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HOME HEALTH

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CGS Medicare Face-to-Face Information

Definition: The actual clinical note is the physician's/practitioner's documentation to show he/she actually saw the patient. It will include such things as vital signs, weight, and specific comments from the examination. The actual clinical note must address the primary reason the patient is receiving home health services and a complete review of systems. Other conditions may be addressed in the same visit.

The face-to-face (F2F) is a note documenting the one-on-one visit with the physician or NPP and is related to the primary reason the patient requires home health services. The encounter cannot be a compilation of data from the patient's Electronic Health Record (EHR), or must it be a single encounter with all the information documented. If all of the information is not documented, see #6 below.

Face-to-Face Facts

1. It is not necessary for the F2F to address each discipline individually, however, the F2F must be related to the primary reason for home health services. For example, the patient may need skilled nursing to perform wound care to a stasis ulcer, the F2F must be related to the stasis ulcer, any additional medically necessary disciplines would be allowed in medical review.
2. A F2F must always be the actual clinical note from the F2F encounter. There is no suitable replacement form.
3. The F2F encounter is only mandated at the SOC.
4. There is no F2F requirement for recertification for home health.
5. **Homebound Status:** There are no specific statements, including 'patient needs assistance of another person/device to exit the home', that are sufficient to support the beneficiary's homebound status in the F2F. While the F2F encounter must be related to the primary reason for home health services, the patient's skilled need and homebound status can be substantiated through an examination of all submitted medical record documentation from the certifying physician, acute/post-acute care facility, and/or home health agency incorporated documentation.
6. **Face-to-Face Form:** Medicare does not require a specific form or format to be used for the F2F, as long as the F2F encounter documentation contains all content requirements the home health agency CAN use the clinic note. If the clinical note from the F2F encounter does not include all the necessary information, a F2F form may be submitted, including the missing information. Both the clinical note and the F2F form will be reviewed in the event of a clinical review.

   There are no specific forms required for F2F documentation. The encounter note from the physician/practitioner is required. The F2F form is OPTIONAL. If your F2F form has wording that suggests it is also a certification, there is an additional requirement, IF the certifying physician/practitioner is not the one performing the F2F. If the F2F form is also a certification, the person completing the form must also indicate who the community physician/practitioner will be.
7. With a multiple-page document, each page should be identified as being part of the entire document. For example, page 1 of 4, page 2 of 4, page 3 of 4 and page 4 of 4. The physician/practitioner is aware he/she is signing the entire document and only needs to sign and date one page of the document.
8. The 485 is not a required form but is used frequently by home health agencies.

9. The physician/practitioner certification should state the patient is confined to their home, needs skilled services, a plan of care is established and periodically reviewed, the patient is under the care of a physician/practitioner, and the date of the F2F encounter.
10. If the hospitalist certifies the patient for home health but will not follow the patient after discharge, he/she must identify the community physician/practitioner who will follow the patient by name.
11. The certifying physician/practitioner does not need to cosign the F2F document. The certifying physician/practitioner needs to document the date the F2F encounter was completed as part of the certification to the home health benefit.
12. The certifying physician/practitioner must document the date of the encounter. This can be achieved by the certifying physician/practitioner including a statement documenting the date of the encounter OR by co-signing the F2F document.
13. As long as the visit is timely and is focused on the reason for home health services, if a patient saw the physician or NPP within the 90 days prior to start of care that would be sufficient. Another encounter (F2F visit) would be needed if the patient's condition had changed to the extent that standards of practice would indicate that the physician or a non-physician practitioner should examine the patient in order to establish an effective treatment plan.
14. To establish homebound status the physician's/acute/post-acute care facility's record, in conjunction with appropriately incorporated home health agency documentation (e.g., Form 485/Plan of Care, OASIS, etc.), may also substantiate the certification of eligibility for home health services. The HHA's generated medical record documentation for the patient, by itself, is not sufficient in demonstrating the patient's eligibility for Medicare home health services. Any documentation used to support certification that was generated by the home health agency must be signed off by the certifying physician and incorporated into the medical record held by the physician or the acute/post-acute care facility's medical record. Once incorporated into the certifying physician's medical record for the patient, the HHA information can be used to support the patient's homebound status and need for skilled care, the reviewer shall consider all documentation for the home health agency that has been signed off in a timely manner and incorporated into the physician/hospital record when making its coverage determination.
15. If the home health agency receives outstanding documentation and a copy of the encounter note, but the encounter note is nothing more than three sentences, CGS (Medicare) will review both the documentation and the copy of the encounter note to meet all the requirements. CGS (Medicare) is able to look at anything within the patient's medical record from the acute or post-acute care facility, as well as any documentation submitted from the agency, as long as the certifying physician incorporates it into their medical record by signing and dating the documentation and it corroborates the overall findings.
16. If a resident in a hospital performs the F2F, the physician must co-sign the home health plan of care. The physician must sign the plan of care.
17. The certifying physician/practitioner does not need to co-sign the F2F. The certifying physician/practitioner must document the date of the F2F encounter, whether by co-signing the F2F form OR including the date of the F2F encounter on the certification form.