IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT2025104 JULY 8, 2025

# Face-to-face encounter and documentation requirements clarified for home health PA requests

The Indiana Health Coverage Programs (IHCP) recently published updated documentation regarding home health prior authorization (PA) requests in *IHCP Bulletins* *BT202525* and *BT202545*. This bulletin addresses additional questions about home health PA face-to-face encounter and documentation requirements.

## Face-to-face encounter requirements

1. ***Who is responsible for the face-to-face encounter?***

   The qualified treating practitioner must document the face-to-face encounter. The documentation must include:

   - The date the practitioner saw the patient
   - Detailed clinical findings from the visits
   - Clear connections between clinical findings and home health care needs
   - Practitioner signatures and dates on all required documents

   The home health agency is responsible for submitting face-to-face documentation to the payer's PA contractor.

   Please note that it is unacceptable for the practitioner to verbally communicate the encounter to the home health agency, where the home health agency would then document the encounter as part of the certification for the provider to sign.

2. ***Can the face-to-face encounter be conducted via telehealth when it may be difficult to get the member to the treating practitioner's office?***

   Yes, face-to-face encounters can be conducted via telehealth. Healthcare Common Procedure Coding System (HCPCS) codes eligible for telehealth reimbursement can be found on *Telehealth and Virtual Services Codes*, accessible from the *Code Sets* webpage at in.gov/medicaid/providers. Providers must follow the billing policies for telehealth, which can be found in the *Telehealth and Virtual Services* provider reference module.

3. ***For the continuation of long-term home health services, is the face-to-face annual encounter requirement on a rolling or fixed calendar year?***
   The face-to-face encounter requirement will be on a **rolling 12-month basis** that is within 90 days prior or 30 days after the previous year's face-to-face date.

   

   For example, the member's previous face-to-face encounter took place on Dec. 30, 2025. Therefore, the annual face-to-face encounter would need to be conducted between Oct. 1, 2026, and Jan. 29, 2027.

   A face-to-face encounter needs to be documented within the past 12 months and considered valid at the time of the PA request by Jan. 1, 2026. This guideline applies to long-term home health services delivered through fee-for-service (FFS) and managed care programs.

4. ***Who is responsible for verifying the annual face-to-face encounter (for long-term home health) if the member changes payers?***
   The home health care new or existing provider is responsible for ensuring the new or existing payer receives the face-to-face encounter. Treating practitioners must attest that the face-to-face encounter is completed on a 12-month rolling basis.

   Managed care entities (MCEs) and Acentra Health, the FFS prior authorization and utilization management (PA-UM) contractor, are responsible for validating that the face-to-face encounter has occurred on a 12-month rolling basis and is up-to-date when a new PA request is submitted.

5. ***If the condition of focus changes, is a new face-to-face encounter required?***
   If the primary condition changes, a new face-to-face encounter and PA request is required **only** if there is an increase in home health hours.

   Please note that when an existing plan of care overlaps with a new prior authorization request, an updated plan of care (POC) must be submitted. The total medical POC shall be reviewed by the ordering practitioner and home health agency personnel as often as the severity of the patient's condition requires, but at least once every 60 days per *Code of Federal Regulations 42 CFR 484.60(c)(1)*.

6. ***For long-term home health services, can the face-to-face encounter be an encounter while hospitalized during the face-to-face time frame, or must it be from the certifying practitioner?***
   For continuation of home health services after the PA exception for hospital discharge, a qualified practitioner must follow PA requirements for new PA requests and reauthorization requests.

   The medical necessity for home health services must be certified by the member's qualified treating practitioner. Qualified practitioners review the written plan of care every 60 days .
   Qualified practitioners include:
   - Ordering physician
   - Nurse practitioner
   - Clinical nurse specialist
   - Physician assistant

7. ***Does the home health agency need to submit a new face-to-face encounter to the PA-UM contractor if the member goes to the hospital even if their PA has not expired?***
   No, if the PA has not expired, the original face-to-face encounter would still be in effect.

8. ***What is considered an interruption in home health services?***
   The IHCP considers an interruption of service to be 60 days or more from the end of the last authorization period.

   A new face-to-face encounter is required if there is an interruption of home health services.

## Additional documentation requirements

1. ***Does the comprehensive assessment need to be sent with the POC?***
   Yes, the comprehensive assessment needs to be submitted with the POC, along with the Home Health CMS 485 form. This form can be found on the *Forms* webpage at in.gov/medicaid providers (under the *Medical Clearance Forms and Certifications of Medical Necessity* section).

2. ***Is there specific guidance on how to document the member's acceptance of the POC?***
   Documentation of the member's acceptance of the POC is the responsibility of the home health agency. It is at the agency's discretion to ensure the documented acceptance in case of an audit.

   Per *42 CFR 484.60(e)*, the expectation is that the members are involved, aware and acknowledge the POC. The member should be given a copy of the POC.

3. ***Will documentation by the clinician in the patient chart stating that the member acknowledges plan of care be sufficient?***
   Documentation of the member's acceptance of the POC is the responsibility of the home health agency and it is at their discretion to ensure the documented acceptance in case of an audit.

   Per *42 CFR 484.60(e)*, the expectation is that the members are involved, aware and acknowledge the POC. The member should be given a copy of the POC.

   Acceptable work/school requirement documentation for the nonpaid caregiver includes the following:

   - A current work letter must be completed and signed by a manager, supervisor or Human Relations (HR) representative including, but not limited to:
     - ⇒ Company letterhead
     - ⇒ Work and travel time, including overtime
       - ♦ Documentation or map should be included to support travel time.

   *Note: If self-employed, the employee must sign the letter (on company letterhead if available) but must follow the same guidelines as listed above.*

***3. Will documentation by the clinician in the patient chart stating that the member acknowledges plan of care be sufficient? (Continued)***

- Other acceptable forms if it is difficult to obtain work letters:
  - ⇒ Two months of the most recent caregiver paystubs
  - ⇒ A company email from a supervisor, including contact information for the supervisor
  - ⇒ Letters that reflect the hours worked in the week if the work hours are unable to be broken down into specific days and times due to the nature of the job, such as on-call staff, individuals working in the service industry or factory. As much detail as possible must be presented.
- A current class schedule (if caregiver is in school) including, but not limited to:
  - ⇒ Official or unofficial transcript and/or class schedule, including the following information:
    - ♦ Name and contact information of the institution
    - ♦ Class times and locations (for dates of service [DOS])
    - ♦ Travel time to and from class if class is conducted in-person
    - ♦ Office hours of instructors if caregiver requires the use of office hours

*Note: If the caregiver works while attending school, the work letter is still required.*

## QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 800-457-4584.

## COPIES OF THIS PUBLICATION

If you need additional copies of this publication, please download them from the *IHCP Bulletins* page of the IHCP provider website at in.gov/medicaid/providers.

## SIGN UP FOR IHCP EMAIL NOTIFICATIONS

To receive email notices of IHCP publications, subscribe by clicking the blue subscription envelope or sign up from the IHCP provider website at in.gov/medicaid/providers.