**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/NPP 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/NPP 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. (Allowed NP includes NP, PA, CNS, or CNM)*

Specifics based on referral source:

**Acute/Post-Acute Care Referral**: if patient is referred to home health directly from an acute or post- acute care facility, facility encounter performed by physician or NPP with privileges who cared for patient in the acute/post-acute setting may serve as F2F if criteria met

Note: acute/post-acute is defined by setting (e.*g. hospital, SNF, rehab*), not by inpatient status, therefore ED or observations stays could serve as F2F

**Community Referrals:** if patient is referred to home health from the community (not a direct referral from acute/post-acute setting), F2F encounter must be performed by the certifying provider signing the HH POC (primary/certifying MD/NPP). A community provider cannot acknowledge/use a F2F encounter from another MD or NPP (except CNM working in collaboration with certifying MD).

*Example: If specialist sees patient and makes referral, but won’t certify and sign HH POC , then primary provider who will oversee and sign the HH POC must have a valid F2F encounter with the patient, for the primary reason related to home care - F2F by specialist does not meet criteria unless they will certify eligibility and sign the HHPOC*

*Refer to page 2 for specific F2F criteria*

**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)*

*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 they were referred to home health services. If patient was seen for reasons entirely unrelated to home care services, a new F2F encounter is needed.

\**reason needs to be addressed on encounter note, cannot just be listed as an active dx*

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

F2F can be performed by:

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

*\*Certifying MD does not need to countersign note if F2F performed by CNM, but must indicate date F2F encounter occurred by CNM on certifying documentation (POC)*

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

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 provider for review.

The certifying provider 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/NPP communications, coordination notes, and/or POC signed by certifying MD/NPP
  + Supporting documentation may also include inpatient documentation, progress notes, discharge summaries, etc