

## **Face-to-Face Guidelines for Documentation**

### **Face-to-Face Visit Attestation:**

I certify that this patient is under my care and that I had a face-to-face encounter that meets the physician face-to-face encounter requirements on:

Date of Visit: 90 days before or within 30 days of Home Health Ordered

### **Medical Condition:**

**PRIMARY** reason for ordering Home Health.

*Examples:* COPD/CHF exacerbation, Recent fall due to peripheral neuropathy, New onset of Disease..., Debility due to CVA which effected dominant side, Joint replacement with gait abnormality.

### **Clinical Findings:**

Provide a summary of **CLINICAL FINDINGS THAT SUPPORT THE PATIENT'S ELIGIBILITY FOR HOME HEALTH SERVICES. SPECIFIC NEED FOR INTERMITTENT SKILLED NURSING AND/OR THERAPY SERVICES.**

*Examples:*

1. SN need for teaching/instruction/monitoring/disease management of above diagnosis (**STATE WHICH DIAGNOSIS**) Wound Care/IV Infusion as well.
2. PT/OT need for strengthening/endurance/balance/mobility/safety related to above diagnosis. (**STATE WHICH DIAGNOSIS**).
3. ST needs related to above diagnosis. (**STATE WHICH DIAGNOSIS**).
4. MSW needs and why.
5. Home Health Aide needs and why related to above diagnosis. (**STATE WHICH DIAGNOSIS**).

### **Statement of Homebound Status:**

Must state reason related to above diagnosis for Home Care.

*Examples:* Has high fall risk due to weakness and diminished balance, unable to manage steps/stairs/uneven surfaces. Leaves only for Medical Care due to weakness, unable to drive without assistance. Needs assistive devices.

# Face-to-Face Encounter Documentation

Patient Name (Last Name, First Name) & MRN:

Gender: DOB:

- M  
 F

Agency Name/Branch:

Agency FAX:

**Please complete, sign and return to the home health agency or therapy company. All fields are required.**

## Face-to-Face Visit Attestation

I certify that this patient is under my care and that I, or a nurse practitioner/clinical nurse specialist/certified nurse-midwife or physician assistant working in collaboration with me or under my supervision, had a face-to-face visit encounter that meets the physician face-to-face encounter requirements with this patient on:

Date of Visit:     /     /     mm/dd/yyyy

## Medical Condition

The encounter with the patient was directly related to the **following medical condition**, which is the **primary reason for home health care**:

## Clinical Findings In Support of Patient's Eligibility

Provide a summary of **clinical findings that support the patient's eligibility for home health services**, including **specific need for intermittent skilled nursing and/or therapy services**. The Face-to-Face visit findings must be related to the primary reason for home health admission.

## Statement of Homebound Status

I certify that the patient's clinical condition, as evidenced in the face-to-face encounter, supports that this **patient is homebound** (i.e., absences from home require considerable and taxing effort and are for medical reasons or religious services OR are infrequent or of short duration when for other reasons) **due to**:

Certifying Physician Name

Physician Phone:

Physician Fax:

Certifying Physician Signature

Date:     /     /