

Intake / Admissions Processes

Now that the elements of providing quality customer service have been reviewed, the intake and admission processes will be covered. Some homecare companies make a distinction between Intake and Admissions. For these companies, the Intake Process is the process of taking a referral, as well as gathering and verifying information. By contrast, the Admissions Process is the acceptance of a patient onto service with the company after qualifying the patient, and performing all of the necessary tasks to service the patient with proper documentation. These two separate processes can be broken down into the following tasks:

Intake Process:

1. Receive Referral Phone Call
2. Gather All Necessary Information
3. Log the Referral
4. Verify Insurance Benefits
5. Coordinate With Other Departments
6. Determine Whether to Accept or Reject Referral
7. Call Case Manager Back With Acceptance or Rejection
8. If accepting the referral, Agree on Pricing, Conditions, Terms

Admissions Process:

1. Set Up the Patient in the Computer System
2. Gather Any Additional Missing Information
3. Call Patient to Explain Services and Benefits
4. Prepare Patient Packet with Initial Order
5. Procure Documentation/Forward to Billing Department

Most homecare companies do not make a distinction between the intake and admission process. For them, the same person, from start to finish, performs all of the tasks associated with both intake and admissions. Although different companies have different titles for this position, nearly everyone can relate to an Intake Coordinator. This is the position title used to associate with the person performing all of the above-mentioned tasks.

INTAKE VERIFICATION FORM

Every homecare company has a form that is used to write down the information being given by a referral source on a potential patient. This form is filled out regardless of whether the patient is accepted or rejected. Strange as it may sound, it is true that the same amount of time, energy, and effort is spent on a referral that does not come onto service as it is for those who do come onto service. Referrals that are rejected, i.e. not accepted onto service, are commonly called **Non-Admits**. There are no short cuts that can be taken when taking a referral. All necessary information is gathered and verified *first* before a decision can be made on acceptance. Non-Admit referrals are still logged on a Referral Log Form, and Non-Admits intake forms are usually retained in a separate file. This is done so that information can be retained regarding the total number of referrals in any given time period, such as a

week or a month. Remember that the same amount of time is spent on a Non-Admit referral as any other referral, and therefore will be counted on management productivity reports.

The information taken from a referral source is written down on an intake verification form. Intake verification forms may vary from company to company, but there are some **basic features that all insurance verification forms share:**

- Demographic Section
- Financial Section
- Clinical / Service Section

The Demographic Section contains all of the initial information regarding the referral source. The Financial Section would have the name of the insured, relationship to the insured, name of the insurance, policy and group numbers, deductible met, etc. Discharge planners, who work for the patient's insurance company, call in some referrals and know the status on the patient's deductible. The Clinical Section will contain all of the information needed in order to make a clinical determination of whether the patient can be accepted onto service. Type of access, IV line, number of lumens, drug(s), dosages, frequencies, method of administration, whether or not nursing visits are required, how far away the patient lives, and what type of equipment is being requested are all examples of the type of information is gathered in the Clinical / Service Section. All of the above are factors in the final decision to either accept or reject the referral to service the patient.

DEMOGRAPHIC INFORMATION

Demographic information is obtained for different reasons. First, the proper name, address, phone number, date of birth, and social security number must be used in order to get paid for the products and services provided. Secondly, additional information, such as next of kin or an emergency contact person is information required for compliance to accreditation.

Case managers and other referral sources, do not always provide all the needed information to the Intake Coordinator. Time is critical, and the case manager will give the minimum essential information necessary to verify benefits. This information should be sufficient upon which to base a decision as to whether the referral will be rejected or accepted. Some referrals are faxed in, rather than phoned in. Incoming faxes are treated like incoming phone calls. **The missing information can be gathered after the referral has been accepted from any of the following sources:**

1. Physician's Office
2. Hospital Billing Office / Medical Records
3. Patient
4. Patient's Caregiver or Next of Kin

The important thing to remember is that once the referral is accepted, this information must be *complete*. The homecare company, or the immediate supervisor, will establish the guidelines for the critical fields that must be completed or the minimum amount of information that must be obtained.

FINANCIAL INFORMATION

The financial section of the intake verification form generally serves two purposes:

1. Gathered Information is Written Down on the Form
2. Information Can be Verified on the Same Form

Some homecare companies will utilize a separate form with which to verify insurance benefits; however, some companies simply use a separate page from the intake verification form. This single page or single form can then be forwarded to the Billing Department in order to post revenue and bill the resulting accounts receivable charges.

CLINICAL / SERVICE INFORMATION

The clinical information or service information gathered will be *unique* to each patient. Information specific to the therapy being requested, type of access, method of administration, and nursing requirements will depend upon the type of therapy and the drugs ordered. Diagnosis information taken is needed for clinical monitoring and reimbursement purposes also. ICD-9 codes or Diagnosis codes will be explained at a later time.

Additional clinical information regarding any known allergies is required for compliance to accreditation organizations and by law for any healthcare provider dispensing medication. It is critical for the pharmacist and nursing staff to have this on file, not just for the present medications being ordered, but also for any medications that might be ordered in the future, after the start of service.

INTAKE COORDINATOR

The Intake Coordinator is one of the most important positions in any homecare company. Business, and repeat business, will largely depend upon the relationships developed with referral sources. It is one of the most visible positions in the company because relationships will be developed with co-workers from all departments, such as Pharmacy, Warehouse, and Nursing, in addition to Sales staff and personnel from the Billing and Collections departments.

To summarize what has been covered, the main intake tasks are:

1. Take the Referral Call.
2. Gather Information and Fill out the Intake Form.
3. Log the Referral.
4. Verify the Insurance Benefits.
5. Coordinate with Pharmacy, Nursing, and Warehouse.
6. Confirm or Deny Acceptance of the Referral.
7. If Accepted, Follow Through with Admissions Tasks.

When speaking with a referral source, whether it is a case manager, a nurse from the physician's office, or a discharge planner from the patient's insurance company, it is vitally important to adhere to the following principles.

1. Be thorough in gathering information.
2. Be honest about the availability of the product(s).
3. Be honest about the ability to service or deliver at a specific time.
4. Be thorough in communicating information to all persons.
5. Be prompt in communicating back to all persons.
6. Be accurate and complete with paperwork.

No homecare company can keep every type of product in stock at all times. If a case manager or referral source is asking for the company to provide a certain product that is not in stock, it is important to be honest. Remember that case managers do not *expect* every product to be provided at the exact time, every time he or she calls the company. Even though a particular product may not be in stock, it may be possible to order it and receive it the next day. Consider that the case manager may need to call three companies to find a product. It is important to be the first Intake Coordinator that is willing to go the extra mile to accommodate the case manager, and ultimately the patient. In this situation, the case manager may take notice of the excellent customer service demonstrated.

In other cases, it is equally important for the Intake Coordinator to be honest about the ability to deliver or provide services at a specific time. For example, a case manager calls in a referral at 9:35 AM for a patient being discharged out of the hospital the same day. The patient has been on Rocephin antibiotic Q8, and the physician has ordered the drug regimen to be continued at home for the next five days. The patient received the first dose of the day in the morning at 7:00 AM in the hospital, and is due to be discharged at noon. The second dose is due at 2:00 PM, and the third dose is due at 9:00 PM. All of the company's nurses are already scheduled out on patient visits, and the earliest the Intake Coordinator can have a nurse out to the home is 4:30 PM. It is extremely important to be honest about this, rather than to say it can be done and then be late for the patient's second dose. *Note:* It is a serious infraction to be out of compliance with the physician's orders.

In some cases, the case manager may still give the Intake Coordinator the referral, opting to give the patient the second dose in the hospital before discharging, and let the company's nurse do the setup that evening for the third dose. Again, case managers do not necessarily expect every company to be perfect enough to handle every request 100% of the time. However, in this example, telling the case manager a delivery time request can be met, and then showing up two hours late, would *not* be acceptable. Chances are the case manager would not give the opportunity to service another patient.

When speaking with a case manager on the phone, remember that they are used to answering questions, and understand the need to gather as much information as possible. This is true for insurance benefit information as well as clinical data about the patient. Case managers will usually be able to give all of the clinical information needed regarding the patient's condition. It would be rare that the case manager would have to confer with the patient's physician unless some critical piece of information had been left off of the patient's chart. Case managers are motivated to give as much information as they possibly can. They know that the faster the information needed is gathered, the faster an answer as to whether or not the company can service the patient will be provided.

Filling out paperwork completely is paramount to all positions in the healthcare industry. For the Intake Coordinator, there are several types of paperwork that must be done prior to (Intake process) and after acceptance of a patient onto service (Admissions process). More detailed information on Documentation will be forthcoming.

The following are the main types of paperwork for an Intake Coordinator:

- Referral Form
- Referral Log
- Insurance Verification Form (Financial Section)
- Patient Packet Forms
- Reimbursement Documentation

The average initial referral phone conversation with a referral source is between 5 and 10 minutes. When the Intake Coordinator hangs up the phone with the referral source, the referral call is logged onto the Referral Log, and the process begins.

There is a great sense of urgency that accompanies the tasks associated with taking a referral, namely to accomplish several tasks before the case manager can be called back with a yes or no answer. **The primary tasks to complete before calling a case manager back are listed in the following steps:**

1. **Verify Insurance Benefits** - If the patient does not qualify financially, management approval will be necessary or company policy should be followed on accepting an indigent patient. Some companies do not accept patients without any means of paying, and therefore, this would be the stopping point if a patient did not qualify. In this case, there would be no need to continue on to Step 2.
2. **Verify Product Availability** - Once the patient qualifies financially, the next step is to make sure that the products, i.e. drug, pump, supplies, etc. are in stock and available. In this step the Intake Coordinator is checking with Pharmacy on the availability of the infusion equipment, supplies, and drug(s).
3. **Verify Clinical / Service Availability** - Once past steps 1 and 2, the next step is to check the availability of nursing staff and/or warehouse to deliver to the patient's home. In some cases, it will be both. Perhaps the nurse is already out on the road. It may be closer and more cost effective for the nurse to go directly to the patient's home, rather than come back to the branch to pick up the order. In this case, a delivery driver could meet the nurse at the patient's home with the drugs and supplies.

A potential patient (referral) must be able to *pass all three steps* before being admitted on service with the homecare company. Consider that the patient may live two hours away from the branch office. There may be some additional clinical / service considerations that would make it undesirable to accept this patient. For instance, perhaps this particular drug is only stable for 24 hours. This would require a daily delivery, but may not be profitable enough to deliver daily. Due to the instability of the drug and frequent deliveries, it may be better for another company who is geographically closer to service this patient. Whatever the outcome of passing through the three steps, the case manager or referral source should be called back ASAP with a yes or no answer.

Once the referral passes the three steps and is accepted on service, everything must be prepared to meet that initial delivery. Required information that is missing or unknown must be gathered first, and the patient must be set up in the computer system before a delivery ticket or invoice can be generated and printed. Once the delivery ticket or invoice is generated, the order is filled by the pharmacy and warehouse for drugs, equipment, and supplies. The patient packet (usually a folder) is then prepared with information regarding the therapy ordered, as well as several forms that the patient must sign. This packet is taken with the initial delivery to the patient. All of **the following forms are placed in the**

patient packet. Those marked with an asterisk (*) must be signed and dated by the patient for the reason indicated.

- **Delivery Ticket *** - To verify the items being delivered.
- **Assignment of Benefits *** - To allow the homecare company to bill the patient's insurance company on behalf of the patient, and to inform the patient of the cost of services that will be incurred, including the patient's insurance benefits expected and the co-pay or patient's portion of the cost of treatment.
- **Consent to Treatment *** - To give the homecare company permission to provide medical treatment to the patient as ordered by his or her physician.
- **Therapy Training Instruction *** - To confirm that the patient has been taught or informed about the products, equipment, supplies, and services being provided, and to confirm any teaching or training that the homecare employee (nurse, pharmacist, or driver) has provided to the patient regarding their infusion therapy.
- **Drug Information Sheet** - To confirm the patient's understanding of what the drug is, possible drug interactions, and possible side effects, including instructions on what to do in the event of certain adverse reactions.
- **Company Information** - To inform the patient about the company, and to give the patient phone numbers to call when they need information, more supplies, service, or to register a complaint, compliment, or suggestions.
- **Medicare Supplier Standards** - For Medicare patients only.

Once the patient packet has been prepared, it will be taken to the patient's home with the initial delivery. The Intake Coordinator will begin to procure the necessary reimbursement documentation for the patient's chart. Depending on the type of insurance benefits the patient has, the Intake Coordinator may prepare (or request) one or more of the following documents:

- **PBA (Prior Billing Authorization)** - Usually a number given by a case manager from the insurance company that must be obtained prior to providing service to the patient. Without it, payment for products and services may be denied for payment.
- **Prescription** - Prescriptions for drug infusion, signed by the physician, are generally faxed over to the pharmacist. A copy must be obtained for the patient's billing chart as well as the clinical chart (pharmacy and nursing).
- **SMN (Statement of Medical Necessity)** - Usually a letter from the physician stating why the products and/or services ordered are medically necessary for the patient. (Admissions must request this from the physician.)
- **DIF (DME Information Form)** - For Medicare, where provider information must be completed. The DIF must be signed and dated by the provider and the original signed and dated physician orders must be on file (and revised orders if applicable).
- **Verbal Order** - Obtained by a clinician, pharmacist or nurse, which shows the verbal orders from the physician on a written form. The physician must sign verbal orders taken by a nurse (RN); however, verbal orders taken by a pharmacist may stand without the physician's signature. (Admissions must request a copy of this from clinical.)
- **POT (Plan of Treatment)** - Similar to a Verbal Order, but more detailed information is listed regarding the entire time period of treatment expected.

The Intake Coordinator will call the patient to explain the services being provided to them, and what benefits their insurance company will reimburse. He or she will also explain information on co-pays and

deductibles, and any additional financial responsibility the patient will have regarding un-covered products or services. The Intake Coordinator will also advise the patient of all items coming to them in the initial packet, and at what time delivery is expected.

The last task is to create the patient's chart. Some companies (depending on state regulations) may have separate clinical charts and billing charts. Each company will have a set standard chart order which details where each form or document must be physically placed in the chart. Refer to the company's guidelines on standard chart order.

REVIEW OF CONCEPTS

- **Intake Process:**
 1. Receive Referral Phone Call
 2. Gather All Necessary Information
 3. Log the Referral
 4. Verify Insurance Benefits
 5. Coordinate With Other Departments
 6. Determine Whether to Accept or Reject Referral
 7. Call Case Manager Back With Acceptance or Rejection
 8. If accepting the referral, Agree on Pricing, Conditions, Terms
- **Admissions Process:**
 1. Set Up the Patient in the Computer System
 2. Gather Any Additional Missing Information
 3. Call Patient to Explain Services and Benefits
 4. Prepare Patient Packet with Initial Order
 5. Procure Documentation/Forward to Billing Department
- **Non-Admits** – Referrals that are rejected, i.e. not accepted onto service. These referrals take the same amount of time, energy, and effort as a referral that does come onto service.
- **Basic Features that all Insurance Verification Forms Share:**
 - Demographic Section
 - Financial Section
 - Clinical / Service Section
- **The missing information can be gathered after the referral has been accepted from any of the following sources:**
 - Physician's Office
 - Hospital Billing Office / Medical Records
 - Patient
 - Patient's Caregiver or Next of Kin
- **The Financial Section of the Intake Verification Form Generally Serves 2 Purposes:**
 3. Gathered Information is Written Down on the Form
 4. Information Can be Verified on the Same Form
- **The Main Intake Tasks Include:**
 1. Take the Referral Call.
 2. Gather Information and Fill out the Intake Form.
 3. Log the Referral.
 4. Verify the Insurance Benefits.
 5. Coordinate with Pharmacy, Nursing, and Warehouse.
 6. Confirm or Deny Acceptance of the Referral.
 7. If Accepted, Follow Through with Admissions Tasks.
- **When speaking with a referral source, whether it is a case manager, a nurse from the physician's office, or a discharge planner from the patient's insurance company, it is vitally important to adhere to the following principles.**
 7. Be thorough in gathering information.
 8. Be honest about the availability of the product(s).

9. Be honest about the ability to service or deliver at a specific time.
 10. Be thorough in communicating information to all persons.
 11. Be prompt in communicating back to all persons.
 12. Be accurate and complete with paperwork.
- **The following are the main types of paperwork for an Intake Coordinator:**
 - Referral Form
 - Referral Log
 - Insurance Verification Form (Financial Section)
 - Patient Packet Forms
 - Reimbursement Documentation
 - **The primary tasks to complete before calling a case manager back are listed in the following steps:**
 4. **Verify Insurance Benefits** - If the patient does not qualify financially, management approval will be necessary or company policy should be followed on accepting an indigent patient. Some companies do not accept patients without any means of paying, and therefore, this would be the stopping point if a patient did not qualify. In this case, there would be no need to continue on to Step 2.
 5. **Verify Product Availability** - Once the patient qualifies financially, the next step is to make sure that the products, i.e. drug, pump, supplies, etc. are in stock and available. In this step the Intake Coordinator is checking with Pharmacy on the availability of the infusion equipment, supplies, and drug(s).
 6. **Verify Clinical / Service Availability** - Once past steps 1 and 2, the next step is to check the availability of nursing staff and/or warehouse to deliver to the patient's home. In some cases, it will be both. Perhaps the nurse is already out on the road. It may be closer and more cost effective for the nurse to go directly to the patient's home, rather than come back to the branch to pick up the order. In this case, a delivery driver could meet the nurse at the patient's home with the drugs and supplies.
 - **Forms that should be included in the patient packet: (Those marked with an asterisk (*) must be signed and dated by the patient for the reason indicated.)**
 - **Delivery Ticket *** - To verify the items being delivered.
 - **Assignment of Benefits *** - To allow the homecare company to bill the patient's insurance company on behalf of the patient, and to inform the patient of the cost of services that will be incurred, including the patient's insurance benefits expected and the co-pay or patient's portion of the cost of treatment.
 - **Consent to Treatment *** - To give the homecare company permission to provide medical treatment to the patient as ordered by his or her physician.
 - **Therapy Training Instruction *** - To confirm that the patient has been taught or informed about the products, equipment, supplies, and services being provided, and to confirm any teaching or training that the homecare employee (nurse, pharmacist, or driver) has provided to the patient regarding their infusion therapy.
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- **POT (Plan of Treatment)** - Similar to a Verbal Order, but more detailed information is listed regarding the entire time period of treatment expected.

QUESTIONS

1. Which of the following is NOT considered an Intake task?
 - a. Verify the Insurance Benefits
 - b. Take all Referral Information
 - c. Re-Submit Denied Claims**
 - d. Coordinate with clinical warehouse and pharmacy when appropriate.
2. Which of the following tasks are associated with the Admissions Process?
 - I. Verify Insurance Benefits
 - II. Computer System Entry
 - III. Contact the patient and explain the services and benefits
 - IV. Obtain any missing information
 - a. I, III and IV
 - b. II, III and IV**
 - c. I, II, and III
 - d. II and III Only
3. What is the term describing a referral that does not qualify to be admitted to Homecare services?
 - a. Non-Admit**
 - b. Rejection
 - c. Discharge
 - d. All of the Above
4. What three types of information are gathered on a referral form?
 - a. Work History, Credit History, Clinical History
 - b. Financial History, Credit History, Demographic Information
 - c. Financial History, Medical History, Criminal History
 - d. Demographic History, Financial History, Clinical History**
5. Which of the following sources should be contacted to obtain missing information?
 - a. Physician
 - b. Patient Caregiver
 - c. Hospital
 - d. All of the Above**
6. When speaking to a referral source on the phone, which of the following statements is NOT correct?
 - a. Tell the referral source the product is in stock even if it is not.**
 - b. Be accurate and complete with paperwork.
 - c. Be honest about the ability to service or deliver product at a specific time.
 - d. Be thorough in gathering information.
7. What time frame is considered to be serious consequence of issue when late for an Infusion set-up?
 - a. 1 Hour
 - b. 2 Hours**

- c. 3 Hours
 - d. 4 Hours
8. Prior to calling a referral source back with the acceptance or denial of a referral, which of the following processes must be verified?
- a. Insurance Benefits
 - b. Product/Equipment
 - c. Clinical/Warehouse Delivery Schedule Availability
 - d. All of the Above**
9. Which of the following items are NOT included in the initial packet to the patient?
- a. Company Information
 - b. DIF**
10. Which of the following documents are prepared by the Intake Department?
- I. Prescription
 - II. DIF
 - III. POT
 - IV. PBA
 - V. AOB
 - VI. Waiver
- a. I, II, IV and V
 - b. I, II, IV and VI
 - c. II, IV, V and VI**
 - d. All of the Above