Medicare Beneficiary Discharge Planning REFERENCE LIST

Patient Choice

Section 43219a) of the Balanced Budget Act of 1997 requires that Medicare participating hospitals, as part of the discharge planning process, share with each beneficiary a list of Medicare-certified home health agencies (HHAs) that serve the beneficiary's geographic area and which request to be listed. In addition, the statute prohibits hospitals from specifying that beneficiaries receive services from a particular HHA. Further, the statute requires that hospitals identify any HHA or other entity in which they have a disclosable financial interest or which have a financial interest in them. The intent of section 4321(a) is to protect patient choice. (*Federal Register* / Vol. 67, No. 226 / Friday, November 22, 2002 / Proposed Rules)

To qualify for Medicare Home Health Services

- The patient is under the care of a physician (community physician willing to sign home care orders).
- The patient requires skilled nursing, physical therapy, or speech therapy services; or has a continuing need for occupational therapy on an intermittent basis. (If daily, then there is an endpoint to daily care.)
- Services are provided in the patient's home.
- Services must be reasonable and necessary.
- The patient is homebound.

Definition of homebound

Homebound means the condition of the patient causes an inability to leave home. When the patient does leave home, it requires a considerable and taxing effort.

Homebound Qualifiers:

- Absences from the home are infrequent or of short duration

  Examples of infrequent or short duration absences

  - Attendance at religious service
  - Attendance at a significant family event
  - Trip to barber or hairdresser
  - Walk outdoors
- To receive health care treatment
- To receive medical daycare services

Considerable and taxing effort means the patient requires use of a supportive device (walker, cane, wheelchair), use of special transportation, or assistance of another person to leave their home; or leaving home is medically contraindicated.

Definition of reasonable and necessary

- Skilled services are reasonable and necessary if there is a reasonable **potential** of a complication or further acute episode.
- Skilled services are usually covered for a reasonable period of time (three weeks), or more as long as there remains a reasonable potential of a complication or further acute episode.

Willing, able, and available caregiver

Home health services are reimbursed regardless if there is someone available to furnish the services. Where there is a caregiver willing and able to provide the services that adequately meet the patient's needs, it would not be reasonable for the home health agency to provide the services. Ordinarily, it is presumed there is no able and willing person in the home, or no one is available to provide the services rendered by the home health agency.

Definition of skilled service

Skilled services encompass observation and assessment, teaching and training, performance of skilled treatments and procedures, or management and evaluation of the care plan.

- There is a likelihood of a change in the patient's condition that may require a change in the patient's plan of care.
- There is complexity of the patient's condition
- Teaching includes evaluating the ability of the patient/caregiver to learn and to demonstrate/verbalize information taught by the clinician.

Source: *CMS Online Manual Medicare Benefit Policy Manual* Publication 100-2 Chapter Seven: Home Health Services (http://www.cms.hhs.gov/Manuals/iom/list.asp)

Pfaadt, M., (2000). A Review of the Basics – Understanding the Categories of Skilled Nursing Services. *Home Healthcare Nurse,* 18 (5), 297

FIVE QUESTIONS TO ASK

1. Does the patient have Medicare?
2. Is the patient under the care of a physician?
3. Does the patient have a willing, able, and available caregiver?
4. Is the patient homebound?
5. Does the patient require a skilled service (nursing, physical or speech therapy)?

IF YES to all ,the patient qualifies for home care services under the Medicare benefit.

CONSIDERATION: Has the home care referral and plan been shared with the patient's caregiver? ☐ Yes ☐ No

This material was prepared by IPRO, the Medicare Quality Improvement Organization for New York State, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 8SOW-NY-TSK1B-08-17

CRITICAL PATIENT INFORMATION

to include when transitioning patients between health care settings

- ☐ 1. Date and time of transfer
- ☐ 2. Patient name
- ☐ 3. Sex
- ☐ 4. Date of birth
- ☐ 5. Address
- ☐ 6. Insurance information, including documentation of payer authorization for transfer of care to the receiving healthcare provider and transportation payer
- ☐ 7. Medical diagnosis
- ☐ 8. Treatment provided with timeframes
- ☐ 9. Clinical condition
- ☐ 10. Medical summary that includes history and physical with update for discharge disposition, including influenza and pneumococcal immunization status
- ☐ 11. Recent reports of lab work, x-rays, EKG, and other relevant tests
- ☐ 12. Medications and treatments required by the patient (if applicable, include medications patient was administered on the day of discharge)
- ☐ 13. Prescriptions
- ☐ 14. DNR and/or Advance Directive information (health care proxy)
- ☐ 15. Physician's order for treatment
- ☐ 16. Relevant therapy notes (if applicable)
- ☐ 17. Psychosocial history/summary
- ☐ 18. Summary of nursing care needs
- ☐ 19. Physician order to transfer—signed, dated, and timed
- ☐ 20. Reason for discharge/transfer
- ☐ 21. Patient destination
- ☐ 22. Current discharge plans, including discharge arrangements
- ☐ 23. Patient/family agreement to discharge
- ☐ 24. Discharge PRI/SCREEN (if applicable)
- ☐ 25. List of personal effects, money, valuables (if transferring to another facility)
- ☐ 26. Any other required patient assessment documentation (MDS/OASIS/M11Q/M27R)
- ☐ 27. Sending and receiving facility transfer/discharge documents
- ☐ 28. Mode of transfer (transportation)
- ☐ 29. COBRA transfer form (if applicable)
- ☐ 30. Summary of patient education, assessment of learning and response to teach back provided during episode of care

Source: New York State Finger Lakes Region Community-Wide Transfer Agreement

This information is provided as guidance and should not be considered to be an all inclusive list of discharge planning options. Providers need to select and/or develop protocols that apply to their specific patient population and region.

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