VNA COMMUNITY HEALTHCARE
BESIDE YOU AT EVERY TURN

PHYSICIAN'S GUIDE TO MEDICARE HOME CARE

Medicare "Homebound" Definition

Cannot leave home without considerable and taxing effort.

Possible ways to describe homebound status:

- Patient states " I don't go out"
- Family states "he doesn't go out"
- Homebound due to mobility problems
- Homebound due to poor vision
- Homebound due to gait disorder/falling
- Homebound due to neurological disorder that limits movement
- Homebound temporarily due to infection
- Homebound due to recovery from surgery
- Homebound due to poor cognition
- Cannot leave home without assistive device or help of another person
- Homebound because of severe dyspnea

Medicare Home Care Rules

1. Patient must be homebound.
2. Home care must be medically necessary.
3. Patient must require intermittent skilled care. Skill =nursing, physical or speech therapy.
4. The patient must have a "face to face encounter" with a physician, APRN or PA in the 90 days prior to the start of home care or within 30 days after the start of care.
5. Only a **PHYSICIAN** can sign and date a document that states:
   a. Reason for face to face encounter
   b. Why patient is homebound
   c. What clinical findings support the need for homecare

NOTE: Documentation must be signed by the MD only, cosignatures are not permissable.

6. Physician must sign the plan of care (Medicare form 485) and return it to the agency within 21 days of the start of care.

Some Clinical Indications for Home Care

- Wound care for nonhealing wounds/ulcers
- New diagnosis, medication, treatment plan
- New history of falls/balance problems
- Declining mental status
- Patient requires home medical procedure
- Newly prescribed special diet or bowel regimen
- Patient must learn to perform medical procedure at home or to administer new meds
- New disability and need for home modification
- Pain control plan
- Medication management and medication prepours
- Monitoring for new med, declining physical status
- Decline in ability to perform ADLs

Steps in the Home Care Referral/Certification Process

- Call or fax the referral form to Transitional Care.
- Attach documentation of "face to face" encounter.
- Complete and sign Form 485, the Medicare Plan of Care and return to agency within 21 days of the start of care.
- Communicate with home care staff, sign and return supplemental orders as needed.
- Bill Medicare with code G 180 for home care certification.

Revised: 4.8.13

Intake/Transitional Care: 203.458.4275 or toll free: 866.862.0888 FAX: 203.458.4388