UP Webinar Q&A: January 28, 2015

Home Health Scope of Practice for Therapists

**Discipline-specific**

**Q:** What is the most strategic way for speech language pathologist (SLP) to get referrals to avoid allowing patients to fall through the cracks? Therapists and physicians seem to be uneducated regarding what SLPs actually do in home health.

**A:** HHAs are required to perform a comprehensive assessment of the patient at the start of care to identify the patient’s specific needs for care. These should be based on the patient’s specific body structure and body function impairments and the activity limitations or participation restrictions they impart. I have found the best strategy is to use the comprehensive assessment to identify SLP needs. For example, there are multiple OASIS items that could indicate the need for an SLP (please reference the Delta’s Excellence in Therapy Report which identified SLP triggers from OASIS). You could also build in specific forms that identify medical necessity for SLP services. We have built in a dysphagia assessment and cognitive assessment for all patients which has helped in this area.

**Q:** Any restrictions on a SLP being in a lead therapist position, mainly scheduling and oversight of the PT, OT, and SLP therapy staff?

**A:** There are no federal restrictions; however in some states (such as CT) you are required to have a supervisor for each discipline once you exceed certain staffing levels. Other states may have their own requirements.

**Maintenance Therapy**

**Q:** What are the requirements for maintenance therapy in home health?

**A:** Please reference the Medicare Benefit Policy Manual Section 40.2.1 - General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy. CMS also published transmittal R179BP related to maintenance therapy and a Medicare Learning Network publication MM8458.

**Q:** When is maintenance therapy initiated? Are the visits performed only by PTs and OT's not PTAs or COTA's?

**A:** Please see the above guidance for the first question. Maintenance therapy may NOT be performed by assistants.
Q: How many visits can we provide per week for a maintenance therapy?
A: There is no guidance related to the number of visits. It must be reasonable and necessary for the patient’s condition.

Q: Do you re-certify patients for maintenance therapy?
A: So long as the patient continues to meet eligibility requirements for home health services Medicare does not stipulate a limit on how many episodes are allowed for any home health benefit including maintenance therapy.

Homebound

Q: Is the patient considered homebound if they can walk 150 feet?
A: Homebound definitions now have a two-step process to take into account when determining homebound status see Medicare Benefit Policy Manual, Chapter 15, Section 60.4.1.

Medicare has attempted to define homebound status and the language is outlined in the Medicare Benefit Policy Manual Chapter 7. But it is not very specific. Medicare regulations explicitly forbid the use of “rules of thumb” to deny home health services. So Medicare may not use a rule of thumb such as “walking more than 150 feet means a patient is not homebound”. Instead Medicare will look at the specific documentation in the record to see if it supports homebound status. Distance alone has nothing to do with this determination.

Many private insurance companies limit approval based on distances alone. It is recommended to create a resource library of documents that define the required functional tasks that people should be able to perform to function safely and be considered community ambulators (not homebound). Suggested article: Andrews AW, Chinworth SA et al. Update on Distance and Velocity Requirements for Community Ambulation. J Geriatr Phys Ther. 2010;33:128-134.

Medications

Q: Please comment on drug regimen review versus medication reconciliation with the later including the comparison of the pill bottles to the discharge medication list?
A: Drug Regimen Review (DRR) is the Medicare Home health equivalent of Medication Reconciliation, though it can be a bit more specific. DRR can be performed with assistance of technology or other clinical team members (e.g., an office nurse). DRR is a required condition of participation for Home Health Agencies. The standard for DRR and State Operations Manual (SOM) interpretive guidelines are below:

- §484.55(c) Standard: Drug Regimen Review
- The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective
drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.

- **Interpretive Guidelines §484.55(c)**
  - This requirement applies to all patients being serviced by the HHA, regardless of whether the specific requirements of OASIS apply. For patients to whom OASIS does not apply, the drug regimen review must be conducted in conjunction with the requirements at 42 CFR §484.18, Condition of Participation: Acceptance of patients, plan of care, and medical supervision.
  - The drug regimen review must include documentation of ALL medications the patient is taking. Review medications on the current physician plan of care and in clinical record notes to determine the accuracy of the medication regimen. This may be included as part of the case-mix, stratified sample of clinical records.
  - Determine if clinical record documentation includes medication review, etc. In therapy-only cases, determine the HHA’s policy for medication review.
  - Drugs and treatments ordered by the patient’s physician and not documented on the care plan should be recorded in the clinical record. This includes over-the-counter drugs. If the qualified clinician (RN or therapist) determines that the patient is experiencing problems with his/her medications or identifies any potential adverse effects and/or reactions, the physician must be alerted.
  - The label on the bottle of a prescription medication constitutes the pharmacist’s transcription or documentation of the order. Such medications are noted in the patient’s clinical record and listed on the physician plan of care. This is consistent with acceptable standards of practice. Federal regulations do not have additional requirements.

Q: If there is a restriction in physical therapists taking medication orders in the state, how can therapist record the medications in the patient record during the SOC, or when a new medication is found during the episode of care?

A: This is a better question for your board, but please note the language in the interpretive guidelines above. The last bullet point states “The label on the bottle of a prescription medication constitutes the pharmacist’s transcription or documentation of the order. Such medications are noted in the patient’s clinical record and listed on the physician plan of care.” In this case all the therapist is doing is documenting an existing order from a label, not taking a new order.

Q: In regards to medication management, we recently had an accreditation organization surveyor recommended that we review the medications in regards to list of diagnoses and ensure that all medications match to a diagnosis. Our therapists had concerns with this when we do therapy only SOC's.

A: This can be a concern because they will not always match. So many medications are used off label or for indirect treatment or symptom management of a disease process. However, I think the suggestion makes sense from a clinical perspective; we should review the meds with one eye on the diagnosis list as part of the Drug Regimen Review (DRR). Therapists who do not have pharmacology as a competency can be educated and should pursue this education as part of being a lifelong learner.
However, in the meantime agencies can and should support DRR efforts by therapists with help from a nurse in the office. This can even be done on the phone while therapist is in the patient home. There are many innovative approaches to this intervention.

Procedures

Q: Where do you find information about therapists performing wound care? Does it only apply if the wound is affecting function?
A: Comprehensive wound care management is present in most curriculums. Therapists can also substantiate their own competence by presenting evidence of continuing education or certification. Each state’s practice act should address the scope of practice related to wound care for therapists and assistants. The Commission on Accreditation of Physical Therapy Education (CAPTE) includes the integumentary system as part of the core curriculum.

Q: Can therapy do finger stick PT/INR?
A: Yes, but some state boards and/or practice acts have something to say about this, some do not. Where there is silence on this matter it should be addressed through agency policy and procedures.

Q: Do you utilize Pulse Oximetry readings with vital sign monitoring? If so, do you obtain a separate order as nursing does?
A: Yes, all licensed disciplines in my company utilize pulse oximeters when indicated (not routinely) but only with an order, and only with established parameters. JCAHO has said an order is not required simply to perform pulse oximetry. The FDA does not require it either; however, home health surveyors typically expect to see an order and physician established parameters as part of the plan of care.

There is a free podcast available on the Home Health Section Website on Pulse oximetry. Each accreditation body (TJC, CHAP, ACHC) have their own sets of standards and interpretations of the CMS regulations. CMS regulations do not specify that pulse oximetry may only be done with an order (similar to blood pressure). A clinician does not need orders to perform blood pressure, but, rather will have orders for alert parameters. Same for pulse oximetry, orders are not necessary to perform the test, but, alert parameters for physician notification should be in the record.

QAPI/PI

Q: What are some of the functions appropriate for therapists in agency Professional Advisory Committee (PAC) meetings?
A: There are too many to list here. It depends on the role of the therapist. Are they a field clinician? Administrator? Other? Therapists can report on results of QI activities or outcomes related to their activities…honestly the list goes on and on.

Q: What is the term QAPI referring and PIP stand for?
A: QAPI stands for Quality Assessment and Performance Improvement
   - Click here for a description with the Nursing Home Quality Project. Home Health will be incorporating it into quality improvement with the proposed Conditions of Participation (CoP).
   - Click here for NAHC’s short description on the proposed CoP that mentions QAPI plans.

Barriers and Myths

Q: Expectation of contractors - talk about your thoughts; referenced on slide 4.
A: You decide what your expectations of contractors will be. But please note that surveyors, MACs, RACs, etc. do not make special allowances for contractors. They must follow your policies and procedures. They must also adhere to all home health regulations. I recommend agencies outline expectations clearly in your contracts which may require consulting an attorney. We need to hold contractors accountable for quality care.

General

Q: With home health being intermittent care, is it ever appropriate for therapy (PT/OT) to do daily visits 5-7 days a week? Isn't the focus more on education and monitoring?
A: Actually, the CMS Medicare Benefit Policy Manual only describes “intermittent” service in relation to nursing and home health aide. Here is how the language reads:
   - For purposes of benefit eligibility, under §§1814(a)(2)(C) and 1835(a)(2)(A) of the Act, "intermittent" means skilled nursing care that is either provided or needed on fewer than 7 days each week or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).

The only regulatory guidance we have from CMS (some MACs offer guidance on the number of visits for therapy services) is that services must be:
   - MBPM 40.2
     - To be covered as skilled therapy, the services must require the skills of a qualified therapist and must be reasonable and necessary for the treatment of the patient’s illness or injury as discussed below. Coverage does not turn on the presence or absence of an individual’s potential for improvement, but rather on the beneficiary’s need for skilled care.
   - MBPM 40.2.1
The service of a physical therapist, speech-language pathologist, or occupational therapist is a skilled therapy service if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the general supervision of a skilled therapist. To be covered, assuming all other eligibility and coverage criteria have been met, the skilled services must also be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury. It is necessary to determine whether individual therapy services are skilled and whether, in view of the patient's overall condition, skilled management of the services provided is needed.

The development, implementation, management, and evaluation of a patient care plan based on the physician's orders constitute skilled therapy services when, because of the patient's clinical condition, those activities require the specialized skills, knowledge, and judgment of a qualified therapist to ensure the effectiveness of the treatment goals and ensure medical safety. Where the specialized skills, knowledge, and judgment of a therapist are needed to manage and periodically reevaluate the appropriateness of a maintenance program, such services would be covered, even if the skills of a therapist were not needed to carry out the activities performed as part of the maintenance program.

While a patient's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by unskilled personnel.

A service that is ordinarily considered unskilled could be considered a skilled therapy service in cases where there is clear documentation that, because of special medical complications, skilled rehabilitation personnel are required to perform the service. However, the importance of a particular service to a patient or the frequency with which it must be performed does not, by itself, make an unskilled service into a skilled service.

Assuming all other eligibility and coverage criteria have been met, the skilled therapy services must be reasonable and necessary to the treatment of the patient's illness or injury within the context of the patient's unique medical condition. To be considered reasonable and necessary for the treatment of the illness or injury:

1. The services must be consistent with the nature and severity of the illness or injury, the patient's particular medical needs, including the requirement that the amount, frequency, and duration of the services must be reasonable; and
2. The services must be considered, under accepted standards of medical practice, to be specific, safe, and effective treatment for the patient's condition, meeting the standards noted below. The home health record must specify the purpose of the skilled service provided.

Many Home Health Agencies will provide higher frequencies of therapy visits on cases whereby a patient is discharged as early as post op day 2-5 to home. I have not seen a problem with denials from Medicare (Medicare Administrative Contractors) as long as the skilled need,
reasonable and necessary, medical necessity and homebound status criteria are all met and documented appropriately.

Q: Can you provide the link for the book please?
A: The *3rd Edition of the Providing Physical Therapy in the Home handbook* was created to clear up misconceptions about care provision in the home setting and the first 6 chapters are geared towards administrators and clinicians in order to provide information related to PT practice in home health.

Special thanks to the presenters for their expertise.

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