Acceptance-to-Service Policy

PURPOSE

To establish a consistent, standardized process for the acceptance of a patient that meets the eligibility criteria for home health services. The policy ensures the agency evaluates its capacity to meet the needs of the referred patient and complies with regulatory requirements outlined by CMS at 42 CFR § 484.105(i). This policy aims to promote timely and appropriate care for patients while maintaining the quality and safety of services provided.

SCOPE

This policy applies to all new patient referrals or readmission referrals made to home health agency for home health services, including skilled nursing, therapy services (physical, occupational, speech-language pathology), medical social services and home health aide services.

DEFINITIONS

- Referral: A formal request for home health services made to the agency. It may be generated by a patient, physician (or allowed practitioner/provider), caregiver, health facility representative or community member.
- Capacity: The HHA's ability to meet the anticipated care needs of a referred patient, considering factors such as case load, staffing, geographical location, and skilled services ordered by a provider or other authorized healthcare provider.
- Case Load: The total number of patients currently under care by the HHA at any given time.
- Case Mix: The types and complexity of patients currently under care, which may impact the ability of the agency to accept new patients.

POLICY OVERVIEW

The HHA will only accept patients for home health services when there is a reasonable expectation that the agency has the capacity to meet the patient's care needs. The decision to accept or deny a referral will be made based on an evaluation of the following criteria:

- **Anticipated Needs for the Referring Patient:**
    - Evaluation of the patient's clinical condition, care requirements, signing physician (or allowed practitioner), and expected treatment duration.
    - Review of any specific medical orders, diagnosis, or recent hospitalizations provided by the referring provider.
- **Case Load and Case Mix:**
    - Consideration of the current census of patients being served by the agency, ensuring that the agency is not overloaded and can provide adequate attention and resources to new referrals based on medical necessity and skilled need.
    - Assessment of the types of patients currently under care to determine if the agency can appropriately accommodate the complexity and type of services needed by the new patient.
- **Staffing Levels**
    - The HHA will assess whether it has sufficient qualified staff (e.g., registered nurses, therapists, home health aides) to provide timely and appropriate care to the new patient without compromising the care of existing patients.
    - Staffing levels must the regulatory requirements and the needs of the agency's patient population.
- **Skills and Competencies of the HHA Staff:**
    - Assessment of whether the HHA staff has the necessary skills and competencies to meet the specific needs of the referred patient.
    - If specialized services (e.g., wound care, specialized therapy) are required, the agency must ensure it has appropriately skilled staff to provide these services.

PROCEDURES FOR ACCEPTANCE OF REFERRALS

- **Referral Intake:**
    - Referrals are to be received through phone, fax, secure email or facility secure portals.
    - Upon received a referral, the agency's Intake Coordinator will initiate a preliminary review, ensuring that all necessary information (e.g., provider, orders, medical history, recent hospitalizations) is provided.
    - If required by payer, documentation of a face-to-face encounter within the past 90 days or scheduled within the next 30 days with the qualified provider who has agreed to oversee the plan of care or if a patient is coming from an inpatient facility with the referring provider from that facility.
    - A reimbursement source including preauthorization of visits if required.

  - The Intake Coordinator , in collaboration with the clinical team, will assess the patient's anticipated care needs, case load, case mix, staffing availability, and staff competencies.
  - If the patient's need match the agency's capacity, the referral will be moved forward for scheduling and care plan development.
  - If the agency determines it cannot meet the patient's needs, the referral will be declined. In such cases, the referring provider will be notified, and alternative home health services may be recommended.
- **Notification of Acceptance or Denial:**
  - The referring provider and the patient (or their representative) will be notified of the agency's decision to accept or deny the referral.
  - The patient will be provided with information regarding the specific services available and duration of the frequency of the services, as well as any limitations related to those services.
- **Documentation**
  - All decisions regarding the acceptance or denial of a referral will be documented in the patient's electronic health record (EHR) including the rationale for the decision.
- **Periodic Review and Updates:**
  - The Patient Acceptance-to-Services Policy will be reviewed annually by the HHA's leadership team to ensure its continued relevance and compliance with regulatory requirements.
  - Any changes to the agency's capacity, staffing, services, or referral process will be communicated to staff and made publicly available.