Health Home Care F2F

Addendum to Face-to-Face Assessment

Patient Name: _____ Date of Birth: _____

This document should be viewed as an adjunct to the face to face assessment documented in a progress note. It will be used to ensure that the required documentation to support home care service is complete.

Clinical conditions requiring skilled services:

The patient qualifies for skilled home care services based on the following clinical findings as seen during the face-to-face encounter **(***rational for *each* discipline needed)**

_____

_____

_____

Skilled services needed; include each discipline and the specific education/intervention being requested:

SN for: _____

PT for: _____

ST for: _____

OT for: _____

HHA for: _____

Homebound Status:

Describe patient-specific clinical findings resulting in patient's need for assistance and/or equipment to leave home. Include activity restrictions which limit patients from leaving home. **What conditions make patient homebound? Why/How does conditions make patient homebound?** _____

_____

Certification Statement:

I certify that home care services are or were needed because patient is homebound. An individual shall be considered "confined to home" (homebound) if the following **TWO criteria are met**:

Criteria One: the patient must meet ONE of these conditions: *(circle one)*

- Because of illness or injury;
- Need the aid of supportive devices such as crutches, cane, walker, & wheelchair
- Need the use of special transportation
- Or the assistance of another person in order to leave their place of residence

The patient meets the following homebound criteria,

Criteria Two: There must exist a normal inability to leave home; **AND** leaving home must require a considerable and taxing effort.

The patient needs or needed skilled services on an intermittent basis. A plan of care for furnishing such services has been established. The services are or were furnished while the patient is or was under the care of a physician or advance practice provider.

NP/PA PRINTED NAME: _____ SIGNATURE: _____ DATE: _____

PHYSICIAN PRINTED NAME: _____ SIGNATURE: _____ DATE: _____

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Clinical Conditions Requiring Skilled Services:

Good for Nursing;

- Status post joint replacement
- Status post-surgery with limited endurance, ability to perform ADL's
- New onset or exacerbation of diagnosis as noted by_____ (e.g. shortness of breath, lower extremity edema, coarse breath sounds)
- Acute change in, or unstable clinical condition
- Pain management interfering with ADL's
- Complications of open wound
- Medical restrictions due to infectious disease
- Compromised cardiac status
- Compromised respiratory status
- Compromised neurological status

Good for Therapy;

- Gait/Balance/strength deficits with high risk for falls
- Status post-surgery with limited endurance, ability to perform ADL's • Pain interfering with IADL's

Skilled Services: The clinical findings support the need for the following skilled services

- Skilled nurse to assess disease process, symptom management, medication knowledge and compliance. Perform any procedures included on the plan of care. Provide education and training related to the medical condition.
- Physical Therapy to evaluate and treat for functional deficits related to mobility, ROM, strength, balance, equipment needs and home safety deficits. Provide education and training based on functional deficits.
- Speech Therapy to evaluate and treat for functional deficits related to communication, cognitive, and/or swallowing deficits. Provide education and training based on functional deficits.
- Occupational Therapy to evaluate and treat for functional deficits related to ADLs/IADLs, UE strengthening and ROM, adaptive equipment needs, energy conservation, safety awareness. Provide education and training based on functional deficits.
- HHA for personal hygiene care and bathing

Home Bound Status

The face-to-face (FTF) encounter must document that a recent encounter has occurred between the patient and either the physician or the advanced practice provider.

The FTF encounter can be addressed in a **Progress Note or Discharge Summary** but **must** have the appropriate documentation of an assessment/encounter describing the reason skilled service is necessary for treatment of the patient's illness/injury.

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- Needs the aids of supportive devices such as: Crutches, Cane, Walker, Wheelchair
- Patient is bedbound
- Patient must use special transportation
- Needs the assistance of another person to leave their place of residence
- Leaving home is medically contraindicated
- Unable to tolerate standing or walking for extended period
- Uses walls and furniture to ambulate
- To leave home is exhausting requiring extended periods to rest to recover
- Requires human assist due to unsteady gait/poor balance
- Balance impaired with potential for falls
- Experiencing pain that impairs /restricts mobility
- Visually impaired- requires constant attendance
- Cognitively impaired, unable to safely leave home w/o assist

CMS mandates the FTF encounter have the following "required elements" documented.

1. The patient's **clinical symptoms** supporting the **primary diagnosis** for home care services and must ***not*** be summarized as a "diagnosis".
2. The skill that is required by *each* specific discipline that will be involved in the patient's home care.
3. An explanation that documents the reason patient is homebound.

- **The FTF documentation must show the reason skilled service is necessary for the treatment of the patient's illness or injury.**

- **This justification will be based on the physician or advanced practice provider's clinical findings during the face-to-face encounter as well as specific statements regarding why the patient is homebound**.

Examples of **appropriate** documentation include:

"Wound care to left great toe. No s/s of infection, but patient remains at risk due to diabetic status. Skilled nurse visits to perform wound care and assess wound status. Patient on bed to chair activities only."

"Lung sounds coarse throughout. Patient finished antibiotic therapy today for pneumonia, and to follow up with pulmonologist due to COPD and emphysema. Short of breath with talking and ambulation of 1-2 feet. Nurse to assess respiratory status for s/s of recurring infection/ changes in respiratory status."

"CHF, weakness, 3+ edema in R & L legs; needs cardiac assessment, monitoring of signs & symptoms of disease, and patient education; homebound due to shortness of breath with minimal exertion, e.g., walking 5 feet."

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"Status post right total hip replacement. Needs physical therapy to restore ability to walk without assistance. Homebound temporarily due to requiring a walker, inability to negotiate uneven surfaces and stairs, inability to walk greater than 5-10 before needing to rest"

***As a physician or advanced practice provider, you are responsible for providing appropriate and accurate supporting documentation of your FTF encounter with your patients regarding home health care and certification of need. Acceptable FTF documentation does not have to be lengthy or overly detailed.**