Certification of Home Health/Face to Face Documentation

Face to Face Encounter

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient on: (Insert date that visit occurred): _____

Month Day Year

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 (List medical condition):

_____

I certify that, based on my findings, the following services are medically necessary home health services (Check all that apply):

_____Nursing _____Physical therapy _____Speech language pathology

My clinical findings support the need for the above services **because:** _____

_____

_____

_____

Further, I certify that my clinical findings support 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) **because:** _____

_____

_____

_____

Home Health Certifying Physician

Physician Signature: _____ Date: _____

Physician Printed Name: _____

Name of Non-Physician Provider who performed the FTF encounter (if not Physician)):

Provider Printed Name: _____

Patient Name: _____ Patient ID: _____

DOB: _____

Agency of Choice: **ENVISION HOME HEALTH**

Utah County
Ph. 801.225.7971
Fax 866.899.2356

Salt Lake County
Ph. 801.359.7600
Fax 866.660.0101

Northern Utah
Ph. 801.316.8099
Fax 866.782.8922

Refer to definitions on Back

In accordance with the Patient Protection Affordability Act, CMS issued a final regulation that requires, effective January 1, 2011, a patient to have a face-to-face encounter with a physician who is certifying the patient's plan of care.

When does this need to occur?
This encounter must occur within 90 days prior to the start of home health care services or within 30 days after the start of home health care services. This encounter must be related to the need of the home health services.

Medical Reason
This would be the primary reason why your patient is in need of Home Health Services.

Clinical Findings
This would include specific clinical findings related to the care/treatment statement, i.e., increased shortness of breath, post-op pain, diabetic ulcer to left foot, etc.

Homebound Definition
The Medicare homebound definition does not mean that the patient never leaves the home. Homebound is defined as absences from home requiring considerable and taxing effort and are for medical reasons or religious services or infrequently or of short duration when for other reasons

Non-Physician Practitioners
This regulation does allow for non-physician practitioners (NPP) to perform the face-to-face encounter. If a NPP performs this encounter, then the clinical findings must be documented in your clinical record and provided to the certifying physician. (Please provide the name of the NPP who performed the face-to-face encounter.)

Certifying Physician
The Medicare regulations state that only a doctor of medicine, osteopathy, or podiatric medicine may approve a patient for home health services. **Even if a NPP completed the face-to-face, the certifying physician is responsible for documentation of the face-to-face encounter and their signature (and Date) is required on the form.**

Signatures
Along with the physician's signature, their title and signature date must also be included/documented.

Medical Records
This form needs to be routed to the Home Health Agency of choice as soon as possible. It is part of the permanent record of the Home Health Agency.

If you have questions whether a patient's situation would be considered homebound or other questions related to this form, please contact:

Utah Association for Home Care
1327 South 900 East Salt Lake City, UT 84105
(801) 487-8242

ENVISION
HOME HEALTH & HOSPICE

Utah County
Ph 801.225.7971
Fx 866.899.2356

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request for home health orders

TO: **FROM:**

DATE: **PAGES:** **Including this cover sheet**

PATIENT NAME: **PATIENT DOB:**

Dear Physician,
Please review the following request and respond at your earliest convenience by faxing this form back to us. We have recommended that the patient also make an appointment with you. We appreciate your response.

reason for requesting home health:

_____

_____

_____

proposed home health orders:

- **Nursing**
- ☐ 1. Disease management/education (i.e. HTN, CHF, DM, CVA, Anticoag, Infection, Pneumonia, Cellulitis)
- ☐ 2. Medication management/teaching (i.e. new meds, compliance issues)
- ☐ 3. Administration of medication (i.e. B12 IM, IV Antibiotics):_____
- ☐ 4. Wound care: _____
- ☐ 5. Urinary catheter care
- ☐ 6. Other: _____
- **Physical Therapy**
- ☐ 7. Evaluation and treatment (gait training, therapeutic exercises, ROM)
- ☐ 8. Balance evaluation/training (i.e. vestibular)
- ☐ 9. Other: _____
- **Other _____**

physician signature: _____ **Date:** _____