CMS limited F2F encounter/certification by one physician and plan of care by a second physician to cases where a patient comes to home care from an inpatient stay. From the CMS F2F Q&As

Can you please clarify the hospitalist's role?

A. 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 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.

From the Medicare Manual 100-01, Chapter 2, Section 30.1 Physician Certification Under Exceptions:

5. If the below conditions are met, an encounter between the home health patient and the attending physician who cared for the patient during an acute/post acute stay can satisfy the face-to-face encounter requirement.
A physician who attended to the patient in an acute or post-acute setting, but does not follow the patient in the community (such as a hospitalist) may certify the need for home health care based on his/her contact with the patient, and establish and sign the plan of care. The acute/post-acute physician would then transfer/hand off the patient’s care to a designated community-based physician who assumes care for the patient.

Or,
A physician who attended to the patient in an acute or post-acute setting may certify the need for home health care based on his/her contact with the patient, initiate the orders for home health services, and transfer the patient to a designated community-based physician to review and sign off on the plan of care.
To: NAHC Member Network  
Subject: RE: F2F Form

If the surgeon saw her for the reasons she needs home health, he can do the face to face and the local physician can do the cert.

If the physician who did the H&P is a partner of the local physician, that partner can do the face to face for the physician as a partner I believe.

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Question and not sure what to do. I have a physician who has been on a month vacation and during that time the patient had rt knee replacement, a physician did the surgery, another physician did the H&P prior to surgery due to her primary being on vacation. Patient went to skilled care and now we are 20 days post op and NH called for HH care and some PT.HCA and nursing for monitoring some new elevated BS. The primary doc is back from vacation but has not seen patient since November. Who can I have sign my FTF? Should I send patient to primary for her to be seen and have her do FTF and cert? Can I have the surgeon who saw her last in acute do the FTF and send orders and cert to the primary physician, or can I do that? Help me think this out PLEASE!

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Here is one

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Would anyone mind sharing some of their’s after all this great discussion has led to some editing?