

Date: January 10, 2002 DSL-BQA-02-002
To: Home Health Agencies HHA 01
From: Jan Eakins, Chief
Provider Regulation & Quality Improvement Section
Via: Susan Schroeder, Director
Bureau of Quality Assurance

Home Health Update – January 2002

The purpose of this home health update is to provide guidance on federal and state requirements for physician orders and documentation of medications. The information included in this memorandum is currently in effect and provided as clarification to current Center for Medicare and Medicaid Services (CMS) and Bureau of Quality Assurance (BQA) policy.

A plan of care, which includes physician orders, must be established for every patient accepted for care by a home health agency. Wisconsin Administrative Code, Section HFS 133.20, and the federal Condition of Participation, 42 CFR 484.18, outline the regulatory requirements for the plan of care.

Additional CMS guidance related to 42 CFR 484.18: Acceptance of patients, plan of care, and medical supervision were sent to all home health providers via BQA memorandum DSL-BQA-01-030 in April 2001.

Physician Orders

Frequency of visits:

Physician orders for patient care may authorize a specific range in the frequency of visits for each service. Identifying a specific range for visits may ensure that the most appropriate level of service is provided to meet the needs of the patient. If fewer visits than the upper limit of the range are provided, clinical record documentation must support the patient specific circumstances that guided the agency's decision to provide fewer than the upper limit ordered.

When physician orders specify a visit range, the minimum number within the range should be ***at least one*** unless the physician identifies the ***patient specific criteria*** for no visits during a given time frame.

Examples may include:

- Daily home health aide visits one to seven days a week to assist with personal care except when a family member notifies the provider of *their* availability to assume the responsibility for the physician ordered care.
- Daily skilled nursing visits for wound care (specifics of wound care would be identified) except on days the patient visits the physician for dressing change.

Note: If the physician order specifies a range of visits, the visits must be provided within the range based on the patient's needs, not staff availability. Staff availability is not an acceptable reason for changing the frequency of physician ordered services.

Patient condition changes:

If a home health patient's condition changes, the physician must be notified. If the physician determines an adjustment to the visit frequency is needed, a subsequent physician order should reflect the change. Clinical record documentation must be evident to demonstrate physician notification, information exchange, and subsequent orders, as appropriate.

Documentation of Medications and Diagnoses

The BQA has received questions from providers regarding the following state and federal requirements related to documentation of medications and diagnoses.

- The federal Condition of Participation at 42 CFR 484.55 requires a complete comprehensive assessment of the patient including a drug regimen review of **all** the medications (prescription and over-the-counters) a patient is currently using. The review is not limited to just the medications related to the primary or secondary diagnosis.
- 42 CFR 484.18 (b) of the federal Condition of Participation and Wisconsin Administrative Code, Section HFS 133.20 (3), require that the plan of care be reviewed as often as required by the patient's condition, but no less often than every 60 days.
- Wisconsin Administrative Code, Section HFS 133.21 (5) (f), requires that the home health agency maintain an up-to-date medication list including documentation of patient instructions. The medication list must include **all** the medications the patient is currently taking, including over-the-counter medications.

Based on these provisions, the clinician must complete a "comprehensive assessment" of the patient and their medication regimen and use his/her professional judgement to determine the impact of **all** medications on the patient's total health status.

For example, hypertension or hypothyroidism may not be the primary or secondary diagnosis for which the patient is receiving home care, but such diagnoses and related medications may have significant and pertinent implications for a holistic approach to the patient's care.

The current expectation is that the clinical record reflects documentation to support the reason the patient is taking medications, including over-the-counters. This can be accomplished by including documentation of each medication with either of the following:

- A corresponding diagnosis on the plan of care; or,
- Other supporting clinical record documentation (assessments, summary reports to the physician, and progress notes).

Internal policies/procedures would delineate the agency's expectations related to the location of relevant documentation within the clinical record.

If the skilled clinician determines through the assessment process that the patient is experiencing problems with their medication regimen such as potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy, the physician must be alerted. To maintain compliance with state and federal regulations, the BQA encourages clinicians to consistently incorporate an evaluation of the patient's medication regimen through interview and observation.

BQA Resources

Please direct questions, including question related to the CMS memo, to the following:

- Juan Flores, Health Care Regulatory Southern Unit Supervisor, at florejj@dhfs.state.wi.us or 608-261-7824.
- Jane Walters, Chief, Health Services Section, at walteja@dhfs.state.wi.us or 608-267-7389.
- Barbara Woodford, Nurse Consultant, Provider Regulation & Quality Improvement Section at woodfba@dhfs.state.wi.us or 715-855-7310.