Tool: Face-to-face encounter checklist

Use this face-to-face encounter tool to ensure that your documentation is in order and avoid auditor scrutiny. The tool was created by Joe Osentoski, senior consultant for Gateway Home Health Coding and Consulting in Madison Heights, Mich. (*See related story, p. 3.*)

Patient:

	Questions	Yes	No	NA
1	A Face-to-Face (F2F) Encounter note/MD progress note is present.			
2	The F2F note completed within 90 days before and 30 days after the start of home health services.			
3	The F2F note is signed and dated by an allowed practitioner.			
	The F2F note supports the encounter was RELATED TO the need for home health services.			
4	Describes patient condition and symptoms--not just a list of diagnoses			
5	The reason for home health is a new problem			
6	The reason for home health is an exacerbation of a old problem			
7	If exacerbation--shown by more than just a date listed			
8	If post-operative patient it contains date, details, and any complications of surgery			
9	If pain present identifies if new symptom, severity, and limitations due to pain			
10	Review of systems, history of present illness, and physical examination contain narrative findings (not solely check boxes)			
11	Clinical findings identify deficits, problems, or changes relevant to home health services			
12	Reason for encounter is identified (may or may not be Chief Complaint)			
13	Functional or structural impairment related to primary diagnosis is detailed			
14	Identifies a primary diagnosis for home health service			
15	Supporting clinical documents are present, from the physician's medical records and/or the acute/post acute care facility records, matching the identified date of encounter.			
	NOTE: Either Question 16 or Question 17 are needed to comply with certification requirements			
16	If the F2F encounter physician/NPP is not the certifier (Plan of Care), the F2F enounter physician/NPP identifies by name the certifying physician/allowed practitioner.			
17	If the F2F encounter physician/NPP is not the certifier (Plan of Care) and did not identify by name the certifying physician/allowed practitioner, the certifying physician/allowed practitioner states that the F2F encounter physician findings were incorporated into the home health certification.			
18	If a Non-Physician Practitioner (NPP) completed the encounter, the certifying physician states that the NPP Face-to-Face encounter findings were incorporated into the home health certification. NA if state allows NPP to certify for home health.			
	Homebound Requirement			
	Homebound Criterion-One. Does the physician/facility documentation indicate that the patient requires:			
14	(Condition) a supportive mobility assist device, special transportation, or assistance of another person to leave the home?			
15	(Condition) does the patient have a condition such that leaving home is medically contraindicated?			
	If only has one Criterion-One condition, agency medical records or plan of care ***MUST ALSO SATISFY BOTH*** Criterion-Two homebound conditions:			
16	(Condition) The patient has a normal inability to leave the home ***and***			
17	(Condition) Leaving the home requires considerable and taxing effort.			
18	The physician/facility documentation supports that the patient has a normal inability to leave the home and requires a considerable and taxing effort to leave the home			
19	Agency generated information is used to support homebound and corroborate the certifying physician/allowed practitioner and/or acute or post-acute care facility documentation.			
20	If so, the agency information is signed/dated by the certifying physician/allowed practitioner.			
	Certification, Diagnosis			
21	The physician/allowed practitioner certifies the DATE of the F2F encounter (and this matches the actual encounter date)			
22	Home Health PoC, OASIS Primary Diagnosis, F2F findings are consistent.			
23	Variances of coding between documents is explained in communication/collaboration note.			
24	Coding reflects information available during assessment time frame.			