Jefferson County
PUBLIC HEALTH SERVICE

Public Health Facility, 531 Meade Street, Watertown, New York 13601

MEDICARE HOME HEALTH CERTIFICATION REQUIREMENT: FACE-TO-FACE ENCOUNTER
A GUIDANCE TOOL

For coverage of patients' Medicare home health care (HHC) services, CMS **"face-to-face" (F2F) encounter rule** in effect for all patients with a HCC start of care date of January 1, 2011 or later. (Affordable Care Act 11/2010).

Effective Date	Effective January 1, 2011
Who – Performed By	A physician who certifies a patient as eligible for Medicare home health services must see the patient – the regulation permits a non-physician practitioner (NPP) to see the patient and communicate findings to the physician to complete the narrative. The certifying physician must be Medicare-enrolled; and, document the face-to- face encounter findings, even if the visit was conducted by the NPP.

Required Documentation	Based upon the F2F encounter, the physician must document (certify) on the narrative:
	
	• Physician or NPP who saw the patient
	• Date of the F2F
	• How the patient's clinical condition relates to the primary reason the patient requires home health services
	• Types of home health services needed
	• Why the clinical findings of the encounter support:
	  o **Homebound status*** and
	  o Need for **skilled services**** (i.e. medical necessity)
	• If a hospitalist completes the narrative, the community primary physician who will follow the patient should be noted.
	
	Finally, the certification narrative must be signed AND dated by the MD.

Time Frame	F2F encounter must occur within the **90 days prior** to the start of home health care, or **within the 30 day period following admission to At Home Care**.
Additional Information	The physician F2F visit must be related to the primary reason for the home health admission. If the F2F is not related to the reason At Home Care services are requested, the patient must have another face-to-face visit within the required timeframe(s).
Consequences of not having the F2F document	Inability to bill for any home health care services provided.

- For Reference (Over) Medicare Home Health definition and examples – **Homebound*** and **Skilled****

Medicare HHC Terms	Definition and Examples Please note, examples are not all inclusive
HOMEBOUND	Homebound is an assessment of condition…there exists a normal inability to leave home and, consequently, leaving home would require a considerable and taxing effort (CMS) *Patient may be considered homebound if*: • Absences from the home for non medical purposes are infrequent or for periods of relatively short duration • Attributable to the need to receive health care treatment – include, but not limited to: .Attendance at NYS licensed adult day centers to receive medical care .Ongoing outpatient kidney dialysis, or .Outpatient chemotherapy or radiation therapy • Attending religious services. • Aid of supportive devices such as crutches, canes, wheelchairs, and walkers; requires use of special transportation; or, the assistance of another person. • Leaving home is medically contraindicated (new dx., new medications, immunocompromised, wound, etc.) Generally, it is expected that in most instances absences from the home will either be infrequent, for periods of short duration (barber, short walk, attend family reunion, funeral, graduation) and/or for purposes of receiving health care treatment.
SKILL	**Professional Nursing – Skill – Examples** Observation, assessment, intervention pertaining to a patient's changing health care condition Close "skilled" monitoring to detect signs of clinical deterioration - new or unstable/exacerbation of health condition Medication management: side effect / adverse effect monitoring, education – prescribed medication(s) Surgical patients while in the complicated, unstable, postoperative period Patients, who, in addition to their physical problems, exhibit acute psychological symptoms such as depression, anxiety, or agitation *Examples – skilled nursing:* Cardiac/Respiratory/GI/GU assessment; IV/central line management; IM injections; enteral feeding; NGT care; insertion, sterile irrigation and replacement of foley catheters; wound management involving prescription medications and aseptic technique; wound vac management; and, decubitus or pressure ulcer care
	Physical Therapy – Occupational Therapy – Speech Language Therapy – "skill" Ongoing assessment of rehabilitation need and measurable potential Tests and measurements of activities that require involvement of technical or professional personnel in order to meet the patient's needs, promote recovery, and ensure medical safety range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders Therapeutic exercises or activities which, because of the type of exercises employed or the condition of the patient, must be performed by or under the supervision of a qualified (PT or OT) therapist to ensure the safety of the patient and the effectiveness of the treatment Gait evaluation and training…to restore function in a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality