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 therapies above.
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, because of illness or injury;
    a) Need supportive mobility assist devices such as crutches, canes, wheelchairs, and walkers; or
    b) Need use of special transportation to leave their place of residence; or
    c) Require the assistance of another person in order to leave their place of residence; or
    d) Have a medical condition that prohibits leaving their place of residence.

    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: In determining whether the patient met Criteria Two (see above) in the homebound definition, the reviewer needs to take into account the illness or injury for which they met Criteria One (see above) and also consider the patient's overall condition. ***Determination of homebound status requires clinical judgment****. Clinical judgment is the application of information based on actual observation of a patient and/or review of a patient's clinical records to assimilate subjective and objective data that lead to a conclusion.*

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

If Yes, Is HHA information incorporated in the patient's medical records? _____Yes ____No

If Yes: Is the HHA information specifically identified as to source? _____Yes ____No

Has the responsible physician reviewed, signed and dated the HHA records? ____Yes ____No

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:

_____

_____

_____

Relevant procedures (e.g. surgical)
(required if related to need for home health services or homebound status)

ICD-10-CM	Description	Date

Medications (Status: N=New, C=Current, M=Modified, D=Discontinued)

RxNorm	Description	Dose	Frequency	Route	Status

Other medications

Allergies (Include RxNorm if known)

RxNorm	Description	RxNorm	Description

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:_____

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:_____

Other:_____
_____

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:_____

Other:_____

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: _____

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
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*
_____	_____	*nervous system / mental functions*
_____	_____	*sensory functions (eye, ear and related structures)*
_____	_____	*voice and speech*
_____	_____	*cardiovascular system*
_____	_____	*hematological and immunological system*
_____	_____	*respiratory system*
_____	_____	*digestive system*
_____	_____	*metabolic and endocrine systems*
_____	_____	*genitourinary system*
_____	_____	*skin and related structures*
_____	_____	*neuromusculoskeletal and movement-related structures*
_____	_____	*other, describe* _____

*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:_____

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: _____

_____

Physician and/or NPP Attestation

Physician: I certify that I have no financial relationship with the HHA _____Yes _____No

NPP: I certify that I have no financial relationship with the HHA _____Yes _____No

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:*_____