**Home Health Certification Requirements:**

1. ***SKILLED NEED:*** *Patient requires intermittent SN, PT and/or SLP services, or continues to need OT*

*(Skilled services ordered by MD are included in orders and Plan of Care)*

1. ***HOMEBOUND****: Patient is confined to the home / homebound (Documentation, orders and/or POC signed by certifying MD must support)*

*\*not a Medicaid requirement*

1. ***PLAN OF CARE****: Plan of care (POC) established and periodically reviewed by a physician or NPP*
2. ***PROVIDER****: Services will be furnished under the care of a physician or NPP*
3. ***FACE TO FACE:***[*Face-to-face*](https://www.youtube.com/watch?v=Ga31FMTxn9k) *encounter performed by the certifying physician or allowed NPP.*

Exception: if patient is referred to home health directly from an acute or post- acute care facility, facility physician encounter may meet F2F criteria.

\*Community Referrals: patients referred from the community (not a direct referral from acute/post-acute setting) must have a F2F encounter with the provider signing the HH POC (primary/certifying MD/NPP), or with an NPP working in collaboration with the certifying physician. The community provider cannot acknowledge/use a F2F encounter from another MD (i.e. specialist sees patient and makes referral, but won’t sign HH POC , then primary provider who will oversee/sign the HH POC must have a valid F2F visit with patient for the primary reason related to home care--F2F by specialist does not meet criteria unless they will sign the HHPOC)

Allowed NPP would include a NP, PA, CNS, or CNM working under the direction of the primary/certifying MD. The NPP may perform the F2F encounter, and the primary/certifying MD acknowledges this as the F2F encounter on the certification form/POC.

**Home Care Face-to-Face & Teleheath:**

Through 12/31/2024, the required Face to Face encounter for home care may be performed via two-way audio-video telehealth encounter with the provider and patient.*(COVID PHE waiver with extension provided in Consolidated Appropriations Act, 2023)*

*Refer to page 2 for specific F2F criteria*

*F2F Background: A physician/NPP must order Medicare home health services and must certify a patient’s eligibility for the benefit. The face-to-face requirement ensures that the orders and certification for home health services are based on a physician’s/NPP’s current knowledge of the patient’s clinical condition*

**Home Care Face-to-Face Checklist**

***F2F needed for all new Medicare/Medicare HMO/Medicaid skilled home care starts of care.***

* **VISIT NOTE**: Copy of F2F visit encounter note obtained and filed in home care record *(e.g. Progress note, Discharge summary, Admission H&P)*
* **TIMEFRAME:** Encounter occurred within required timeframe

No more than 90 days prior to, or 30 days after, admit to home care

* **REASON**: Encounter is **related to primary reason for home care services**.

Documentation of the encounter must include clinical information regarding the patient’s diagnosis for which he/she is being referred to home health services. If patient was seen for reasons entirely unrelated to home care services, a new F2F encounter is needed.

* **PROVIDER**: Encounter was completed by appropriate practitioner.

F2F can be performed by:

* Primary Certifying MD enrolled in Medicare (PECOS) or NP/PA/CNS/CNM working in collaboration with primary certifying MD; ***OR by***
* MD who cared for patient in acute/post-acute facility (or NP/PA/CNS/CNM working in collaboration with acute/post-acute facility MD) if referred to home care following facility stay

*\*A non-physician practitioner may complete and sign the F2F encounter. Certifying MD does not need to countersign note, but will indicate date F2F encounter occurred by NPP on certifying documentation (POC)*

* **DATE**: Certifying MD/NPP verifies the date the F2F encounter occurred on certifying documentation *(date of F2F may be included on Plan of Care certification statement)*
* Certifying MD (MD signing cert statement/POC) matches MD on claim

**SUPPORTING DOCUMENTATION**:

* Documentation supports need for **skilled services**
* What services were ordered and what *skill* will be provided (included on POC)
* Documentation supports **homebound status** when required
* Required by Medicare, Medicare HMO, but not Medicaid

If the F2F note does not specifically address the need for skilled home health services and/or homebound status, supporting information may be provided to the certifying MD for review.

The certifying MD must review and sign off on anything incorporated into the patient’s medical record that is used to support the certification of patient eligibility.

* + Additional supporting documentation may include orders, MD communications/coordination notes, and/or POC signed by certifying MD
  + Supporting documentation may also include inpatient documentation, progress notes, discharge summaries, etc