

Use of this template is voluntary / optional

Home Health Services F2F Encounter Template Guidance

Purpose

This template has been designed to assist a non-home health clinician in documenting the Face-to-Face (F2F) encounter and in establishing the Medicare beneficiary's eligibility and need for home health services. As described in 42 CFR 424.22, the F2F encounter must be related to the primary reason the patient requires home health services and must be performed no more than 90 days prior to the home health start of care date or within 30 days after the start of the home health care. A F2F encounter must be performed by the certifying physician, 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, or allowed Non-Physician Practitioner (NPP)¹ who does not have a financial relationship with the Home Health Agency (HHA) (unless the financial relationship meets one of the exceptions set forth in §411.355 through §411.357 of the Act).

Patient Eligibility for Coverage of Home Health Services under Medicare

For a Medicare beneficiary to be eligible to receive Medicare home health services, the physician must certify that:

1. The patient needs or needed:
 - a. intermittent skilled nursing care;
 - b. physical therapy;
 - c. speech-language pathology services; or
 - d. has a continuing need for occupational therapy, if the patient no longer needs any of the above therapies.
2. The patient is or was confined to the home (i.e., homebound).²
3. A patient plan of care for furnishing the services has been established by a physician who is a doctor of medicine, osteopathy, or podiatric medicine, and who is has no financial relationship with the Home Health Agency (HHA).
(A doctor of podiatric medicine may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under state law.)
4. The patient services will be or were furnished under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine.
5. A face-to-face 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.

¹ A Medicare allowed NPP is defined as a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861 (aa) (5) of the Social Security Act) who is working in accordance with State law. The allowed NPP must be working in collaboration with or under the supervision of the certifying physician or the physician who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health.

² As defined in sections 1835(a) and 1814(a) of the Social Security Act.

“Confined to the Home” (Homebound)

Documentation from the certifying physician/acute/post-acute care facility’s medical records serves as the basis upon which patient eligibility for the Medicare home health benefit is to be determined. Such documentation includes information that substantiates that the patient is confined to his/her home. In order to be considered “confined to the home” (i.e., homebound), the following two criteria must be met:

1. Criteria-One: The patient must either;
 - a) 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
 - b) Have a condition such that leaving his or her home is medically contraindicated.

The patient must meet one of the Criteria One conditions listed above and also meet the two additional requirements defined in Criteria Two below to be considered homebound for purposes of eligibility for the Medicare home health benefit.

2. Criteria-Two:
 - a) There must exist a normal inability to leave home; and
 - b) Leaving home must require a considerable and taxing effort.

NOTE: The clinician needs to take into account the illness or injury for which the patient met criterion one and consider the illness or injury in the context of the patient’s overall condition. The clinician is not required to include standardized phrases reflecting the patient’s condition (e.g., repeating the words “taxing effort to leave the home”) in the patient’s chart, nor are such phrases sufficient, by themselves, to demonstrate that criterion two has been met. For example, longitudinal clinical information about the patient’s health status is typically needed to sufficiently demonstrate a normal inability to leave the home and that leaving home requires a considerable and taxing effort. Such clinical information about the patient’s overall health status may include, but is not limited to, such factors as the patient’s diagnosis, duration of the patient’s condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, etc.

If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment. Likewise, occasional absences from the home for nonmedical purposes does not necessitate a finding that the patient is not homebound if the absences are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home: e.g.;

- a) Occasional trip to the barber,
- b) Walk around the block or a drive,
- c) Attendance at a family reunion,
- d) Funeral,

- e) Graduation, or
- f) Other infrequent or unique event.

Telehealth

The F2F encounter can be performed by a telehealth service provided the service takes place at an approved originating site. An originating site is the location of an eligible Medicare beneficiary at the time the F2F was performed using a telecommunications system.

Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in:

- A county outside of a Metropolitan Statistical Area (MSA); or
- A rural Health Professional Shortage Area (HPSA) located in a rural census tract.

The originating sites authorized by law are:

1. The office of a physician/NPP;
2. Hospitals;
3. Critical Access Hospitals (CAH);
4. Rural Health Clinics (RHC);
5. Federally Qualified Health Centers (FQHC);
6. Hospital-based or CAH-based Renal Dialysis Centers (including satellites);
7. Skilled Nursing Facilities (SNF); and
8. Community Mental Health Centers (CMHC).

Supporting Documentation

Information from the HHA may be incorporated into the certifying physician's and/or the acute/post-acute care facility's medical record regarding the patient for whom the home health services are ordered/certified. When considering incorporation of information from the HHA the following are expected and required:

- Information from the HHA must be corroborated by other medical record entries and align with the time-period in which services were rendered.
- The certifying physician must review and sign off on anything incorporated into the patient's medical record that is used to support the certification of patient eligibility (that is, agree with the material by signing and dating the entry).

Completing the Home Health Services F2F Encounter Template does not guarantee eligibility and coverage but does provide guidance in documenting the need for home health services ordered and billed to Medicare by the HHA. This template may be used with the HHA Plan of Care/Certification Template.

Note: If the Home Health Services F2F Encounter Template is used:

- 1) CDEs in black Calibri are required
- 2) CDEs in *burnt orange Italics Calibri* are required if the condition is met
- 3) CDEs in *blue Times New Roman* are recommended but not required

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Home Health Services Face-to-Face Encounter Template			
Patient information			
Last name: _____ First name: _____ MI: _____			
DOB (MM/DD/YYYY): _____ Gender: ___M ___F ___Other Medicare ID: _____			
Date of F2F encounter (MM/DD/YYYY): _____			
F2F encounter for home health services? ___Yes ___No Note: HHA = Home Health Agency			
<i>If Yes, Is HHA information incorporated in the patient's medical records? ___Yes ___No</i>			
<i>If Yes: Is the HHA information specifically identified as to source? ___Yes ___No</i>			
<i>Has the responsible physician reviewed, signed and dated the HHA records? ___Yes ___No</i>			
Diagnoses (status: acute, chronic, acute-chronic, resolved, resolving, managed)			
ICD-10-CM	Description	Start date	Status
Related to the need for home health services			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Other pertinent diagnoses			
_____	_____	_____	_____
_____	_____	_____	_____
Chief complaint / history of present illness and associated signs / symptoms:			

Related past medical / surgical history:			

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Relevant procedures (e.g. surgical)

(required if related to need for home health services or homebound status) (include ICD-10-PCS, HCPCS, ... code when available)

Code	Description	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications (Status: N=New, A=Active, C=Changed, D=Discontinued)

RxNorm	Description	Dose	Frequency	Route	Status
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Other medications

_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Allergies (Include RxNorm if known) (include all allergies, not just to medications)

RxNorm	Description	RxNorm	Description
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Review of systems (significant as per history of present problems): (required if necessary to support need for home health services and/or homebound status)	
General:	___ weight gain, ___ weight loss, ___ sleeping problems, ___ fatigue, ___ fever, ___ chills, ___ night sweats / diaphoresis ___ other: _____
Skin:	___ pressure ulcers, ___ rashes, ___ changes in nails/hair, ___ eczema, ___ pruritus, ___ other: _____
Lymphatic:	___ swollen glands/masses: ___ in the neck, ___ axilla, ___ groin, ___ other: _____
Head:	___ fainting, ___ dizziness, ___ headaches, ___ other: _____
Eyes:	___ diplopia, ___ glasses/contact lenses, ___ redness/discharge, ___ blurred vision, ___ glaucoma, ___ cataracts, ___ other: _____
Ears:	___ tinnitus, ___ discharge, ___ hearing loss, ___ other: _____
Nose:	___ epistaxis, ___ sinus infections, ___ discharge, ___ polyps, ___ other: _____
Oral:	___ dysphagia, ___ hoarseness, ___ teeth/dentures, ___ other: _____
Neck:	___ lumps, ___ pain on movement ___ other: _____
Breast:	___ masses/tumors, ___ tenderness, ___ discharge, ___ gynecomastia, ___ other: _____
Pulmonary:	___ cough, ___ shortness of breath, ___ pain, ___ wheezing, ___ hemoptysis, ___ sputum production ___ other: _____
Cardiac:	___ chest pain, ___ palpitations, ___ orthopnea, ___ murmur, ___ syncope ___ other: _____
Vascular:	___ edema, ___ claudication, ___ varicose veins, ___ thrombophlebitis, ___ ulcers ___ other: _____
Gastrointestinal:	___ swallowing problems, ___ abdominal pain, ___ constipation, ___ diarrhea, ___ incontinence, ___ nausea, ___ vomiting, ___ ulcers, ___ melena, ___ rectal bleeding, ___ jaundice, ___ heartburn, ___ hematemesis ___ other: _____
Renal:	___ dysuria, ___ frequency, ___ urgency, ___ hesitation, ___ flank pain, ___ hematuria, ___ incontinence, ___ nocturia, ___ polyuria, ___ other: _____

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Musculoskeletal:	___ pain, ___ swelling, ___ stiffness, ___ limitation of range of motion, ___ arthritis ___ gout, ___ cramps, ___ myalgia, ___ fasciculation, ___ atrophy, ___ fracture, ___ deformity, ___ weakness, ___ other:
Neurologic:	___ seizures, ___ poor memory, ___ poor concentration, ___ numbness / tingling, ___ pins and needles sensation, ___ hyperpathia, ___ dysesthesia, ___ weakness, ___ paralysis, ___ tremors, ___ involuntary movements, ___ unstable gait, ___ fall, ___ vertigo, ___ headache, ___ stroke, ___ speech disorders ___ other:
Psychiatric:	___ hallucinations, ___ delusions, ___ anxiety, ___ nervous breakdown, ___ mood changes ___ other:
Hematology:	___ anemia, ___ bruising, ___ bleeding disorders (conditional) ___ other:
Endocrine:	___ heat or cold intolerance, ___ diabetes, ___ lipid disorders, ___ goiter ___ other:
Additional observations:	_____ _____ _____ _____ _____ _____ _____ _____
Pain assessment (required if necessary to support need for home health services)	
Location:	_____
Quality:	___ aching, ___ burning, ___ radiating, ___ other _____
Severity: (10 is greatest),	___1, ___2, ___3, ___4, ___5, ___6, ___7, ___8, ___9, ___10
Duration:	___1, ___2, ___3, ___4, ___5, ___6+ ___days, ___weeks, ___months, ___years
Timing:	___ constant, ___ intermittent, ___ time of day, describe _____
Context:	___ better, ___ worse, ___ no change at ___ work, ___ rest, ___ sleep, ___ other _____
Moderating factors:	___ better, ___ worse, ___ no change with ___ heat, ___ ice, ___ other _____
Associated signs/symptoms:	_____ _____

Physical examination:

(required if necessary to support need for home health services and/or homebound status)

Vital signs: T=_____ P=_____ R=_____ BP=_____ / _____ Height=_____ Weight=_____

O2 Sat:_____ (RA at Rest) O2 Sat:_____ (with supplemental O2 at _____ LPM)

General appearance:_____

Head and neck:_____

Chest / lungs:_____

Cardiovascular:_____

Abdominal:_____

Musculoskeletal / extremities:_____

Neurological:_____

Psychiatric:_____

Visual exam:_____

Additional observations:_____

Physician/NPP assessment / summary:

Confined to home (i.e., homebound) assessment (*if evaluation is performed as part of F2F encounter*)

Does beneficiary, because of illness or injury, need: (check all that apply)

*supportive devices, *special transportation, *assistance to leave residence***

Describe: _____

OR

Is there a medical contraindication to leaving home? Yes, No

Describe: _____

Note: *One of the two questions above and both questions below must be affirmed, and confirmation of the affirmative responses needs to be described within the documentation.*

Is there a normal inability to leave home? Yes, No

AND

Does leaving home require a considerable and taxing effort? Yes, No

Describe: _____

Related physical limitations that support homebound status – impairment (check all that apply)

Structural Functional System

<input type="checkbox"/>	<input type="checkbox"/>	<i>nervous system / mental functions</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>sensory functions (eye, ear and related structures)</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>voice and speech</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>cardiovascular system</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>hematological and immunological system</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>respiratory system</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>digestive system</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>metabolic and endocrine systems</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>genitourinary system</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>skin and related structures</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>neuromusculoskeletal and movement-related structures</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>other, describe _____</i>

*Additional information necessary to describe **why** the above selected structural and functional and activity impairments/limitations support homebound status:* _____

Treatment plan: (required if necessary to support patient need for home health services)

Orders for Discipline and Treatments (Specify Frequency/Duration)

Intermittent skilled nursing services (complete all that are required)

Administration of medications	Yes: _____	Frequency: _____	Duration: _____
Tube feeding	Yes: _____	Frequency: _____	Duration: _____
Wound care	Yes: _____	Frequency: _____	Duration: _____
Catheters	Yes: _____	Frequency: _____	Duration: _____
Ostomy care	Yes: _____	Frequency: _____	Duration: _____
NG and tracheostomy aspiration/care	Yes: _____	Frequency: _____	Duration: _____
Psychiatric evaluation and therapy	Yes: _____	Frequency: _____	Duration: _____
Teaching/training	Yes: _____	Frequency: _____	Duration: _____
Observe/assess	Yes: _____	Frequency: _____	Duration: _____
Complex care plan management	Yes: _____	Frequency: _____	Duration: _____
Rehabilitation nursing	Yes: _____	Frequency: _____	Duration: _____
Other: _____	Yes: _____	Frequency: _____	Duration: _____
Other: _____	Yes: _____	Frequency: _____	Duration: _____

Justification and signature if the patient's sole skilled service need is for skilled oversight of unskilled services (management and evaluation of the care plan or complex care plan management):

_____ Signature: _____

Therapy services (complete all that are required)

Physical therapy

Restore patient function	Yes: _____	Frequency: _____	Duration: _____
Perform maintenance therapy	Yes: _____	Frequency: _____	Duration: _____
Therapeutic exercises	Yes: _____	Frequency: _____	Duration: _____
Gait and balance training	Yes: _____	Frequency: _____	Duration: _____
ADL training	Yes: _____	Frequency: _____	Duration: _____
Other: _____	Yes: _____	Frequency: _____	Duration: _____

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Occupational therapy		
Restore patient function	Yes: _____	Frequency: _____ Duration: _____
Perform maintenance therapy	Yes: _____	Frequency: _____ Duration: _____
Therapeutic exercises	Yes: _____	Frequency: _____ Duration: _____
ADL training	Yes: _____	Frequency: _____ Duration: _____
Other: _____	Yes: _____	Frequency: _____ Duration: _____
Are OT services above provided because physical therapy services ceased? Yes: ___ No: ___		
Speech-language pathology		
Swallowing	Yes: _____	Frequency: _____ Duration: _____
Restore language function	Yes: _____	Frequency: _____ Duration: _____
Restore cognitive function	Yes: _____	Frequency: _____ Duration: _____
Perform maintenance therapy	Yes: _____	Frequency: _____ Duration: _____
Other: _____	Yes: _____	Frequency: _____ Duration: _____
Other Services		
Home health aide services	Yes: _____	Frequency: _____ Duration: _____
Medical social services	Yes: _____	Frequency: _____ Duration: _____

Other Orders:

Medications (other drugs): _____

Supplies: _____

Investigations / diagnostic testing: _____

Consults: _____

Other: _____

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NOTE: One or Both of the following signatures are required.

Signature, Name, Date and NPI of NPP, if NPP completed the face-to-face-evaluation:

Signature: _____

Last name: _____ *First name:* _____ *MI:* ____ *Suffix:* _____

Date (MM/DD/YYYY): _____ *NPI:* _____

Telephone Number: (_____) _____ - _____ Ext: _____

Signature, Name, Date and NPI of physician, if physician completed the face-to-face-evaluation:

NOTE: Physician signature is also required if Medicare home health services are being ordered and the F2F evaluation was completed by an allowed NPP

Signature: _____

Last name: _____ *First name:* _____ *MI:* ____ *Suffix:* _____

Date (MM/DD/YYYY): _____ *NPI:* _____

Telephone Number: (_____) _____ - _____ Ext: _____