Get doctors to detail homebound status on face-to-face forms to avoid denials

Now more than ever, agencies need to analyze doctors’ narratives on face-to-face forms to avoid claim denials due to lack of enough detail to justify the patient’s homebound status.

Face-to-face forms have been under greater scrutiny from intermediaries in the past several months, and lack of proper documentation of homebound status is one of the top reasons for claim denials.

Regardless of why the patient is homebound, the physician’s narrative must be thoroughly detailed.

Circular logic, such as “They’re homebound because they’re homebound,” with no explanation as to why, will result in a denial from an intermediary such as Medicare administrative contractor Palmetto GBA.

Other documentation that could trigger denials include: frequent absences from the home for non-medical reasons, the beneficiary is working a regular job or the beneficiary is regularly walking out of the home.

Reviewers and administrative law judges place little weight on the following reasons doctors provide for homebound status: Unable to safely leave home unassisted; medical restrictions; severe shortness of breath, shortness of breath upon exertion; confusion, unable to get out of home alone; dependent upon adaptive devices; and requires assistance to ambulate. To avoid denials, these items must be explained in detail. For example, doctors should explain what happens when patients do leave home alone.

If a doctor says on the face-to-face form that a patient is homebound due to Parkinson’s disease, that alone won’t explain why the patient is homebound. Further explanation, such as noting that the patient was in the latter stages of Parkinson’s, would be needed.

Examples of good, bad narratives

Nearly half of the denials Palmetto issues are for face-to-face encounter requirements not met, according to an analysis of the home health claims it processed from April 2013 to June 2013.

Use these examples as a guide to narratives that are acceptable and those that were not approved:

**Acceptable example:** Patient paralyzed from a recent stroke and is unable to ambulate safely, requires wheelchair for home mobility and is unable to drive. Transfer and self care ADLs require assistance from another person and patient is limited by low back pain rated 9/10. Patient also experiences dyspnea with minimal exertion. Further, when out of the home without supervision the patient’s safety is an issue due to diagnosis of dementia. The totality of these findings support a considerable and taxing effort to leave home by way of mobility, pain, mobility and altered mental status.

This narrative is acceptable due to its length and level of specificity. There is detail relative to the pain rating, patient safety, and specific diagnostic reasons for the care and for the homebound status.

**Denied example:** I certify my clinical findings support that this patient is homebound per CMS guidelines due to: Patient unable to leave home unattended and continues to require assistance with ADLs. This was denied due the circular logic, lack of specificity to the patient and lack of detail.
**Acceptable example:** The patient is temporarily homebound secondary to status post total knee replacement and currently walker dependent with painful ambulation. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decomposition or adverse events from the new COPD medical regimen. This narrative is detailed and offers specific information for a specific patient, listing safety issues relative to the patient’s inability to leave home.

**Denied example:** I certify my clinical findings support that this patient is homebound per CMS guidelines due to: s/p left hip fracture surgery. There is circular, nonspecific logic in the narrative and could relate to any patient who had hip surgery.

**Acceptable example:** Based on my clinical findings this patient is homebound due to extreme dyspnea limiting her ambulation. This patient is currently walker dependent related to muscle weakness. PT is needed to restore the ability to walk without support. This example has specificity, the homebound reason is related to the dyspnea and the patient is currently unsafe.

**Denied example:** My clinical findings support the need for home health services as follows: skilled nursing, home health aide, physical therapy. I certify my clinical findings support that this patient is homebound per CMS guidelines due to: poor ambulation, risk for falls. The narrative is vague and generalized. There is no detail as to what is actually going on with the patient. Many folks have poor ambulation and are at risk for falls. What is different here?

**Improve your face-to-face chances**

To improve your odds of getting doctors to fill out a homebound status narrative correctly the first time, agencies should:

**Educate the office manager or medical supervisor at the doctor’s office about proper wording.** The office manager or medical supervisor would be the one responsible for gathering the needed documentation and getting the doctor to sign the face-to-face form.

**Give physicians’ offices a list of questions doctors can use to probe for homebound status during face-to-face visits.** Questions would include such details as how far can a patient walk before feeling shortness of breath, says Mary Carr, associate director for regulatory affairs for the National Association for Home Care & Hospice.

**Adapt the face-to-face forms you provide doctor’s offices.** Remove unnecessary information, such as asking for the referral date or patient’s birth date, since those details aren’t needed by intermediaries and will eat into the doctors’ time. Asking for unnecessary details will cause the physicians to spend less time writing detailed narratives.

**Include on the face-to-face form two distinct areas in which doctors will fill out narratives:** One for homebound status, the other to detail a need for skilled services. And provide plenty of space for doctors to fill out each of those narratives. The extra space will help doctors understand they need to provide detailed content.

**Provide a list of scenarios from the Medicare Benefit Policy Manual** that can help physicians understand key terms CMS may expect to see. Such terms include what is meant by leaving the home with “taxing effort” and what is meant by leaving for a “short term duration,” Carr advises.

**Provide doctors’ offices with examples of narratives that an intermediary might find acceptable.** Your agency can include information from its MAC explaining what the MAC wants. Information from Palmetto, for instance, can be found at [http://tinyurl.com/orbznna](http://tinyurl.com/orbznna).