (TPE)
- Office of Inspector General (OIG)

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Home Health Medical Review

What does a Recovery Audit Contractor (RAC) do?

- RAC's review claims on a post-payment basis. The RAC's detect and correct past improper payments so that CMS and Carriers, FIs, and MACs can implement actions that will prevent future improper payments

What does a Unified Program Integrity Contractor (UPIC) do?

- UPICs perform fraud, waste, and abuse detection, deterrence and prevention activities for Medicare and Medicaid claims processed in the United States. Specifically, the UPIC's perform integrity related activities associated with
  - Medicare Part A & B, Durable Medical Equipment (DME),
  - Home Health and Hospice (HH+H), Medicaid, and
  - The Medicare-Medicaid data match program (Medi-Medi).

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Home Health Medical Review

What does a Supplemental Medical Review Contractor (SMRC) do?

- The Centers for Medicare & Medicaid Services (CMS) contracts with a Supplemental Medical Review Contractor (SMRC) to help lower improper payment rates and protect the Medicare Trust Fund. The SMRC conducts nationwide medical reviews of Medicaid, Medicare Part A/B, and DMEPOS claims to determine whether claims follow coverage, coding, payment, and billing requirements. The focus of the medical reviews may include vulnerabilities identified by CMS data analysis, the Comprehensive Error Rate Testing (CERT) program, professional organizations, and Federal oversight agencies. At the request of CMS, the SMRC may also carry out other special projects to protect the Medicare Trust Fund.

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Targeted Probe and Educate

- MAC medical record reviews include up to three rounds of TPE review. If the provider's error rate remains high upon completion of the first round, then the provider is retained for the second and, potentially, a third round of review.
- Providers with an elevated error rate after three rounds of TPE will be referred to CMS for additional action
- Your MAC will select the topics for review based upon existing data analysis procedures.
- The claim sample size per provider, per topic, and a round of TPE review is limited to a minimum of 20 and a maximum of 40 claims
- Note that the sample is per provider, **per topic**, and per round.
- The TPE process includes provider specific education that will focus on improving issues without allowing other problems to develop along with an opportunity for the provider to ask questions. Education will be offered after each round of 20 to 40 claims reviewed.
- In addition, there is an opportunity for intra-round education as well if the nurse reviewer identifies an easily curable error that can be easily corrected during the review phase.

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Additional Development Request

- An Additional Development Request (ADR) is generated by a Medicare MAC Medical Review Department to request a provider's medical record documentation for a specific claim. Claims are reviewed to ensure compliance with Medicare's coverage, coding, payment and billing policies.
- When a claim is selected for an ADR, the claim is moved to the Fiscal Intermediary Standard System (FISS) **status/location S B6001**.
- **MAC/Contractors will select the topics for review based upon existing data analysis procedures.** Provider nonresponse to medical records requests will count as an error.
- **RECEIPT OF DOCUMENTATION** (if by the MAC)– When your documentation has been received the claim is moved from status/location S B6001 to S M50MR for review. Providers can monitor the S M50MR status/location in FISS, to verify that their documentation has been received. Confirmation of receipt is also provided when using to submit your documentation.

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Home Health Medical Review

What does Office of Inspector General (OIG) do?

- Since its 1976 establishment, the Office of Inspector General (OIG) has been at the forefront of the Nation's efforts to fight waste, fraud and abuse and to improve the efficiency of Medicare, Medicaid and more than 100 other Department of Health & Human Services (HHS) programs.
- Audits vary in length from a few weeks to several months, depending on the complexity of the project and the amount of required research. We provide management with periodic updates of our progress and we attempt to minimize disruption to staff and operations during the process.
- All appeals are sent back through the OIG

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Documentation for Submission

- OASIS form for the dates of service in question
- Face-to-face encounter document
- Current home health certification and plan of care (appropriately signed and dated by doctor and nurse; and/or the receipt date from agency as needed)
- Any additional MD orders for the date of service in question, signed and dated by the doctor
- Therapy initial evaluation, reevaluations, and treatment visit notes for previous month and date of service in question
- Skilled nursing visit notes for previous month and date of service in question
- Social worker notes as applicable
- Home health aide visit notes for date of service in question
- ABN (if issued): The written notice issued to the beneficiary by the provider of services when they believe that Medicare will not pay for the services
- Records such as orders, clinic notes, discharge summary, from the MD office, hospital, or skilled nursing facility may be submitted to support the home health services were reasonable and necessary

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#1 Denial – Certification Requirements

Common Denial Reason Cited for Certification Requirements NOT met:

- The initial certification was missing or invalid
- The five elements of the certification for the referral to homecare were not attested to by the same physician, making the certification statement incomplete.
- The physician signed the certification/plan of care prior to the date of the face-to-face encounter occurring. The certifying physician and/or allowed practitioner must have a face-to-face encounter assessment before they certify the beneficiary for eligibility for home healthcare.
- The plan of care/certification was signed after the claim was billed.
- The certification statement on the plan of care was altered/illegible and/or did not contain all the required elements.

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#1 Denial – Certification Requirements

How to Avoid claim denial: The initial certification requirements below must be met to avoid denials for claims billed in subsequent episodes.

The 5 elements must be attested to or acknowledged by the certifying physician or allowable provider for the initial certification:

1. The patient is confined to their home
2. The patient needs intermittent skilled nursing, or physical therapy, or speech-language pathology services.
3. Patient is under the care of a physician or allowable provider
4. The plan of care has been established and is periodically reviewed by a physician or allowable provider.
5. A F2F encounter occurred no more than 90 days prior to or within 30 days after the start of the home health care, was related to the primary reason the patient requires home health services and was performed by an allowed provider type.

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Documentation At Time of Admission

- Admission Documents address multiple requirements under regulation for home health providers related to information that must be provided to patients both verbally and in writing including consent to treat, patient rights, grievance process, contact information for the agency, specific policies – infection prevention and control, etc.
- All clinicians should be educated to stress the importance of the admission packet/documents to patients and caregivers.
- Establishing a practice that all clinicians review the admission packet/documents at the start of each visit and prior to leave to update the visit schedule , note communication documentation between disciplines, perform medication reviews is recommended.

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Signatures

- (SOM Appendix B) In the absence of a state requirement, the HHA should establish a timeframe for physician *or allowed practitioner* authentication, i.e. for obtaining a physician *or allowed practitioner* signature for verbal/telephone orders received. The signature may be written or in electronic form following the requirements of the particular system. A method must be established to identify the signer.
- SOM Appendix M Review all entries, including physician (written and verbal) orders to determine whether they are legible, clear, complete, and authenticated and dated in accordance with hospice policy and currently accepted standards of practice.

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Signatures

- Handwritten - A handwritten signature is a mark or sign by an individual on a document signifying knowledge, approval, acceptance, or obligation. NOTE: Stamped signatures are not typically acceptable. CMS permits use of a rubber stamp for signature in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability. By affixing the rubber stamp, the provider is certifying that they have reviewed the document.
- Electronic - Providers using electronic systems shall recognize there is a potential for misuse or abuse with alternate signature methods. For example, providers need a system and software products that are protected against modification, etc., and should apply adequate administrative procedures that correspond to recognized standards and laws. The individual whose name is on the alternate signature method and the provider bear the responsibility for the authenticity of the information for which an attestation has been provided. Physicians are encouraged to check with their attorneys and malpractice insurers concerning the use of alternative signature methods. (Electronic Signature Policy)

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Signatures

- Signature Logs - Providers will sometimes include a signature log in the documentation they submit that lists the typed or printed name of the author associated with initials or illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document. Reviewers should encourage providers to list their credentials in the log. However, reviewers shall not deny a claim for a signature log that is missing credentials. Reviewers shall consider all submitted signature logs regardless of the date they were created. Reviewers are encouraged to file signature logs in an easily accessible manner to minimize the cost of future reviews where the signature log may be needed again.
- Signature Attestation Statement

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#2 Denial – Face-to-Face Requirements Not Met

5FF2F/5TF2F — Face-to-Face Encounter Requirements Not Met

- **Reason for Denial**
  The services billed were not covered because the documentation submitted for review did not include (adequate) documentation of a face-to-face encounter.
- **How to Avoid This Denial**
  Specific documentation related to face-to-face encounter requirements must be submitted for review. This includes, but is not limited to, the following:
  - A face-to-face encounter must occur no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care;
  - Encounter was related to the primary reason the patient requires home health services; and
  - Encounter was performed by a physician or allowed nonphysician practitioner
- **The certifying physician must also document the date of the face-to-face encounter.**

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Face-to-Face Encounter FINAL Update

Finalize to revise § 424.22(a)(1)(v)(A) to state that the face-to-face encounter must be performed by one of the following: a physician, a nurse practitioner, a clinical nurse specialist, or a physician assistant as defined at 42 CFR 484.2; or a certified nurse-midwife as defined in section 1861(gg)) of the Act as authorized by State law. We also finalize to remove § 424.22(a)(1)(v)(C), which limits the face-to-face encounter to the certifying physician or allowed practitioner unless the encounter is performed by either of the following:

● A certified nurse midwife as described in paragraph (a)(1)(v)(A)(4) of this section.

● A physician, physician assistant, nurse practitioner, or clinical nurse specialist with privileges who cared for the patient in the acute or post-acute facility from which the patient was directly admitted to home health and who is different from the certifying practitioner.

The additional flexibility should decrease ambiguity regarding which providers are able to complete the face-to-face encounter and potentially improve access to home health services by increasing the number of providers allowed to perform the face-to-face encounter.

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#2 Denial – Face-to-Face Requirements Not Met

- **The certifying physician's and/or the acute/post-acute care facility's medical record for the patient must contain the actual clinical note for the face-to-face encounter visit that demonstrates that the encounter:**
  1. Occurred within the required time frame;
  2. Was related to the primary reason the patient requires home health services; and
  3. Was performed by an allowed provider type
- **This information can be found most often in, but is not limited to the following examples:**
  - Discharge summary;
  - Progress note;
  - Progress note and problem list; or
  - Discharge summary and comprehensive assessment

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TELEHEALTH Face-to-Face

- Telehealth visits allowed to meet the **Face-to-Face (F2F)** requirement for all patients
- This visit would be conducted by allowed physician or NP (PA not allowed)
- These visits are NOT reported on the claim.
- F2F via telehealth is extended through **December 31**, **2027** after which CMS expects telehealth services to be summarily limited to follow-up contact with patients and would not expect to see provision of hospice services furnished via telecommunications systems
- Telehealth system utilized must be HIPAA Compliant

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#3 Denial – Medical Necessity

- **5F041/5A041 — The Documentation Submitted Was Insufficient to Support That the Skilled Nurse Service(s) Billed Was/Were Reasonable and Necessary**
- **Reason for Denial**
  The skilled nursing visit denied were not covered because the documentation submitted in response to the Additional Development Request (ADR) did not support medical necessity for continuation of skilled services.
- Initially, skilled nursing services were required to observe and assess the beneficiary's medical condition and response to the plan of care. The key to Medicare coverage is for the documentation to "paint a picture" of the beneficiary's overall medical condition indicating the need for skilled service.

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#3 Denial – Medical Necessity

- Skilled observation and assessment beyond a three-week period may be justified when documentation supports the likelihood of further complications or an acute episode. However, observation and assessment are not reasonable and necessary when the documentation indicated that the abnormal findings are part of a longstanding pattern of the patient's condition and there is no attempt to change the treatment to resolve them
- CMS Internet-Only Manual (IOM), Pub 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4 (PDF)
- CMS Medicare Learning Network (MLN) Matters article MM6698 — Signature Guidelines for Medical Review Purposes

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#3 Denial – Medical Necessity

- Use the most appropriate ICD-10-CM codes to identify the beneficiary's medical diagnosis/diagnoses
- Submit documentation to support the need for skilled care. Some reasons for services may include, but are not limited to, the following:
  - New onset or acute exacerbation of diagnosis (include documentation to support signs and symptoms and the date of the new onset or acute exacerbation)
  - New and/or changed prescription medications — new medications: those the beneficiary has not taken recently, i.e., within the last 30 days. Changed medications: those, which have a change in dosage, frequency, or route of administration within the last 60 days.
  - Hospitalizations (include date and reason)
  - Acute change in condition (be specific and include changes in treatment plan as a result of changes in medical condition, e.g., physician contact, medication changes)

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#3 Denial – Medical Necessity

- Changes in caregiver status or an unstable caregiving situation (e.g., involvement of many services or community resources, unsafe or unclean environment which interferes with putting the plan into action)
- Complicating factors (i.e., simple wound care on lower extremity for a beneficiary with diabetic peripheral angiopathy)
- Inherent complexity of services; therefore, the services can be safely and effectively provided only by a skilled professional
- Lack of knowledge or understanding of the beneficiary's care, which requires initial skilled teaching and training of a beneficiary, the beneficiary's family or caregiver on how to manage the beneficiary's treatment regime
- Reinforcement of previous teaching when there is a change in the beneficiary's physical location (i.e., discharged from hospital to home)
- Any type of reteaching due to a significant change in a procedure, the beneficiary's medical condition, when the beneficiary's caregiver is not properly carrying out the task, or other reasons which may require skilled reteaching and training activities

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#4 Denial – Medical Necessity for Therapy Services

Reason for Denial
The medical documentation submitted did not show that the therapy services were reasonable and necessary and at a level of complexity which requires the skills of a therapist.

How to Avoid This Denial
Ensure that the documentation submitted supports the medical necessity of the therapy services when responding to an ADR.

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#4 Denial – Medical Necessity for Therapy Services

Skilled therapy services must be reasonable and necessary to the treatment of the patient's illness or injury within the context of the patient's unique medical condition. To be considered reasonable and necessary for the treatment of the illness or injury these services must be:

- Consistent with the nature and severity of the illness or injury, the patient's particular medical needs, including the requirement that the amount, frequency, and duration of the services must be reasonable;
- Considered, under accepted standards of medical practice, to be specific, safe, and effective treatment for the patient's condition

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#4 Denial – Medical Necessity for Therapy Services

- Provided with the expectation, based on the assessment of the patient's rehabilitation potential, that the condition of the patient will improve materially in a reasonable and generally predictable period of time, or the services are necessary to the establishment of a safe and effective maintenance program
- Services involving activities for the general welfare of any patient, e.g., general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation **do not constitute skilled therapy**.

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#4 Denial – Medical Necessity for Therapy Services

To ensure therapy services are effective, at defined points during a course of treatment, for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must perform the ordered therapy service.

During this visit, the therapist must assess the patient using a method which allows for objective measurement of function and successive comparison of measurements.

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#4 Denial – Medical Necessity for Therapy Services

Initial Therapy Assessment

- For each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must assess the patient's function using a method which objectively measures activities of daily living

Reassessment at least every 30 days (performed in conjunction with an ordered therapy service)

- At least once every 30 days, a qualified therapist (instead of an assistant) must provide the ordered therapy service, functionally reassess the patient, and compare the resultant measurement to prior assessment measurements.

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#4 Denial – Medical Necessity for Therapy Services

Ensure the documentation below is supported in each therapy visit:

- Are the skills of a therapist needed to treat the illness or injury? Could the services be carried out by non-skilled personnel after sufficient training?
- Why did the patient require professional treatment, education or training?
- What specialized treatment, education or training did the clinician actually provide?
- How did the patient and/or caregiver respond to the treatment/training provided?
- How did the patient benefit from the specialized knowledge of the clinician?
- Did the service(s) provided meet the accepted standards of medical practice, as well as specific and effective treatment for the patient's condition?
- Were reassessments performed by the qualified therapist for each therapy provided at least every 30 days? Did the reassessment include comparative measurements to prior measures and documentation of the effectiveness (or lack of) of the therapy?
- Was the amount, frequency and duration for each therapy service provided reasonable?

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#5 Denial – Homebound

How to Avoid Claim Denial: - Documentation must meet the homebound requirement
An individual shall be considered "confined to the home" (homebound) if the following two criteria are met:

1. Criterion One:
The patient must either:
- Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence **OR**
- Have a condition such that leaving his or her home is medically contraindicated.

If the patient meets one of the criterion one conditions, then the patient must ALSO meet two additional requirements defined in criterion two below.

2. Criterion Two:
- **There must exist a normal inability to leave home; AND**
- **Leaving home must require a considerable and taxing effort.**

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#5 Denial – Homebound Status

Examples of Homebound Documentation:

- The patient is homebound due to recent hospitalization s/p right TKA with muscle weakness requiring the use of a walker and another person to leave home safely due to shortness of breath, poor endurance, pain and decreased mobility with an increased risk for falls.
- The patient is homebound following a traumatic fall with injury requiring the use of a wheelchair and another person to leave home safely due to muscle pain/weakness, impaired balance and shortness of breath with exertion. The patient's recent exacerbation of CHF and current cardiac status contributes to the taxing effort requiring frequent periods of rest due to shortness of breath and chest pain.

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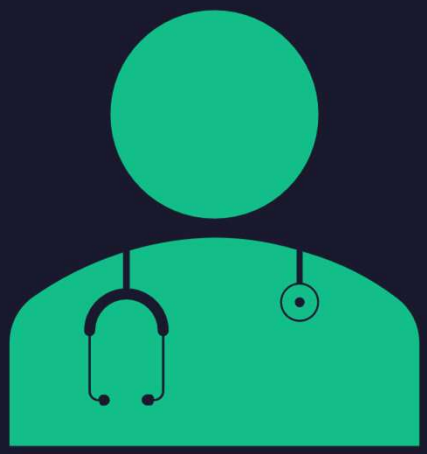
Medical Review Appeals Process



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Medical Review Appeal Levels

Five levels of appeals for all claim denials

- 1st Level – Redetermination
- 2nd Level – Reconsideration
- 3rd Level – Administrative Law Judge
- 4th Level – Department of Appeals Board (DAB)
- 5th Level – Federal Court Review

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Medical Review Appeal Levels

- **1st Level – Redetermination**
- Time limit for filing electronically/portal/fax: 120 days from the receipt of the notice of initial determination. (Date noted on results letter)
- Appeal the specific reason for the claim denial that is limited to the denied claim dates.
- Technical denials may not be possible to appeal – Examples:
  - Late F2F
  - Absence of a F2F
  - Untimely verbal or written certifications
  - Untimely signatures on Plan of Care

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Medical Review Appeal Levels

1st Level – Redetermination

- MAC has 60 days to make the redetermination decision and send a letter to the agency with the results of the review.
- Unfavorable decisions may result in an overpayment for which the agency will receive a Demand Letter with the amount due in 30 days.
- Read letter carefully regarding overpayment amounts.
  - Possible to stop recoupment by submitting the appeal within 30 days of the Demand Letter.

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Overpayment Demand Letters- 1st Level of Appeal

- Agency receives notification by first class mail of overpayment determination. (Letter date is the determination date)
- Day 1-15: May submit a rebuttal request within 15 days of the dated on the demand letter.
- Day 16-30 and 31-40: Can request a redetermination and potentially prevent any recoupment from occurring on day 41.
- Day 41: Recoupment begins unless a request for redetermination has been submitted. MAC shall continue to stop recoupment on or after day 41 from the demand letter date when the appeal request is received and validated.
- Please note that interest will continue to accrue during this period.
- If unfavorable, recoupment begins on day 76 of the demand letter date.

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Medical Review Appeal Levels

2nd Level of Appeal – Reconsideration

- Appeal is reviewed by a Qualified Independent Contractor (QIC)
  - Consists of a panel of physicians and other healthcare professionals
  - QIC will obtain a copy of the redetermination decision and medical record
- File a request within 180 days of the receipt of the redetermination decision.
- Read letter carefully to ensure how to submit the appeal and where to mail it. Appeals have been dismissed due to not sending to the right address of the QIC.
- QIC has 60 days to determine a decision.

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Overpayment Demand Letters- 2nd Level of Appeal

- May receive a Reconsideration Revised Overpayment Demand Letter on open balances only with 30 calendar days from the date of the appeal decision.
- Day 30 (following reconsideration decision): Provider must either pay the full amount of the overpayment or request for and Extended Repayment Schedule (ERS) to avoid recoupment.
- Day 60 (following reconsideration decision): Recoupment continues until the debt is fully paid.
- Recoupment does not cease based on an appeal to the Administrative Law Judge.

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Medical Review Appeal Levels

3rd Level of Appeal – Administrative Law Judge (ALJ)

- Administrative Law Judge is an adjudicator employed by the Department of Health & Human Services (HHS), Office of Medicare Hearings and Appeals (OHMA)
- File a request for a hearing before an ALJ within 60 days after the receipt of the QIC's reconsideration decision. Must have at least $190 in controversy to file.
- File a written request using the CMS form OMHA-100 or a written request that includes the:
  - Name and address of the beneficiary including their Medicare number
  - Name and address of appellant (hospice agency)
  - Control number assigned by the QIC
  - Dates of service
  - Reason the appellant disagrees with the QIC's reconsideration
  - A statement of any additional evidence to be submitted and the date it will be submitted.

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Medical Review Appeal Levels

3rd Level of Appeal – Administrative Law Judge (ALJ)

- Send a copy of the request for the hearing to other parties such as the beneficiary or the beneficiary's estate. Failure to send a copy of the request may be result in the hearing request to be vacated and dismissed.
  - Recommend sending certified mail and retain a copy of the mailing notice to include in the request.
- Receive a Notice of Hearing from the court assigned to hear the appeal with the date, time and name of the ALJ. Ensure all parties are available the date and time assigned. May request to change the date by immediately notifying the court.
- All hearings are held by telephone.

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Medical Review Appeal Levels

4th Level – Department of Appeals Board (DAB)/Medicare Appeals Council

- 60 days from the receipt of the ALJ decision to file an appeal request

5th Level – Federal Court Review

- 60 days from the receipt of the Council's decision to file an appeal request
- Amount in controversy must be a minimum of $1900

https://www.cms.gov/medicare/appeals-grievances/fee-for-service

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QUESTIONS?

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Have any questions?
Scan the QR Code to schedule a call!
Thank You for Participating!
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