REFERRING THE MEDICARE BENEFICIARY TO HOME HEALTH SERVICES

When referring the Medicare beneficiary to home health services, the following should be documented and shared with the home health agency:

- **Order** for home health services – specify the treatments to be furnished and the skilled professional required (skilled nurse, physical therapist, etc).

- **Homebound Status :**

Criteria 1:

- The type of support and/or supportive device or assistance required to assist the patient in leaving home OR the condition such that leaving his or her home is medically contraindicated, such as a mental or psychological illness.

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Criteria 2:

Explain the patient's normal inability to leave home and define the taxing effort considering these areas:

- Patient's diagnosis
- Duration of the patient's condition
- Clinical course (worsening or improvement)
- Prognosis
- Nature and extent of functional limitations
- Other therapeutic interventions and results, etc.
- Pain meds
- Rest Periods
- Oxygen needs
- Continence Issues
- Confusion
- Safety concerns
- Other accommodation necessary

- **Need for Skilled Services:**

  - Disclose clinical information (beyond a list of recent diagnoses, injury, procedure or codes) that is individual and specific to the patient that describes the services to be provided in the home.

  - Explain why a skilled professional is necessary. If the care could safely and effectively be performed by the patient or unskilled caregivers, such services will not be covered under

the home health benefit.

- Face-to-Face Encounter Documentation:

  - Progress note written at the time of the patient one on one visit with the physician, nurse practitioner, or physician's assistant or discharge summary from the acute/post-acute facility.

  - Must occur 90 days prior or 30 days after the Start of Care and be related to the same reason the beneficiary needs home health services

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