

House Calls

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The demand for house calls is increasing because of the aging U.S. population, an increase in patients who are homebound, and the acknowledgment of the value of house calls by the public and health care industry. Literature from current U.S. home-based primary care programs describes health care cost savings and improved patient outcomes for older adults and other vulnerable populations. Common indications for house calls are management of acute or chronic illnesses, coordination of a post-hospitalization transition of care, health assessments, and end-of-life care. House calls may also include observation of activities of daily living, medication reconciliation, nutrition assessment, evaluation of primary caregiver stress, and the evaluation of patient safety in the home. Physicians can use the INHOMESSS mnemonic (impairments/immobility, nutrition, home environment, other people, medications, examination, safety, spiritual health, services) as a checklist for providing a comprehensive health assessment. This article reviews key considerations for family physicians when preparing for and conducting house calls or leading teams that provide home-based primary care services. House calls, with careful planning and scheduling, can be successfully and efficiently integrated into family medicine practices, including residency programs, direct primary care practices, and concierge medicine. (*Am Fam Physician*. 2020;102(4):211-220. Copyright © 2020 American Academy of Family Physicians.)



Illustration by Jonathan Dimes

House calls, also referred to as home visits, are increasing in the United States.¹ Approximately 40% of patient visits in the 1930s were house calls.^{1,2} By 1996, this decreased to 0.5% because insurance reimbursements for house calls decreased.^{1,2} The pendulum in the United States is swinging again to house calls because of the need to develop care models for the growing aging population.^{1,3,4} The proportion of house calls to outpatient clinic visits conducted by family physicians in the United States is unlikely to reach the 1930s levels; however, the number of house calls conducted from 1996 to 2016 doubled.³ Medicare Part B billing and reimbursement for house calls are also increasing, with nearly 2.6 million house calls paid in 2015.⁵

The increasing popularity of and call for home-based care have led to an increased need to study the outcomes and design of home-based primary care models in the United States. The two largest home-based primary care studies are the Centers for Medicare and Medicaid Services Independence at Home Demonstration and the U.S. Department of Veterans Affairs home-based primary care program.^{6,7} The Independence at Home program demonstrated a 23% reduction in hospitalizations, a 27% decrease

WHAT'S NEW ON THIS TOPIC

House Calls

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A systematic review of nine studies (N = 46,156) evaluating home-based primary care outcomes for homebound older adults reported fewer hospitalizations, hospital bed days of care, emergency department visits, long-term care admissions, and long-term bed days.

See related Editorial at <https://www.aafp.org/afp/2020/0701/p8.html>.

Additional content at <https://www.aafp.org/afp/2020/0815/p211.html>.

CME This clinical content conforms to AAFP criteria for CME. See CME Quiz on page 207.

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SORT: KEY RECOMMENDATIONS FOR PRACTICE

Clinical recommendation	Evidence rating	Comments
Family physicians should refer eligible older adults with frequent hospitalizations to home-based primary care programs because of decreased hospitalization rates and 30-day hospital readmissions. ⁶⁻¹²	B	Large-scale patient-oriented evidence including systematic review of observational studies and a randomized controlled trial from the U.S. Department of Veterans Affairs home-based primary care program and the report to Congress on Medicare's Independence at Home Demonstration Year 3
For patients with terminal cancer, the patient's goals for end-of-life care and preference for dying at home vs. in the hospital should be assessed. ^{18,26-28}	B	Limited patient-oriented results from an international systematic review and cross-sectional data
Family physicians should consider using a house call checklist, such as INHOMESSS or similar mnemonics, to prepare for and guide the geriatric assessment of older adults in their home. ¹⁸	C	Clinical review and expert opinion, recommendations from the American Geriatrics Society
A house call supply bag should include equipment to check vital signs, supplies to take samples for laboratory tests and perform minor procedures, personal protective equipment for the physician, and digital or paper records for documentation. ¹⁸	C	Clinical review and expert opinion

INHOMESSS = impairments/immobility, nutrition, home environment, other people, medications, examination, safety, spiritual health, services.

A = consistent, good-quality patient-oriented evidence; **B** = inconsistent or limited-quality patient-oriented evidence; **C** = consensus, disease-oriented evidence, usual practice, expert opinion, or case series. For information about the SORT evidence rating system, go to <https://www.aafp.org/afpsort>.

in 30-day readmissions, and a cost savings of \$111 per beneficiary per month, which is a \$70 million savings over three years.⁷⁻¹⁰ Similarly, a large systematic review (N = 46,154; nine studies) evaluating home-based primary care outcomes for homebound older adults reported fewer hospitalizations, hospital bed days of care, emergency department visits, long-term care admissions, and long-term bed days of care.¹¹ The U.S. Department of Veterans Affairs home-based primary care study of chronically ill, frail adults (N = 179) in urban populations also found fewer hospital admissions and bed days of care, but no change in emergency department use.¹²

House calls benefit patients post-hospitalization by reducing readmission rates, associated health care costs, and errors related to transitions of care.^{13,14} There is an increased need for home-based care for the most vulnerable populations because of the recent shift in the United States toward value-based health care.^{1,3} In 2011, there were 2 million homebound people in the United States, of which only 12% reported receiving home-based primary care.¹⁵ This number is expected to increase to 4 million by 2030.¹

House calls also benefit patients with socioeconomic barriers to care, including pregnant patients and children who are at high risk of abuse.¹⁶ Nurse- or social worker-led home visiting programs have reduced child maltreatment, decreased child health care overutilization, and improved cognitive skills of children born to a low income household with limited psychological resources.¹⁶⁻¹⁸ Outcome data for physician-led house calls are limited for younger populations because most data are from studies on older adults. A meta-analysis of 51 studies of home-based family

care reported small, statistically significant improvements in child cognitive outcomes, maternal life outcomes, and parental behaviors and skills.¹⁹ Additionally, a Cochrane review of 11,000 newly postpartum patients receiving frequent in-home visits from interdisciplinary teams showed a decrease in infant health service utilization and an increase in maternal interest in exclusive breastfeeding.²⁰

Historically, family physicians have been the workforce that meets the critical needs of the United States' most vulnerable populations. Family physicians need to learn how to incorporate house calls into their practices. The Accreditation Council for Graduate Medical Education requires family medicine residents to conduct house calls.²¹ Varying the type of calls and including patients with complex needs of all ages add training value that is consistent with the American Academy of Home Care Medicine clinical competencies.²² House calls, with careful planning and scheduling, can be successfully integrated into a busy office-based practice or residency program. Portable technologies, including electronic health records, battery-powered examination equipment, and point-of-care diagnostic testing, enable health care teams to bring office capabilities to patients' homes.¹ This article provides tools for conducting house calls and reviews strategies for implementing house calls into a variety of outpatient practices, including residency programs, direct primary care (DPC), and concierge medicine models.

Conditions for the Initiation of House Calls

House calls may be needed for acute reasons because of a change in health status, serial visits for chronic conditions, or a one-time visit requested by caregivers or the physician

to evaluate for a specific concern. The type of house call guides the goals and objectives for each patient encounter¹⁸ (Table 1^{18,21,23,24}). For older adults, consider assessing for geriatric syndromes (e.g., recurrent falls, polypharmacy, frailty, memory loss). Evaluation for suspected elder abuse, neglect, or self-neglect may provide valuable information. Illness or injury prevention house calls for frail, older, homebound adults should focus on preventing functional loss and avoiding hospitalization.¹⁸

A patient who is enrolled in Medicare must meet two criteria to be considered homebound (Table 2).²⁵ Most patients who are homebound have chronic medical conditions including heart failure, chronic obstructive pulmonary disease, renal failure, or advanced dementia. The goal of the house call for patients who have a chronic illness is to ensure safety at home, prevent exacerbation of symptoms, and evaluate caregiver burden and ability to care for the patient.¹⁸ Patients enrolled in Medicare who do not meet homebound criteria for home health care may be eligible for home-based primary care services. These services include hospital-based, veterans affairs-based, or freestanding home-based primary care that provides acute and chronic management of medical conditions, polypharmacy management, improved access to durable medical equipment, community resources for the patient and caregivers, and symptom management in end-of-life care.³ Medical necessity should be documented (i.e., frequently missed appointments, poor medication adherence, high use of emergency department services, or a need to assess function in the home environment).³

For patients reaching the end of life, care focusing on comfort (rather than function or longevity) is a common reason for house calls. Most patients with terminal cancer want to die at home; therefore, home care is a valuable service that helps reduce the likelihood of death in the hospital.^{18,26-28} House calls made by family physicians for patients who are dying are primarily to provide symptom management such as pain relief for patients not using hospice services, and to provide psychosocial support to the patient and caregivers before death, and to family members and caregivers after the patient's death.²⁹

Preparing for and Conducting House Calls

Previsit planning is essential to ensure the patient's maximum benefit from a house call. A member of the care team should call the patient in advance of arrival to verify the patient's availability and home address. Physicians should review the patient's medical record and medication list in advance, and bring a copy of the most recent information to the house for reconciliation during the visit. Once the physician is at the home, it is important to follow safety

TABLE 1

Conditions for and Types of House Calls

Conditions for initiation

Patient is homebound (see Table 2)

Patient, family member, or member of the home health team requests a house call that is medically necessary, or the patient is willing to pay for a house call

Physician needs to negotiate care or clinical decision-making with the patient and caregivers

Physician needs to assess the home environment or patient and caregiver interactions

Physician needs to verify eligibility for third-party reimbursement for home health services

Required family medicine resident education*

Types

Concierge medicine service

Direct primary care visit

Family medicine resident education*

Family visit (e.g., well-child examinations and immunizations for multiple children; prenatal and postpartum visits)

Hospitalization follow-up

Illness and injury prevention for patients who are homebound (e.g., immunizations, patient home safety evaluation, strength conditioning, health promotion, disease prevention)

Illness management for patients who are homebound (e.g., emergency care, acute care, management of chronic conditions including rehabilitation services and palliative care for any stage of a serious, life-limiting illness)

Patient assessment* (e.g., polypharmacy, multiple medical problems, excessive health care use, social isolation, frailty, suspected abuse, suspected neglect or self-neglect, need for family meeting, recent major change in health, consideration for long-term care admission)

Patients who are dying (e.g., terminal care, death pronouncement, grief support)

Travel medicine

*—A comprehensive geriatric patient assessment is often ideal for a resident's or trainee's initial exposure because it allows time for teaching and working through the INHOMESSS mnemonic (impairments/immobility, nutrition, home environment, other people, medications, examination, safety, spiritual health, services) checklist and assessment tools. Patients with private insurance who are aging and request home-based services or patients enrolled in Medicare who meet homebound criteria for ongoing management of chronic illness are optimal for trainees, specifically when the home environment is familiar, safe, and known to be supportive of learners.

Information from references 18, 21, 23, and 24.

precautions (Table 3³⁰) to prevent personal injury or infection.^{18,30} Table 4^{18,31} and Table 5^{18,29,32} list recommended supplies for house calls.

If needed, a house call checklist, such as the INHOMESSS mnemonic (impairments/immobility, nutrition, home

TABLE 2

Medicare Definition of Homebound

To be eligible for home health services, a Medicare beneficiary must meet both criteria

Criterion 1:

The patient must either:

Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence

or

Have a condition such that leaving their home is medically contraindicated

If the patient meets one of the criterion 1 conditions, then they must *also* meet two additional requirements defined in criterion 2.

Criterion 2*:

There must exist a normal inability to leave home

and

Leaving home must require a considerable and taxing effort

Additionally, the following should not disqualify a person from being considered confined to the home:

Participation in therapeutic, psychosocial, or medical treatment in an adult daycare program that is licensed or state certified

Any absence of short duration for the purpose of attending a religious service

Any absence for the need to receive health care treatment (e.g., ongoing outpatient kidney dialysis, outpatient chemotherapy, outpatient radiation therapy)

Any other absence from the home that is infrequent or of relatively short duration

For examples of homebound status, see the Medicare Benefit Policy Manual (Chapter 7, §30.1.1)

*—Longitudinal clinical information documented in the patient's chart about their health status is typically needed to sufficiently demonstrate a normal inability to leave the home and that leaving the home requires a considerable and taxing effort. Clinical information about the patient's overall health status may include the patient's diagnosis, duration of the patient's condition, clinical course (i.e., worsening or improving), prognosis, nature and extent of functional limitations, and other therapeutic interventions and results. When determining whether the patient meets criterion 2 of the homebound definition, it is important to note the illness or injury for which the patient met criterion 1 and to consider the illness or injury in the context of the patient's overall condition. Physicians are not required to include standardized phrases reflecting the patient's condition (e.g., repeating the words "taxing effort to leave the home") in the patient's chart. Additionally, these types of phrases are not sufficient, by themselves, to demonstrate that criterion 2 has been met.

Adapted from Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual: Chapter 7 – Home health services. Accessed October 30, 2019. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf>

environment, other people, medications, examination, safety, spiritual health, services; *Figure 1*), can be used as a guide for performing a complete geriatric assessment.¹⁸ A typical approach begins with observing how the patient enters their home and evaluating for transitions of flooring in entryways and the need for extra grab handles, ramps, or rails. Once inside the home, begin by addressing any urgent patient concerns, then shift the conversation to focus on the items found on the checklist if time permits. This process typically takes 45 to 90 minutes, and frequent breaks are common.

Allocate time to review the patient's prescribed medications, herbs or supplements, and over-the-counter medications. The patient or caregiver should show the physician where these medications are kept and organized to provide further insight into medications that may not have been mentioned, issues with compliance, and identification of stockpiles of old or expired medications. Laying out the

TABLE 3

House Call Safety Tips

Ask the patient in advance to cage their pets to avoid the risk of animal bites or other injuries

Avoid attracting unwanted attention when arriving and entering the home; consider leaving your white coat and expensive equipment at the office

Bring equipment for sharps handling and disposal that is in compliance with Occupational Safety and Health Administration Bloodborne Pathogens Standard

Call ahead to remind the patient of the visit; avoid surprising the patient, in particular those with weapons in the home

Coordinate house calls with other members of the multidisciplinary care team; alternatively, bring a learner (e.g., medical student, resident, nurse practitioner, physician assistant) or other office member for assistance and to enhance personal security by traveling as a team

During the house call, sit on nonclothed furniture, avoid pet droppings, wear gloves or respiratory masks if there is concern for environmental exposure or acute infections; use hand sanitizer before, during, and after the visit

Keep other trusted individuals (e.g., office staff members, partners, care team members) informed of the location and appointment time in the event that something does not go as planned

Preplan emergency and safety-concern codes (i.e., yes-or-no questions) with another person; these codes should alert that person to send emergency personnel to your location if needed

Schedule check-ins with a designated person on arrival and after completion of the visit

Travel in a well-maintained vehicle appropriate for anticipated terrain and weather conditions

Information from reference 30.

HOUSE CALLS

medications is recommended to perform true medication reconciliation, in addition to checking for drug-drug interactions.

While the patient is still seated, check vital signs, and perform a focused examination. Once that is completed, the physician should observe the patient as they stand and note if they have difficulty changing positions, need an assistive device to stand (e.g., chair with arms, cane), and how they move around the house (e.g., with a walker,

cane, grasping onto furniture). Ask permission to follow the patient through the most frequented areas of the house while observing the patient's gait and noting any balance issues. Looking for transitions in flooring; stairwells; rug placement; pathway obstructions; height of chairs, bed, and toilet; type of showers (walk-in vs. tub); and location of smoke detectors, fire extinguishers, and firearms helps provide an understanding of the patient's functional status and identify potential patient safety and fall hazards (*Table 6*).¹⁸

TABLE 4

Recommended Supplies for House Calls

Physician supplies

Antibiotic ointment, hydrogel ointment, petroleum jelly
Bacterial culture swabs
Bandage scissors
Batteries (including extra for otoscope, flashlight)
Cell phone
Cerumen spoons and ear irrigation kit
Face mask
Flashlight
Gauze, tape, packing materials
Gloves (sterile and nonsterile)
Glucometer, alcohol pads, test strips, lancets
Hand sanitizer
Lubricant
Otoscope or ophthalmoscope
Patient address and directions
Phlebotomy equipment
Pulse oximeter
Reflex hammer
Sharps container
Sphygmomanometer (variety of cuff sizes)
Sterile specimen cups
Stethoscope
Tape measure
Thermometer
Toenail clippers
Tongue depressor
Tuning fork

Physician supplies (optional)

Catheters
Complementary alternative medicine supplies (e.g., acupuncture supplies, osteopathic manipulation table)
Device to access electronic health record
Dictation software or equipment
Disposable bed pads
Drug identification and drug-drug interaction checker on smartphone app, computer, or a drug-reference manual
Externally worn hearing amplifier
Garbage bags or biohazard bags
Hazardous materials suit (disposable) including a mask and booties
Hemoccult cards and developer
Laptop computer with accessories
N95 disposable masks
Portable electrocardiograph machine
Saline flushes, intravenous supplies
Silver nitrate sticks
Specimen cups
Splint or casting materials, crutches, external musculoskeletal brace
Suture kit, small forceps, scalpel, staple remover
Syringes and needles
Vaccines (properly stored)
Vaginal speculum
Venipuncture supplies
Wound care supplies (i.e., sterile and nonsterile gauze, silver impregnated [antibacterial] gauze, iodine impregnated [antibacterial] gauze, methylene blue dressing [antifungal], thin hydrocolloid dressings, staples, sutures, replacement collection bags, tape, wound vacuum supplies, or other supplies based on wound care needs of the patient)

Patient supplies

CPAP (continuous positive airway pressure) or other home breathing machine
Glucometer and glucose testing supplies
Home blood pressure monitor
Nebulizer
Peak flow meter
Scale

Documentation

Advance document preparation (e.g., names, phone numbers, policies, scope of services, advance directives, questionnaires, patient forms)
Billing documentation
Business and appointment reminder cards
Cognitive assessment tools (e.g., Mini-Cog, Mini-Mental State Examination, Montreal Cognitive Assessment, Saint Louis University Mental Status, Lawton Instrumental Activities of Daily Living, Katz Index of Independent Activities of Daily Living, Mini Nutritional Assessment [Nestle Nutrition Institute], Geriatric Depression Scale, Screen for Caregiver Burden, Clinical Assessment of Driving-Related Skills)
List of essential community resources and services with websites (e.g., <https://www.caregiver.org/family-care-navigator>, <https://alz.org>, <https://familydoctor.org>, <http://www.HealthyAging.org>, <https://www.aafp.org/afp/handouts/viewAll.htm>)
Medication reconciliation list
Patient record
Prescription pad, laboratory slips, radiology forms

Adapted with permission from Unwin BK, Tatum PE III. House calls. Am Fam Physician. 2011;83(8):929, with additional information from reference 31.

TABLE 5

Suggested Emergency Kit Supplies

Condition	Treatment
Acute coronary syndrome	Nonenteric-coated aspirin to be chewed Nitroglycerin
Agitation and delirium	Risperidone (Risperdal) or haloperidol
Allergic reaction	Epinephrine autoinjector
Dehydration	Intravenous fluids, infusion set, butterfly needles (21-gauge), tape, occlusive dressing
Dyspnea	Benzodiazepine* for subcutaneous or sublingual administration Albuterol inhaler with spacer Opioid† for subcutaneous or sublingual administration
Heart failure	Furosemide (Lasix) for subcutaneous administration
Hypoglycemia	Glucose tablets, glucagon kit
Pain	Opioid† for subcutaneous or sublingual administration
Seizure	Benzodiazepine‡
Trauma	Tourniquet for extremity injuries

*—Consider lorazepam (Ativan, 2 mg per mL) for patients receiving hospice services.

†—Consider morphine, 20 mg per mL sublingual administration, for patients receiving hospice services.

‡—Consider diazepam (Dialstat, 10 mg) for rectal administration.

Information from references 18, 29, and 32.

Provide written safety recommendations to the patient and caregiver addressing all urgent concerns and provide additional comments based on findings from the completed checklist. Some durable medical equipment recommendations, such as hospital beds, may be covered by insurance, including Medicare Part B; however, other equipment, such as grab bars or shower chairs, is not typically covered by insurance. The use of assessment tools (Figure 1¹⁸) can be incorporated into the house call based on the complexity of the patient's condition, the time allowed, and the purpose of the visit. Having an in-depth discussion of end-of-life care choices, guided by the patient's goals, may be appropriate, even if they have already been addressed in a clinic or hospital setting. End-of-life care choices should be confirmed or readdressed as the patient's health care situation changes.

Providing prescriptions, supplies, handouts with helpful websites, or local resources communicates further support to the patient and caregivers.

Incorporating House Calls into Office-Based Practice

The benefits of house calls are substantial for physicians and their patients. Physicians experience a change of pace from typical clinic appointments, and house calls can provide additional important information about the patient, including insight into a patient's actual home situation, medication management, diet, and overall lifestyle. Patients report experiencing peace of mind, increased respect and trust in their physicians, and better access to care after a house call.^{2,4,33}

However, integrating house calls into office-based practice is challenging. Barriers include geography, travel time, and perceived loss of revenue.¹⁸ Grouping house calls together within a half-day, grouping locations, and conducting the visits after the conclusion of a clinic day may minimize this barrier. A multidisciplinary strategy for house calls can help decrease physician burden and improve care. The care team commonly includes a customized combination of a physical therapist, occupational therapist, speech therapist, dietitian, licensed social worker, clinical pharmacist, licensed practice/vocational nurse, registered nurse, psychiatric nurse, wound care nurse, and nurse practitioners or physician assistants. With a multidisciplinary team, improved tracking and scheduling of patients can optimize time management, allowing for greater spacing and efficiency of physician visits, and can decrease loss to follow-up.

A travel bag, dedicated house call vehicle, and a mobile office are tools that help keep house calls organized. Besides regular office equipment needed for a focused examination and gathering vitals, an emergency supply kit (Table 5^{18,29,32}) may be useful. House calls for dying patients are unique because of the symptoms and treatment needs specific to that population. *American Family Physician* has previously published an article on managing common symptoms in end-of-life care.²⁹ Additional specialized equipment may be necessary based on the patient's needs (Table 4^{18,31}). It is important to have a good understanding of patients' individualized needs and commit to goals for the visit in advance. When applicable, physicians should provide educational materials, medication reconciliation forms, do-not-resuscitate and do-not-intubate forms, out-of-hospital resuscitation forms, home health forms, and hospice-required documents.¹⁸

Documentation for a house call is similar to that for an office visit. A note template can help with consistent documentation and serve as a checklist (eFigure A). Recommendations for continued care and changes to the care plan

FIGURE 1

Sample House Call Checklist (Based on the INHOMESSS Mnemonic)

Impairments/immobility

Evidence of cognitive impairment?

☐ Yes ☐ No

Demonstrated activities of daily living (*check problem areas*):

☐ Ambulating

☐ Bathing

☐ Continence (bowel/bladder/both)

☐ Feeding

☐ Toileting

☐ Transferring

Demonstrated instrumental activities of daily living (*check problem areas*):

☐ Driving

☐ Finances

☐ Housework

☐ Meal preparation

☐ Shopping

☐ Taking medications

☐ Telephone

☐ Transportation

Demonstrated advanced activities of daily living (*check all that apply*):

☐ Employment/volunteering

☐ Hobbies

☐ Music

☐ Reading

☐ Socialization

☐ Other

Falls assessment (*follow CDC-STEADI algorithm [https://www.cdc.gov/steadi/materials.html]; check all problem areas*):

☐ Balance (consider 30-Second Chair Stand [https://www.cdc.gov/steadi/pdf/STEADI-Assessment-30Sec-508.pdf] and 4-Stage Balance Test [https://www.cdc.gov/steadi/pdf/4-Stage_Balance_Test-print.pdf])

☐ Gait (consider using the Timed Up & Go Assessment [https://www.cdc.gov/steadi/pdf/TUG_Test-print.pdf])

☐ Strength

Left: arm swing, stance, leg swing, step
Right: arm swing, stance, leg swing, step

Sensory impairments (*check problem areas*):

☐ Hearing

☐ Smell

☐ Tactile

☐ Taste

☐ Vision

Comments: _____

Nutritional status and eating habits

Variety and quality of foods

Freezer: _____

Pantry: _____

Refrigerator: _____

Other food storage/sources: _____

Description of daily eating habits: _____

Nutritional status (consider using Mini Nutritional Assessment [www.mna-elderly.com])

Malnutrition: _____

Obesity: _____

Other: _____

Fluid intake: _____

Alcohol presence/use: _____

Swallowing difficulty: _____

Oral health: _____

Comments: _____

Home environment

Neighborhood safety: _____

Exterior of home: _____

Interior of home (*check all that apply*):

☐ Books

☐ Crowding/hoarding

☐ Good housekeeping

☐ Hominess

☐ Information and communication technology

☐ Internet

☐ Memorabilia

☐ Pets

☐ Privacy

☐ Television

Comments: _____

Other people

List name of caregiver(s): _____

Tasks:

Abuse concerns? _____

Coping? _____

Hours of caregiving per day: _____

Need for respite? _____

Physically or emotionally capable? _____

Stress? ☐ Yes ☐ No

Social supports? ☐ Yes ☐ No

If yes, what is/are their greatest source(s) of social support? _____

If no, were community resources provided? _____

Living will? ☐ Yes ☐ No

If yes, where is it located? _____

If no, were resources provided? _____

Advance directives (https://polst.org/; https://prepareforyourcare.org/)

☐ Yes ☐ No

If yes, where are they located? _____

If yes, has the patient provided an updated copy for the medical record? _____

If no, were resources provided today? _____

Medical power of attorney? ☐ Yes ☐ No

If yes, whom (*list all*): _____

If no, were resources provided today? _____

Consider this resource for downloadable state-specific medical power of attorney (https://www.aarp.org/caregiving/financial-legal/free-printable-advance-directives/)

Code status (*check all that apply*):

☐ Do not intubate

☐ Do not resuscitate

☐ Full code

Documented discussion of patient's care goals? ☐ Yes ☐ No

If yes, is this information current (recommend updating information after any major changes in the patient's health condition)? _____

If no, what was the date of the last discussion of patient care goals? _____

Financial resources: _____

Comments: _____

continues

INHOMESSS = impairments/immobility, nutrition, home environment, other people, medications, examination, safety, spiritual health, services.

should be included in the documentation with proper coding and billing information (*eTable A*).

Direct Primary Care and Concierge Medicine House Calls

DPC is an innovative practice model that offers patients a variety of primary care services for a low, periodic membership fee.^{34,35} Integrating house calls into this type of practice

may be easier because the DPC model enables physicians to spend more time with patients, and DPC physicians typically have smaller panel sizes. According to Phil Eskew, DO, founder of DPC Frontier, there were more than 1,100 DPC practices in the United States in 2019, and 68% of these practices offered house calls, including eight practices that were completely mobile (i.e., had no actual office). House calls may be included as part of the membership, or DPC

FIGURE 1 (continued)

Sample House Call Checklist (Based on the INHOMESSS Mnemonic)**Medications**

Allergies to medications: _____

Dietary supplements: _____

Medication adherence? ☐ Yes ☐ NoMedications organized? ☐ Yes ☐ NoMultiple prescribers? ☐ Yes ☐ No

If yes, whom? _____

Date state-specific prescription monitoring program last checked? _____

Nonprescription/over-the-counter drugs: _____

Polypharmacy? ☐ Yes ☐ No

Prescription medications (including date, quantity, and prescriber name for controlled substance): _____

Summary of medication discrepancies identified: _____

Written instructions: _____

Comments: _____

Examination

Blood pressure: _____

Cognitive assessment (e.g., Mini-Cog, Saint Louis University Mental Status, Mini-Mental State Examination, Montreal Cognitive Assessment or other resources [<https://mini-cog.com/>; <http://aging.slu.edu/pdfs/surveys/mentalstatus.pdf>]): _____Depression screening (i.e., Geriatric Depression Scale [<https://consultgeri.org/try-this/general-assessment/issue-4.pdf>]): _____

General physical condition: _____

Glucose: _____

Heart rate: _____

Height: _____

Incontinence assessment: _____

Pain assessment: _____

Pulse oximetry: _____

Respirations: _____

Unintended weight loss? ☐ Yes ☐ No

If yes, include percentage and time period over which weight loss occurred.

Urinalysis: _____

Weight: _____

Other: _____

Findings from focused examination: _____

Comments: _____

SafetyAssess the following for safety concerns. Document findings and recommendations for correction in the comments section (*check all that apply*):☐ Access to emergency services☐ Adaptations/modifications to home needed☐ Alternative power source if needed☐ Bathroom☐ Carpets, rugs, and other transitions in flooring☐ Cell phone availability☐ Electrical cords☐ Emergency plans, bracelet or necklace that alerts emergency personnel☐ Evacuation route☐ Fire and smoke detectors☐ Fire extinguishers☐ Gas or electric range☐ Heating and air-conditioning☐ Hot water heater☐ Internet availability☐ Kitchen☐ Lighting☐ Stairs☐ Tables, chairs, and other furniture☐ Water source

Comments: _____

Spiritual health (or cultural and ethnic influences):Obtain a spiritual history (<https://smhs.gwu.edu/gwish/clinical/fica/spiritual-history-tool>)Religious services/support? ☐ Yes ☐ No

Comments: _____

Services

Assess access to/response time/recent use of the following services:

☐ Assistant/visiting angels☐ Emergency medical services☐ Financial advisor☐ Fire department☐ Food delivery service/Meals on Wheels America☐ Health benefit advisor☐ Home health agency☐ Home health equipment☐ Hospice agency☐ Lawn care services☐ Legal services☐ Means of transportation☐ Pet care services (if applicable)☐ Police☐ Social services

Comments: _____

INHOMESSS = impairments/immobility, nutrition, home environment, other people, medications, examination, safety, spiritual health, services.

Adapted with permission from Unwin BK, Tatum PE III. House calls. *Am Fam Physician*. 2011;83(8):928.

physicians may charge a flat rate or a variable amount based on travel time or mileage.³⁶

Although DPC physicians often provide house calls to older adults and to patients who are disabled, terminally ill, and to patients who are homebound, some physicians may also offer newborn visits and well-child examinations. Additionally, house calls are commonly made for sick visits and postoperative care. Large families or families with young children may benefit from house calls because of the convenience and comfort of seeing multiple members at once in a familiar and safe environment. DPC physicians report that offering house calls is useful

for recruiting new patients, and families appreciate the home-based service.

Concierge practices also routinely offer house calls but charge higher membership fees and may continue to bill insurance for covered services.³⁷ Concierge practices may also provide hotel calls for travelers seeking more personal, convenient care.

This article updates a previous article on this topic by Unwin and Tatum.¹⁸

Data Sources: A PubMed search was conducted using the key terms home visits, house calls, home-based primary care, post-hospitalization visits, homebound, and direct primary care.

TABLE 6

Home Safety Assessment

Bathroom

Are handholds sturdy and in appropriate places?
Can the toilet seat be reached?
Does the bathtub or shower have a nonslip surface?
Is the bathroom floor slick?

Drug use

Is there evidence of tobacco, alcohol, or other illicit drug use in the home?
If yes, is the substance used by the patient or other inhabitant of the home?

Electrical cords/appliances

Are cords frayed or damaged?
Do cords cross walking paths?

Emergency actions/evacuation route

Are emergency numbers available?
Does the patient carry on their person a mode of contacting emergency services (e.g., bracelet or necklace that alerts emergency personnel, cell phone)?
Are do-not-resuscitate and do-not-intubate forms displayed in a location easily spotted by emergency service personnel?
Are there means of egress from home?

Firearms

Are firearms present?
If yes, are they secured? (e.g., gun lock, locked case or cabinet, weapon and ammunition separated)
Who knows how to access?

Fire extinguishers

Are fire extinguishers present?
If yes, are they accessible and in working order?
Is the patient or caregiver able to use them?

Heating and air conditioning

Are controls accessible and easy to read?
Is the home an appropriate temperature year-round?

Hot water heater

Is the temperature set below 120°F (49°C)?

Kitchen safety (especially gas stoves)

Is it easy to tell if a burner is on or open gas flame is present?
Does the patient wear loose garments while cooking?
Where is food stored? Is the food expired?

Lighting and night-lights

Is lighting present and sufficient throughout the main living spaces?

Loose carpets and throw rugs

Are carpets and throw rugs present?
If yes, do they need to be secured or removed to prevent falls?

Pets

Are pets present?
If yes, are they easy to care for?
If yes, are they likely to be a fall hazard?

Smoke detectors and carbon monoxide monitors

Are they present?
If yes, are they functioning and monitored?

Stairs

Does the home have external or internal stairs?
If yes, are they carpeted and is the carpeting secured?
Are the stairs well lit?
Are there railings?
Are assistive devices (ramps, chairlifts) present or needed?

Tables, chairs, furniture

Is the furniture sturdy, balanced, and in good repair?

Utilities

Are the systems monitored and maintained?

Water source

Is water from a public source or a well?
Is the source functioning and safe?

Adapted with permission from Unwin BK, Tatum PE III. House calls. Am Fam Physician. 2011;83(8):929.

The search included systematic and clinical reviews, meta-analyses, reviews of clinical trials and other primary sources, and evidence-based guidelines. Also searched was the Cochrane database. References from these sources were consulted to clarify the statements made in publications. Search dates: April 2019, August 2019, December 2019, and March 2020.

The opinions and assertions contained herein are the private views of the authors and are not to be construed as the official policy or position of the Department of Defense or the U.S. government.

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HOUSE CALLS

eFIGURE A

Comprehensive Geriatric Note Template

Type of (or reason for) house call

- ☐ Care coordination (e.g., visit with care-givers, other professionals, transition of care evaluation)
- ☐ Evaluation of geriatric syndromes (e.g., frailty, falls, cognitive impairment)
- ☐ Missed appointments
- ☐ Patient request
- ☐ Patient safety concerns (e.g., environmental assessment, medication/polypharmacy evaluation, abuse concerns, mobility issues)
- ☐ Terminal illness

Chief problem/history of the present illness:

Medical history (fill this section out using the patient's health record before the visit):

Advance directives

Code status: _____

Copy in medical record? ☐ Yes ☐ No

Copies obtained for medical records: _____

Living will? ☐ Yes ☐ No

Location of documents: _____

Medical power of attorney? ☐ Yes ☐ No

Location of documents: _____

Patient/caregiver notified to provide copies: _____

Allergies: _____

Medication list (from inpatient/outpatient note. Delete medications that are not found in home): _____

Additional medications and supplements found in home: _____

Impairments/immobility

Activities of daily living:

Bathing: _____

Continence: _____

Dressing: _____

Feeding: _____

Toileting: _____

Transfer: _____

Instrumental activities of daily living:

Doing housework: _____

Medication use: _____

Paying bills: _____

Preparing meals: _____

Shopping for food: _____

Telephone use: _____

Balance and gait problems: _____

Sensory impairment: _____

Nutrition

Meals/source: _____

Nutritional status: _____

Variety and quality of food: _____

Home environment

Patient is currently living in: _____

Type of home (apartment, townhouse, single-story house, multiple-story house with stairs, retirement community, nursing facility): _____

Size and accessibility of home: _____

Patient is currently living with: _____

Other people (list names)

Financial resources: _____

Living will: _____

Medical resources: _____

Power of attorney: _____

Social support: _____

Subjective: _____

Medications

Medication adherence? ☐ Yes ☐ No

Medication list: _____

Medication organized with list of medication readily available: _____

Medication polypharmacy assessed: _____

Safety, spiritual health, and services

Bathroom: _____

Electrical cords: _____

Emergency plans/evacuation route: _____

Fire extinguisher: _____

Fire/smoke detectors: _____

Floors: _____

Furniture: _____

Home health services: _____

Home monitoring/alarm service: _____

Kitchen: _____

Lighting: _____

Spiritual health: _____

Stairs: _____

Water source: _____

Examination

Vital signs: _____

Physical examination

General: _____

Head, eyes, ears, nose, and throat: _____

Neck: _____

Cardiovascular: _____

Respiratory: _____

Abdominal: _____

External: _____

Skin: _____

Neurology: _____

Special testing: _____

Assessment and plan

Referral for additional skilled services needed (e.g., physical therapy, occupational therapy, speech, nursing, clinical pharm.): _____

Community referrals (e.g., food resources, transportation, medication management, day programs/respite care, case management): _____

Family follow-up: _____

Next appointment: _____

Current procedural terminology coding

(low- to high-severity and complexity)

New patient home visit: 99341-99345

Established patient home visit: 99347-99350

Domiciliary or rest home visit, new patient: 99324-99328

Domiciliary or rest home visit, established patient: 99334-99337

Care plan oversight: 99339 (15 to 29 minutes); 99340 (30 minutes or more)

Advance care planning: 99497 (15 to 29 minutes); 99498 (add on for each additional 30 minutes)

Information from:

Perissinotto C, Aronson L. Housecalls tips sheet. University of California San Francisco. Accessed April 13, 2020. <https://geriatrics.ucsf.edu/sites/geriatrics.ucsf.edu/files/2018-06/housecalltipsheet.pdf>.

Unwin BK, Tatum PE III. House calls. Am Fam Physician. 2011;83(8):928.

eTABLE A

House Call Coding and Billing Information

CPT codes 99341 – 99350 are home service codes used to report evaluation and management services provided to a patient residing in their own private residence (POS code 12).

Home services: new patient

99341	Level 1, low severity problem, 20 minutes
99342	Level 2, moderate severity problem, 30 minutes
99343	Level 3, moderate to high severity problem, 45 minutes
99344	Level 4, high severity problem, 60 minutes
99345	Level 5, patient is unstable or significant new problem requiring immediate attention, 75 minutes

Home services: established patient

99347	Level 1, self-limited or minor problem, 15 minutes
99348	Level 2, low to moderate severity problem, 25 minutes
99349	Level 3, moderate to high severity problem, 40 minutes
99350	Level 5, patient is unstable or significant, new, high-severity problem requiring immediate attention, 60 minutes

CPT codes 99324 – 99337 are domiciliary, rest home, or custodial care services codes and are used to report evaluation and management services provided to patients living in a facility that provides room, board, and other personal assistance services, generally on a long-term basis (POS codes 13, 14, 33, and 55).

Domiciliary (assisted living, group home), rest home, or custodial care visits: new patient

99324	Level 1, low severity problem, 20 minutes
99325	Level 2, low to moderate severity problem, 30 minutes
99326	Level 3, new patient, moderate to high severity problem, 45 minutes
99327	Level 4, new patient, high severity problem, 60 minutes
99328	Level 5, new patient, high complexity problem, 75 minutes

Domiciliary (assisted living, group home), rest home, or custodial care visits: established patient

99334	Level 1, established patient, self-limited or minor problem, 15 minutes
99335	Level 2, established patient, low to moderate severity problem, 25 minutes
99336	Level 3, established patient, moderate to high severity problem, 40 minutes
99337	Level 4, established patient, unstable or significant new problem, 60 minutes

Care plan oversight

99339	Supervision of patient requiring complex or multidisciplinary care, 15 to 29 minutes
99340	Supervision of patient requiring complex or multidisciplinary care, 30 minutes or more

Advance care planning evaluation and management services

99497	Advance care planning including the explanation and discussion of advance directives such as standard forms, face-to-face with the patient, family members, or surrogate, first 30 minutes, minimum 15 minutes
99498	Each additional 30 minutes, list separately and in addition to the code for the primary procedure

continues

CPT = current procedural terminology; POS = place of service.

eTABLE A (continued)

House Call Coding and Billing Information

This information applies to public and private health insurance billing for patients of all ages.

The time spent includes telephone calls to other health professionals (not patient family members or caregivers) ordering and reviewing tests. When applicable, document 30 minutes of time spent coordinating care unrelated to a face-to-face visit.

CPT codes for **prolonged services** should be used in conjunction with time-based companion codes:

99354, for other outpatient setting, with direct patient contact, first hour.

99355, for each additional 30 minutes.

Place of service codes

POS 12	Private residence – patient home, apartment, townhome, etc.
POS 13	Domiciliary care facility – A home providing mainly custodial and personal care for people who do not require medical or nursing supervision, but may require assistance with activities of daily living because of physical or mental disability (e.g., assisted living facility, adult living facility, “sheltered living environment”).
POS 14	Group, rest, or boarding home – A place where people live and are cared for when they cannot take care of themselves.
POS 33	Custodial care facility – Any facility that provides non-medical assistance with the activities of daily life (e.g., bathing, eating, dressing, using the toilet) for someone who is unable to fully perform those activities without help.
POS 55	Residential substance abuse facility – A facility that provides treatment for substance (alcohol and drug) abuse to live-in residents.

Checking with the billing department of a patient’s hospice agency for proper documentation and coding tips can help prevent rejected claims.

Home services are billable to home health agencies in the community. A CMC-485 form must be reviewed and signed.

G0180 Home health certification, \$53.00

G0179 Home health recertification, \$44.17

G0181 Home health care, \$104.31

G0182 Hospice supervision, \$105.67

Effective January 1, 2019, the Centers for Medicare and Medicaid Services announced in the 2019 Physician Fee Schedule Final Rule that documenting the medical necessity of a home visit instead of an office visit is no longer needed for billing purposes.

CPT = current procedural terminology; POS = place of service.

Information from:

American Academy of Family Physicians. *Advance care planning*. Accessed October 30, 2019. <https://www.aafp.org/practice-management/payment/coding/medicare-coordination-services/acp.html>

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Department of Health and Human Services. *Billing Code 4120-01-P*. Accessed November 4, 2019. <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24170.pdf>

Noridian Healthcare Solutions. *Home and domiciliary visits*. Updated August 7, 2019. Accessed December 19, 2019. <https://med.noridianmedicare.com/web/jfb/specialties/em/home-and-domiciliary-visits>