Administrative and Professional Issues for the Occupational Therapist in Home Health Care

(home care services, occupational therapy services, organization and administration, reimbursement mechanisms)

Patricia B. Trossman

Since the enactment of the Medicare legislation in 1965, all types of health services for the homebound have been expanded. The occupational therapist plays an essential role in helping home care patients attain their maximal levels of independence. As more occupational therapists are employed in home health, administrative and professional issues unique to this area of practice have emerged. Some of these issues are discussed in this paper.

The care of most of the patients receiving occupational therapy at home is coordinated by home health agencies. A home health agency (HHA) has been defined by Medicare as a public agency or private organization primarily engaged in providing skilled nursing and other therapeutic services such as physical, occupational or speech therapy, home health aide services, and medical social services. To qualify as an HHA, a public or voluntary nonprofit health agency must furnish skilled nursing and at least one other therapeutic service directly to its patients. The HHA may make arrangements with another public or voluntary nonprofit agency to furnish the services that it does not provide directly. Some additional regulations apply to private organizations (1). Although the Medicaid law does not define “home health agency,” Medicaid regulations define it as a public or private agency or organization, or its subdivision, that satisfies Medicare’s conditions of participation of HHAs (2).

Use of Independent Contractors

Home health agencies can provide occupational therapy services for their patients by hiring full- or part-time occupational therapists or by contracting with occupational therapists who will provide therapy on a fee-for-service basis. The latter method has become more common in recent years.

The use of independent contractors or “contract” therapists has advantages for the HHA and for individual therapists. It is cost...
effective for the HHAs because they need not provide these self-employed therapists with fringe benefits, annual, sick, or educational leave, or equipment. The staff can be expanded or reduced to meet agency needs without making an expensive commitment to full-time employees. Contract therapists maintain a high productivity level, and the HHA is reimbursed for their services by third-party reimbursers at a rate that includes the therapist’s fee and the HHA’s overhead. Thus, the cost of providing occupational therapy services is completely funded by third-party reimbursement.

As an independent contractor, the therapist can have a flexible schedule, which may allow time to develop other practice or interest areas, such as office practice, graduate work, consultation, teaching, or raising a family. In addition, the therapist can benefit from all the other advantages of self-employed status.

Contracts
The contrast between the therapist and the HHA should specify both the agency’s responsibilities and the therapist’s responsibilities. Agency responsibilities include paying the therapist at a specified frequency and rate per visit, coordinating the cases, providing relevant patient information, providing an annual performance evaluation, and supervising peers. The therapist’s responsibilities include being available during certain times to provide therapy, participating in redevelopment of a plan of care, providing documentation on each visit, giving periodic summaries and discharge summaries, attending team meetings, and complying with other state and agency policies.

Some items in the contract are a result of the various organizations that certify or regulate the HHA, such as the Joint Commission on Accreditation of Hospitals (JCAH), which accredits hospital-based HHAs, Medicare, and state regulatory agencies. For example, most contracts require a written summary of progress with revised goals at least every 60 days. Both Medicare and JCAH require that the patient care plan be reviewed and that a written summary report be sent to the primary physician every 60 days (1,3). The therapist should read the contract carefully and ask for clarification of any clauses or regulations that are unfamiliar.

Referrals
New patients are referred to the therapist directly by the HHA. Referrals are usually made by telephone but are followed by a written referral. New patients must be evaluated in a timely manner. In New York, the patient must be seen by the therapist within five days of the referral to the HHA. Saturdays and Sundays are counted whether or not the therapist works on those days. Such requirements differ from one state or another. Therapists should develop systems whereby the HHA can reach them to refer new patients. An answering machine can facilitate such communications, particularly when the therapist is out in the field for much of the day. The voice-activated (VOX) type is recommended; this allows incoming messages of unlimited length so that the HHA can leave complete referral information.

Reimbursement
A working knowledge of third-party reimbursement for home health care is essential to any therapist working in this area. The contract therapist may be new to home health care, and he or she needs to become familiar with reimbursement issues and changes in legislation that may affect coverage of occupational therapy services.

The Medicare Program (Title XVIII of the Social Security Act) provides medical care for the aged and disabled. Beneficiaries include people 65 years old and over, people on Social Security Disability for more than two years, and individuals needing kidney transplants or dialysis. For a Medicare beneficiary to receive home health care, he or she must a) be homebound, b) have services prescribed by and be under the care of an MD, and c) need part-time or intermittent skilled nursing, physical therapy, or speech therapy (1).

The Omnibus Reconciliation Act of 1980 recognized the need for occupational therapy as a qual-
ifing criterion for home health care. This Act was in effect only between July 1, 1981 and December 1, 1981 (4), after which time it was replaced by the Omnibus Budget Reconciliation Act of 1981 (5), which states the following.

Medicare patients may continue to receive occupational therapy under the home health benefit after their need for skilled nursing, physical therapy or speech therapy ends. However, the need for occupational therapy alone will not qualify them for Medicare Home Health Services (chap 1, sect 2122:468).

Although simply worded, this paragraph requires much clarification, and some HHAs are still not allowing occupational therapy to continue after the qualifying skilled services have ended. For occupational therapy to continue, it must begin before those services end. It is my experience that when occupational therapy is the sole service, the case is subject to close scrutiny. Early referral to occupational therapy will decrease the amount of time that such therapy must continue alone. This requires planning with other team members and an understanding of the regulation by all involved.

The Medicaid Program (Title XIX of the Social Security Act: Medical Assistance for the Poor) assumes the major burden for providing home health care for low-income people. Although regulated on a federal basis, Medicaid is a state-administered program that has been implemented in every state except Arizona. The cost of the program is shared between the state and the federal government, with the federal share based on the per capita income. Thus, high per capita income lowers the federal share. States are required by the 1967 Social Security Amendments that went into effect in 1970 to provide home health coverage to Medicaid beneficiaries covered for Skilled Nursing Facility Care. The Medicaid Program differs from Medicare in that “skilled” care is not required, and the patient need not be homebound (2).

The Long-Term Home Health Care Program (LTHHCP) was developed in New York state as a result of the “Nursing Home Without Walls” law passed in 1977 (6). The purpose of the LTHHCP is to provide long-term care to Medicaid patients at home who might otherwise be placed in nursing homes. Some features of the program follow (7).

- A cap is placed on patient expenditures, so that the total cost of home health services is limited to no more than 75% of the average Medicaid cost of maintaining a patient in a residential health care facility.
- Only those patients who would otherwise be eligible for placement in a residential facility are admitted to the program.
- Case coordination and 24-hour management are stressed.

Long-Term Home Health Care Programs are required to provide respiratory therapy, audiology, medical social work, personal care nutritional services, and homemaker and housekeeper services. Many LTHHCPs also provide occupational, physical, and speech therapy (2). The therapist must remember that because of the expenditure cap, there is a strict budget for each patient. Thus the visit frequency of all team members must be worked out carefully with the case coordinator. The LTHHCP may be used as a model for similar programs in other states.

The majority of Blue Cross policies cover home care benefits. By 1981, 61 out of 69 plans provided some type of home care benefits for their 60 million subscribers (2). Under many Blue Cross plans, occupational therapy cannot continue if skilled nursing and physical therapy services have ended. The patient must be receiving skilled nursing or physical therapy services simultaneously. Planning ahead with the physical therapist or nurse can minimize this problem. Occupational therapy coverage by other insurance companies varies and will usually be investigated by the HHA prior to referring the patient.

Each HHA will develop its own system for recording and reimbursing therapists’ visits. The contract therapist may be required to call in visits, submit vouchers or bills, or submit verification of visits, such as the patient or relative’s signature after each visit or

Under many Blue Cross plans, occupational therapy cannot continue if skilled nursing and physical therapy services have ended. The patient must be receiving skilled nursing or physical therapy services simultaneously.
all three. Completion and submission of all progress notes is generally required prior to reimbursement to the therapist.

It has been my experience in New York that the HHA’s reimbursement rate to their contract occupational therapists is often based on salary equivalency guidelines developed by the Health Care Financing Administration for physical and respiratory therapists. These guidelines are periodically published in the Federal Register and are called “Medicare and Medicaid Programs: Schedule of Guidelines for Physical Therapy and Respiratory Therapy” (8). As recommended in the guidelines, the cost of the contract services may not exceed the cost the HHA would incur if it actually employed these staff members. The schedule is based on several factors, including a) a prevailing hourly salary rate based on the 75th percentile of salaries paid by providers for similar services in the geographic area, b) a fringe benefit and expense factor, c) a travel allowance, and d) certain other factors. There is a different rate for each state for adjusted hourly salary equivalency and standard travel allowance (equal to half the hourly salary). The sum of these two is the maximum that may be paid per visit to contract therapists. In rural areas, where distances between patients is greater, therapists may be reimbursed for travel time at one rate and treatment time at another. In urban areas, therapists are usually reimbursed by the visit, at a rate based on the guidelines mentioned earlier.

Although occupational therapy is not specifically mentioned in these guidelines, many New York HHAs still use the guidelines to help equalize reimbursement for all rehabilitation services. However, a specific schedule is used by the Medicare fiscal intermediary to reimburse the HHA, which sets a yearly cost limit for rehabilitation services provided (9). This limit is based on the actual number of visits made by particular disciplines and also on whether or not the HHA is located in an urban area. This schedule includes the HHA’s administrative and salary costs for occupational, physical, and speech therapy, medical social services, skilled nursing, and home health aides.

**Documentation**

Documentation of occupational therapy services is an integral part of the home care therapist’s responsibilities. An evaluation that describes the patient’s functional status and establishes a treatment plan, short- and long-term goals, a progress note on each visit, periodic summaries, and a discharge summary are all required. In addition to any guidelines that the individual HHA may have, the therapist should consult the American Occupational Therapy Association’s book *Standards of Practice for Occupational Therapy Services in a Home Health Program* (10). Dunleavey’s (11) suggestions on service documentation are also useful. In preparing notes, the therapist must be sensitive to the requirements of third-party reimbursers. The Medicare requirement that a patient be homebound is important to remember. An individual does not have to be bedridden to be considered homebound; however, leaving the home should require a considerable and taxing effort (1). A patient who leaves the home may still be considered homebound if these absences are infrequent or for periods of short duration and do not indicate that the patient is able to obtain health care in an outpatient department facility rather than at home. There is an expectation that these absences are for the purposes of receiving medical treatment; however, an occasional nonmedical absence, such as a trip to the barber, is permitted (1). The following is according to the Medicare Home Health Agency Manual (1).

A beneficiary may be considered homebound if he has a condition due to an illness or injury which restricts his ability to leave his place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person, or if he has a condition which is such that leaving his home is medically contraindicated (sect 208.4:163).

Some examples given are as follows (1).

1) a beneficiary paralyzed by a stroke who is confined to a wheelchair or who requires the aid of crutches in order to walk;

2) a beneficiary who is blind or senile and requires the assistance of another person in leaving his place of residence;

3) a beneficiary who has lost the use of his upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., and therefore requires the assistance of another individual in leaving his place of residence, . . . (sect 208.4:163)

The patient must be homebound during the entire course of therapy. As patients recover they gradually become less homebound, and a plan must be devel-
As patients recover they gradually become less homebound, and a plan must be developed for an alternative location for therapy, such as an outpatient clinic, if further therapy is required.

To be covered under Medicare, occupational therapy treatment is also required to be restorative in nature and lead to a "significant practical improvement in the individuals functioning within a reasonable period of time" (sect 205.2:14.14). An example of treatment that might be considered restorative is teaching self-ranging exercises to a patient who has normal range of motion. The physical therapy section of the Medicare Home Health Agency Manual (1) states that, "Generally, range of motion exercises which are not related to the restoration of a specific loss of function but rather are related to the maintenance of function do not require the skills of a qualified physical therapist" (sect 205.1:14.14). I suggest that such treatment does not require the skills of an occupational therapist either. Such nonrestorative treatment should be taught to the home health aide, patient, or family so that the therapist can focus on treatment that is restorative in nature. Appropriate use of terminology is crucial here. Perhaps, in the case of a hemiparetic patient, what the therapist described as self-ranging exercises was actually a form of neurodevelopmental treatment. Bilateral upper extremity activities (with the hands clasped together) have been recommended by Bobath (12) and Davis (13) to accomplish a number of goals, including increasing...
awareness of the affected side, increasing proprioceptive input to the affected side, decreasing flexion synergy by protraction of the scapula and extension of the elbow and wrist, and decreasing spasticity of the hand by placing the fingers and thumb in abduction.

The use of bilateral exercises and activities to meet such goals could be restorative; however, if such activities are only described by the phrase "self-ranging exercises," they may be interpreted as a maintenance program. Progress notes should emphasize the patient's progress toward goals outlined in the initial evaluation. In discussing with therapists the questionable wording of notes, I found that in most cases the treatment actually was restorative and that changes in the wording of the documentation would indicate this more clearly.

The treatment performed by the occupational therapist should not sound like physical therapy. Although both disciplines may be working to improve range of motion or strength, the occupational therapist's notes should emphasize the patient's improvement in functional activities. Reference to modalities that have been traditionally in the domain of the physical therapist can also be a problem. If hot packs, whirlpool, or paraffin are documented in the occupational therapy notes, Medicare will not pay (14). However, those patients who perform more effectively during occupational therapy treatment after application of heat can be taught by the physical therapist to apply the heat themselves prior to treatment. Thus, the documentation can then state that the patient applied heat prior to the therapist's arrival, as instructed by the physical therapist. In most cases where the patient cannot learn to do this independently, an aide or a family member can be taught to assist the patient.

Communication Between Disciplines

The therapist coming to home health care after working in a hospital setting may have grown accustomed to communicating with other team members in team meetings or by walking over to the physical or speech therapy clinic to discuss common problems. In home care, interdisciplinary communications often take place by telephone. When therapists are working on a contract basis, they do not usually have a regular time to be in the office of the HHA. Voice activated answering machines can facilitate interdisciplinary communications. In special cases, a joint visit may be useful. Any communications with other team members should be documented in progress notes. The accrediting agencies look for evidence of teamwork between disciplines when they evaluate the HHA. Such teamwork is usually present, but it is often not documented.

Equipment

Contract therapists are expected to supply the equipment and supplies necessary to perform therapy. The therapist should have samples of commonly used assistive devices to show patients. Items used in therapeutic exercises and activities can be gradually acquired. It may be possible for a therapist to establish a cooperative relationship with an occupational therapy clinic in the vicinity, so that rarely used or expensive items can be borrowed for trial use. A clinic that refers a large number of patients to the HHA may be especially willing to establish such a relationship with the home care therapist. Also, equipment vendors are often willing to lend equipment.

A familiarity with third-party coverage of equipment can guide the therapist in his or her decision regarding a patient's equipment. It can be disappointing to train a patient to use certain equipment and then learn that the patient is unable or unwilling to pay for it. If the patient is to purchase the item, this should be clear from the beginning, and alternatives should be presented.

Medicare will pay for certain types of durable medical equipment, such as hospital beds, canes, wheelchairs, walkers, and bedside commodes. A complete list of covered equipment is available from many equipment vendors. Medicare will not pay for bathroom equipment such as tub seats, tub benches, raised toilet seats, and grab bars (1). These items have inexplicably been classified as comfort or convenience items, not primarily medical in nature. Most occupational therapists would question the wisdom of this classification system. When the patient is unable to purchase such items, the therapist should be able to suggest innovative alternatives. For example, a bedside commode, with its pail removed, often fits over the toilet and can substitute for a toilet safety armrest and raised toilet seat. If the patient uses the commode at bedside at night, an aide or family member can move it into the bathroom during the day. Certain walkers can be placed over the toilet to substitute for toilet safety armrests. A kitchen chair placed on a
bathmat may substitute for a shower chair or tub seat.

Splinting materials and adaptive devices are not covered as durable medical equipment by the Medicare Program; however, according to a Medicare A Intermediary Letter (dated Oct 1980), these items should be covered as medical supplies (15). Medical supplies are delivered to the patient and billed to the HHA. However, budgetary constraints have forced many HHAs to limit severely the kind and number of medical supplies they will provide. A unified effort by occupational therapists working in home health care is required to make sure that these items are routinely provided for patients as medical supplies.

The Medicaid Program will pay for durable medical equipment, including bathroom equipment, splinting materials, and assistive devices. Prior approval is required for items that cost over a certain amount and for unusual items not routinely ordered. This approval is facilitated by a letter accompanying the order from the therapist, the physician, or both.

Standards of Practice and Ethical Issues

Some HHAs have standards regarding the length of time spent on a therapy visit, whereas others leave this to the discretion of the therapist. Lacking an agency standard, therapists must establish their own standards. I recommend 30–60 min per visit, with an average visit lasting 45 min. If less than 30 min is being spent per visit, perhaps the patient does not really need occupational therapy. If more than 60 min is being spent, the patient may need to be visited more frequently. The length of time spent with a patient should have some relationship to the extent of the patient’s problems. Visits to a hip fracture patient to work on lower extremity dressing may be shorter than visits to a hemiplegic patient who has motor, sensory, perceptual, and activities of daily living (ADL) problems.

There are no official standards as to the frequency and duration of occupational therapy treatment. If the doctor has not specified a particular visit frequency, the therapist must establish a frequency and predict, based on experience with similar patients, the expected duration of occupational therapy services. This information is included in the overall plan of care, which is certified by the MD. With Medicare patients, the therapist must keep in mind the requirement that treatment be restorative and that significant practical improvement take place in a reasonable period of time (1, sect 205.2:15.2). It is important not to overtreat the patient. Medicare, in particular, will not continue paying for treatment until the patient is totally recovered or ADL independent. According to the Health Care Financing Agency, reimbursable ADL activities are those which enable the patient to achieve a level of semi-independence. Clear examples of these types of activities are eating, dressing and personal hygiene. Activities designed to reach a level of total independence are not considered reimbursable. A narrow distinction frequently separates the two types of activities. Borderline cases will require an individual assessment of all the factors involved in the situation (14, p 23).

These requirements may be interpreted differently by different intermediaries. Problems can be eliminated through the occupational therapist’s proper documentation and good judgment as to what period of time is reasonable.

It is important to establish the professional nature of the occupational therapist’s relationship with the patient and family on the first visit. It can be exhausting for the family if they perceive the therapists and other professionals as guests whom they must entertain. Therapists can alleviate this strain by making it clear that they are there to perform a professional service. When working in a clinic-based setting, therapists may feel comfortable making recommendations because they are in their own territory. However, the home is the territory of the patient and family, and some of the therapist’s recommendations may affect that environment. For example, a therapist’s request to rearrange the furniture, to give more room or a safer environment, requires both diplomacy, and the ability to compromise and collaborate.

After their home health benefits have ended, patients may approach the therapist to continue treating them privately. The ther-
apist should check with the HHA to find out if such activities are restricted. Because there is currently no Medicare coverage for private occupational therapy, I feel that the Medicare patient should be informed of the availability of outpatient occupational therapy, which is partially covered. The patient can then choose the alternative that is most cost effective and convenient.

Challenges

Home health care continues to be an exciting practice area for the occupational therapist. The advent of diagnostic-related groups and other changes in reimbursement for inpatient care allow patients to leave the hospital sooner. The home care therapist will be performing more functions that have more traditionally taken place in the acute hospital setting or the rehabilitation center. This will require closer collaboration with referring hospitals, along with a continued need to educate legislators, the medical community, and the consumer about the role of occupational therapy.

REFERENCES

5. Omnibus Budget Reconciliation Act of 1981, Elimination of occupational therapy as a basis for initial entitlement to home health services, USC §3892, chap 1, sect 2122.468
9. Medicare program; schedule of limits on home health agency costs per visit for cost reporting periods beginning on or after July 1, 1984, Federal Register 49:128, 27272-27286, July 2, 1984
10. Standards of Practice for Occupational Therapy Services in a Home Health Program. Rockville, MD: AOTA, 1979