ASSESSMENT, PLANNING & COORDINATION

# ACCEPTANCE OF PATIENTS

Approval Date: 9 2023

Revision Date: 9 2024

Tags : APC.1.D, APC.3.I, APC.3.I.M1, APC.5.I

## PURPOSE

To accept / admit patients for treatment based on a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence without regard to race, color, national origin, disability, or age.

## POLICY

The agency designated office personnel determines the patient's eligibility to receive home health services before making an initial visit to the patient in his/her home. (APC.3.I)

Eligible patients are accepted for treatment on the basis of a reasonable expectation that their medical, nursing, rehabilitative, and social needs can be met adequately by the agency in their place of residence. (APC.3.I.M1) (G570)

Consistent with the patient's immediate needs or within 48 hours after the referral for services, or as specified by the physician, or the physician assistant or the advance practice registered nurse, the agency registered nurse will conduct patients' assessments and/or evaluations to verify that there is a reasonable expectation that the patients' medical, nursing, rehabilitative, and social needs can be met adequately by the agency.

In therapy-only cases a qualified therapist (P.T./O.T*/SLP) who is a direct employee or a contractor with the agency, may proceed with the evaluation and recommend acceptance of the patient if the agency selects that option. However, only the agency may accept the patient for care.

An occupational therapist may conduct a home health initial assessment visit and complete a comprehensive assessment under the Medicare program, but only when occupational therapy is on the home health plan of care, **with** either physical therapy or speech therapy, **and when skilled nursing services are not initially in the plan of care.**

* The need for O.T. cannot stand alone to qualify for Medicare billable services despite the fact that in therapy only cases, O.T. can complete the initial assessment and accept/admit the patient for care.

The agency accepts / starts the care for patients and provides them with home health services directly or through a contractor or any other entity with which the agency arranges to carry out its programs and activities as required by Federal law without regard to race, color, national origin, disability, or age. (APC.5.I)

The agency specializes in the geriatric population and the majority of our patients are over the age of 65. The agency reserves the right to only accept patients that the agency is able to appropriately treat, based on the:

1. Availability of staff trained in special age groups, such as pediatrics and teenagers;
2. Source of payment as the agency is not a recipient of Medicaid & CHIP funds for example

The agency accepts any adult that it is able to serve.

**PROCEDURE**

**Intake & verification of home health benefits**

Upon reception of the referral, except during the weekend if this is not reasonably feasible, the office designee will verify the:

1. Patient's eligibility to the Medicare or other payer home health benefits by accessing the Medicare eligibility database electronically or by calling the patient's insurance company. When services ordered will be paid under the Medicare HHPPS, before providing any services, information will be reviewed to determine whether a beneficiary is currently in a home health episode of care. In such case, the clinical supervisor will follow the agency policy & procedure "Beneficiary Elected Transfer".

2. Physician or the physician assistant or the advance practice registered nurse's eligibility to order services covered by Medicare, when applicable, by accessing the PECOS database and the OIG Exclusion List if not done recently.

3. That services will be provided in a home located in one of the counties that the agency is licensed for;

4. That the Physician or the physician assistant or the advance practice registered nurse ordering/referring Medicare covered home health services:
    a) Has an individual (Type 1) NPI;
    b) Is a Doctor of Medicine or Osteopathy, and/or a Doctor of Podiatric Medicine or is a Resident who has an appropriate State license and is enrolled in Medicare;
    c) Is enrolled in PECOS effective no later than July first 2012; and
    d) Has not been excluded by the Office of Inspector General (OIG) as a Medicare Provider.

**Initial evaluation visit and determination of eligibility to receive services**

When the patient has home care benefits, within 48 hours of the referral or as specified by the physician or the physician assistant or the advance practice registered nurse, taking into consideration the patient and/or family needs, the registered nurse* or the qualified therapist assigned to make the first visit will, before accepting / starting the care for the patient,

1. Evaluate for appropriateness of home care services in the home:
    a) The patient's medical, nursing, and social needs can be met adequately by the agency;
    b) The patient is able to care for him/herself or be cared for by his/her representative who can meet his/her needs in between the intermittent visits from the agency staff;
    c) Patient's home supports that home health services be provided safely;
    d) Communication is possible with the patient, or with another person designated by the patient, either through a staff person or, at no cost to the patient, through either an interpreter that speaks the same language or through technology that translates so that the services can be provided;

Additionally for services to be covered under Medicare, the patient must be

    e) Homebound / confined to the home
    f) Under the care of a physician or the physician assistant or the advance practice registered nurse as described in the policy above
    g) In need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology. Occupational therapy alone does not establish eligibility for the Medicare home health benefit at the start of care; however, occupational therapy services only may qualify for eligibility under other programs, such as Medicaid.
    h) In need of services that are reasonable and necessary

The Director of Nursing or an RN Clinical Manager will call the patient prior to assigning the evaluation visit to a qualified therapist in order to determine as best as possible that the patient will not require nursing services. If the patient has new/changed medications, wound care or other needs that may suggest that nursing services might be required the agency will assign a registered nurse to make the evaluation/start of care visit. The RN visit must be scheduled on the same day that the therapist is scheduled for his/her evaluation visit. (Rationale: if the case remains therapy-only, the SOC OASIS must be completed on or after the first billable visit). Notwithstanding if an RN makes the first visit or not in therapy-only cases, the P.T. must complete his/her initial evaluation within the 48 hours explained in paragraph B above. (APC.1.D)

**Acceptance/Admission of the patient**

1. When the evaluation by the agency RN/P.T./SLP/O.T. determines that the patient is appropriate and eligible for home health care, the agency employee or contractor will

    a) In advance to providing any services, discuss and provide <u>in writing</u> the following information to the patient / guardian / representative as most appropriate:

    Patient's Bill of Rights, Patient's Responsibilities and the agency's transfer and discharge policy. (Please refer to the Patient-Centered Care policy "PATIENT BILL OF RIGHTS")

        i. Information regarding Advance Directives such as "Health Care Advance Directives _ The Patient's Right to Decide" - State of Florida / Policy of the agency or other such publication;
        ii. Toll-free telephone number of the Florida home health hotline and of the Community Health Accreditation Program, their hours of operation, clarifying that the purpose of the hotline is to receive complaints or questions about the agency;
        iii. The Administrator's name, agency address and phone number;

iv. The Clinical Manager's name and phone numbers for this patient should any questions or concerns arise regarding care;
v. OASIS privacy notices.

b) The signature of the patient and/or authorized representative is then obtained to evidence acknowledgement of items listed in (a) above and confirms the admission of the patient to the agency;

c) The employee or contractor explains to the patient / guardian / representative as most appropriate the Written Agreement for services (AKA Consent). If the patient appears confused and has not been declared incompetent by a Judge, the patient and the designated health care surrogate or next of kin should both sign the agreement.

The completion of the agreement with the patient or the patient's legal representative to provide home health services determines that the decision was made by the agency to accept the patient, during or after an evaluation visit to the patient's home. Acceptance or start of care means that there is reasonable expectation that the patient's medical, nursing, and social needs for skilled care can be adequately met by the agency in the patient's place of residence.

d) A comprehensive assessment is then completed by a qualified registered nurse or therapist as applicable when any skilled services are ordered (Please refer to the ASSESSMENT, PLANNING & COORDINATION policy "Comprehensive Assessment of Patients and OASIS");

e) The agency employee or contractor initiates the development of the patient specific plan of care for services in consultation with the patient, representative (if any) and caregiver(s) when applicable, the patient's physician (doctor of medicine, osteopathy or podiatric medicine) or the physician assistant or the advance practice registered nurse acting within the scope of his/her state license, certification or registration and the disciplines who are involved in providing the care and services required to carry out the physician, or the physician assistant or the advance practice registered nurse's treatment orders. The plan of care and is based on the assessment of the patient's immediate and long term needs and identifies patient-specific measurable outcomes and goals (Please refer to the ASSESSMENT, PLANNING & COORDINATION policy "Plan of Care").

f) The registered nurse or therapist provides other information as required per the agency Policies and Procedures to the patient such as but not limited to: "Notice of Nondiscrimination"

2. Before the end of the second visit by a skilled professional, the agency staff will provide

a) A schedule of the disciplines that will furnish care, employees & contractors, and their ordered frequencies;
b) A summary of the Plan of Care, inclusive of all disciplines that will provide the care, using a language easily understandable to the patient. (APC.1.D)

**Emergency management information**

The start of care registered nurse or therapist completes the "Patient Evacuation Plan" form in collaboration with the patient or caregiver, to include and special needs registration, when applicable, to be maintained by the county Emergency Management office; and

Informs the patient/caregiver of the agency's procedures during and immediately following a disaster or an emergency. See "Emergency Management Plan" Policy

**Home health aide assignment**

If aide services have been ordered, the registered nurse or therapist completes the aide care plan with the patient and/or caregiver and leaves a copy in the home folder before leaving the premises.

**Other communication tools**

Prior to leaving the patient's home, the registered nurse or therapist as applicable initiates the calendar of visits and the multidisciplinary communication flow sheet and leaves them in the home folder.

**Patients residing in an ALF**

When a patient resides in an ALF and is accepted for care, the registered nurse or therapist as applicable must complete the ALF Non-Duplication form with the Administrator or the facility nurse before commencing nursing or personal care services. The agency will not provide any services that the facility is held to provide by its contract with the patient/resident.

**Follow-up with the office**

1. The registered nurse or therapist as applicable reports the following information to the office as soon as possible:
   a) Start of care completed or denied
   b) Proposed frequencies & duration
   c) Other disciplines needed as discussed with the patient & the physician or the physician assistant or the advance practice registered nurse.

2. Office management follow-up
   a) The administrative assistant updates the referral window immediately re: admitted vs. non-admitted.
   b) The start of care visit is reported on the schedule;
   c) The DON or designee adds the patient to the "Emergency Management Patients Priority List";
   d) The Clinical Manager or designee assigns and coordinates all other services needed and ordered: therapy, aides, social worker;
   e) The Plan of Care is audited by the Clinical Manager prior to being submitted to the physician or the physician assistant or the advance practice registered nurse as determined by the quality management program.

3. Non-acceptance of patients

In situations where the patient cannot be accepted by the agency, the registered nurse or therapist as applicable will report to the Clinical Manager and will follow-up immediately with a call to the ordering physician or the physician assistant or the advance practice registered nurse. No comprehensive assessment with or without OASIS will be completed.

When the patient is not accepted because his/her medical, nursing, and social needs cannot be met adequately by the agency, the Clinical Manager or designee will call and inform the ordering physician or the physician assistant or the advance practice registered nurse and will assist in an alternate referral process. The Clinical Manager or designee will document all arrangements and patient disposition and the information in the referral window of the management Information software.

The registered nurse or therapist as applicable who suspects that a patient is a victim of abuse, neglect or exploitation will discuss immediately with the Clinical Manager of the agency and will report to the FL Central Abuse Hotline. This should be documented thoroughly on an occurrence report. The agency will keep such records for a period of six years in compliance with HIPAA.