HOMECARE & HOSPICE
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COVID-19 Waiver Allowing HHAs Flexibility for OT to Open Cases – Part 1

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Objectives

- Define the COVID-19 waiver allowing OTs to perform initial and comprehensive assessments.
- Explain the difference between qualifying and skilled services and how it precipitated the need for the waiver.
- Describe the components of the initial and comprehensive assessment required by regulation.

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The Waiver

- On April 9, the Centers for Medicare & Medicaid Services (CMS) temporarily suspended certain regulatory requirements through 1135 waivers so that health care facilities can maximize the use of frontline medical staff during the COVID-19 public health emergency (PHE).
- **Allow occupational therapists (OTs) to perform initial and comprehensive assessment for all patients.** 42 C.F.R. 484.55(a)(2) and 484.55(b)(3). CMS is waiving the requirement that OTs may only perform the initial and comprehensive assessment if OT is the service that establishes eligibility for the patient to receive HHA services.

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The Waiver (cont.)

- *This temporary blanket waiver allows OTs to perform the initial and comprehensive assessment for all patients receiving therapy services as part of the plan of care, to the extent permitted under state law, regardless of whether OT is the service that establishes eligibility.* (emphasis added)
- The existing regulations at § 484.55(a) and (b)(2) would continue to apply that OTs and other therapists would not be permitted to perform assessments in nursing only cases. HHAs are expected to continue to match the appropriate discipline that performs the assessment to the needs of the patient to the greatest extent possible.

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The Waiver (cont.)

- Therapists must act within their state scope of practice laws when performing initial and comprehensive assessments and access a registered nurse or other professional to complete sections of the assessment that are beyond their scope of practice.
- *Expanding the category of therapists who may perform initial and comprehensive assessments to include OTs provides HHAs with additional flexibility that may decrease patient wait times for the initiation of HHA services.* (emphasis added)

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CMS Clarifications

- Physician order includes nursing and OT: *OT may perform the initial and comprehensive assessments*
- Physician order includes OT: *OT may perform the initial and comprehensive assessments*
- Physician order includes nursing and PT (not OT): *HHAs should match the needs of the patient o the clinician who performs the assessment, to the greatest extent possible. While it would not be ideal, OT may perform the initial and comprehensive assessments.*

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CMS Clarifications

- Physician order includes SLP (not OT): HHAs should match the needs of the patient to the clinician who performs the assessment, to the greatest extent possible. While it would not be ideal, *OT may perform the initial and comprehensive assessments.*
- Physician order includes another therapy service and OT: *OT may perform the initial and comprehensive assessments.* HHAs should match the needs of the patient to the clinician who performs the assessment, to the greatest extent possible.

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Importance of Waiver to HHAs

- "Occupational therapists from home health agencies can now perform initial assessments on certain homebound patients, allowing home health services to start sooner and freeing home-health nurses to do more direct patient care."
- The regulation this actually waives is from the Conditions of Participation (CoPs) §484.55. It is important to remember the CoPs apply to all patients in an HHA, regardless of payor. Therefore, when the need for OT "establishes program eligibility" for any payor source OT can, and have always been able to, open the case.

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Home Health Flexibility Act

Importance of the Act

"…a home health agency may determine the most appropriate skilled service to make the initial assessment visit for an individual who is eligible for home health services under title XVIII of the Social Security Act…"

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Qualifying vs Skilled Services

- According to the CMS Conditions for Coverage, OT does not qualify, or establish eligibility, for HHA coverage as a stand alone service. Once the patient meets qualifying criteria by virtue of needing skilled nursing on an intermittent basis, physical therapy or speech-language pathology, then OT is a covered, skilled service for continued need after the qualifying discipline has initiated service.
- Furthermore, the home health Conditions of Participation (CoPs) require that the only disciplines permitted to perform the initial and comprehensive assessment are the services that establish eligibility for the patient to receive HHA services.
- This is the requirement being waived.

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Dispelling Myths about Qualifying Service

- The qualifying service requirement was designed to include only those disciplines that had its own state licensing and oversight in all states, which at the time the Medicare benefit was written did not include OT.
- OT now has practice acts in all fifty states and the American Occupational Therapy Association (AOTA) has long advocated for OT to become a qualifying discipline, since 1971.
- In 2008, AOTA advocacy resulted in the Home Health Flexibility Act to allow HHAs the flexibility of OT performing initial and comprehensive assessments once the patient meets qualifying criteria for HHA services, though has yet to be passed.
- The waiver accomplishes this very flexibility.

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Initial Assessment *42 Code of Federal Regulations 484.55(a)*

- *Initial assessment 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.*
- *An initial assessment visit must be made to determine the immediate care & support needs of the patient; &, for Medicare patients, to determine eligibility for the Medicare HH benefit, including homebound status.*
- In very many cases, this is accomplished in conjunction with the Comprehensive Assessment
- Does NOT have to be performed at the same time or by the same person performing the Comprehensive Assessment
- Nor do the regulations require the same *discipline* do both assessments
- Two different clinicians or disciplines could be responsible for completing the initial and comprehensive assessments.

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Initial Assessment Components

- Establish eligibility
  - Homebound status
  - Skilled need
- An actual assessment *to determine the immediate care and support needs of the patient,*
- Consents signed, admission packet reviewed
- Medication reconciliation/drug regimen review (includes handoff to office for completion)
- Deliver a skill
- May be the Start of Care visit (1st day of the episode) ***only*** if the ***discipline*** that conducts ***is on the initial order*** AND as ***skilled service is performed***.

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SOC Within 48 Hours of Referral

- In cases where home care is requested by a hospitalist who will not be providing an ongoing plan of care for the patient, the agency must contact an alternate, or attending physician, and upon agreement from this following physician for referral and/or further orders, the agency will note this as the referral date in M0104.
- If SOC or ROC is delayed due to the patient's condition or physician request (for example, extended hospitalization), then the date the agency received **updated/revised** referral information for home care services to begin would be considered the date of referral.

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Establish Eligibility

- Home health eligibility varies by payer. Not all payers require homebound status.
- Medicare home health benefit eligibility at start of care:
  - Has a need for intermittent nursing, or PT, or SLP, ***and***
  - Under care of physician ordering/coordinating the care, ***and***
  - Is homebound
- Medicare Learning Network detailed presentation on eligibility for the home health benefit.

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Homebound Criteria

The following two criteria must be met:

Criteria One One must be met:	Criteria Two Both must be met:
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 in order to leave their place of residence	There must exist a normal inability to leave home;
Have a condition such that leaving his or her home is medically contraindicated.	Leaving home must require a considerable and taxing effort.

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Immediate Care & Support Needs

- Immediate care and support needs:
  - Are there immediate needs that indicate EMS should be summoned?
  - Is there a priority for one of the ordered disciplines?
  - Is there a need for a discipline/service not ordered?
  - If inpatient discharge, does patient have all meds ordered?
  - Are there gaps in patient or caregiver knowledge that pose an immediate risk?
  - Is there an immediate need for supplies (maybe on discharge order but not present)? Common examples: oxygen, Hoyer lift, hospital bed, wheelchair.

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Consents, Rights & Responsibility

- Consents/Agreements
  - Patient's Rights and Responsibilities
  - Financial Responsibility
  - Does patient have guardian/HCPOA?
    - Guardian: Must complete all consents/agreements
    - HCPOA: Patient may complete
- Any other agency-specific content to establish provider-patient relationship
- How to contact agency: hours/numbers/complaints
- Emergency Preparedness

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Medication Reconciliation

- The process of comparing a patient's medication orders to all of the medications that the patient has been taking.
- Done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions.
- Should be done at every transition of care in which new medications are ordered or existing orders are rewritten.
- This process comprises five steps:
  1. develop a list of current medications;
  2. develop a list of medications to be prescribed;
  3. compare the medications on the two lists;
  4. make clinical decisions based on the comparison; and
  5. communicate the new list to appropriate caregivers and to the patient.

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Drug Regimen Review

- The *comprehensive assessment* must include a review of all medications the patient is currently using to identify:
  - any potential adverse effects & drug reactions
  - including ineffective drug therapy,
  - significant side effects,
  - significant drug interactions,
  - duplicate drug therapy,
  - noncompliance with drug therapy
- Collaboration is expected in which the assessing clinician evaluates patient status, and another clinician (in the office) assists with review of the medication list (e.g., possible duplicate drug therapy or omissions)

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Comprehensive Assessment *42 Code of Federal Regulations 484.55(b)*

- *Each patient must receive, a patient-specific, comprehensive assessment.*
- *For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of 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 SOC.*
- OASIS data captured within the assessment can and should be collaborated on by disciplines for greater accuracy.

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Comprehensive Assessment *42 Code of Federal Regulations 484.55(b)*

- *Content of the comprehensive assessment. The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information:*
  1) *The patient's current health, psychosocial, functional, and cognitive status;*
  2) *The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA;*
  3) *The patient's continuing need for home care;*
  4) *The patient's medical, nursing, rehabilitative, social, and discharge planning needs;*

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Comprehensive Assessment *42 Code of Federal Regulations 484.55(b)*

5) 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.

6) The patient's primary caregiver(s), if any, and other available supports, including their:

i. Willingness and ability to provide care, and

ii. Availability and schedules;

7) The patient's representative (if any);

8) Incorporation of the current version of the Outcome and Assessment Information Set (OASIS) items . . .

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More to Know, More to Come

- There is certainly more to know regarding completing a Start of Care for a Medicare Home Health patient.
- Part 2 of this series will provide more detail and resources for OTs to access as they get more comfortable with this process.
- The opportunity is to create greater flexibility for home health agencies during COVID-19.

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Q & A

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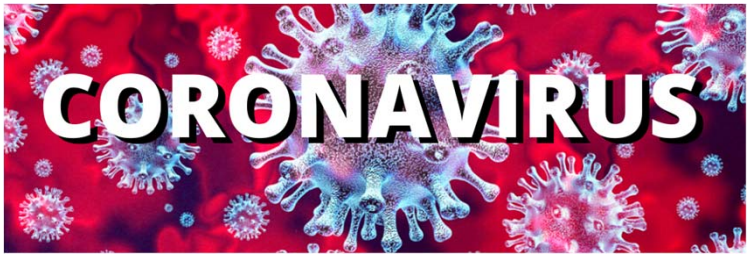
NAHC COVID-19 Information and Resources



nahc.org/covid19
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Upcoming Events

PDGM 2020 Virtual Summits
April 28 & 29

COVID-19 Waiver Preparation for OTs Opening Cases– Part 2
Tuesday, May 5

COVID-19 Virtual Town Hall
Wednesday, May 6

2020 Financial Management Conference & Expo
July 26-28
Las Vegas, NV

2020 Home Care and Hospice Conference and Expo
October 18-20
Tampa, FL

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