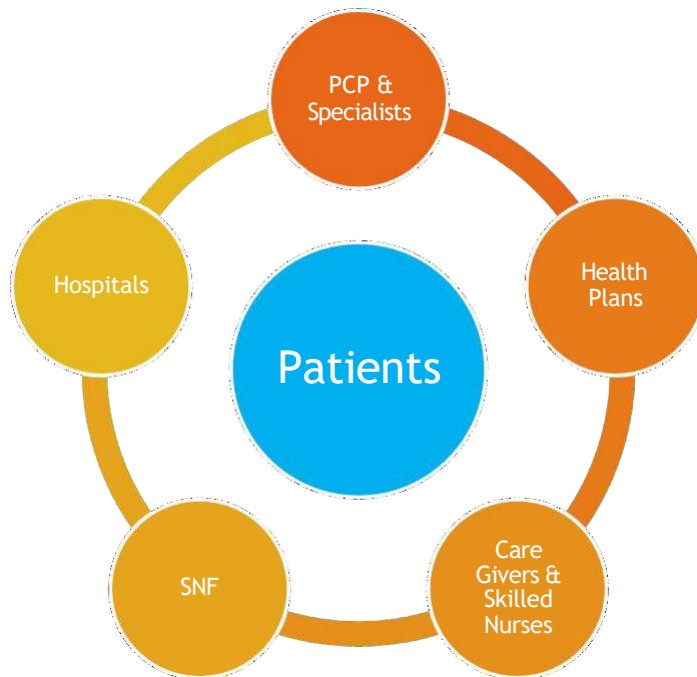




# Referral Source

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## QUICK REFERENCE GUIDE





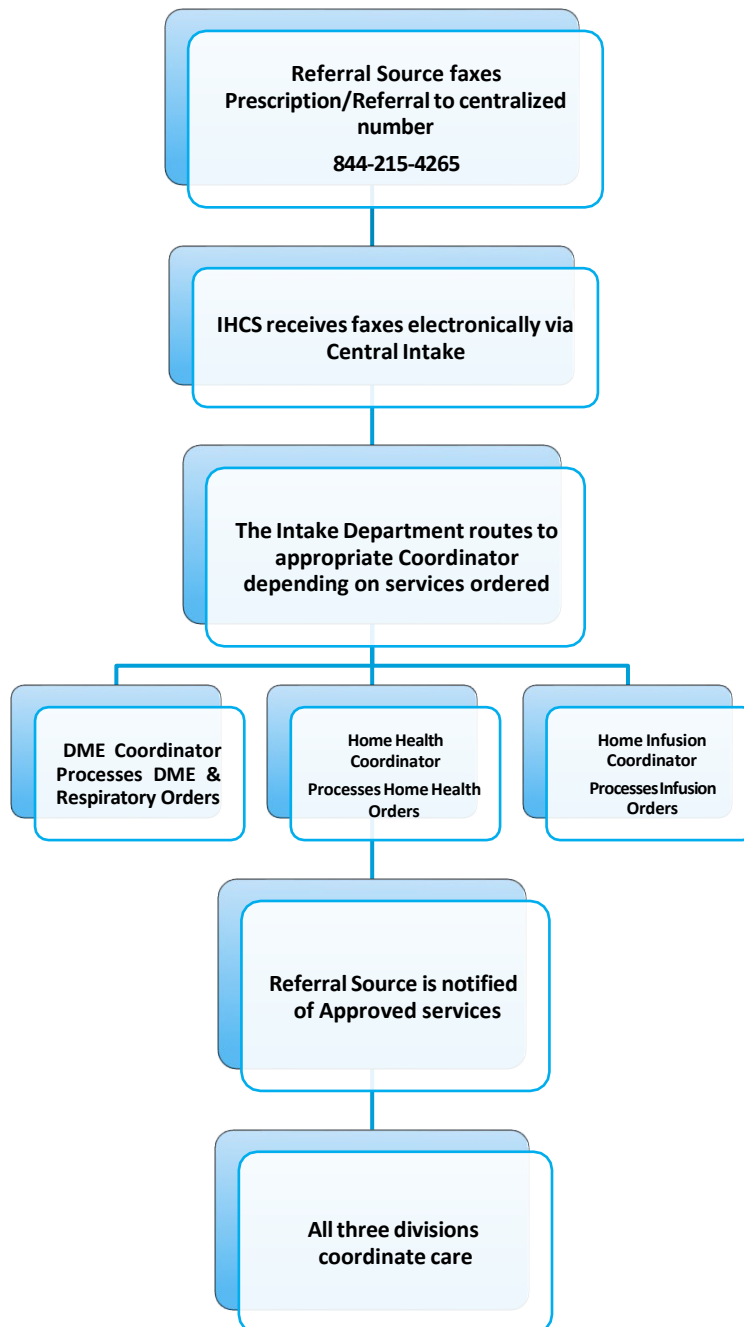
## CONTACT INFORMATION

|  |   |
|--|---|
| <b>Customer Service</b>  |   |
| Customer Service   | (844) 215-4264 Ext 2530   |
| <b>Authorization Requests or Inquiries</b>                           |   |
| Initial Authorization Requests Fax                                   | (844) 215-4265  |
| Home Health Call Center  | (844) 215-4264 Ext 2533   |
| DME Call Center  | (844) 215-4264 Ext 2531   |
| Pharmacy   | (844) 215-4264 Ext 2562   |
| <b>Claims</b>  |   |
| For any questions regarding Claims<br>(Status, Appeals, and Support) | (844) 215-4264 Ext 2532<br><a href="mailto:ClaimsInquiry@ihscorp.com">ClaimsInquiry@ihscorp.com</a>                                 |
| <b>Provider Contracting &amp; Credentialing</b>                      |   |
| Florida Provider Contracting & Nationwide Credentialing              | (844) 215-4264 Ext 2534<br><a href="mailto:ProviderNetwork.Credentialing@ihscorp.com">ProviderNetwork.Credentialing@ihscorp.com</a> |
| Network Development Department (states outside Florida)              | ProviderNetworkSupport@ihscorp.com  |
| <b>Provider Relations</b>  |   |
| Provider Relations Department  | (844) 215-4264 Ext 2546<br><a href="mailto:Providerservices@ihscorp.com">Providerservices@ihscorp.com</a>                           |
| MedTrac Portal Access & Training                                     | (844) 215-4264 Ext 2546<br>Providertraining@ihscorp.com   |
| <b>Compliance</b>  |   |
| Compliance   | (954) 381-7954<br>Compliance@ihscorp.com  |



# INTEGRATED HOME CARE SERVICES

## Delivery System Process Flow





## Sending Orders

You may send orders via:

**CarePort:** IHCS can be found by selecting the IHCS tab in the attribution link next to the member's name or by selecting "Care Intermediary" in the "Service" tab followed by selecting "Payor Navigator" in the "Level of Care" tab

<https://training.extendedcare.com/professional/home/logon.aspx>

**Availity Essentials:** HCS only utilizes Availity Essentials, not Availity EDI or Availity Essentials Pro

<https://www.availity.com/training-and-education/>

**Parachute Health for DME**

<https://www.parachutehealth.com/learnmore>

**Fax to 844-215-4265**

This includes utilizing your EMR to send IHCS faxes, faxing via Aidin, or hard faxing directly to IHCS.





# What is a Complete Order / Prescription?

A complete order is one that includes ALL necessary information to allow IHCS to provide the ordered service(s) to the member.

MD, DO, APRN, or PA must sign all orders; must be legible; and must include the following:

- Member Information
- Complete Name
- Member Health Plan & ID Number
- Date of Birth
- Gender
- Complete Address, City, and Zip Code
- Phone Number
- Allergies, Disability Status, Height, Weight, or Diabetic Status
- Diagnosis and Diagnosis Code(s)

## **Delivery Location**

- Hospital Name, Admit Date, Discharge Date
- Hospital Discharge – need current “homebound” information, address, and phone number (indicate patient or relative)

## **Referring MD Information:**

- Group Name and Referring MD Name
- NPI Number
- Backline Phone and Fax Number, including the area code

## **Start Date of Service**

**Clear and Specific written orders – examples will follow**

## **Clinical Documentation**





## Requirements on Orders

**For all DME, HH, and Infusion orders, the following information is required: Patient Demographics, Prescription or Physician's Orders, Diagnosis, Height, and Weight.**

| Trach Patient Requiring Oxygen   | Non-Oxygen Trach Patients   |
|--|---|
| <p>Specific O2 Percentage (FIO2) – no liter flow required</p> <p>Cool humidity via trach collar</p> <p>Usage (PRN or Continuous)</p> <p>Method of Intake: Via Trach Collar</p> <p>Oximetry/Blood Gas Results</p> <p>Suction Machine (size is required) and Yankauers</p> <p>Large Volume Nebulizer</p> <p>Corrugated Tubing</p> <p>Trach Care Kits</p> <p>Trach Ties</p> <p>Trach Tube Brand/Size and Letters</p> <p>Prescription/Physician's Orders</p> <p>Diagnosis with Diagnosis Codes</p> <p>Length of Need</p> | <p>50 PSI Compressor to humidify the trach</p> <p>Trach Collar (Adult or Pediatric)</p> <p>Suction Machine – Stationary or Portable</p> <p>Suction Catheters (size is required) and Yankauers</p> <p>Large Volume Nebulizer</p> <p>Corrugated Tubing</p> <p>Trach Care Kits</p> <p>Trach Ties</p> <p>Trach Tube Brand/Size and Letters</p> <p>Prescription/Physician's Orders</p> <p>Diagnosis with Diagnosis Codes</p> <p>Length of Need</p> |

| Home Health Orders  | Home Health / I.V.   |
|---|--|
| <p>Home Health Care Orders</p> <p>Specific RN Eval and Disciplines (PT, OT, MSW, HHA, ST)</p> <p>Specific Wound Care Orders and Supplies*</p> <p style="padding-left: 20px;">*Description, Modality, (detail wound care)</p> <p>Enteral Feedings (<i>see requirements on Equipment Orders</i>)</p> <p>Diagnoses</p> <p>Prescription / Physician's Orders</p> <p>MD Signature Required (No APRN, PA)</p> | <p>Home Health Care/RN for IV Antibiotics</p> <p>Name of Medication</p> <p>Dosage</p> <p>Frequency and Duration</p> <p>Diagnoses</p> <p>Route of Administration (I.V., I.M., Sub-Q, or Injection)</p> <p>Last Dose / Next Dose Due</p> <p>Type of Line / (Access Picc, Peripheral, Groshong Cath)</p> <p>Allergies</p> <p>MD Signature Required (No APRN, PA)</p> <p>Prescription/Physician's Orders</p> |

| Infusion Orders Antibiotics  | TPN   |
|--|---|
| <p>Name of Medication</p> <p>Dosage</p> <p>Frequency and Duration</p> <p>Route of Administration (I.V., I.M., Sub-Q, or Injection)</p> <p>Last Dose / Next Dose Due</p> <p>Type of Line / (Access Picc, Peripheral, Groshong Cath)</p> <p>Allergies</p> <p>Dosage</p> <p>Prescription/Physician's Orders</p> <p>Confirm First Dose Given</p> <p>MD Signature Required (APRN, PA accepted with MD approval)</p> | <p>Formula ingredients including Electrolytes</p> <p>Specify if Continuous or cycle</p> <p>Dosage</p> <p>Frequency and Duration</p> <p>Route of Administration</p><br><p>History &amp; Physical</p> <p>Labs</p> <p>Medication Reconciliation form or MAR</p> <p>Allergies</p> <p>Diagnosis</p> <p>Prescription/Physician's Orders</p> |



## Requirements on Equipment Orders

For all DME, HH, and Infusion orders, the following information is required: Patient Demographics, Prescription or Physician's Orders, Diagnosis, Height, and Weight.

| Oxygen   | Nebulizer Compressor   | Suction Pump  |
|--|--|---|
| Liter Flow<br>Frequency of Use (PRN or Continuous)<br>Method of Intake<br>Diagnosis<br>Oxygen Saturation or PO2 Results<br>Prescription/Physician's Orders<br>Physician Signature<br>Physician Name Printed<br>Physician NPI | Diagnosis<br>Length of Need<br>Prescription/Physician's Orders<br>Medication | Prescription/Physician's Orders<br>Frequency<br>Type of Catheter<br>Catheter Size (8fr to 14fr)<br>Length of Need |

| CPAP   | Bipap  | Vent  |
|--|--|---|
| Settings<br>Sleep Study<br>Prescription / Physician's Orders<br>Mask Size (S, M, or Large)<br>Headgear Size (S, M, or Large)<br><br>Ramp Setting<br>Length of Need | Settings<br>Sleep Study<br>Prescription / Physician's Orders<br>Mask Size (S, M, or Large)<br>Headgear Size (S, M, or Large)<br><br>Ramp Setting<br>Length of Need | Tidal Volume or minute volume<br>Respiratory Rate<br>Oxygen Concentration (in % FIO2)<br>SIMV, if applicable (breaths per minute)<br>PEEP or CPAP, if applicable (in centimeters of water pressure)<br>Continuous or desired hours on ventilator<br>Vent setting must be verified by RT |

| Tens of Muscle Stimulator  | Lymphedema Pump   | Nutrition  |
|--|---|--|
| 2 leads or 4 leads<br>Setting (OHMS 1 to 8)<br>Daily hours of treatment<br>Area to perform treatment<br>Length of need | Type of pneumatic compressor<br>Segmental, Segmental W/O CAL<br>Pressure or segmental with CAL<br>Measurement of the area | Nutrition type and strength<br>Method of Intake (pump, bolus, or gravity)<br>Cc's per hour and hours per day |

| Continuous Passive Motion Machine (CPM)   |
|---|
| <p>The following information must be obtained by Customer Services Representative when processing a CPM order:</p> <p style="margin-left: 40px;">Flexion angle expressed in degrees</p> <p style="margin-left: 40px;">Extension angle expressed in degrees</p> <p style="margin-left: 40px;">Therapy Duration (i.e. Q2Hrs TID) = 2 hours, 3 times a day</p> <p style="margin-left: 40px;">Length of therapy (i.e., 14 days)</p> |



## Requirements on Orders

For all DME, HH, and Infusion orders, the following information is required: Patient Demographics, Prescription or Physician's Orders, Diagnosis, Height, and Weight.

| Portable Concentrator Order for Travel   | Portable Concentrator Order for Daily Use   |
|--|---|
| <p>Complete POC Prescription Form<br/>           Referral Authorization HCPC E1392<br/>           Letter of Medical Necessity<br/>           Traveling Date (Departure and Return)<br/>           Method of Travel (Airplane, Car, Cruise Ship, Train)</p> <p>Length of Travel Time<br/>           Oximetry/Blood Gas results if O2 Rx on file expired<br/>           Clinical Note<br/>           Diagnosis</p> | <p>Complete POC Prescription Form<br/>           Referral Authorization HCPC E1392<br/>           Letter of Medical Necessity<br/>           Liters per Minute<br/>           Oximetry/Blood Gas results if O2 Rx on File expired<br/>           Clinical Note<br/>           Diagnosis</p> |

| PMD Orders  | Repair to Patient's own PMD/Customer Orders   |
|---|---|
| <p>Prescription/Physician's Orders<br/>           Referral Authorization<br/>           *HCPC based on equipment being ordered<br/>           Diagnosis<br/>           Clinical Notes<br/>           Face-to-Face Evaluation*<br/>           Must be within 45 days</p> | <p>Prescription/Physician's Orders<br/>           Diagnosis<br/>           Clinical Notes<br/>           Authorization HCPC K0739 with price quoted<br/>           PEEP or CPAP, if applicable (in centimeters of water pressure)</p> |

| Customer Wheelchair Orders  |
|---|
| <p>Prescription/Physician's Orders<br/>           Diagnosis and Clinical Notes<br/>           *Face-to-Face Evaluation (must be within 45 days)<br/>           Authorization with HCPC EW1220 with price quoted</p> |



## Home Health Cheat Sheet Qualifying Criteria

1. In order to be generally appropriate for home care services, patients must continuously meet the following criteria:
  - The patient's clinical needs can be met at home.
  - The patient can either self-care or there is a paid or voluntary reliable primary caregiver to meet the needs of patients when staffing cannot be provided or between home visits.
  - The patient's home environment supports home care services.
2. Patient must be homebound. A Patient will be considered to be homebound if he/she has a condition due to an illness or injury that restricts his/her ability to leave his/her place of residence without a taxing effort and/or the aid of supportive devices such as canes, walkers, wheelchairs, etc.
3. Care must be intermittent.
4. Patient must require a skilled need i.e., skilled nurse, physical therapy or speech therapy.
5. Skilled nurse orders must require the skill of a nurse, i.e., injection, IV, wound care. Taking vital signs does not require the skill of a nurse, glucometer checks are not a skill, changing a colostomy bag is not a skill, placing cataract eye drops is not a skill.
6. Patient must have a physical therapy diagnosis to qualify for physical therapy visits, i.e., new CVA, new fracture, ORIF, total knee/hip, functional decline, unstable gait, etc. "Weakness" is not a qualifying diagnosis.
7. A social services visit (MSW) is covered when patient has skilled services in the home (SN, PT, ST).
8. What is Not Covered by Medicare:
  - Help getting a bath and other types of personal care unless skilled services are also ordered.
  - 24 hour care at home
  - Meals delivered to your home
  - Homemaker/companion services
  - Venipuncture – lab draws (if only reason for home health)

Source: CMS HIM 11 – Medicare Manual



# Guide for Home Health Care

This information sheet is designed as a guide to help determine the client's eligibility for covered home health care services.

## **First**

Determine that the client meets the following criteria:

1. There is a physician's order for all care to be provided. The primary physician develops a plan of care and agrees to review the plan periodically.
2. The client requires intermittent or part-time care as described below.
3. The client is homebound, defined as a functional impairment that limits the ability to leave the residence without a taxing effort. Remember that being blind, deaf or paralyzed does not automatically constitute an acceptable homebound status. A client's diagnosis alone does not support homebound status, nor does an appliance, i.e., foley catheter. Also, remember that if a client is able to drive, even if it is a specially equipped automobile, he or she does not satisfy the homebound requirement. The client must require the assistance of another person to leave the home. A client is allowed to leave home for Physician's appointment and for occasional short trips to accomplish personal business. If a client leaves home on a frequent basis for training, day care, etc., he or she is not considered homebound.

## **In addition, the client must require one of the following services:**

- Nursing care (must be part-time or on an intermittent schedule)
- Physical therapy
- Speech therapy

The following are some definitions to help you in determining eligibility for care.

## **Nursing**

Definitions of Nursing care includes skilled assessment, direct care tasks, and teaching and training. The assessment, direct care and teaching and training activities must require the expertise of a trained nurse, in order to effectively benefit the client. Examples of skilled assessment include signs and symptoms related to a specific disease process, effectiveness of medication regimen, effectiveness of disease management, and wounds for healing process. Examples of direct care include, but are not limited to injections, intravenous therapy, wound treatment, bladder catheter maintenance, tube feeding, and respiratory treatments. Teaching and training include disease process, therapeutic diet, medication regimen, and disease management.



## **Physical Therapy**

Physical therapy services include Gait training, transfer training, passive and active range of motion training, muscle re-education, and establishment of an effective home exercise program. In order to qualify for physical therapy services, the client must exhibit a current condition or medical diagnosis that supports the benefit of the therapy. Examples would include recuperation from a fracture, postoperative recuperation from an orthopedic procedure, or marked functional decline related to an extended illness. Remember that the functional status of the client must support the need for the therapy services. Physical therapy evaluations are not covered for palliative purposes.

## **Speech Therapy**

Speech therapy services include treatment of swallowing disorders, communication disorders, both cognitive and functional. Interventions would include assessment, speech, voice and language communication tasks, with cueing, and restorative exercise for swallowing, and chewing. Examples would include a post (CVA) stroke patient who has lost the ability to speak, a patient who has lost the use of the swallowing function and cannot maintain adequate nutrition. In order for a client to qualify for speech therapy, the evaluation must indicate that the therapy will be beneficial on improving the disorder.

## **Once the client qualifies for home health services, additional services will be covered when provided in conjunction with the qualifying services (SN, PT, and ST)**

These services include occupational therapy. Home health aide services (intermittent or part time only), Medical Social Services, and medical supplies or equipment provided by the agency in the provisions of care.

Intermittent care is defined as care that can be accomplished with visits and is not continuous in nature. (A visit is accomplished in less than two hours).

## **Occupational Therapy**

Occupational therapy services include assessment, teaching and supervising task-oriented activities to restore functional abilities and instruction of devices to assist in regaining or improving motor function and ability to perform activities of daily living. In order to qualify for occupational therapy services, the client must exhibit a current condition or medical diagnosis that supports the benefit of the therapy.

## **Medical Social Services**

Medical Social Services may be provided to the client or the family member for resolution of social or emotional problems that are expected to be an impediment to the effectiveness of the medical treatment (i.e., skilled nursing, physical therapy, and speech therapy) and or rate of recovery.

The medical social visit may not be for the purpose of completing forms or filing paperwork related to government assistance programs.



### **Home Health Aide**

Home Health Aide services may include personal care, i.e., bathing, hair care, oral care, grooming, and light housekeeping in the patient's area, preparing and serving meals. The aide services do not include cooking or providing housekeeping chores for the other members of the household. This service is covered only when the patient is receiving skilled care (i.e., skilled nurse, physical therapy or speech therapy).

### **Delivery of Services**

Home health services are not designed to provide emergency care. We have up to 24/48 hours to staff a case from the time that we received a referral. However, on certain IV cases we will staff the case with 6 hours.



## Examples of Home Health Complete Orders

### ➤ Home Health:

1. Home Health Care (HHC) RN Eval, PT Eval, PT and HHA
2. Home Health Care RN Eval for teaching of new onset of CHF, for signs, symptoms and new medications
3. Home Health nurse for diabetic teaching of new medication Glucotrol 5mg po daily and glucometer
4. Home Health Care for insertion of a Foley catheter 16fr 30cc balloon/change Q month and PRN. Instruct patient and caregiver on Foley Care.

**Note: RNE can be ordered when there is a skilled service identified such as a new DX that requires a nurse to teach disease process/skilled monitoring, teaching of a new medication, foley catheter insertion/care, peg tube feeding care/teaching, and trach care teaching. PT/OT/ST requires an acute DX (CVA, Hip FX, etc.) and frequency is determined on evaluation.**

### ➤ Home Health Orders involving Wound Care:

1. HHC RN Eval, wound care on left leg: cleanse with H<sub>2</sub>O and apply Silvadene cream QD
2. HHC, second degree burn right forearm; nurse to cleanse wound with soap and water, pat dry and apply Silvadene cream, cover with Telfa dressing and secure with tape QD
3. HHC, nurse to cleanse wound on sacrum with normal saline and apply Duoderm, change Q 3 days

**Note: Type of wound, location, cleansing instructions, application of medications or specific wound care product, and how often to change are required.**

### ➤ Home Health Orders involving IV/Infusion (follow first dose policy):

1. HHC nurse to administer Lovenox 30 mg SQ q 12 hrs. x 21 days (last & next dose needed)
2. HHC nurse to administer Vancomycin 1 gm IV q 12 hrs. x 10 days (last & next dose needed)
3. HHC nurse to administer Glytrol 480cc q 6 hrs. w/150cc H<sub>2</sub>O flush
4. HHC nurse to administer and teach how to self-administer Humulin 70/30 10 units Q AM

**Note: Name of medication, dose, frequency, duration, route of administration, type of line/access, height, weight, and allergies are required.**

### ➤ Home Health Orders involving Enteral/Formula Peg Tube Feeding Patients:

1. Home Health Care for instructions of peg tube feeding care. Ensure 65cc/hr via feeding pump continuous.
2. Home Health Care for instructions of peg tube feeding care. Fibersource HN 1 can via bolus 5 times a day
3. Home Health Care for instructions of peg tube feeding care. Ensure 40cc bolus Q6 hours and flush with 100cc of H<sub>2</sub>O.



# OXYGEN PRESCRIPTION

Physician Name \_\_\_\_\_

NPI # \_\_\_\_\_

The Department of Business and Professional Regulation (DBPR) and Medicare / Medicaid requires complete physician orders for medical oxygen to include the liter flow, hours of use, application device, and as appropriate, orders for the portable cylinders and oxygen conserving device. Medical oxygen is classified as a drug, as such; prescriptions are valid for only one year. Prescriptions must be renewed on an annual basis for the therapy to be continued. As the prescribing physician of record, please complete the following form in its entirety, sign and return fax as soon as possible. Please do not hesitate to call with any questions.

Patient Name: \_\_\_\_\_ Date of Order: \_\_\_\_\_

Date of Face-to-Face visit with Physician regarding Home Oxygen Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Length of Need: \_\_\_\_\_ (99 = Lifetime)

New Prescription     Prescription Renewal     Update Current Prescription

Discontinue Oxygen and Pick-Up Equipment

Oxygen Saturation or PO<sub>2</sub> results: \_\_\_\_\_ Date of Test: \_\_\_\_\_

Liter Flow per Minute: \_\_\_\_\_

Via:  Nasal Cannula  Simple Mask  Other \_\_\_\_\_

Frequency of Use:  Continuous     With Exertion     Hours of Sleep

Bleed into CPAP / BiPAP     PRN     Other: \_\_\_\_\_

Delivery Device:  Concentrator     Portable Cylinders

Liquid Helios Portable     Liquid Stationary (reservoir)

Portable Oxygen with Conserving Device

Comments: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(Stamped signature and date are not accepted)*

*(Not valid without date)*

Physician Printed Name: \_\_\_\_\_



# OXYGEN PRESCRIPTION FOR POC

Physician Name \_\_\_\_\_

NPI # \_\_\_\_\_

The Department of Business and Professional Regulation (DBPR) and Medicare / Medicaid requires complete physician orders for medical oxygen to include the liter flow, hours of use, application device, and as appropriate, orders for the portable cylinders and oxygen conserving device. Medical oxygen is classified as a drug, as such; prescriptions are valid for only one year. Prescriptions must be renewed on an annual basis for the therapy to be continued. As the prescribing physician of record, please complete the following form in its entirety, sign and return fax as soon as possible. Please do not hesitate to call with any questions.

Patient Name: \_\_\_\_\_ Date of Order: \_\_\_\_\_

Date of Face-to-Face visit with Physician regarding Home Oxygen Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Length of Need: \_\_\_\_\_ (99 = Lifetime)

- New Prescription     Prescription Renewal     Update Current Prescription
- Discontinue Oxygen and Pick-Up Equipment

Oxygen Saturation or PO<sub>2</sub> results on Room Air: \_\_\_\_\_ Date of Test: \_\_\_\_\_

Liter Flow per Minute: \_\_\_\_\_

Via:  Nasal Cannula     Simple Mask     Other \_\_\_\_\_

Frequency of Use:  Continuous     Pulse Dose

Delivery Device:  Portable Oxygen Concentrator

**For a Portable Oxygen Concentrator a letter of medical necessity is required.**

Comments: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(Stamped signature and date are not accepted)*

*(Not valid without date)*

Physician Printed Name: \_\_\_\_\_



# CPAP / BiPAP PRESCRIPTION REQUEST

Dr. \_\_\_\_\_

NPI: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Health Plan: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Date Last Seen in Office: \_\_\_\_\_

## COPY OF THE SLEEP STUDY NEEDS TO BE INCLUDED:

New Prescription

Update Current Prescription

### EQUIPMENT:

CPAP @ \_\_\_\_\_ cmH2O Ramp: \_\_\_\_\_ Minutes

BiPAP ST - IPAP: \_\_\_\_\_ EPAP: \_\_\_\_\_ Back-Up Rate: \_\_\_\_\_

BiPAP AUTO (please note: no backup rate on this equipment)

Max IPAP Pressure \_\_\_\_\_ Minimum EPAP Pressure \_\_\_\_\_

Pressure Support \_\_\_\_\_

Other: \_\_\_\_\_

Heated Humidification

Chin Strap

Heated Tubing

### PATIENT INTERFACE (Mask)

Full Face  Nasal  Nasal Pillows Mask Size: \_\_\_\_\_

Other: \_\_\_\_\_  Oxygen Bleed-In @ \_\_\_\_\_ LPM

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(Stamped signature and stamped date are not accepted)*

*(Not valid without date)*

**PLEASE FAX ATTN: RESPIRATORY DEPARTMENT**

**Fax # 844-215-4265**



# INTEGRATED HOME CARE SERVICES WOUND CARE ORDER FORM

For Care Plus send to ACS PHONE # 954-748-1966 FAX # 954-748-3748

For AvMed, Doctors, Devoted, Simply and MCCI Send to IHCS PHONE # 1-844-215-4264 FAX # 1-844-215-4265

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone # \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ ZIPCODE \_\_\_\_\_

Health Plan: \_\_\_\_\_ Member ID # \_\_\_\_\_ Auth# \_\_\_\_\_

IF PATIENT UNDER HHA AGENCY NAME: \_\_\_\_\_ PHONE # \_\_\_\_\_

**PRIMARY DIAGNOSIS ON FILE / WOUND LOCATION**

ICD-10 CODE \_\_\_\_\_ Code Description \_\_\_\_\_

**REFILLS:**  3  6      Ordering for  30 Days or  14 days      **START DATE:** \_\_\_/\_\_\_/\_\_\_

Use "✓" to indicate primary and secondary dressings for each wound. One dressing per change unless supportive documentation is attached. Doctor's orders are required with all forms.

| PRIMARY DRESSING                                  | QTY   | WD1 | WD2 | WD3 |
|---|-------|-----|-----|-----|
|   | Ea/BX | X   | X   | X   |
| Collagen _____ 2x2 _____ 4x4                      |       |     |     |     |
| Collagen with Silver _____ 2x2 _____ 4x4          |       |     |     |     |
| Calcium Alginate _____ 2x2 _____ 4x4 _____ Rope   |       |     |     |     |
| Silver Alginate _____ 2x2 _____ 4x4 _____ Rope    |       |     |     |     |
| Hydrogel _____ tube _____ 4x4 pad                 |       |     |     |     |
| Silvery Hydrogel _____ 1.5oz tube _____ 3 oz tube |       |     |     |     |
| Hydrocolloids Thick/Thin _____ 2x2 _____ 4x4      |       |     |     |     |
| Hydrocolloids Bordered _____ 2x2 _____ 4x4        |       |     |     |     |
| Gauze _____ 2x2 _____ 4x4                         |       |     |     |     |
| Gauze N/S _____ 2x2 _____ 4x4                     |       |     |     |     |
| ( ) Xeroform ( ) Vaseline Gauze ( ) Adaptic       |       |     |     |     |
| Normal Saline 100ml                               |       |     |     |     |

| SECONDARY DRESSING                              | QTY   | WD1 | WD2 | WD3 |
|---|-------|-----|-----|-----|
|   | Ea/BX | X   | X   | X   |
| ABD _____ 5x9 _____ 8x10                        |       |     |     |     |
| Non Adherent Pad/Telfa 3x4 ( ) OTHER:           |       |     |     |     |
| Foam _____ 2x2 _____ 4x4                        |       |     |     |     |
| Bordered Foam _____ 4x4 _____ 6x6               |       |     |     |     |
| Composite _____ 4x4 _____ 6x6                   |       |     |     |     |
| Kerlix/Bandage Roll 4"                          |       |     |     |     |
| Sofform/king/conform _____ 2" _____ 3" _____ 4" |       |     |     |     |
| ( ) Coban ( ) Elastic Bandage                   |       |     |     |     |
| Cloth Tape _____ 1" _____ 2" _____ 3"           |       |     |     |     |
| Mefix Tape _____ 2" _____ 4"                    |       |     |     |     |
| Paper Tape _____ 1" _____ 2" _____ 3"           |       |     |     |     |
| Other   |       |     |     |     |

**ADDITIONAL MEDICAL INFORMATION (REQUIRED) PLEASE ATTACH DR ORDERS FOR WOUND SUPPLY**

| WOUND 1  | WOUND 2          | WOUND 3          |
|--|------------------|------------------|
| LOCATION: _____  | LOCATION: _____  | LOCATION: _____  |
| LENGTH: _____ CM   | LENGTH: _____ CM | LENGTH: _____ CM |
| WIDTH: _____ CM  | WIDTH: _____ CM  | WIDTH: _____ CM  |
| DEPTH: _____ CM  | DEPTH: _____ CM  | DEPTH: _____ CM  |
| FREQUENCY CHANGE OF DRESSING: ( ) Q ( ) Q.O.D. ( ) Q.W.K ( ) OR: _____ |                  |                  |

**IF THERE ARE ADDITIONAL WOUNDS, PLEASE ATTACH INFORMATION ON A SEPARATE SHEET**

DOCTOR NAME: \_\_\_\_\_ NPI: \_\_\_\_\_ PHONE: \_\_\_\_\_

DOCTOR SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



# FUNCTIONAL MOBILITY EVALUATION

## INTEGRATED HOME CARE SERVICES

THIS EVALUATION WILL GUIDE YOU THROUGH A STEP WISE PROCESS FOR PRESCRIBING MOBILITY PRODUCTS

### PATIENT INFORMATION

|               |      |        |     |     |
|---------------|------|--------|-----|-----|
| Patient Name: |      | SSN:   |     |     |
| Address:      |      | Phone: |     |     |
| City:         | Zip: | DOB:   | Ht: | Wt: |

### MEDICAL EVALUATION

|   |                 |
|---|-----------------|
| Date of Face-to-Face Evaluation:  | Length of Need: |
| ICD-10 Diagnoses:   |                 |
| Mobility devices currently used in the home: <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Manual WC <input type="checkbox"/> Other:   |                 |
| Why are these no longer appropriate or safe?  |                 |
| 1. Does the patient have mobility limitation(s) that significantly impair(s) his/her ability to perform one or more mobility related activity of daily living (MRADL)? <input type="checkbox"/> Yes (Explain) <span style="float: right;"><input type="checkbox"/> No</span><br><input type="checkbox"/> Safety <input type="checkbox"/> Imbalance <input type="checkbox"/> Weakness <input type="checkbox"/> Dyspnea <input type="checkbox"/> Pain <input type="checkbox"/> Loss of ROM <input type="checkbox"/> Hx of Falls<br>Other: |                 |
| 2. Are there other conditions that limit the patient's ability to participate in MRADLs in the home? <span style="float: right;"><input type="checkbox"/> No</span><br><input type="checkbox"/> Yes (Explain)<br><input type="checkbox"/> Vision <input type="checkbox"/> Cognition <input type="checkbox"/> Hearing  |                 |
| 3. Can the limitations be compensated sufficiently that the provision of mobility assistive equipment (MAE) will reasonably be expected to significantly improve the patient's ability to perform or obtain assistance to participate in MRADLs <u>in the home</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No (Explain)   |                 |
| 4. Does the patient or caregiver demonstrate the capability & willingness to operate the power mobility device in their home? <input type="checkbox"/> Yes <input type="checkbox"/> No  |                 |
| 5. Can the functional mobility deficit be sufficiently resolved with the use of a cane or walker? <input type="checkbox"/> Yes <input type="checkbox"/> No  |                 |
| 6. Does the patient's home support the use of wheelchairs including a power mobility device to be used in the home for completion of MRADLs? <input type="checkbox"/> Yes <input type="checkbox"/> No   |                 |
| 7. Does the patient have sufficient upper extremity function to self-propel a manual wheelchair in the home to complete MRADLs? (Consider and document limitations of strength, endurance, range of motion, coordination, presence of pain, or deformity) <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Explain:  |                 |
| 8. Can the patient safely use a manual wheelchair? <input type="checkbox"/> Yes <input type="checkbox"/> No   |                 |
| 9. Is there a caregiver who is available, willing, and able to provide assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No   |                 |
| 10. Does the patient have sufficient trunk strength, postural stability, hand grip, motor coordination, balance to sit upright, ability to stand and pivot, transfer and space in the home to safely maneuver a power mobility device? <input type="checkbox"/> Yes <input type="checkbox"/> No   |                 |
| 11. Does the patient need and have the judgement, mental and physical capabilities to safely use a power mobility device in the home and MRADLs? <input type="checkbox"/> Yes <input type="checkbox"/> No   |                 |
| Physician's Name:   | NPI:            |
| Physician's Signature:  | Date:           |

**Return completed form to Integrated Home Care Services at 844-215-4265**  
**ALL QUESTIONS MUST BE COMPLETED**



## **CUSTOM WHEELCHAIR PT EVALUATION**

### **Full Mobility Assessment:**

- 1. Transfers (Bed Mobility/Toileting/etc.)**
- 2. How does the patient transfer?**
- 3. Activities of Daily Living (ADL) and Mobility Related Activities of Daily Living (MRADL)**
- 4. Ambulation Assistance**
- 5. Basic Measurement**
- 6. Range of Motion**
- 7. Outlining Limiting Factors**
- 8. Full Body Assessment (Documenting any ulcers)**
- 9. Functional Assessment**
- 10. Recommendation of a PMD or Manual Device to meet the needs of the patient**