Examples of Compliant Face-to-Face Encounter Documentation

This information may be used as a resource for completing the Face-to-Face Encounter form, but it may not be used as a substitute for the form.

[Note: Physician Assistants and Nurse Practitioners may perform the encounter visit and complete the form, but it must be signed by an MD, DO or DPM. A Medical Assistant can collect data from the medical record and complete the form, but it must be signed by an MD, DO or DPM]

Patient needs: (examples)

<table>
<thead>
<tr>
<th>Skilled Nursing for...</th>
<th>Physical Therapy for...</th>
<th>Occupational Therapy for...</th>
<th>Speech Therapy for...</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Med management &amp; teaching</td>
<td>• Home exercise program</td>
<td>• ADL training</td>
<td>• Swallowing</td>
</tr>
<tr>
<td>• Teach disease &amp; symptom mgmt.</td>
<td>• Gait training</td>
<td>• Adaptive equipment</td>
<td>• Communication</td>
</tr>
<tr>
<td>• Wound care</td>
<td>• Strengthening</td>
<td>• ROM &amp; Strengthening</td>
<td>techniques</td>
</tr>
<tr>
<td>• Pain management</td>
<td>• Balance &amp; coordination</td>
<td>upper extremities</td>
<td>• Aphasia</td>
</tr>
<tr>
<td>• Catheter teaching &amp; care</td>
<td>• Pain management</td>
<td></td>
<td>• Voice control &amp; production</td>
</tr>
<tr>
<td>• Infusion therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medical Condition(s) that necessitate home care services:

• What diagnoses do the home care services relate to?

Clinical findings and Functional Deficits (Homebound reasons)

Examples:

• Unsteady gait, frequent falls, poor balance
• Assistance of 1-2 people to ambulate/transfer safely
• Requires a walker, wheelchair, stand by assistance
• Dyspnea at rest
• Dyspnea with ambulation greater than ________ feet.
• Unable to leave home unassisted due to mental confusion, psychological impairment
• Medically contraindicated due to recent surgery
• Medically contraindicated due to infection, draining, complicated wound
• Medically contraindicated due to immunosuppression, serious infection risk
• Bed-bound, Chair-bound

Thank you for your referral and attention to CMS’ Face to Face Encounter Requirement
HOME HEALTH REFERRAL FORM

PHYSICIAN VERIFICATION OF FACE-TO-FACE ENCOUNTER

Patient Name: ________________________________

DOB: ________________________________

The visit on ______________________, is/was for the specific purpose of the required Face-to-Face encounter to authorize Home Health Care. This encounter is within the required time frame of 90 days prior to or 30 days after the Start of Care date, and was conducted by a physician or an allowed non-physician provider (NPP).

Based on the findings at this encounter, I certify that the following home care services are reasonable and necessary:

☐ Skilled Nursing for ________________________________

☐ Physical Therapy for ________________________________

☐ Occupational Therapy for ________________________________

☐ Speech Language Therapy for ________________________________

☐ MSW ☐ Aide ☐ Dietician

MEDICAL CONDITION(S) THAT NECESSITATES HOME CARE SERVICES:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

CLINICAL FINDINGS AND FUNCTIONAL DEFICITS THAT SUPPORT THE NEED FOR HOME CARE SERVICES AND VALIDATE THAT THE PATIENT IS HOMEBOUND (as defined in CMS Chapter 7 Medicare Benefits Manual 30.1.1)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

CERTIFYING PHYSICIAN:

Physician Name (print): ________________________________

Physician Signature: ________________________________ Date: ____________

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