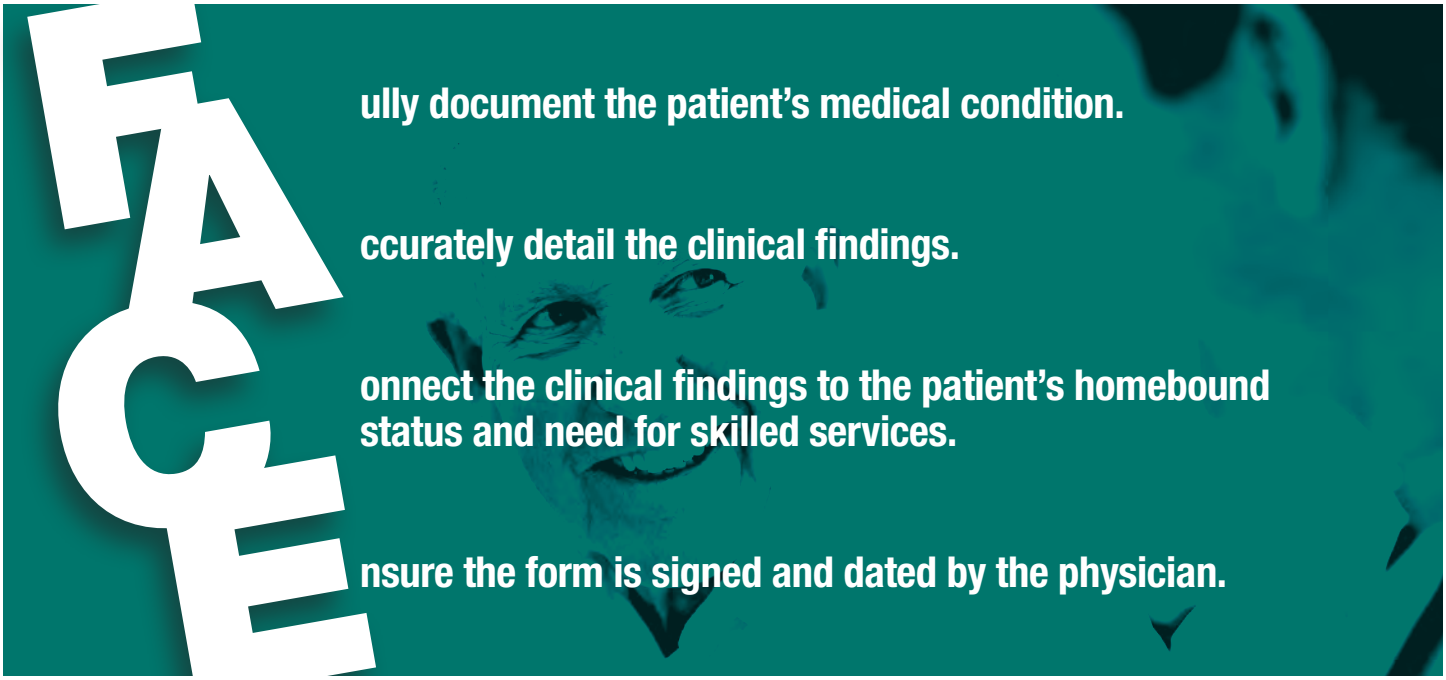


Just the Facts:

A four-step guide to face-to-face documentation requirements

We need your assistance to ensure your patient qualifies for his or her necessary home health services. The information you provide in the face-to-face encounter documentation is extremely important in achieving this goal. This document summarizes the face-to-face requirements and provides guidelines and examples of clinical findings that support the need for home health skilled services and homebound status. Use it to guide your creation of the face-to-face encounter document.

REQUIREMENTS

The face-to-face encounter visit must be:

- Made by the physician responsible for certifying home health, by a physician caring for the patient in an acute or post-acute facility who has privileges at the facility or by a non-physician practitioner*
- Related to the primary reason (diagnosis) for which the patient requires home health services
- Made within 90 days prior to or 30 days after the start-of-care date

** Non-physician practitioners include nurse practitioners or physician assistants working in collaboration with the physician. The face-to-face encounter may be performed by the NPP as long as the NPP documents the clinical findings and communicates those to the physician, and the physician completes, signs and dates the F2F encounter form.*

Face-to-face encounter documentation/certification must include:

- Date of the face-to-face encounter occurring within 90 days prior to or 30 days after the SOC date
- Clear title/label identifying it as the face-to-face encounter documentation
- A brief narrative that describes how the patient's clinical condition, as seen during the encounter, supports the patient's homebound status and need for skilled services
- Certifying physician's signature and date

The encounter must be documented on a clearly titled/identified face-to-face encounter form. It could also be documented on a progress note or discharge summary as long as the documentation relating to the encounter is clearly titled, the required components are included and the documentation is signed and dated by the physician.

Document the medical condition that is the primary reason for home health care:

- If you include a diagnosis in this section, indicate if it is new or acute or an exacerbation. For example: new onset HTN; exacerbation of CHF; fulminant hepatitis
- When you include a condition, be as descriptive as possible and make a clear connection to the primary reason for the skilled care. For example: severe dyspnea related to bacterial pneumonia

Document clinical findings supporting the need for home health skilled services (connect to homebound findings such as those listed in the next section)

- Knowledge deficit for *(insert disease)* disease management
- Knowledge deficit for *(insert medication)* medication management
- Knowledge deficit for *(insert type, e.g., low fat)* diet
- Elevated/poorly controlled blood pressure or blood sugar
- Increased SOB or dyspnea, hypoxia, adventitious lung sounds, productive cough
- Exacerbation or new onset of pain *(insert site)*
- Abnormal readings or lab values: for example, HgbA1c>7; CBG>140; BP 180/110
- Alterations in blood pressure, heart rate, respirations, hypo/hyperglycemia

Document clinical findings supporting the need for home health skilled services, continued

- Alterations in level of consciousness or cognition, dizziness related to *(specify condition)*
- Alteration in ability to perform self-care related to *(specify condition)*
- Conditions managed with injections or infusion therapy *(specify condition)*
- Conditions managed with TPN or lipids *(specify condition)*
- Open, draining, complex, non-healing wound(s) *(list all relevant descriptors)*
- Urinary incontinence managed with a catheter
- Conditions managed with nebulizers, oxygen therapy *(specify condition)*
- Onset/exacerbation of infection *(specify location and list all relevant descriptors)* with fever, redness, tenderness, drainage, culture results, abnormal lab values, etc.
- Weight gain or edema related to heart failure or other condition
- Weight loss related to COPD or other condition
- Nutritional issues, dehydration, poor skin turgor related to *(specify condition)*
- Post-operative risks requiring monitoring and teaching *(specify surgery and specific risks)*
- Gait instability or difficulty walking related to *(specify condition)*
- Decreased or limited mobility, ROM, weight bearing, functional status
- Conditions affecting ability to swallow *(specify condition)*
- Conditions affecting ability to communicate *(specify condition)*
- Balance issues, frequent falls, risk for falling related to *(specify condition)*
- Presence of comorbidities that may impact healing/recovery

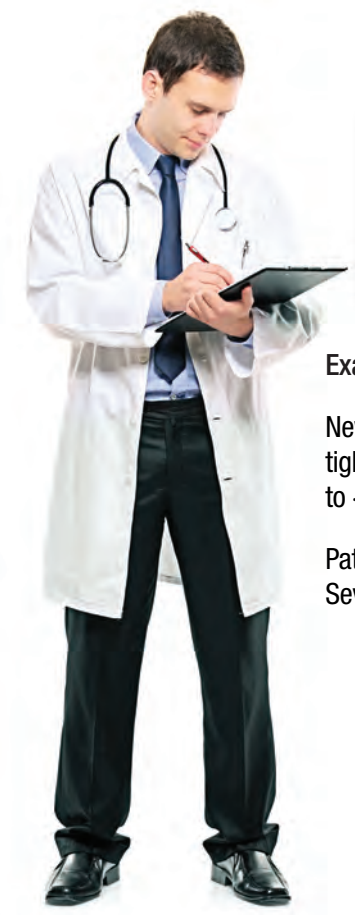
Connect any of the above clinical findings supporting the need for home health skilled services to your patient's homebound status, or include additional clinical findings to support homebound status:

Example of connecting: Joint pain (as described above) impacts patient's mobility, making it extremely difficult to leave home

List additional findings supporting homebound status:

- Requires a taxing effort to leave home as evidenced by: extreme SOB, easily fatigued, compromised mobility, etc.
- Requires assistance (indicate physical/human or device) to leave home
- Poor circulation, numbness, weakness, paralysis or pain in lower extremities, causing balance or other gait disorders/unstable gait
- Visual or auditory deficits that make it unsafe for patient to leave home
- Cognitive impairments, dementias, or mental confusion that make it unsafe for patient to leave home
- Motor or sensory impairments that make it difficult or taxing to leave home
- Psychiatric illness manifested in refusal or safety issues to leave home
- Neurological disorders that limit movement
- Medically restricted from leaving home *(specify reason)*

IMPORTANT: Listing a diagnosis or orders only in the clinical findings/homebound status section of the face-to-face documentation is not sufficient to ensure your patient qualifies for his or her necessary home health services.



The encounter with the patient was in whole or in part for the following **medical condition,** which is the primary reason for home health care.

My **clinical findings** support the need for **home health skilled services.**

Example of documentation:

Newly diagnosed COPD presenting with shortness of breath, persistent productive cough, feeling of tightness in chest. Lung auscultation reveals wheezing. Spirometry results: $FEV_1/FEV < 0.70$, FEV_1 =>30 to <50% of predicted. Prescribed XYZ bronchodilator and/or steroids.

Patient has knowledge deficit of how to manage COPD and self administer and manage medications. Severe SOB with any activity restricts her ability and requires a taxing effort to leave home.

My **clinical findings** support the patient's **homebound status.**