

## FAQs Dealing with F2F

### **What is an example of the physician's narrative on the face-to-face documentation?**

The certifying physician's face-to-face description should be a brief narrative describing the patient's clinical condition and how the patient's condition supports homebound status and the need for skilled services.

For example:

"The patient is temporarily homebound secondary to status post total knee replacement and currently walker dependent with painful ambulation. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decompensation or adverse events from the new COPD medical regimen."

[http://questions.cms.hhs.gov/app/answers/detail/a\\_id/10480](http://questions.cms.hhs.gov/app/answers/detail/a_id/10480)

### **Can existing medical records (such as discharge summary plans) be attached to the certification and meet the face-to-face documentation requirements?**

Whether the face-to-face documentation is on the certification form itself or is an addendum to it, it must be separate and distinct. It must also include the following: 1) the patient's name; 2) date of the encounter; 3) how the patient's clinical condition as seen during the encounter supports homebound status and the need for skilled services; 4) the physician's signature (original signature, a faxed copy, copy of original document with signature or electronic signature - but not stamped signature); and 5) date of the physician's signature.

[http://questions.cms.hhs.gov/app/answers/detail/a\\_id/10483](http://questions.cms.hhs.gov/app/answers/detail/a_id/10483)

### **Can a physician certify a patient's eligibility and document the face-to-face encounter based on information received from another physician who recently saw the patient, such as the patient's attending physician during an acute stay?**

No. The law mandates that either the certifying physician, or certain non-physician practitioners (NPPs) who inform the certifying physician can perform the face-to-face encounter. A patient's encounter with an attending physician during an acute stay does not satisfy the requirement unless the attending physician is also the physician who certifies eligibility. However, certain NPPs in the acute care setting may collaborate with the certifying physician. In such cases, an NPP's encounter with the patient during an acute or post-acute stay may satisfy the requirement.

[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10331/related/1](https://questions.cms.hhs.gov/app/answers/detail/a_id/10331/related/1)

### **Can you please clarify the hospitalist's role?**

The statute requires that the certifying physician must document that the face-to-face encounter occurred with himself or herself, or certain non-physician practitioners (NPPs) who inform the certifying physician. Where the patient is admitted to home health from acute or post-acute care, we believe that current practice associated with the home health certification would apply to the face-to-face encounter as well. In most cases, we would expect the same physician to refer the patient to home health, order the home health

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services, certify the beneficiary's eligibility to receive Medicare home health services, and sign the plan of care. It would be this physician who would be responsible for documenting on the certification that he or she, or a NPP working in collaboration with the certifying physician, had a face-to-face encounter with the patient.

However, we recognize that, in some scenarios, one physician performing all of these functions may not always be feasible. An example of such a scenario would be a patient who is admitted to home health upon hospital discharge. While we would still expect that in most cases, a patient's primary care physician would be the physician who refers and orders home health services, documents the face-to-face encounter, certifies eligibility and signs the plan of care, there are valid circumstances where this is not feasible for the post-acute patient. For example, some post-acute home health patients have no primary care physician. In other cases, the hospital physician assumes primary responsibility for the patient's care during the acute stay, and may (or may not) follow the patient for a period of time post-acute. In circumstances such as these, it is not uncommon practice for the hospital physician to refer a patient to home health, initiate orders and a plan of care, and certify the patient's eligibility for home health services. In the patient's hospital discharge plan, we would expect the hospital physician to describe the community physician who would be assuming primary care responsibility for the patient upon discharge.

We also believe that with growing prevalence of NPPs in the acute and post-acute care settings, NPPs may increasingly collaborate with the community certifying physician regarding the NPP's encounter with the patient in the acute and post-acute settings.  
[http://questions.cms.hhs.gov/app/answers/detail/a\\_id/10295/related/1](http://questions.cms.hhs.gov/app/answers/detail/a_id/10295/related/1)

**Can the homecare agency title a document with a lead-in phrase such as: I had a face-to-face encounter on \_\_\_\_\_(date). The clinical findings support home health eligibility because:**

The lead-in phrase is acceptable as long as the physician completes the description of how the clinical findings support homebound status and the need for skilled services, in his or her own words.

[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10299/related/1](https://questions.cms.hhs.gov/app/answers/detail/a_id/10299/related/1)

**Could you clarify CMS' policy about the homebound status of home health patients who can drive?**

The Benefit Policy Manual (Internet-Only Manual 100-02, Chapter 7, Section 30.1.1) explains in detail what it means to be homebound. While we have excerpted portions below, please see the manual for full details.

“In order for a patient to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician certify in all cases that the patient is confined to his/her home. An individual does not have to be bedridden to be considered confined to the home. However, the condition of these patients should be such that there

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exists a normal inability to leave home and, consequently, leaving home would require a considerable and taxing effort.

If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment.”

A patient’s homebound status is not violated by attendance of religious services or attendance at a State licensed, State certified, or State accredited medical adult day care center.

“Occasional absences from the home for non-medical purposes, e.g., an occasional trip to the barber, a walk around the block or a drive, attendance at a family reunion, funeral, graduation, or other infrequent or unique event would not necessitate a finding that the patient is not homebound if the absences are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home.”

In addition to the information given in our Benefit Policy Manual, we have also addressed this question in a response to an inquiry back in April of 2003. We responded to the query with the following information:

“Homebound status is determined on an individual basis, looking at the patient as a whole. If the net effect of driving indicates that the individual has the capacity to get their health care routinely outside of the home, then it could challenge their eligibility. The fact that a patient is fit enough to drive raises questions as to whether the basic statutory requirement is met. Because individual circumstances can vary greatly, necessitating determinations on a case-by-case basis, we are reluctant to issue a specific policy that relates to driving in every possible occurrence. Inherent in such a policy would be judgments about the particular circumstances under which it may be appropriate for an individual to operate a motor vehicle. We believe that such determinations must continue to be made on a case-by-case basis.”

[http://questions.cms.hhs.gov/app/answers/detail/a\\_id/9070](http://questions.cms.hhs.gov/app/answers/detail/a_id/9070)

### **Can documentation requirements for the face-to-face encounter be satisfied if the certifying physician’s staff complete the document as part, or addendum to the certification using the patient’s medical record & physician reviews and signs?**

The statute requires that the certifying physician document the encounter as part of the certification. A physician's own support staff can help the physician draft the face-to-face encounter documentation narrative in a number of ways which include but are not limited to: the certifying physician can dictate the narrative to the physician's support staff, the support staff can extract the narrative from the physician's own medical record documentation of the encounter, or the support staff can generate the narrative from the physician's electronic medical record software. Such are examples of common practice for physicians to document their patient encounters, and all would meet the statutory

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requirement that the certifying physician must document the encounter as part of the certification. CMS expects that because this same information is often present on the discharge summary and/or physician orders for home health services, the face to face encounter documentation narrative may satisfy multiple purposes. A physician's orders for home health services or an acute/post-acute discharge summary can be used to satisfy the face-to-face documentation narrative, if they reflect the clinical condition of the patient as seen during the encounter, they are drafted by the physician or the physician's support personnel, and they meet these requirements:

- documentation must be on the certification form itself or is an addendum to it, it must be separate and distinct.

- It must also include the following: 1) the patient's name; 2) date of the encounter; 3) how the patient's clinical condition as seen during the encounter supports homebound status and the need for skilled services; 4) the physician's signature (original signature, a faxed copy, copy of original document with signature or electronic signature - but not stamped signature); and 5) date of the physician's signature

[http://questions.cms.hhs.gov/app/answers/detail/a\\_id/10482](http://questions.cms.hhs.gov/app/answers/detail/a_id/10482)

### **Do both the plan of care and the certification have to be signed by the same physician?**

Prior to Calendar Year 2011, CMS manual guidance required the same physician to sign the certification and the plan of care. Beginning in Calendar Year 2011, CMS will allow additional flexibility associated with the plan of care when a patient is admitted to home health from an acute or post-acute setting. For such patients, many asked that CMS allow the contact between the physician who attended to the patient during an acute or post-acute stay to satisfy the encounter requirement, even when the physician may not follow the patient in the community.

These commenters asked CMS to allow such physicians to inform the community certifying physician as the law allows non-physician practitioners (NPPs) to do. We are limited by the law that requires the certifying physician to document that the encounter occurred with himself or herself, or a permitted NPP. To adopt as much flexibility as the law allows, we will allow physicians who attend to the patient in acute and post-acute settings to certify the need for home health care based on their face-to-face contact with the patient (which includes documentation of the face-to-face encounter), initiate the orders (plan of care) for home health services, and "hand off" the patient to his or her community-based physician to review and sign off on the plan of care. As we described above we continue to expect that in most cases the same physician will certify, establish and sign the plan of care. But the flexibility exists for home health post-acute patients if needed.

[http://questions.cms.hhs.gov/app/answers/detail/a\\_id/10296/related/1](http://questions.cms.hhs.gov/app/answers/detail/a_id/10296/related/1)

### **Is the face-to-face required for patients in Medicare Advantage plans?**

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No, the face-to-face provision applies only to Medicare fee for service.

[http://questions.cms.hhs.gov/app/answers/detail/a\\_id/10300/related/1](http://questions.cms.hhs.gov/app/answers/detail/a_id/10300/related/1)

### **The final rule references homebound status and skilled need. Is the documentation of the clinical findings from the face-to-face encounter sufficient?**

The documentation must include the certifying physician's synthesis of how the patient's clinical condition, as seen during the encounter, supports that the patient is homebound and needs skilled services.

[http://questions.cms.hhs.gov/app/answers/detail/a\\_id/10298/related/1](http://questions.cms.hhs.gov/app/answers/detail/a_id/10298/related/1)

### **Is the face-to-face encounter requirement effective only for patients admitted to home health (i.e. have a new start of care) January 1st, 2011 and later?**

Yes, that is correct. We have interpreted the language in the statute to apply only to certifications and not recertifications.

[http://questions.cms.hhs.gov/app/answers/detail/a\\_id/10301](http://questions.cms.hhs.gov/app/answers/detail/a_id/10301)

### **What effect does the face-to-face requirement have on agency practices for meeting Medicare requirements associated with the plan of care and certification?**

Long-standing Medicare regulations have described the distinct content requirements for the plan of care and certification. The Affordable Care Act (ACA) requires the face-to-face encounter as an additional certification requirement. Many providers have implemented the requirements for the plan of care and certification by using one form which meets all the content requirements of both the plan of care and certification. This approach is perfectly acceptable and it will continue to be acceptable. Several years ago, CMS ceased to require that providers use a specific form for the plan of care and/or certification. Providers have the flexibility to implement the content requirements as best makes sense for them.

[http://questions.cms.hhs.gov/app/answers/detail/a\\_id/10294/related/1](http://questions.cms.hhs.gov/app/answers/detail/a_id/10294/related/1)

### **May physicians use their own electronic medical records with drop down menus to select from prepared descriptive language when completing the face-to-face encounter documentation for their patients? Can the narrative be typed?**

Yes. The regulation requires that the certifying physician document how the encounter supports the patient's homebound status and need for skilled services. We allow the documentation to be either on the certification or as a signed addendum to it. This allows the sort of flexibility where such documentation could be dictated by the physician to one of his support personnel, or to allow it to be generated by the physician's electronic medical record software. Such is common practice for physicians to document their patient encounters.

[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10333/related/1](https://questions.cms.hhs.gov/app/answers/detail/a_id/10333/related/1)

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**If a facility physician completes the encounter documentation and the community physician completes the plan of care, which of the two may bill Medicare for physician certification?**

The physician who certifies may bill Medicare for physician certification.  
[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10336/related/1](https://questions.cms.hhs.gov/app/answers/detail/a_id/10336/related/1)

**Will Medicare requirements be met if hospital discharge planners (physician's nurse or social worker) completes the face-to-face encounter document based on information from the patient's medical record and physician's review and signature?**

If the physician's support personnel extract information concerning the physician/patient encounter from the physician's own medical record entries, and those medical record entries include how the patient's clinical condition (as seen during the encounter) supports homebound status and the need for skilled services, the above scenario is acceptable.  
[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10414/related/1](https://questions.cms.hhs.gov/app/answers/detail/a_id/10414/related/1)

**If a patient has a face-to-face encounter on day 33 after the start of care, will the HHA be denied payment for services provided from day 1 through day 30?**

If the certification content requirements are not complete, the agency cannot bill.  
[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10349/related/1](https://questions.cms.hhs.gov/app/answers/detail/a_id/10349/related/1)

**Can a hospital physician perform the face-to-face encounter if the hospital owns the HHA to which the patient is referred?**

The physician who documents the face-to-face encounter must be the certifying physician. Per section 424.22(d), the certifying physician may not have a financial relationship as defined in 411.351 with the HHA to which he or she is referring patients. Similarly, a non-physician practitioner (NPP) performing the face-to-face encounter is subject to the same financial restrictions as the certifying physician.  
[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10411/related/1](https://questions.cms.hhs.gov/app/answers/detail/a_id/10411/related/1)

**When will medical reviewers and other CMS oversight begin to deny claims if the face-to-face requirement has not been met?**

CMS wants to ensure there is no interruption in access to care for Medicare beneficiaries. Although many home health agencies and physicians are aware of and are able to comply with this policy, CMS is concerned that some home health agencies and physicians may need additional time to establish operational protocols necessary to comply with this new law. As such, CMS expects that during the first quarter of CY 2011, home health agencies and physicians who order home health services will collaborate and establish internal processes to ensure compliance. Beginning with the second quarter of CY2011,

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home health agencies will have fully established such internal processes and CMS will expect appropriate documentation of the encounter.

[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10412/related/1](https://questions.cms.hhs.gov/app/answers/detail/a_id/10412/related/1)

**Will subsequent episodes be covered if face-to-face requirements are not met timely during the first episode?**

The face-to-face encounter requirement is necessary for the initial certification, which is a condition of payment. Without a complete initial certification, there cannot be subsequent episodes.

[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10340](https://questions.cms.hhs.gov/app/answers/detail/a_id/10340)

**What happens if the certification isn't documented before a patient is discharged? In other words, should a discharge be "held"?**

We are assuming the question relates to short stay patients. The HHA should treat this scenario as they always have when the patient's care plan goals have been met but the certification is not yet complete.

[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10339/related/1](https://questions.cms.hhs.gov/app/answers/detail/a_id/10339/related/1)

**Will Medicare requirements be met if hospital discharge planners (physician's nurse or social worker) completes the face-to-face encounter document based on information from the patient's medical record and physician's review and signature?**

If the physician's support personnel extract information concerning the physician/patient encounter from the physician's own medical record entries, and those medical record entries include how the patient's clinical condition (as seen during the encounter) supports homebound status and the need for skilled services, the above scenario is acceptable.

[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10414/related/1](https://questions.cms.hhs.gov/app/answers/detail/a_id/10414/related/1)

**If a facility physician completes the encounter documentation and the community physician completes the plan of care, which of the two may bill Medicare for physician certification?**

The physician who certifies may bill Medicare for physician certification.

[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10336/related/1](https://questions.cms.hhs.gov/app/answers/detail/a_id/10336/related/1)

**If a patient has a face-to-face encounter on day 33 after the start of care, will the HHA be denied payment for services provided from day 1 through day 30?**

If the certification content requirements are not complete, the agency cannot bill.

[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10349/related/1](https://questions.cms.hhs.gov/app/answers/detail/a_id/10349/related/1)

**Can a resident conduct the face-to-face encounter?**

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Only the certifying physician or certain NPPs can perform the face-to-face encounter. Additionally, only Medicare-enrolled physicians can certify home health eligibility, per the Affordable Care Act.

[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10332/related/1](https://questions.cms.hhs.gov/app/answers/detail/a_id/10332/related/1)

**In the event that the encounter does not occur within the 90 prior/30 day subsequent period, can an HHA discharge the individual from care or charge for any services the beneficiary wishes to receive beginning with day 31?**

The certification, which now requires documentation of a face-to-face encounter, is a technical requirement for payment. In the case where the face-to-face encounter requirement is not met, an HHA cannot hold a patient financially liable for services provided. Failure to meet a technical condition for payment is not one of the criteria where an HHA can hold a patient financially liable.

Once a patient is admitted, an HHA cannot abruptly discharge a patient unless the patient is properly notified and there is a valid reason for discharge. While there may be scenarios where failure to meet the face-to-face encounter requirement would result in a valid HHA discharge, CMS expects the HHA to facilitate and coordinate efforts of the patient and physician to ensure that the face-to-face encounter occurs timely. It is important to note:

- As a condition to participate in Medicare, the HHA must coordinate all aspects of the HH patient's care needs.
- The HHA has always been required to coordinate with the patient's physician to obtain a signed care plan, to update the care plan as needed, and to obtain a completed certification. The face-to-face encounter is an additional certification content requirement, and we expect the HHA to coordinate with the physician and patient to ensure compliance.

[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10457/related/1](https://questions.cms.hhs.gov/app/answers/detail/a_id/10457/related/1)

**When can the HHABN Option 2 be used if a patient fails to have a face-to-face encounter with the certifying physician?**

HHABN Option 2 must be used if an HHA has initiated home health services and chooses to terminate services for administrative reasons such as lack of a face-to-face encounter. HHABN Option 2 is a change of care notice and has no bearing on financial liability. The HHA is required to provide the specific reason on the HHABN that termination is due to the failure to meet the face-to-face encounter requirements. If possible, the HHA should provide the notice in advance of the termination date so that the beneficiary has an opportunity to work with the HHA and his/her physician in their complying with this requirement. HHAs do not issue the Notice of Medicare Provider Noncoverage (Expedited Determination notice), CMS 10123, before care is terminated under these circumstances. HHAs should recognize that they are responsible for providing information to Medicare beneficiaries prior to the start of care about the extent

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to which Medicare may pay for services and thereafter prior to a change in payment status under the Patient Bill of Rights set out in 42 CFR 484.10(e).

[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10481/related/1](https://questions.cms.hhs.gov/app/answers/detail/a_id/10481/related/1)

**Since the HHABN Option Box 1 does not apply, do Option Box 2 (discontinue services for agency business reasons) or Option Box 3 (no physician orders) apply?**

The HHABN, Form CMS-R-296, has been approved by the Office of Management and Budget (OMB) to provide limitation of liability protections to Original Medicare beneficiaries receiving home health services under section 1862(a)(1)(A) of the Act for care that CMS or its contractors determines is not reasonable and necessary under Medicare; section 1862(a)(9) of the Act, for custodial care; section 1862(g)(1)(A) of the Act, for care when the beneficiary is not homebound; and section 1862(g)(1)(B) of the Act, for care provided to a beneficiary who is not in need of skilled nursing care. The HHABN must not be used to transfer liability to the beneficiary when technical requirements for payment, such as a face-to-face encounter, are not met. The HHABN is not approved for this use. A beneficiary is not financially liable if the certification is incomplete.

[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10338/related/1](https://questions.cms.hhs.gov/app/answers/detail/a_id/10338/related/1)

**Can an HHA obtain and record oral orders regarding the required encounter information, which are then sent to the physician for signature?**

No. We believe that a verbal communication by the physician to the HHA regarding the encounter, where the HHA would then document the certification and get the physician to sign it, does not satisfy the statutory mandate that the certifying physician must document the encounter.

[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10334/related/1](https://questions.cms.hhs.gov/app/answers/detail/a_id/10334/related/1)

**Can the term "physician support staff"-- the staff who can assist the physician in drafting the narrative be further defined?**

Yes. Physician support staff are those staff who work with, or for the physician on a regular basis and, as part of their job duties, regularly perform documentation, take dictation from the physician and/or extract from the physician's medical records to support the physician in a variety of ways. We note that HHA staff cannot assist the physician in drafting the narrative as this would violate the statutory requirement.

[http://questions.cms.hhs.gov/app/answers/detail/a\\_id/10484](http://questions.cms.hhs.gov/app/answers/detail/a_id/10484)

**Can the physician document the certification when the physician or hospitalist has the patient's record in front of him?**

Yes. As long as the face-to-face encounter occurs in the specified timeframe of 90 days prior to the start of care or 30 days after the start of care and the documentation is completed before billing, this scenario is acceptable.

[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10297/related/1](https://questions.cms.hhs.gov/app/answers/detail/a_id/10297/related/1)

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### **Will documentation of an encounter submitted via an electronic portal and electronic signatures on face-to-face encounter documentation be acceptable?**

Yes, that is fine. However, it is important to reiterate that the documentation must be part of the certification itself, or an addendum to it.

[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10302/related/1](https://questions.cms.hhs.gov/app/answers/detail/a_id/10302/related/1)

### **Does Medicare allow HHAs to provide services to beneficiaries whose face-to-face encounter occurred 90 days prior to the start of care & to deny/postpone admission to those whose encounter may occur 30 days after the start of care?**

CMS has no regulation that would force an HHA to admit a patient under the above described circumstances, although CMS would expect HHAs NOT to adopt such admission practices. Rather, we would expect the HHA to coordinate with the patient and physician to ensure that a timely encounter occurs. We are not overly concerned that this is an access risk because we believe most patients will have had an encounter within the 90 days prior to start of care for the following reasons:

- Physicians provided CMS with comments that geriatric patients see their physicians at least once every 3 months, typically
- An OIG study in 2001 (before the surge of HH fraud) showed that about 89% of HH patients see their physicians every month
- Half of HH patients are admitted to HH from an acute setting. Our implementation approach allows the acute attending physician's encounter with the patient to satisfy the face-to-face encounter requirement, to the extent allowed in the law.

And, finally, there is an abundance of HHAs. MedPAC reports that 99% of Medicare beneficiaries reside in an area served by at least 2 HHAs.

[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10458](https://questions.cms.hhs.gov/app/answers/detail/a_id/10458)

### **Can the physician document the certification when the physician or hospitalist has the patient's record in front of him?**

Yes. As long as the face-to-face encounter occurs in the specified timeframe of 90 days prior to the start of care or 30 days after the start of care and the documentation is completed before billing, this scenario is acceptable.

[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10297/related/1](https://questions.cms.hhs.gov/app/answers/detail/a_id/10297/related/1)

### **What happens if the certification isn't documented before a patient is discharged? In other words, should a discharge be "held"?**

We are assuming the question relates to short stay patients. The HHA should treat this scenario as they always have when the patient's care plan goals have been met but the certification is not yet complete.

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[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10339/related/1](https://questions.cms.hhs.gov/app/answers/detail/a_id/10339/related/1)

### **Can physicians or NPPs employed by an HHA perform the face-to-face encounter?**

If the certifying physician or NPPs' relationship with the HHA meets the exemptions of the Stark Law, this would be acceptable.

[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10413](https://questions.cms.hhs.gov/app/answers/detail/a_id/10413)

### **What happens if the certification isn't documented before a patient is discharged? In other words, should a discharge be "held"?**

We are assuming the question relates to short stay patients. The HHA should treat this scenario as they always have when the patient's care plan goals have been met but the certification is not yet complete.

[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10339/related/1](https://questions.cms.hhs.gov/app/answers/detail/a_id/10339/related/1)

### **Will there be an exceptional circumstance whereby an encounter did not occur but the situation was out of the control of the agency (e.g. patient dies, changes physicians, moves, etc.)?**

The face-to-face encounter is an additional content requirement associated with the certification. Agencies should deal with the above described situations as they always have when such occur prior to obtaining a completed, signed certification. Refer to Section 10.11, Chapter 7, Pub. 100-02.

[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/10337/related/1](https://questions.cms.hhs.gov/app/answers/detail/a_id/10337/related/1)

### **Can someone separately draft the face-to-face narrative if the certifying physician performs the encounter?**

Yes, in certain conditions. We allow certifying physicians the flexibility to generate the face-to-face encounter documentation from their electronic medical record entries regarding the patient and we allow the physician's support staff to extract the documentation from the physician's medical record entries for the physician to sign. In the case of patients admitted to home health from the hospital, hospital discharge planners who have access to the medical record entries of the physician who attended to the patient during the hospital stay may extract the documentation, assuming the attending is also the certifying physician. However, because the ACA provision requires the certifying physician to document the encounter, the law does not allow a home health agency to draft the documentation for the physician to sign.

[http://questions.cms.hhs.gov/app/answers/detail/a\\_id/10635](http://questions.cms.hhs.gov/app/answers/detail/a_id/10635)

### **How many signatures are needed for the face-to-face documentation?**

## FAQs Dealing with F2F

One physician signature suffices if the face-to-face encounter documentation is co-located with the physician's certification of eligibility. Otherwise, if the face-to-face documentation is attached as an addendum to the certification (a separate document), the face-to-face documentation and certification each require a signature. Electronic signatures are acceptable.

[http://questions.cms.hhs.gov/app/answers/detail/a\\_id/10633/p/8%2C57%2C613](http://questions.cms.hhs.gov/app/answers/detail/a_id/10633/p/8%2C57%2C613)

### **Can a home health agency Medical Director or physician perform the face-to-face encounter?**

If the financial relationship between a home health agency physician or a Medical Director satisfies the requirements of an exception in 42 CFR §411.355 through §411.357, he or she may perform the face-to-face encounter and subsequently certify home health eligibility.

[http://questions.cms.hhs.gov/app/answers/detail/a\\_id/10634/related/1](http://questions.cms.hhs.gov/app/answers/detail/a_id/10634/related/1)