Missouri Department of Health and Senior Services
Bureau of Home Care & Rehabilitative Standards

THINGS TO NOTE AFTER REVIEW OF THE FINAL HOME HEALTH INTERPRETIVE GUIDELINES

January 2019

TAG	CHANGE	HOW IT DIFFERS FROM DRAFT
G516	Removed the statement regarding occupational therapy alone cannot establish initial eligibility for the Medicare home health benefit.	All guidance for this tag has been removed. This may confuse agencies, in that they may interpret this to mean just the opposite – that occupational therapy can now establish eligibility for the Medicare home health benefit. *CMS was consulted and the eligibility requirements for home health have **NOT** changed. **OT CANNOT establish initial eligibility for the Medicare home health benefit.***
G520	Redefined start of care date and when the comprehensive assessment must be completed (within 5 days of the start of care date).	In the draft interpretive guidelines, SOC date was defined as the date of the initial assessment, which was an error. It also stated that the comprehensive assessment must be completed within 5 days of the initial assessment which was also an error.
G546	Removed guidance for when the update to the comprehensive assessment can be completed	Draft interpretive guidelines stated that the update to the comprehensive assessment is to be completed any time up to and including the 60th day from the previous comprehensive assessment. That was an error.
G572	Deleted the statement "and the visit cannot be rescheduled within the week".	The draft interpretive guidelines stated the physician was to be notified of any missed visits that could result in a potential for clinical impact upon the patient, only if the visit cannot be rescheduled with the week. The final guidelines removed the part about "if the missed visits cannot be rescheduled;" therefore, whether the visit could be rescheduled or not, if the missed visit could result in a potential clinical impact, the physician must be notified.
G576	Added: "…. Routine monitoring of vital signs, including pulse oximetry, do not require a physician order."	This is new guidance.
G584	Removed …"time of receipt" from the interpretive guidelines.	The *draft* interpretive guidelines stated that all orders must be signed and dated, with the date of receipt and "time of receipt" but "time of receipt" is now removed. However, the actual regulatory language has not changed; therefore, all orders must still be signed, dated and *timed*.

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G606	Removed from the interpretive guidelines "…patient preference…"	The draft interpretive guidelines stated that the HHA must integrate services by the various disciplines by taking into consideration patient preferences. This terminology was removed.
G612	The written information to the patient must be provided no later than the next visit after the plan of care has been approved by the physician.	The draft interpretive guidelines stated that once the plan of care is approved by the physician, the listed documents must be provided to the patient and/or representative. The new guidelines specify the documents must be provided "no later than the next visit". The new guidelines also deleted the reference to the comprehensive assessment being completed within 5 days of the initial assessment since that is an inaccurate statement.
G722	Removed the statement that professional staff, whether direct or contracted, are expected to participate in *ALL* in-service trainings/programs.	The regulatory language still requires staff participate in HHA-sponsored in-service training but just not *ALL* the agency's in-service trainings.
G798	Added an explanation that if nursing and physical therapy are involved in the patient's care, nursing must maintain the overall responsibility for patient care instructions.	This was added information to further clarify the regulation. The draft interpretive guidelines only addressed if there was therapy only services, that therapy would do the patient care instructions. It did not address if nursing was involved also how that would be handled; therefore, it is clearer now that if both nursing and therapy services are involved, nursing staff must take responsibility for writing the aide care plan but can have input from the other skilled professionals as needed. Nursing will also be responsible for the aide supervision.
G802	Further defined "assistance in administering medications"	Added several things to the definition of "assistance in administering medications: - Bringing a medication to the patient either in a pill organizer or a medication container as requested by the patient or caregiver. - Reminding the patient to take the medication. - Applying a topical product, such as a non-prescription cream, to intact skin per home health aide instruction in how to apply it. The draft guidelines defined "assistance in administering medications" as only limited to getting water or fluids for the patient to take their medication.

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G804	Specifically states now that all HHA staff involved in the patient's care must be present for, and, where appropriate, should contribute to, any discussion regarding the patient's care during interdisciplinary team meetings.	The draft interpretive guidelines only addressed the HH aide and it alluded that there should be in- person team meetings and that the HH aide *MUST* attend. Now it is clear that there *should* be IDT meetings and that *ALL* HHA staff involved with the patient *MUST* attend; however, it now says the HH aide *MAY* either attend in person, electronically or via telephone. *NOTE: This requirement for IDT team meetings for all staff only appears in the interpretive guidelines under this condition for Home Health Aides, CFR 484.80 and as is noted, the HH aide is not REQUIRED to attend IDT but MAY attend. The regulation that addresses all other staff is under the condition 484.75, Skilled Professional Services, specifically G706. However, the interpretive guidelines for this tag only states there should be "periodic discussions among the team".* *Per CMS: We did not specify the manner in which the IDG meetings are conducted, it is HHA policy driven. However, we don't use the verbiage "in person" for these meetings, but we do say at 484.80(g)(4), the home health interdisciplinary team meets together, and all HHA staff involved in the patient's care must be present for… It is not realistic to expect field staff to be able to be physically present for every IDG meeting for every patient they provide services for.*
G808	Specifies now who must make the supervisory visit when both skilled nursing and physical therapy are involved.	The draft interpretive guidelines did not address which discipline is required to do the on-site supervisory visit every 14 days. The final guidelines now specify that whenever both skilled nursing and therapy are involved, the skilled nurse makes the supervisory visit.
G812	Same as G808	The draft interpretive guidelines lumped together guidance for G808 - 484.80(h)(1)(i), G810 - 484.80(h)(1)(ii) and G812 - 484.80(h)(1)(iii). In this draft guidance it only stated that an annual on-site supervisory visit must be made while the aide is providing care to a single patient. It did not address what discipline was required to do it. In the final guidelines, the guidance is also lumped together and it does not address the annual on-site supervision at all. Instead, the final guidelines address supervisory visits as a whole. Therefore, the same guidance as shown above for G808 would apply to G812. That is, whenever both skilled nursing and therapy are involved, the skilled nurse makes the supervisory visit.

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G954	Deleted the statement "The HHA administrator names, in advance…"	The draft interpretive guidelines specifically stated that the administrator must name, in advance, the person or persons who will assume the administrator responsibilities in his/her absence. Although the final guidelines deleted this statement, the regulatory language still states the pre-designated person must be authorized in writing by the administrator as well as the governing body.
G972	Deleted the statement "If a branch provides a service which the parent does not provide, the parent retains overall responsibility for the quality of all such services provided."	The draft interpretive guidelines had the statement "If a branch provides a service which the parent does not provide…" The SOM requires that the branch location provides the same services as the parent location. Therefore, this statement was an error and was deleted.
G982	Specifically defines what is meant by "under arrangements". Also removed the statement regarding what needs to occur if a staff member is employed by more than one certified provider.	The draft interpretive guidelines had a statement that clearly stated if a staff member was employed by more than one agency, that each agency had to maintain separate records regarding the employee's work schedule and issue a separate W2 form to the employee. The final guidelines have removed this statement. *NOTE: With this deletion in the IGs, we have contacted CMS for guidance on this issue.* *PER CMS: This issue is currently being revised in Chapter 2 of the State Operations Manual. For now, CMS state that it is expected that the agency records denote the hours worked in each HHA (each Medicare provider number).*
G1022	Specifies when the discharge summary must be sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA.	The draft interpretive guidelines stated that the discharge summary was to be sent to the primary care physician or primary care practitioner within 5 business days from the date of the final visit. The final guidelines state that the discharge summary must be sent within 5 business days of the date of the *order* for discharge from the responsible physician.

Disclaimer – This list of changes is not inclusive for all changes made in the Home Health Interpretive Guidelines. These are important things to note that may impact the survey process/outcome for your agency.