COMMUNITY VISITING NURSE ASSOCIATION

Medicare Face to Face Encounter Addendum for Home Health Services

A "Face to Face" Encounter (medical visit) is required for Medicare patients, the encounter must be 90 days prior to or 30 days following the start of home care services

Patient Name: _____ DOB: __/__/__ MRN #: _____ Start of Care: __/__/__

1: *Face to Face Encounter:* I (or a non-physician practitioner working in collaboration with me), had a face to face encounter with this patient during which a medical condition was addressed which is the primary reason for home health care on:

Date of Encounter: ___/___/___ Primary DX for Home Care: _____

(DX must be specific...CAN NOT be a symptom)

2: *Based on my findings, the following skilled services are medically necessary Home Health Services:*

Discipline(s) Requested *(Check those that apply)*	"Reason" for Skilled Service(s) *(Examples of acceptable reasons is attached)* *(Note: Symptoms and/or diagnosis' are not acceptable reasons...must be specific)*
☐ Skilled Nursing for:	_____
☐ Physical Therapy for:	_____
☐ Speech Language Pathology for:	_____

3: *The following clinical findings support that this patient is homebound (See attached examples):*

_____

_____

I, certify that this patient meets the criteria for Medicare Home Health Services. I understand I am required to have documentation in the patient's medical record to support my determination of this patient's eligibility for coverage. I will provide medical records to the home health care agency, which I understand may be used during a review and/or audit being performed by audit entities and/or CMS (Center for Medicare/Medicaid).

4: *Physician's Signature with Credentials:* _____ *Date:* _____

Print Signing Physician's Name: _____

** (If, this form is being completed and signed by a non-physician practitioner, please provide the name of the physician (with his/her credentials) whom you are collaborating with regarding this patient.):* _____

5: ☐ I will be following this patient throughout their home health care episode and understand I will be receiving this patient's Plan of Treatment for signature.

☐ I will not be following this patient throughout their home care episode (Please, provide name of physician who will follow the patient and certify home care in the community) below:

6: *Community Physician Name: (please print first & last name)* _____

Please Fax completed form to: (908) 722-3014 or (908) 526-6064 *** For questions call: (908) 895-2222

Services **FACE-TO-FACE EXAMPLES** Homebound

*POTENTIAL EXAMPLES FOR #2	*POTENTIAL EXAMPLES FOR #3
• PRIMARY REASON FOR HOME CARE SERVICES. Include Diagnosis & Medical Conditions • CLINICAL FINDINGS THAT SUPPORT THE NEED FOR SKILLED NURSING AND PHYSICAL THERAPY.	CLINICAL FINDINGS THAT SUPPORT HOMEBOUND STATUS.
CARDIAC: • Potential for re-hospitalization related to unstable cardiac disease • Instruction on cardiac disease management • Teaching for weight management and diet teaching • Health teaching for medication management • Abnormal lab work results (specify), Abnormal ejection fractions (specify) _____	**CARDIAC:** • Poor endurance, experience shortness of breath with minimal activity or at rest • Illness requires assistance of another person or assistive device to leave residence
PULMONARY DIAGNOSIS: • Potential for re-hospitalization related to unstable respiratory disease • Instruction on respiratory disease management • Health teaching s/s of respiratory infection • Abnormal ABGS (specify) Abnormal pulse or readings (specify) _____	**PULMONARY DIAGNOSIS:** • Patient is at risk for further respiratory infection especially in the flu season • SOB at rest or with minimal activity
CANCER: • Debilitating Chemotherapy treatments • Symptom management • Nutrition and hydration needs • Port care • Abnormal lab work results (specify) _____	**CANCER:** • Patients pain impedes mobility • Profound weakness due to side effects of chemo/radiation • Medically restricted to home to decrease risk of infection
MUSCULOSKELETAL: • Pain and symptom control • Development of an in-home therapy program • Education disease process • In home safety instruction	**MUSCULOSKELETAL:** • Unsteady gait, poor balance s/p surgery • Activity restrictions related to weight bearing status
RENAL: • Instructions on Foley catheter care • Instruction on diet teaching and weight management • Instruction on medication management • Abnormal lab results (specify) _____	**RENAL:** • Fatigue due to ESRD
NEURO: • Neuro assessment and teaching • Development of an in-home therapy program	**NEURO:** • Requires 24 hour care due to fluctuating mental status • Unsteady gait, dizziness, syncope
INTEGUMENTARY: • Wound care and assessment • Instruction on wound care • Instruction on s/s of infection	**INTEGUMENTARY:** • Open wound at risk for infection • Movement restricted due to pain
DIABETES: • Patient has unstable blood sugar • Health teaching regarding diabetes • Health teaching for diet management • Diabetes disease management education • Abnormal labs (specify) _____	**DIABETES:** • Poor balance/unsteady gait due to diminished sensation • Unstable blood sugar levels, experiences severe fluctuations
GENERAL: • Needs assessment and education due to unstable condition • Anticoagulation education and management	**GENERAL:** • Patient is bedbound/chair bound • Patient requires assist of one or stand by assist to ambulate • Significant weakness following hospital stay • Impaired mobility due to recent fracture, surgery, arthritis or paralysis