CMS Revises Appendix B

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The Centers for Medicare & Medicaid Services (CMS) has issued revisions to the Medicare State Operations Manual, Appendix B, Also referred to as the Interpretive Guidelines for the home health Conditions of Participation(CoPs).

CMS has made several conforming changes to the regulatory tags and interpretive guidelines based on several final rules that have amended the home health agency (HHA) CoPs. Additionally, CMS combines the HHA survey protocol and interpretive guidelines into one document, updating Level 1 tags, and making clarifications and technical corrections to other guidance areas based on stakeholder feedback.

A general summary of the changes follows:

- Retires CMS memos that are no longer applicable or have been incorporated into Appendix B.
- Adds the survey protocol for HHAs to Part I of Appendix B. Appendix B replaces older CMS memos that we are retiring and describes the requirements and procedures for conducting an HHA survey.
- Revises the Level 1 standards that surveyors must assess during a standard survey.
- Added three Emergency Preparedness tags to Level 1 standards. A partial extended survey is conducted when noncompliance is identified in any Level 1 Standard.
- CMS no longer identifies specific Level 2 standards; instead, when noncompliance with a Level 1 standard is identified, all remaining standards within the relevant CoP are evaluated, and a determination must be made as to the compliance with the condition.
- Revises tags to reflect updated regulatory language based on final rules and adds interpretive guidance where appropriate.
- Consolidates tags to remove redundancy.
- Adds survey procedures to multiple tags to assist surveyors in assessing compliance with the regulatory requirements.
- Adds a cross-reference to Appendix Z for the HHA emergency preparedness tags.
- Makes multiple technical and formatting revisions to fix regulatory citations, acronyms, and tag titles.

CMS has made several positive changes to the appendix, both in terms of layout and substantive changes to several of the interpretive guidelines. For example:

§484.55(c) Standard: Content of the comprehensive assessment.

(c)(5) A review of all medications the patient is currently using … CMS has modified the guidance to no longer require the RN review the medication list in therapy cases, and states:

- "Each agency must determine the capabilities of current staff members to perform comprehensive assessments, considering professional standards or practice acts specific to the State. No specific discipline is identified as exclusively able to perform the medication review. However, only Registered Nurses (RNs), Physical Therapists (PTs), Occupational Therapists (OTs) and Speech-Language Pathologists (SLPs) are qualified to perform comprehensive assessments (see also §484.55(b)). While only the assessing clinician is responsible for accurately completing and signing a comprehensive assessment, the agency may develop a policy where clinicians may collaborate to collect data for all OASIS items. For example, to assess potential side effects and drug interactions, the agency may wish to have RNs or practical (vocational) nurses, as defined in §484.115, review the mediation lists."

§484.60(a)(2) The individualized plan of care must include the following: (i) All pertinent diagnoses.

CMS revises the definition for pertinent diagnoses to not require all known diagnoses,

- "In general, pertinent diagnoses include, but are not limited to, the chief reason the patient is receiving home care and the diagnosis most related to the current home health plan of care. Additionally, comorbid conditions that exist at the time of the assessment, that are actively addressed in the patient's Plan of Care, or that have the potential to affect the patient's responsiveness to treatment and rehabilitative prognosis should be considered and documented."

§484.80(g)(1) Standard: Home health aide assignments and duties.

CMS clarifies that when both nursing and therapy services are involved, either skilled professional may assign home health aides and develop written patient care instructions.

§484.105(b)(1) Standard: Administrator. The administrator must: (i) Be appointed by and report to the governing body. CMS removed the definition for "reports to" that prohibited the administrator from using intermediaries when reporting to the governing board.