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OVERVIEW

This booklet contains general information regarding your rights and responsibilities as a patient. The booklet is used for all patients of the Agency regardless of age or payor source. Although it is written directly to the patient, it is meant to provide information to guardians, parents, family and caretakers.

As state and federal regulations change, there may be additions or alterations to this booklet as necessary. The complete set of Agency policies and procedures is available, upon request, for your review at the Agency office at any time during normal business hours.

Home Health Admission Criteria

Your admission to home health services depends on the reasonable expectation that your medical, nursing and social needs may be adequately met in your residence. You are not admitted to the Agency until an assessment of your needs has been completed and you have given your consent for treatment. The Agency must have orders from your physician (a Plan of Care) before skilled care can be provided. If your physician has ordered any home health service that the Agency is unable to provide, the Agency must inform you.

Some payors, such as Medicare, require that you be homebound. "Homebound" means that you have a normal inability to leave home. You may still be considered homebound if you leave your home for medical reasons. You may also leave infrequently for short durations as long as leaving home requires a "considerable and taxing effort." If you drive for any reason, you are not considered homebound. Once you are able to freely leave home, you will no longer be eligible for home health services paid for by Medicare.
Face to Face Physician Encounter for Home Health Patients

Requirement for A Face-to-Face Encounter between the Patient and the Patient’s Physician or Non-Physician Practitioner:

Medicare covers home health services for individuals who are confined to their homes and in need on skilled nursing care on an intermittent basis or physical therapy, speech-language pathology, or where they have a continuing need for occupational therapy. To qualify for coverage, a patient must be under the care of a physician who certifies the need for care and that the individual is confined to his home.

A recent change in the law adds a new requirement to qualify for Medicare coverage. To encourage greater involvement of the physician in a patient’s home health care services, a new law requires that the patient be seen face-to-face by the physician, or certain non-physician practitioners working with the physician, before home health services start or soon thereafter.

In many situations, these visits with the doctor would have occurred just before the start of home health care. Where that has not happened, the patient must arrange to see his/her doctor who is involved in the care that would be provided in the home. The key elements of this new law is that the patient must have the face-to-face visit within 90 days of home care starting or within 30 days of the start of care. In addition, the visit must be with the physician who is or will be caring for the patient during the home health care. Finally, the encounter must be for medical service related to the reason why home health services are needed.

The home health agency can help determine whether the patient has met the encounter requirement. The agency would need a full list of all the doctors the patient has seen in the 90 days before the start of home care. If none of those doctor visits qualify, the agency needs to know what doctor will be caring for the patient while in home care.
If the patient is being cared for by a nurse practitioner, physician’s assistant, clinical nurse specialist, or certified nurse midwife, visits with these professionals may meet the requirement too.

This requirement is quite complex and in need of clarifications from Medicare. Here is a summary of the conditions that the new law establishes.

The provisions of the final rule require that the:

- Physician responsible for performing the initial certification (admission or start of care) document that the face-to-face occurred.
- Patient encounter be related to the primary reason the patient requires home health services.
- Encounter has occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care.
- Documentation includes the date of the encounter, and an explanation of why the clinical findings of the encounter support that the patient is homebound and in need of either intermittent skilled nursing services or therapy services.
- Face-to-face encounters may be performed by the certifying physician or by a nurse practitioner or a clinical nurse specialist in consultation with the physician, or a physician’s assistant supervised by the physician.
- Documentation of the face-to-face patient encounter must be a separate and distinct section of, or an addendum to the certification, and must be clearly titled, dated and signed by the certifying physician.
- Non-physician practitioners performing the face-to-face encounter must document the clinical findings of that face-to-face patient encounter in the medical record and communicate those findings to the physician who certifies the encounter.
- Face-to-face patient encounters may occur through telehealth, but only if the telehealth encounter occurs at a Medicare approved originating site that does not include the patient’s home.
- Certification of need for home health services must be obtained at the time the plan of care is established or as soon thereafter as possible and must be signed and dated by the physician who establishes the plan. (Certification is the act of signing the statement).
- Need for home health services may not be certified or recertified, and a plan of care may not be established and reviewed, by any physician who
has a financial relationship that is not a Stark exception or an anti-kickback safe harbor.

- A non-physician practitioner may not perform the face-to-face encounter if prohibited by anti-kickback laws.

If you have any questions about this new rule, please do not hesitate to ask the home health agency staff.

**Discharge Planning**

Discharge Planning will be initiated upon your admission to service. Services will not be terminated until your physician has been consulted and arrangements are made for continuing care, if necessary. In most cases you will be given at least five days notice before discharge. If you are admitted to and remain in the hospital or other acute setting over your certification period you will be discharged. When you are discharged from the hospital, the Agency will readmit you or assist the hospital discharge planner in making other appropriate care arrangements for you.

**Ownership Disclosure**

INSERT AGENCY NAME is owned by INSERT OWNER/CORPORATION NAME. In compliance with Title VI of the Civil Rights Act of 1964, with Section 504 of the Rehabilitation Act of 1973 and with the Age Discrimination Act of 1975, the Agency does not discriminate on the basis of race, color, sex, national origin, age, or disability with regard to admission, access to treatment, or employment. We are committed to ensuring your rights and privileges as a home health patient.

All services provided by this Home Health Agency result in financial benefit to the owner. The agency may also provide other services to you through other categories of service.