WHAT IS SKILLED HOME CARE?

A physician only (i.e. not NP, PA) can refer any patient, with an acute skilled need, to home care as long as they are temporarily or permanently homebound*. A referral requires a physician, NP, or PA to see the patient and complete a face-to-face encounter which must be signed or co-signed by physician.

Examples of reasons for initiating a referral to a home health agency include:

1) Skilled Nursing Care – monitoring of vital signs or cardio/pulm status, wound care, ostomy care, Foley catheter or PEG tube care, education of patients or caregivers regarding diabetic care, skin care, pill management, behavioral management of dementia.
2) Physical therapy – home safety evaluations, falls assessment, gait training, strengthening or transfer training, rehab after hip fracture, training family/aide in ROM exercises. Coverage recently extended to include maintenance PT.
3) Speech therapy – after a stroke, Parkinson disease, dementia or aspiration precautions teaching
4) Infusion therapy – intravenous antibiotics, hydration, chemotherapy or nutrition (no longer fully covered by Medicare)

Once these services are established the following can be added on:

1) Occupational therapy
2) Social work
3) Phlebotomy
4) Temporary home health services (i.e. a home health aide)
5) Behavioral Health Therapy

The services above are billed by the nursing agency to one of the following:

- Medicare - part A and the patient receives no copay or deductible
- Medicare Advantage and Managed Medicare
- Medicaid
- Commercial insurance/HMO
- Out-of-pocket
- Other sources

Medicare home bound rule (11/2013):

Criteria: 1: The patient must either:

- Because of illness or injury, need the aide of supportive devices such as crutches, cances, wheelchairs and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence

OR

-Have a condition such that leaving his or her home is medically contraindicated

AND 2: -There must exist a normal inability to leave home;

AND

-Leaving home must require a considerable and taxing effort.

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MEDICAL EQUIPMENT

Durable Medical Equipment (DME):

Examples: Hospital beds, walkers, wheelchairs, canes, oxygen, mattress overlays, nebulizers, commode chairs, suction pumps and Hoyer lifts

To order:

- Call, fax request (does not need to be an RX)
- Medicare requires the completion of **Certificates of Medical Necessity (CMN)** forms which the vendor will send you
- Physician (or NP) needs to document a patient's need for specific equipment
- **New Face-to-Face Requirement**: The law requires that a physician must document that a physician, nurse practitioner, physician assistant or clinical nurse specialist has had a face-to-face encounter with the patient. The encounter must occur within the six months prior to the written DME order
- Wheelchairs: As of 2007, most physicians will need PT to evaluate the patient and document exact needs, sizes, measurements for all wheelchair orders (manual and electric). MD progress notes supporting request now required as well
- A patient can no longer receive new equipment after five years. Now, the MD (or NP) needs to write a letter to have the equipment fixed and, only if approved, replaced after the five years
- If the family or vendor initiates the need for the equipment, it is imperative that the provider ensures that the equipment is medically necessary and that the CMN form is filled out properly
- Medicare Part B pays 80% cost for renting or purchasing DME if prescribed by a physician and used in the patient's home for legitimate medical reasons. The additional 20% is paid out of pocket, by Medicaid or through other insurance
- Some equipment is not covered by Medicare (e.g. grab bars and reachers)

Non-Durable Medical Equipment (non-DME):

Examples: exam gloves, diapers, dressing materials, and absorbent pads (chux)

Not covered by Medicare but frequently by Medicaid

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WHO PAYS FOR HOME CARE?

Medicare

- Federal program
- Medicare Part A is available to most Americans 65 and older if they or their spouse has worked 40 quarters, those on social security disability (SSDI) for more than 2 years or immediately if diagnosed with ALS, patients with ESRD on dialysis within the first four months after beginning dialysis or within the month if post-kidney transplant.
- Medicare Part A: Hospital care (with deductible), hospice care, and skilled nursing care (at home or at a skilled nursing facility or rehabilitation center)
- Medicare Part B: 80% outpatient hospital care, doctor's services and durable medical equipment (DME). Patients must sign up for Part B and must pay a monthly premium, based on income.
    - Patient pays 20% after annual deductible of $147
- Medicare Part D: Prescription drug program

Medicaid

- State run programs with federal minimum standards
- Extends medical coverage to poor
- Covers skilled home care for younger patients who do not have Medicare
- 9.6 million elderly (2013) in the U.S. are dually eligible for Medicare and Medicaid
- Covers copays, non-durable medical equipment, home attendants

Private/Commercial Insurance

- May cover skilled home care completely or with copay
- There may be limitations to the number of visits authorized

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HOW TO BILL FOR HOME CARE CERTIFICATION AND RE-CERTIFICATION (485)

- Beginning in 2000, Medicare created codes to pay physicians (not NP's) for overseeing home care plans
- This was done to encourage physicians to actively participate in overseeing the complex care of these fragile homebound patients
- Skilled home care must be billed to Medicare
- This is billed to Medicare Part B, therefore you must bill the patient for the additional 20%
- The codes are the following:

	Billing Code	Reimbursement
Certification	G0180	$56.91-$88.69
Re-Certification	G0179	$42.91-$68.91

How do you do this?

- For every 60-day period of home care, the physician will receive a 485 form delineating the plan of care
- Review for accuracy and sign form
- Include proof of involvement in care plan in chart
- In the bill you must include the agency's number found on the 485
- Bill for the first day of the certification, NOT the day you sign the form

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HOW TO BILL FOR CARE PLAN OVERSIGHT (CPO)

- Medicare had implemented payments to physicians (and NP's) for overseeing home care plans
- This was done to encourage physicians to provide closer supervision of the complex care of these fragile, homebound patients
- Patient must be currently receiving Medicare-billed home care
- To bill for a CPO, a physician must spend 30 minutes or more in a calendar month coordinating or overseeing a patient's home care
- This is billed to Medicare Part B, therefore you must bill the patient for the additional 20%
- The codes are the following:

	Billing Code	Reimbursement
Home Care CPO	G0181	$101.62-$142.09
Home Hospice CPO	G0182	$98.48-$149.91

How do you do this?

- Document time spent on billable activities in the chart
- In the bill you must include the agency's number found on the 485
- Must be the same physician who signs the 485 (NP's can bill CPOs, but their collaborating MD must sign the 485)
- Must be a single practitioner's total minutes, i.e. in a group practice you cannot combine minutes from multiple providers on one patient

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HOW TO BILL FOR TRANSITIONAL CARE MANAGEMENT

- Medicare had implemented payments to physicians (and NP's) for transitional care/post discharge visits
- When a patient is discharged from any hospital to home or any subacute rehab facility to home
- Requires an RN/NP or MD call within 2 business days of discharge date and a physician visit within 14 days
- The codes are the following:

	Billing Code	Reimbursement
Transitional Care (14d post dc and equivalent of level IV visit)	99495	$164.06
Transitional Care (7d post dc and equivalent of level V visit)	99496	$ 231.12

*Bill has to be dropped on Day 30 post discharge

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TO INCORPORATE LEARNERS ON HOME-BASED VISITS

Adult learners benefit most from active, participatory learning. Bringing learners on home visits can be a challenge but is also a fantastic teaching opportunity and may be an unforgettable experience for the learner.

Helpful tips when working with adult learners:

Make sure you know your learner's level
Agree upon expectations
Enthusiastically stimulate curiosity
Demonstrate clinical skills
Involve the learner in the educational process
Role model desired behaviors
Give timely, specific feedback focused on behaviors
Have the learner identify learning points from the day
Encourage the learner to reflect on the patients and identify areas for further learning

Specific ideas for home visits:

When possible, have them take the history or lead the physical exam in your presence.

Have them do a geriatric assessment, give them feedback, discuss their interpretations and review possible next steps.

Have them do a home safety assessment and present it to you.

Let them do the medication reconciliation, ask them to consider why each medication is prescribed, what its mechanism of action is, what potential side effects are and if there are any that could potentially be discontinued.

If they need to observe you conduct a visit, ask them for their assessment and plan at the end; probe for evidence supporting their decisions.

When developing a management plan, ask open-ended questions – see if they can come up with alternative diagnoses/treatments, concerns, etc.

Have the learner choose only one skill to work on per visit, to help you stay on schedule.

Don't forget – you are a powerful role model!

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