



Medicare Changes Home Health Eligibility

What Doctors Need to Know to Get Home Health for their Patients in 2011

Effective January 1, 2011, Medicare will require additional paperwork from physicians in certifying and documenting orders for home health care. Baystate Visiting Nurse Association & Hospice (BVNAH) will make this paperwork easy.

Research published over the past few years has shown how better management of transitions of care reduces rehospitalization, reduces Medicare spending, and improves patient recovery. In response, the federal government has taken measures to ensure that more patients seek appropriate post-acute / pre-acute care from a doctor. One of these measures is the new face-to-face encounter requirement for home health eligibility.

Starting January 1, to be eligible for Medicare home health services, a patient must have a face-to-face encounter with the doctor (or a designated professional working with the doctor) within 90 days before or 30 days after the home health start of care. The physician must document, separately from the visit notes, how the visit pertained to the home health care diagnosis, how the patient is homebound, and what skilled need the patient has that merits home health care. For our valued physicians, BVNAH will make this documentation easy. For plans of care not submitted electronically, we will provide a simple form that can be submitted as an addendum to the plan of care or with the home health referral. With a few fill-in-the-blank questions and two or more free-form sentences, BVNAH will make meeting the new documentation requirements fast and easy for physicians.

In the documentation of the face-to-face visit, a physician must describe the nature of the skilled need and why the patient is homebound. The home health agency may not pre-fill these descriptions on the form. Below, we provide a few samples of the types of notes that would be appropriate for doctors to write.

Documenting Skilled Need

- Patient requires skilled observation and assessment due to a likelihood of exacerbation of (CHF, COPD, CAO, etc.).
- Patient requires skilled nursing for wound care and training of patient and informal caregivers.
- Patient demonstrates a likelihood of fall-injuries and requires a fall reduction rehabilitation program.
- Due to a recent change in medication regimen and therapeutic diet, patient requires additional skilled teaching.

Documenting Homebound Status

- Patient experiencing functional deficits secondary to a new diagnosis of stroke and requires assistive device to ambulate
- Patient experiences shortness of breath and fatigue severely limiting ambulation distance, and ability to self manage activities of daily living
- Cardiac instability and compromised ejection fraction contraindicates patient leaving the home
- Mental status changes impacting patient judgment prohibit patient ability to safely leave the home

What Doctors Need to Know About New Documentation Requirements:

- Patients must have a face-to-face encounter within 90 days before or 30 days after the home health start of care.
- The encounter may be conducted by a physician or a non-physician working with the doctor (PA, NP, CNS or nurse midwife), but the supervising physician must complete the documentation of the face-to-face encounter.
- The face-to-face encounter must have been relevant to the home health diagnosis, but the home health diagnosis does not have to be the primary reason for the face-to-face encounter.
- When documenting the reason for homebound status and the skilled need, home health agencies are prohibited from typing this language for doctors and from providing standardized language for doctors to check off. These answers should be free-form notes from the doctor.
- BVNAH simplifies the referral process.

*Consider Baystate Visiting Nurse Association & Hospice for your patients.
To make a referral call: 800-249-8298.*