House Calls and Home Care

Tom J. Wachtel, MD

House Calls and Domiciliary Visits

Introduction

A growing number of people in the United States are homebound and need in-home health care services. “House calls” refer to the provision of physician services to patients in their homes or apartments, including independent living centers. Domiciliary visits refer to physician services provided to patients who reside in assisted living facilities, boarding houses or group homes.

Home visits may be provided as part of an interdisciplinary team or by a solo physician; they may be episodic or exist as ongoing care to patients. Furthermore, the diagnostic house call can provide information to the physician about how the patient functions within the home environment. (Table 1).

The actual visit

The history and physical exams in the patient’s home are similar to office work. In addition, permission should be requested to inspect the living quarters. Is the home clean? Is there food in the house? Can the patient get around? Is the environment safe? Are there loose rugs, nightlights, rails in the bathroom? Medications should be reviewed.

An office visit, no matter how comprehensive, cannot provide a complete understanding of the patient's daily routine. In many situations, a family member or other caregiver should be present during the visit. When the patient's condition requires substantial nursing care, the visiting nurse should be present during some visits, enabling the team to discuss the care plan. Observing the interaction between caregivers and patients is also a valuable source of information. In the home setting, people may be more likely to display their usual patterns of interaction. In some cases (e.g., abuse or neglect), the physician may need to contact an agency that provides adult protective services.

The goals of house calls vary. A “sick” visit may simply address an acute complaint (e.g., respiratory symptoms, a fall). In the case of home-based long term care, the data described in Table 1 should be collected over time or during a comprehensive intake session; included are information on medical problems, physical function (e.g., ADL, IADL) and social and role function, such as visits by friends and relatives; and mental function, affect and advance directives. Unlike the office setting, much of this information can be collected by direct observation during a home visit.

Blood and urine tests, electrocardiograms and portable x-rays can be obtained in the home but they must be scheduled in advance and are rarely available on an emergency basis.

Logistics and Time Management

The logistics of house calls explain why many physicians, busy with their office and hospital work, find house calls inefficient. However, the physician with a substantial caseload of homebound patients can cluster visits geographically. Except for first encounters, multiple house calls can be scheduled per hour when visits are clustered.

Routine house calls can replace idle time caused by cancellations in the office, and improve efficiency. Urgent visits can be made at day’s end. However, it should be made clear to homebound patients that emergencies cannot always be addressed at home, and may require hospital ED.

Payment Codes for House Calls and Domiciliary Visits (effective 1/1/2008)

The CPT codes for house calls and domiciliary visits are different. (Table 2)
Table 2

<table>
<thead>
<tr>
<th></th>
<th>House Call CPT</th>
<th>Domiciliary Visit CPT</th>
<th>History</th>
<th>Examination</th>
<th>Decision-making complexity</th>
</tr>
</thead>
<tbody>
<tr>
<td>New patient-Level 1</td>
<td>99341</td>
<td>9324</td>
<td>Problem focused</td>
<td>Problem focused</td>
<td>Straight forward</td>
</tr>
<tr>
<td>New patient-Level 2</td>
<td>99342</td>
<td>99325</td>
<td>Expanded problem focused</td>
<td>Expanded problem focused</td>
<td>Low</td>
</tr>
<tr>
<td>New patient-Level 3</td>
<td>99343</td>
<td>99326</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Moderate</td>
</tr>
<tr>
<td>New patient-Level 4</td>
<td>99344</td>
<td>99327</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Moderate</td>
</tr>
<tr>
<td>New patient-Level 5</td>
<td>99345</td>
<td>99328</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High</td>
</tr>
<tr>
<td>Established-Level 1</td>
<td>99347</td>
<td>99334</td>
<td>Problem-focused interval</td>
<td>Problem-focused interval</td>
<td>Straight forward</td>
</tr>
<tr>
<td>Established-Level 2</td>
<td>99348</td>
<td>99335</td>
<td>Expanded problem focused interval</td>
<td>Expanded problem focused interval</td>
<td>Low</td>
</tr>
<tr>
<td>Established-Level 3</td>
<td>99349</td>
<td>99336</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Moderate</td>
</tr>
<tr>
<td>Established-Level 4</td>
<td>99350</td>
<td>99337</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Moderate or high</td>
</tr>
</tbody>
</table>

Home care and domiciliary care oversight CPT codes applying only to patients who are not enrolled in a home care agency or hospice (face to face with patient is not required).  
99339: Physician supervision for 15-29 minutes per billing calendar month  
99340: Physician supervision for 30 minutes or more per billing calendar month

Table 3. Examples of Homebound Cases According to Medicare Criteria

Mobility restricted by a disease process such as unsteady gait, draining wounds, or pain.

Poor cardiac reserve, shortness of breath or activity intolerance as a result of an unstable or exacerbated disease process.

Bedridden or wheelchair bound patients who require physical assistance to move any distance.

Patients who require caregiver help with assistive devices such as walker, wheelchair or other special device to leave home.

A tracheotomy, abdominal drains, colostomy, Foley catheter or nasogastric tube that restricts ambulation.

Psychotic ideation, confusion, or impaired mental status that restricts functional abilities outside the home.

Fluctuating blood pressure or blood sugar levels that can cause syncope.

Inability to negotiate stairs or uneven surfaces without assistance of a caregiver.

Postoperative patients whose activity has been restricted by the physician.

Patients who are legally blind or cannot drive.
**TABLE 4**

Clinical Vignettes Related to Medicare Home Care Eligibility Criteria

<table>
<thead>
<tr>
<th>Vignette</th>
<th>Home Confined</th>
<th>Skilled Care needed</th>
<th>Meets Medicare Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient with unsteady gait who requires assistance for ambulation and whose blood pressure is 190/110</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient with a dense hemiparesis who is bedridden or chair bound and who has a pressure ulcer</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient with severe peripheral neuropathy who is blind and wheelchair-dependent for mobility and whose chronic conditions are well controlled with 12 or more oral medications</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Patient with advanced Alzheimer’s dementia; incontinent of urine, and living in his daughter’s home; no other medical problem</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Patient with a draining venous ulcer who is able to walk and drive her car independently</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Patient with severe emphysema and cor pulmonale who is ambulatory and stable on home oxygen therapy and medication</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

**FORMAL HOME CARE – PHYSICIAN ROLE**

**Introduction**

Formal home care is that care provided to homebound patients by home care agencies. Most agencies are certified as Medicare providers; a few are not. Some have service contracts with health insurers or managed care organizations. They typically provide short term, skilled nursing services; rehabilitation services including physical, occupational and speech therapy; and personal care. Such care must be provided under physician approval and oversight.

**Regulations**

When physicians prescribe home care services for Medicare beneficiaries, they must certify that the patient is homebound; is in need of intermittent skilled nursing care or physical, speech, or occupational therapy; and under the physician’s ongoing care. By signing the Medicare authorization form, the physician verifies that the patient has met the three eligibility criteria. The physician must also review the home care plan periodically, but no less often than every 2 months, and re-certify the patient if appropriate.

**Homebound Criteria**

In order to be eligible for homecare, patients need not be bedridden; Medicare considers patients homebound if they cannot leave their residence independently. Such patients may leave their homes with the aid of assistive devices or another person, but absences from the home must be relatively short and in most instances, be for the purpose of medical treatment. Patients are also considered homebound if leaving the home is medically contraindicated.

Table 3 lists qualifying clinical situations for Medicare criteria for home confinement.

**The Skilled Service Requirement**

A homebound person is not eligible for home care unless criteria for intermittent skilled care are also met. Skilled care must be provided by a registered nurse or physical, occupational, or speech therapist. However, just because a service is provided by one of these health professionals does not necessarily mean it is skilled. A service is skilled because of its complexity, its appropriateness for the patient’s condition and because it meets accepted standards of medical and nursing practice. “Intermittent” means that the skilled services are required less frequently than 7 days per week, but at least once every 60 days.

Table 4 provides examples of met and unmet eligibility requirements. Documentation should describe the patient’s condition and the complexity of required services. An assessment of the risk of bad outcomes should the services become unavailable is also required.

**The Physician as a Gatekeeper**

The eligibility criteria for home care are stringent because the intent of the Medicare program is to cover acute care rather than long-term care. However, the clinical reality is that chronic conditions exacerbate and improve over time, causing home care eligibility to change and complicating the physician’s role in approving services. The (re)certification plan-of-care forms, completed by home care agency staff, should document not only patients’ current needs for skilled care, but also the reasons for their homebound status. Without firsthand knowledge or other reliable information of the patient’s condition, the physician should not certify the patient in a perfunctory manner by signing a form.

In many cases, there is no doubt that the patient meets the Medicare criteria for home confinement. Still, physicians should not allow long periods of time to go by without seeing the patient (e.g., 6 months if stable); house calls may be required for some patients. Given that an assessment of functional status is an integral component of geriatric care, the medical record should contain current information about function, in addition to usual medical management issues that will justify patients’ eligibility in case of audit.
The gatekeeping role can be particularly frustrating for patients with chronic conditions, such as congestive heart failure (CHF) or emphysema who meet criteria for skilled services only during episodes of exacerbation. In-home nursing services for some of those conditions have been shown to reduce exacerbations and hospitalizations, yet regulations impede the provision of evidence-based proven interventions.3

**Physician payment codes for formal home care oversight**

Medicare also pays physicians for overseeing the work done by home care agencies. The CPT codes for these services are:

a. G0180 Certification for home care
b. G0179 Re-certification for home care
c. 99374 Care plan oversight for home care: requires at least 15-29 minutes per month and ability to document the time spent.
   99375 Care plan oversight for home care: 30 minutes or more per month
d. 99377 and 99378 Care plan oversight for hospice (same respective time requirements as for home care).

**REFERENCES**


**ADDITIONAL READINGS**


**Disclosure of Financial Interests**

Tom Wachtel, MD. Consultant: Proctor & Gamble. Speaker’s Bureau: Proctor & Gamble, Sanofi-Aventis, Pfizer, Boehringer-Ingelheim, Takeda

---

**THE ANALYSES UPON WHICH THIS PUBLICATION IS BASED** were performed under Contract Number 500-02-R102, funded by the Centers for Medicare & Medicaid Services, an agency of the U.S. Department of Health and Human Services. The content of this publication does not necessarily reflect the views or policies of the Department of Health and Human Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government. The author assumes full responsibility for the accuracy and completeness of the ideas presented.