



Ref: S&C-01-14

DATE: April 23, 2001

FROM: Director
Survey and Certification Group
Center for Medicaid & State Operations

SUBJECT: Home Health Agency (HHA) Questions and Answers-INFORMATION

TO: Associate Regional Administrators, DMSO
State Survey Agency Directors

The purpose of this memorandum is to provide guidance to regional office and state survey agency personnel who are involved in the survey and certification activities of HHAs. We have prepared the following questions and answers for your use in responding to questions that arise concerning the following home health issues: personnel qualifications; patient rights; organization, services and administration; group of professional personnel; and acceptance of patients, plan of care (PoC), and medical supervision.

42 CFR 484.4 Personnel Qualifications

1. Q. 42 CFR 484.4 states an administrator of the HHA is a person who "is a licensed physician, a registered nurse, or has training and experience in health service administration and at least one year of supervisory or administrative experience in home health care or related health programs". How would you define a qualified person who can act in the absence of the administrator?

A. A qualified person should have the same qualifications as the administrator, i.e., a RN or a physician, or a person with appropriate training and experience. In addition, according to 42 CFR 484.14(c) the qualified person must be authorized in writing to act in the absence of the administrator.

42 CFR 484.10 Patient rights

1. Q. Should the home visit consent form contain the patient's complete address, e.g. house #, city, or directions to the home in rural areas?

A. Patient consent forms for home visits include the beneficiary name and address. The address includes the street, apt #, city and zip code. Directions to the home are not required to be placed on this form.

2. Q. You are looking at the HHA's complaint log and want to verify that complaints are being investigated, but the HHA refuses to allow you access to its records because the records contain risk management information. What should one tell the HHA?

A. As part of the patient rights condition of participation (CoP), the HHA is required to investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, and to document both the existence of the complaint and resolution of the complaint. Surveyors, as part of their investigation of the HHA's compliance with this CoP, may ask to review complaints received by the HHA and the resolution of these complaints. The HHA may not refuse to permit examination of these records by or on behalf of HCFA without risking termination from the Medicare program.

3. Q. Is it permissible for an HHA to request that a patient sign a consent indicating he is aware that there is a limited amount of staffing available from the HHA?

A. No. The HHA is required to accept patients for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. If the HHA is unable to provide the ordered care and services that the patient needs, it should not accept the patient for care. Providing less services than the physician orders would be a violation of the CoP at 42 CFR 484.18. Asking the patient to sign a consent form indicating he is aware that there is a limited amount of staffing from the HHA does not release the HHA from its obligation to provide the needed services.

4. Q. With the new hospital CoP—Patient Rights, hospitals are initiating a hotline number. Can the same number be used for both HHA and hospitals?

A. Yes. We are not aware of any Federal requirement that would preclude combining the State hotline number for HHAs and hospitals.

42 CFR 484.14 Organization, services, and administration

1. Q. If an HHA contracts for therapy services from a therapy company, may that company in turn sub-contract with another company or individual? If not, what reference can we use to cite this?

A. If the HHA contracts for services, it must comply with the requirements of 42 CFR 484.14 (f), "Personnel under hourly or per visit contracts." This includes services provided through a contractor that in turn subcontracts with another person, group, or entity.

2. Q. If an agency has all employees sign an "employee agreement" does this mean all are under "contract or arrangement" and services are not provided direct?

A. For Medicare compliance, an individual is considered an employee of the HHA if the HHA is responsible for paying the individual directly for services performed either through a salary or on an hourly or per visit basis and the HHA is required to issue a W-2 on his/her behalf.
3. Q. We do not review contracts during a standard survey unless there is a problem that would be related to contracts. Should we routinely review them?

A. No. The regulation at 42 CFR 484.14 (f) is not a part of the standard survey and does not have to be reviewed during a standard survey unless you have questions about how the HHA is complying with its oversight responsibility for all its personnel.
4. Q. 42 CFR 484.14 (c) (G133-137) describes the qualifications and responsibilities of an administrator. In a hospital based HHA, can the HHA director be the administrator or does the hospital administrator need to meet the interpretive guideline tags at G133-137?

A. The hospital administrator does not have to fulfill the role of the HHA administrator. The HHA administrator may be a separate person who meets the qualifications and requirements specified at 42 CFR 484.14 (c).
5. Q. How often do we have to look for CLIA certificates?

A. Verify CLIA certificates on initial certification. Check the CLIA certificates on recertification if you identify issues related to the HHA performing tests or when determining compliance with 42 CFR 484.14 (j).
6. Q. If the HHA hired a home health consultant as an acting administrator and s/he states the HHA is looking for an administrator, how long can the consultant be the administrator for the HHA?

A. The interpretive guidelines to 42 CFR 484.14 (a) indicate a contracted employee may be considered an HHA employee if the HHA is required to issue a W-2 form on his/her behalf. If the consultant/acting administrator is hired as an employee, the consultant may be the acting administrator indefinitely.
7. Q. How would we cite an HHA if it refuses to give the surveyor records regarding employees contracted by the HHA?

A. The HHA may not refuse to permit examination of the requested personnel records by, or on behalf of HCFA, without risking termination from the Medicare program. 42 CFR 489.53 (a)(5) describes the basis for termination of the provider agreement as it relates to examination of the HHA's records.

42 CFR 484.16 Group of professional personnel

1. Q. What are recommendations for "frequently" regarding professional advisory committee (PAC) involvement with reviewing "scope of services?" If the MD is not present did the PAC meetings officially occur?

A. We do not define "frequently" in 42 CFR 484.16 (a), "Advisory and evaluation function." "Frequently" should be defined within the agency's policies and procedures. In addition, it must annually review the agency's policies that govern services offered, admission and discharge policies, clinical records, program evaluation, etc. If the HHA's policy states the professional advisory group meets four times a year, there should be evidence to support the meetings occurred. 42 CFR 484.16 requires the group to include at least one physician, one RN, and representation from other disciplines. If the physician did not participate during the meeting, then the meeting is not complete.

2. Q. What type of information should we as surveyors expect to review on annual evaluations? How can the agency present the information to us?

A. 42 CFR 484.16 (G153) describes information that is reviewed on annual evaluations. It includes a review of the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. The information may be presented in the format the agency deems most acceptable

42 CFR 484.18 Acceptance of patients, plan of care, and medical supervision

1. Q. Can Physician Assistants (PA) sign the PoC and does the duration for home health aide need to be specified on the PoC?

A. The PA may not sign the PoC in lieu of the doctor in Medicare approved HHAs. Section 1861(m) of the Social Security Act specifically states that home health patients must be under a plan of care signed by a doctor. The doctor must also specify the frequency and the expected duration of the visits for each discipline.

2. Q. The plan of care requires the HHA to indicate the visit frequency for services provided to the patient. Does the initial visit have to be included in the frequency and can a visit be made every other week? This would cause some weeks to have a zero visit frequency.

A. 42 CFR 484.18 (a) describes the requirements for completing the PoC. The initial visit needs to be included in the visit frequency for the first week. Visits are made according to patient needs and may be stated in days, weeks, or months (e.g. 3x/wk x 4 wk or 1 x mo. x 2 mos). Visits may also be made every other week, and may be written as visits "every other week."

3. Q. 42 CFR 484.18(a), G159, states the PoC covers the patient's pertinent diagnoses, services and equipment required, frequency of visits, prognosis, medications and treatments, and any

other appropriate items. How does it pertain to patient goals and how do we explain to HHA personnel that this tag includes goals? Where else do you cite if goals and objectives are not specific and measurable?

A. The plan of care requirement includes a caveat for the addition of "any other appropriate items." Goals should be included as a part of the PoC and are referenced in the regulation at 42 CFR 484.14(g) which requires personnel who provide service to patients to coordinate their efforts and support the **objectives** outlined in the PoC. Goals are stated as objectives.

4. Q. How specific do modalities and procedures need to be to meet G161—specific procedures and modalities to be used in orders for therapy services?

A. Modalities must be specified by name, e.g., ultrasound, and must include time, frequency and duration of services, e.g., ultrasound for ten minutes twice a week for eight weeks. Procedures are broader in scope and must include frequency and duration, e.g., dressing activities twice a week for four weeks.

5. Q. The PoC usually includes treatment specifics. If the PoC does not include specifics for wound care (aseptic, sterile, or clean technique), where would this be cited? Is it a failure to revise the PoC?

A. You may cite under G158, G160, and G173. G158 refers to a failure to follow the written plan of care established by the physician. G160 refers to a failure to consult with the physician to approve modifications to the original plan of care. G173 refers to the registered nurse's failure to make revisions to the plan of care. The above example is a failure to revise the POC. The RN should contact the physician for specific orders on wound care.

6. Q. G165 states "Drugs and treatments are administered by agency staff only as ordered by the physician." G158 states "Care follows a written plan of care established and periodically revised by a doctor of medicine, osteopathy, or podiatric medicine." When would you cite either G165 or G158? If you identify care not following the doctor's plan of care/orders, does that not always lead to the two citations?

A. G158 is cited for care issues that do not follow a written PoC established by the physician. It may not always refer to drugs and treatment problems. G165, 484.18(c): Conformance with physician's orders, refers specifically to drugs and treatments provided by agency staff.

7. Q. Please clarify "verbal orders accepted by authorized personnel." Are nurses the only ones who can accept "verbal orders?"

A. Federal regulations permit the RN or the appropriate therapist to receive a verbal order. However, state law or the HHA's policies may preclude the therapist and/or the social worker from doing this.

Page 6 – Associate Regional Administrators, DMSO; State Survey Agency Directors

8. Q. Is it permissible for HHAs in rural areas to indicate, due to lack of available aides, that the patient must hire the aide privately? Also if limited services, should the patient be

admitted in the first place?

A. An HHA may not require a Medicare patient to privately hire aides to provide Medicare covered services. The HHA is required to accept patients for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met by the agency in the patient's place of residence. The HHA may have others furnish covered services through arrangement and receive payment from the HHA through consolidated billing requirements that are part of the Medicare Home Health PPS. If the HHA is unable to provide the ordered care and services that the patient needs, it should not accept the patient for care. While the patient could have a need for services that the HHA is not obligated to furnish under Medicare, the HHA cannot require the patient to privately hire an aide.

9. Q. Are surveyors supposed to get into reimbursement issues, i.e. patients who are not appropriate for home health, and if so, what tag?

A. No, the surveyor's primary responsibility is to assess an agency's compliance with the conditions of participation (CoP). As a part of reviewing the CoP at 42 CFR 484.55 surveyors review homebound status for Medicare patients. The HHA that accepts patients who are inappropriate for home care, i.e., ambulatory and independent, should be referred to the RO for any necessary action.

10. Q. During the opening conference at a recertification survey, the HHA lets you know it only has one aide. Then it lets you know that the one aide is on vacation the week you showed up. Should you continue the survey?

A. Yes, you should continue the survey in this situation and determine whether the plan of care was followed and if any patients needed the services of a home health aide. The HHA is required to accept patients for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. Providing less services than the physician orders would be a violation of the CoP at 42 CFR 484.18.

11. Q. HHAs in a state are using computer generated 485s input by HHA staff. The physician does not sign the PoC for up to 30 days after the start of care. The HHAs seem to be initiating care without much physician involvement. Is there any way to cite this although the HHA is in paper compliance?

A. In order to initiate care, the HHA needs to have a verbal or written order from the physician. The HHA is also responsible for assessing the patient's needs and consulting with the physician to develop the plan of care. The HHA must document in the patient's record any communications with the physician regarding the development of or changes to the plan of care. If the HHA is not complying with this requirement, you may cite this under G160. G160 refers to a failure to consult with the physician to approve modifications to the original plan of care.

Page 7 – Associate Regional Administrators, DMSO; State Survey Agency Directors

12. Q. The HHA advertises it offers skilled nursing and home health aide services. Reviewing the patient's chart and documentation strongly shows the patient would benefit from medical

social services. What is the agency's responsibility to provide the service or to refer the patient and make sure there is social service intervention?

A. The HHA is required to accept patients for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met by the agency in the patient's place of residence. If the HHA does not provide social services as one of its services, HHA staff should discuss the patient's needs with his doctor to determine other resources that are available to the patient.

The guidance and recommendations provided in this memorandum apply to all accredited HHAs that participate in Medicare and to HHAs that are required to meet the Medicare CoPs, including Medicaid HHAs.

Effective Date: This policy is currently in effect. It is a clarification of current policy.

Training: This policy should be shared with all survey and certification staff, HHA surveyors, their managers, and the State/Regional Office training coordinators.

/s/

Steven A. Pelovitz