How to Refer: HOME HEALTH

ELIGIBILITY REQUIREMENTS

Medicare pays for health care in the patient's residence only if the following conditions are met. The patient:

- Requires medically reasonable and necessary intermittent skilled services (nursing, physical and/or speech therapy; occupational therapy if combined with additional discipline)
- Is **confined to home (homebound)** (See Criteria for Homebound Status.)
- Is **under the care of a doctor** who determines the need for home health care, certified the patient's plan of care and periodically reviews the plan
- Must have **face-to-face (F2F) encounter by a doctor or other allowed practitioner** who meets Centers for Medicare & Medicaid Services (CMS) criteria (See F2F Encounter Documentation Requirements.)

HOW TO MAKE A REFERRAL

- Call home health agency or skilled home health care.
- Fax the following documents to the agency:
  - **Home health referral/F2F form and F2F encounter documentation** that supports patient's skilled home health need and homebound status, which may include **discharge summary**, **progress or office visit note(s)**, **operational notes**
  - **Face sheet/demographics** (DOB, SSN, phone, address) and insurance carrier and ID number (Please provide a copy of insurance card, if available.)
  - **History and physical** (PMH, disease Dx, surgeries)
  - **Current medication list**

PAYMENT SOURCES

- Medicare
- Medicaid
- Veterans Administration

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F2F ENCOUNTER DOCUMENTATION REQUIREMENTS

- Encounter was related to primary reason patient requires home health
- Date of encounter occurred no more than 90 days prior or within 30 days of home health SOC
- Date of encounter is included in the F2F documentation
- Encounter was performed by a physician or allowed non-physician practitioner
- F2F document is signed/dated by practitioner who performed F2F encounter, e.g., home health nurse signature, RN/referring NP/PA signature, oversight MD signature

CRITERIA FOR HOMEBOUND STATUS

Patient must either:

- Because of illness, **need the aid of supportive devices** such as crutches, canes, wheelchairs or walkers; the **use of special transportation** or the **assistance of another person** to leave his/her place of residence OR
- Have a condition such that leaving his/her home is medically contraindicated

Then:

- There must exist a normal inability to leave home, and leaving home must require a **considerable and taxing effort**, whether physical or cognitive.
- **Infrequent absences or periods of relatively short duration** for therapeutic, psychosocial or medical treatments, e.g., chemotherapy, radiation or dialysis, or occasional non-medical needs, e.g., family reunion, funeral or church, do qualify for homebound status.

ACUTE/POST-ACUTE FACILITIES: When a patient is referred to home health following discharge from an acute/post-acute facility, the referring facility physician must identify the community physician who will be following the patient in the community.

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How to Refer: HOSPICE

ELIGIBILITY REQUIREMENTS

- Attending physician confirms patient's **terminal condition/diagnosis** (life expectancy of 6 months or less)
- Patient/family elects treatment directed toward **symptom relief versus cure** of underlying disease

HOW TO MAKE A REFERRAL

- Call hospice agency and initiate a referral.
- Fax the following documents to the agency:
  - **Physician order** for hospice referral
  - **Face sheet/demographics** (DOB, SSN, phone, address, payor information)
  - **History and physical**
  - **Current physician notes**
  - **Current medication list**

BENEFITS OF EARLIER HOSPICE REFERRAL

- Better pain and symptom control
- Reduced patient and family anxiety
- Skilled nursing available to ensure patient comfort 24/7
- Greater ability to meet bereaved family needs
- Better opportunity for patients to spend time the way they choose
- Greater patient satisfaction; feeling more "in charge" of life
- Increased caregiver confidence in providing care and support
- Reduced caregiver "burnout"

Many hospice experts feel that a hospice stay of at least three months is needed to provide adequate services to both patient and family.

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How to Refer: HOSPICE

TIPS FOR DISCUSSING HOSPICE WITH PATIENT AND FAMILY

- Ask the patient if family members or others should be present.
- Introduce the subject: “I’d like to discuss overall goals for your care.”
- Assess the patient’s understanding of his/her health condition.
- Review the patient’s condition in language the patient/family can understand.
- Ask about goals and what the patient expects in the future/what is important.
- Listen and summarize your understanding of the patient’s goals and wishes.
- Introduce hospice care as a way to help the patient achieve his/her goals.
- Ask the patient/family what the term “hospice” means to them.
- Probe for previous experiences with hospice and their point of view.
- Correct misconceptions about hospice.
- Let the patient know he/she can continue to see his/her current physician.
- Offer to have someone from hospice meet with him/her.

PAYMENT SOURCES

- Medicare
- Medicaid
- Veterans Administration
- Some private insurance
- Private pay

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How to Refer: DURABLE MEDICAL EQUIPMENT

ELIGIBILITY REQUIREMENTS

- Attending physician **documents the patient's medical necessity** for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
- Patient's **medical records that support request**, which may include physician notes, hospital records, nursing home records, home health agency records, other health care professionals records and/or test reports
- Request must meet payors' applicable statutory and regulatory requirements (See Medicare LCDs.)

HOW TO MAKE A REFERRAL

- Call durable medical equipment (DME) supplier to initiate a referral.
- Fax the following documents to the supplier prior to delivery of DME:
  - **Detailed written physician's order**, filled out completely
  - **Medical records** that support request
  - **Face sheet/demographics** (DOB, SSN, phone, address, payor information)

PAYMENT SOURCES

- Medicare
- Medicaid
- Veterans Administration
- Some private insurance
- Private pay

How to Refer: DURABLE MEDICAL EQUIPMENT

COMMON DME REQUESTS (MEDICARE)

Oxygen/respiratory equipment:

- Oxygen concentrator
- Portable gas
- Nebulizer
- Care check/T.E.A.M.
- Overnight oximetry

Date of test: _____

Saturation levels: At rest: _____ Nocturnal: _____

Walk test: Rest: _____ Walk: _____

Walk with O2: _____

Sleep therapy:

- CPAP
- CPAP (auto-titrating)
- Bilevel w/o rate
- Bilevel w/rate
- Mask interface choice
- Sleep therapy accessories
- Heated humidifier
- Cool humidifier
- Other: _____

Wheelchair and other ambulatory aides:

- Standard wheelchair
- Heavy duty wheelchair
- Lightweight wheelchair
- High-strength lightweight wheelchair
- Ambulatory aides
- Accessories

Hospital beds and accessories:

- Semi electric
- Patient lift
- Gel overlay
- Trapeze
- Pressure-reducing mattress overlay
- Other: _____

Pressure-reducing support surfaces

Commodes

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How to Refer: PERSONAL CARE AGENCY

HOW TO MAKE A REFERRAL

- Call personal care agency (PCA) and initiate a referral.
- Fax the following documents to the agency:
  - **Face sheet/demographics** (DOB, SSN, phone, address, payor information)
  - **Current medication list**
  - **Information about follow-up appointments** (if applicable)

PAYMENT SOURCES

- Private pay
- Long-term insurance
- Veterans Administration

How to Refer: SKILLED NURSING HOME

ELIGIBILITY REQUIREMENTS

- Physician documents the patient's medical necessity and appropriateness for skilled stay; patient was in a hospital inpatient bed for the qualifying 3 nights
- Request must meet payors' applicable statutory and regulatory requirements

HOW TO MAKE A REFERRAL

- Call skilled nursing facility (SNF) and initiate a referral.
- Fax the following documents to the facility:
  - **Physician's order** for skilled stay and therapies (PT, OT, ST)
  - **Face sheet/demographics**
  - **History and physical**
  - **Current medication list**

Did you include?

- Social Security number
- Payor source
- Height and weight
- Progress notes/therapy notes
- Primary care doctor's name
- Case manager's name/phone
- CPR or DNR

DATE OF DISCHARGE INFORMATION NEEDED

- Oxygen and liters/minute (LPM)
- Weight and bearing status
- Last pain medication taken
- Last bowel movement
- Narcotic scripts
- Foley catheter in place or taken out before admit
- IV or PICC line

PAYMENT SOURCES

- Medicare
- Medicaid
- Veterans Administration
- Long-term insurance
- Private pay

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How to Refer: SKILLED NURSING FACILITY

QUESTIONS TO ANSWER WHEN CONSIDERING SNF REFERRALS

- Is the patient safe to return home?
- Does the patient have adequate support in place? PCA? Home health? Hospice? Other?
- Is there a low risk of readmission?

If you answer "no" to any of the questions above, consider:

- Is it possible to meet the patient's health care needs at his/her current home?
- Is this a long-term or short-term need for additional support?
- Does the patient need skilled nursing or rehab? Other?
- Does the patient need therapy (PT, OT, ST)?
- What level of care/service does the patient need?
- What types of amenities does the patient require?
- What resources are available to the patient?

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How to Refer: ASSISTED LIVING FACILITY

ELIGIBILITY REQUIREMENTS

- Patient must be18 years of age or older
- Assisted living facility is licensed to provide the level of care required by the patient:
  - **A Bed** (low level of care): The resident needs occasional supervision, assistance or reminders to perform some activities of daily living (ADLs) but is independent in other activities. He/she may require assistance or reminders to take medications or may be able to take medications independently. The resident cannot be dependent in 3 or more ADLs.
  - **B Bed** (moderate level of care): The resident requires more substantial support with some ADLs while needing only minimal assistance with others. Assistance with medications may be provided.
  - **C Bed** (high level of care): The resident needs frequent and comprehensive assistance with ADLs. Staff administers medications or assists the resident in taking them. Staff monitors the resident for effects of medications. Generally a locked facility for memory care residents.

HOW TO MAKE A REFERRAL

- Call assisted living facility (ALF) and initiate a referral.
- Fax the following documents to the facility:
  - **Face sheet/demographics** (DOB, SSN, phone, address, payor information)
  - **History and physical**
  - **Hard scripts for any opioids**
  - **Current medication list**
- Facility will contact patient/family to start admission process, including face-to-face health assessment.

PAYMENT SOURCES

- Medicaid waiver
- Veterans Administration
- Private pay
- Long-term insurance

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How to Refer: ASSISTED LIVING FACILITY

QUESTIONS TO ANSWER WHEN CONSIDERING ALF REFERRALS

- Is the patient safe to return home?
- Does the patient have adequate support in place? PCA? Home health? Hospice? Other?
- Is there a low risk of readmission?

If you answer "no" to any of the questions above, consider:

- Is it possible to meet the patient's health care needs at his/her current home?
- Is this a long-term or short-term need for additional support?
- Does the patient need assisted living or rehab? Other?
- Does the patient need therapy (PT, OT, ST)?
- What level of care/service does the patient need?
- What types of amenities does the patient require?
- What resources are available to the patient?
- Does the patient have a progressive disease, i.e., Parkinson's, dementia, Alzheimer's?
- Does the patient need more than Level Three care?

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