NPs, CNSs, & PAs Can Order Home Health Services

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Presented by

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CARES ACT – Signed into Law 3/27/2020

- Enacted Coronavirus Aid, Relief, and Economic Security (CARES) Act, is one way that CMS is working to lessen the financial hardships of providers facing extraordinary challenges related to the COVID-19 pandemic, and ensures the nation’s providers can focus on patient care.
- Trump Administration issued an unprecedented array of temporary regulatory waivers and new rules/regulations.

SEC. 3708. IMPROVING CARE PLANNING FOR MEDICARE HOME HEALTH SERVICES

- Permanent new rules/regulations
- (a) PART A PROVISIONS.—Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)) is amended—
  - (1) in paragraph (2)—
    - (A) in the matter preceding subparagraph (A), by inserting “, a nurse practitioner or clinical nurse specialist (as such terms are defined in section 1861(aa)(5)) who is working in accordance with State law, or a physician assistant (as defined in section 1861(aa)(5)) who is working in accordance with State law, who is” after “in the case of services described in sub-paragraph (C), a physician”; and...

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(e) APPLICATION TO MEDICAID.—The amendments made under this section shall apply under title XIX of the Social Security Act in the same manner and to the same extent as such requirements apply under title XVIII of such Act or regulations promulgated thereunder.

(f) EFFECTIVE DATE.—The Secretary of Health and Human Services shall prescribe regulations to apply the amendments made by this section to items and services furnished, which shall become effective no later than 6 months after the date of the enactment of this legislation. The Secretary shall promulgate an interim final rule if necessary, to comply with the required effective date.

- Interim final rule with comment period that was released in the Federal Register 4/6/2020. 60 days to make comments (June 1, 2020).
- These regulations effective 3/31/20.

Plans of Care and Certifying /Recertifying Patient Eligibility

Health & Human Services (HHS) is utilizing enforcement discretion with regards to the requirements at §§ 409.43 and 424.22 in order to allow a patient to be under the care of a nurse practitioner or clinical nurse specialist (as such terms are defined in section 1861(aa) (5)) who is working in accordance with State law, or a physician assistant (as defined in section 1861(aa)(5)) who is working in accordance with State law, and for such physician/practitioner:

(1) order home health services;
(2) establish and periodically review a plan of care (POC) for home health services (e.g., sign the plan of care),
(3) certify and re-certify that the patient is eligible for Medicare home health services.

This will provide the flexibility needed for more timely initiation of services for home health patients, while allowing providers and patients to practice social distancing.

HHS will not conduct audits to ensure that only physicians provided orders, signed and dated the plans of care, and certified/recertified patient eligibility for claims with “claim through dates” of March 1 or later submitted during this public health emergency.

This is the temporary fix.
Medicare Certified Home Health Agency
Conditions of Coverage

Medicare Certified Home Health Agency Conditions of Coverage

Enforced by Palmetto GBA
Certifying Patients for the Medicare Home Health Benefit


- Intended for Medicare-enrolled physicians who certify patient eligibility for home health care services and submit claims to Medicare Administrative Contractors (MACs) for those services provided to Medicare beneficiaries.

- Article gives Medicare-enrolled providers an overview of the Medicare home health services benefit, including patient eligibility requirements and certification/recertification requirements of covered Medicare home health services.

Practitioner Requirements

- Licensed in Ohio

- Medicare Enrolled
  - Medicare Provider Enrollment, Chain, and Ownership System (PECOS)

- Medicaid Enrolled
  - Medicaid Information Technology System (MITS)

- National Provider Identifier (NPIs)
Conditions for Coverage

➤ Person is eligible Medicare Beneficiary
➤ Agency has a valid Medicare agreement
➤ Services are covered
➤ Medicare is the appropriate payer

Certifying Patients

➤ Five certification requirements:
  • 1. Be confined to the home;
  • 2. Need skilled services;
  • 3. Be under the care of a physician;
  • 4. Receive services under a plan of care established and reviewed by a physician; and
  • 5. Have had a face-to-face encounter with a physician or allowed non-physician practitioner (NPP).
Reasonable & Necessary

- Physician certifies need for services and homebound status
- Determined from information on Plan of Care
- Determined from information on OASIS
  - Outcome Assessment Information Set

Homebound

- Patient confined to home
  - At this time any individual determined by their physician to be at high risk of contracting COVID-19 virus due to a compromised health condition, meets the homebound requirement because it is “medically contraindicated” to leave the home.
- Normal inability to leave home
- Infrequent basis for short durations
- Considerable and taxing effort
- Medical treatment not included
- State accredited Adult Day Care is permitted
- Please note: ONLY Medicare Beneficiaries are required to be homebound
Components of Homebound Documentation

- Functional – limitations that restrict mobility
- Medical or Physical reasons
- Impact of limitations
- Absences from home

Patient Eligibility—Confined to Home

- Section 1814(a) and Section 1835(a) of the Act specify that an individual is considered “confined to the home” (homebound) if the following two criteria are met:

<table>
<thead>
<tr>
<th>First Criteria</th>
<th>Second Criteria</th>
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<tbody>
<tr>
<td>One of the Following must be met:</td>
<td>Both of the following must be met:</td>
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<tr>
<td>1. Because of illness or injury, the individual needs the aid of supportive</td>
<td>1. There must exist a normal inability to leave home.</td>
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<td>devices such as crutches, canes, wheelchairs, and walkers; the use of special</td>
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<td>transportation; or the assistance of another person to leave their place of</td>
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<td>residence.</td>
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<td>2. Have a condition such that leaving his or her home is medically contrain-</td>
<td>2. Leaving home must require a considerable and taxing effort.</td>
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<td>dicated.</td>
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Face To Face Encounters

- By physician or NPP
- Within 90 days prior to the home care Start of Care (SOC) date if reason for care is the same reason for physician or NPP encounter
- Up to 30 days after SOC if no encounter prior to, or previous encounter was not the reason the need for home care
- Note: Certifying physician must also document the date of the face-to-face encounter.

Face to Face Encounters

- Documentation include why the clinical findings of the encounter support HH (Home Health) eligibility
- NO standardized forms
- Obtain face to face visit note from physician or d/c from facility
Face to Face Encounters

- Ensure physician documents:
  - Encounter related to primary reason for home care
  - How patient’s condition supports homebound status and need for skilled services

- The physician (or PCP) who establishes the POC must sign and date the certification (i.e. POC Form)
  - This is the primary care practitioner (PCP) that is following the patient at home.

Face to Face

- Mandatory information in physician visit (encounter) note:
  - Date of encounter
  - Who provided visit (Physician is not required to co-sign NPP encounter documentation!)
  - Why needs HH care
    - Must match POC diagnosis
  - Support of homebound status
  - Skilled services
  - Sign, dated by Physician or NPP
Face to Face

• Home Health Agency (HHA) responsible for ensuring all information completed
• HHA may provide information from comprehensive assessment to physician
  • i.e. ADL related questions for HB status
• Check boxes will not pass audit for homebound status – must be a clinical narrative specific to patient

Face to Face

• If patient d/c’d from facility agency must review d/c forms for acceptable clinical narratives
• Must have documentation of:
  • Face to face visit
  • Clinical note from physician/NPP
  • If send clinical narrative to physician must get it back signed and dated – physician to keep copy in record
  • Can include clinical narrative on POC orders
Initial Assessment

- The initial HH assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.
- Completed by the RN, PT, or SLP
- To determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status.

Comprehensive Assessment

- The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.
- The start of care date is considered to be the first visit where the nurse or therapist actually provides hands on, direct care services or treatments to the patient.
- The comprehensive assessment must be completed within 5 calendar days of the first visit where the HHA provides hands on, direct care services/treatments to the patient.
- POC discussion and sign/date POC Form
- Outcome Assessment Information Set (OASIS)
Recertifications Every 60 days

- The patient's continuing need for home care;
- Medicare does not limit the number of continuous 60-day episode recertifications for beneficiaries who continue to be eligible for the home health benefit.
- Recertification comprehensive assessment must clearly demonstrate the continuing need, i.e., eligibility, for the home health benefit.
- Updated POC discussion and sign/date POC Form

Plan of Care Form

- Signed by qualified physician - now this would also include NPs, CNSs, or PAs
- All pertinent diagnosis
- Supplies, DME
- Disciplines, frequency and duration
- Supplemental/PRN orders are part of the POC
- 60 day episodes
Types of Services

- Skilled Nursing
- Physical Therapy
- Occupational Therapy
- Speech Language Pathology
- Medical Social Worker
- Home Health Aide

Skilled Nursing

- Services that require a nurse for the care to be provided safely and effectively
- Part-time or intermittent care
- Reasonable and necessary care for the treatment of the illness or injury
Skilled Nursing

• Intermittent or part-time
  – Fewer than 7 days a week, or
  – < 8hrs/day for periods < 21 days, with
  – Extension in exceptional circumstances when care is finite and predictable when the need for additional care is finite and predictable

Principles of Skilled Nursing

• Skilled Observation & Assessment
• Management and Evaluation of a Patient Care Plan
• Teaching and Training Activities
• Administration of Medications
• Nasopharyngeal & Tracheostomy Aspirations
• Catheters, Wound Care, Ostomy Care
• Rehabilitation Nursing
• Psychiatric Evaluation, Therapy & Teaching
Management and Eval Certification

• Per 42 CFR 424.22(a)(1)(i), if a patient's underlying condition or complication requires a registered nurse (RN) to ensure that essential non-skilled care is achieving its purpose and a RN needs to be involved in the development, management, and evaluation of a patient's care plan, the physician will include a brief narrative describing the clinical justification of this need.

Management and Eval Certification

• If the narrative is part of the certification form, then the narrative must be located immediately prior to the physician’s (& NPPs) signature. If the narrative exists as an addendum to the certification form, in addition to the physician's signature on the certification form, the physician must sign immediately following the narrative in the addendum.
**Example**: An aged patient with a history of diabetes mellitus and angina pectoris is recovering from an open reduction of the neck of the femur. He requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to notice signs of deterioration in his condition or complications resulting from his restricted, but increasing mobility.

• Although a properly instructed person could perform any of the required services, that person would not have the capability to understand the relationship among the services and their effect on each other. Since the combination of the patient's condition, age, and immobility create a high potential for serious complications, such an understanding is essential to ensure the patient's recovery and safety.
• The management of this plan of care requires skilled nursing personnel until nursing visits are not needed to observe and assess the effects of the non-skilled services being provided to treat the illness or injury until the patient recovers.

**Therapy Services**

1. Physical Therapy
2. Speech-Language Pathology
3. Occupational Therapy
Physical Therapy

1. Assessment
2. Evaluations at least every 30 days
3. Therapeutic Exercises
4. Gait Training
5. Range of Motion Wound Care
   Provided within scope of state practice acts
6. Supervision of PTA

Speech-Language Pathology

- Assessment
- Evaluations at least every 30 days
- Specific speech/voice production
- Improve ability to improve communicative activities of daily living
- Cognitive functions
Speech-Language Pathology

- Train patient/family to augment speech-language communications
- Assist patients with aphasia in rehabilitation of speech
- Assist patients with voice disorders to develop control of vocal and respiratory systems

Occupational Therapy

1. Assessment
2. Evaluations at least every 30 days
3. Planning, implementing and supervision of therapeutic programs
4. ADL retraining
5. COTA supervision
Therapy Reassessment

- Reassessment at least every 30 days
  - Within 30 calendar days, span episodes
- Is discipline specific
- Clock begins with first therapy assessment and resets after each therapists visit/assessment, etc.

Therapy Reassessments

- Assessments done using method that includes:
  - Objective measurement
  - Enables comparison of successive measurements that determines effectiveness of therapy (progress)
  - Assess activities of daily living i.e. eating swallowing, bathing, dressing, toileting, walking, climbing stairs, using assistive devices, mental and cognitive factors
- Change in goals or plan of therapy requires new orders – must call Physician or NPPs
- Every visit note, documentation between visits must demonstrate measurable progress/effectiveness of therapy
Home Health Aide

1. Services must be part-time or intermittent
2. Services
   a. Personal Care
   b. Simple dressing change
   c. Assistance with self-administered medications
3. Assistance with activities directly supportive of skilled therapy
4. Routine care of prosthetic and orthotic devices

Medical Social Services

1. Resolve social or emotional problems that are an impediment to medical treatment

2. Assessment of social and emotional factors related to illness

3. Assessment of patient’s home situation, financial resources, availability of community resources
Medical Social Services

4. Obtain community resource to resolve patient’s problem

5. Counseling services which are required by patient

Medical Supplies

➢ Necessary for agency personnel to carry out ordered treatment

1. Covered Medical/wound supplies

2. Non-Covered supplies – comfort and convenience

3. Routine – used in the course of most home visits
Plan of Care Completion

- Medicare no longer requires a specific form – but whatever form is used must include all required elements according to the conditions of participation to be a certified home health agency (HHA), and must contain the same information as the initial certifications and recertifications
  - “POC Form”
- All blocks must be completed – If no information necessary enter N/A
- Information on the POC must match the OASIS data set and the UB-04 (billing form)

POC Completion

- SOC is always first billable qualifying skilled visit
- Diagnosis is most related to plan of care (agency must use appropriate coding guidelines)
- Diagnosis codes updated October 1st each year
- V-Codes allowed as secondary dx
- Non-routine supplies must be specifically order by physician i.e. wound care supplies
POC Completion

• Orders on POC must include all disciplines whether or not Medicare is the payer
• Order must state what services the discipline will perform, the frequency and duration
• Signature and date indicated the verbal order for SOC (was Block 23) when applicable

Concerns going forward

• Ohio Dept. of Medicaid –
• CMS has not given the Ohio Dept. of Health any guidance
• HHAs’ EMR systems may not be able to process claims
• Recommend that all communications are documented by NPPs and the HHAs
WHAT QUESTIONS DO YOU HAVE FOR ME?

Resources/Links

MEMBERS ONLY
OCHCH Website – www.ochch.org

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