Home Care Accreditation

Q&A Guide

Concise answers to frequently asked questions about how to begin the accreditation process, whom to call with questions and much more!

- Home Health
- Hospice
- Personal Care
- DMEPOS
- Pharmacy

The Joint Commission
Accreditation
Home Care
Home Care Frequently Asked Questions and Answers

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**Appendix A**
Accreditation Basics

What are the requirements to become accredited?

Our requirements for accreditation fall into 3 primary categories:

- Accreditation Participation Requirements (APRs)
- The Standards
- National Patient Safety Goals

All of these requirements can be found in the Comprehensive Standards Manual for Home Care that you will receive free-of-charge upon receipt of your application deposit. You will receive both a hard copy print version and new e-dition of the manual approximately 3 weeks after your deposit is processed.

You can purchase the Standards Manual in advance. Please visit www.jcrinc.com to order online.

NEW! You can also request free 60 day trial access to our online standards manual! Contact us at 630.792.5070 to learn more or visit the home care page on our website at www.jointcommission.org.

What are your accreditation fees?

Joint Commission fees on average consist of an $1100 annual fee and an on-site fee of $2,935 (payable once every three years). If you have more than one location (than is not simply a warehouse location), additional branch fees would also apply.

Our annual and on-site fees are based upon an average daily census (ADC) ranges for each eligible home care service your organization provides. An ADC represents those that have been admitted to your organization, but not discharged, for which you have ongoing care or service responsibilities. If your organization has had a relatively stable population, then a sample from a few representative days should be sufficient in determining ADC.

We encourage organizations to contact us for a free quote at 630.792.5070.

Can we have only part of our organization accredited?

Joint Commission accreditation is for your entire organization, not individual services.

We will survey all services for which we have applicable standards and make one accreditation decision for your organization. If, for example, you provide both home health and home medical equipment services, we must include both of these services in your survey.

At the request of an organization, we will evaluate whether a related organization may be excluded from the scope of an accreditation survey. If this is acceptable, your
organization must make it clear to the public that the related organization is not included in the scope of its accreditation.

**My home health agency is considering the deemed status survey option. How does this process work?**

If your home health agency is eligible for Medicare certification, you may choose to participate in a modified Joint Commission accreditation survey that can be used for both accreditation and for Medicare certification (called deemed status).

If you choose this option, The Joint Commission will conduct an unannounced survey that will replace the Medicare survey usually conducted by your state agency. Once we accredit you through this process, CMS will deem your organization to be in compliance with federal standards, the Conditions of Participation for home health agencies. CMS retains the authority to conduct random validation surveys and complaint investigations for Medicare-certified organizations.

The deemed status option applies only to organizations that meet the Medicare definition of a home health agency and are eligible for certification as determined by federal regulations. To participate, CMS requires organizations seeking home health deemed status provide skilled nursing services and at least one other therapeutic service to a minimum of 10 unduplicated patients (in the last 12 months) with 7 active and receiving skilled care at the time of survey. Additionally, 5 home visits must be made for CMS to consider your survey complete. All of the 5 visits must be made to patients receiving skilled care.

Organizations selecting this option should have completed and verified their CMS 885a form prior to completing a Joint Commission application. Initial organizations must also provide proof of a successful OASIS transmission, and notify their state they intend to utilize Joint Commission accreditation for Medicare certification.

On average, the on-site deemed status survey fee is $3,800 for most organizations. If you are a currently accredited organization interested in pursuing this survey option please contact your Account Executive at 630.792.3007. General questions from prospective customers on this option can be directed to 630.792.5070.

**My hospice organization is considering the deemed status survey option. How does this process work?**

Hospice deemed status surveys, like home health deemed status surveys, must be unannounced. The deemed status option is open to organizations seeking Medicare funding for hospice services as well as those already Medicare certified. Organizations choosing that option will be evaluated against both Joint Commission standards and Hospice Medicare Conditions of Participation. Accreditation remains voluntary and seeking deemed status through accreditation is not a requirement for Medicare certification.

The deemed status option applies only to organizations that meet the Medicare definition of a hospice agency and are eligible for certification as determined by federal
regulations. To participate, CMS requires organizations seeking hospice deemed status have served minimum of 5 unduplicated patients in the last 12 months with 3 active patients at the time of survey.

Organizations selecting this option should have completed and verified their CMS 885a form prior to completing a Joint Commission application.

Please contact your Account Representative at 630.792.3007 if you are a currently accredited organization interested in pursuing this survey option. General questions from prospective customers on this option can be directed to 630.792.5070.

**Will my survey be announced or unannounced?**

If you are using your survey to meet Medicare certification requirements, your survey will be unannounced. Check your extranet site each morning after the noted “ready” month provided on your application to see if a surveyor is arriving that day.

If you are not using your survey to meet Medicare certification, your initial survey can be announced. You will be notified of your survey dates 30 days in advance on your extranet site.

**Basic Eligibility**

**What types of services are eligible for home care accreditation with Joint Commission?**

**Home Health Services**
Home health services involve the provision of any health care services by health care professionals to a patient in his or her place of residence. These services include, but are not limited to, performance assessments; provision of care, treatment, or counseling; and/or monitoring of the patient’s health status by nurses (both intermittent skilled and private duty), occupational therapists, physical therapists, speech-language pathologists, audiologists, social workers, dietitians, dentists, physicians, and other licensed health care professionals in the patient’s home. It also includes the extension or follow-up of health care services provided by hospital professional staff in the patient’s home.

**Personal Care and/or Support Services**
Personal Care and/or Support Services involves the provision of assistance because of a health-related condition with personal care, activities of daily living, or management of household routine by paraprofessional staff to a patient in his or her home. These services include the provision of services by home health aides, personal care aides, home attendants, nursing assistants, companions, and homemakers.

**Hospice**
Hospice is an organized program that consists of services provided and coordinated by an interdisciplinary team to meet the needs of a patient who is diagnosed with a terminal illness and has a limited life span. The program specializes in palliative management of
pain and other physical symptoms, meeting the psychosocial and spiritual needs of the patient and the patient’s family, use of volunteers, and provision of bereavement care to survivors. Hospice includes, but is not limited to, all programs licensed as hospices and Medicare-certified hospice programs. All services provided by the hospice (for example, pharmacy, home medical equipment services) and care provided in all settings (for example, inpatient, nursing home) are included.

**Deemed Status Option for Home Health and Hospice**

Through a specific survey option with The Joint Commission, the home health agency or hospice organization can achieve deemed status, and not be required to undergo a separate Medicare survey from the State agency. The deemed status option is one way of combining compliance activities and reducing duplicative regulatory surveys.

**DMEPOS Services**

To be eligible for Joint Commission accreditation for HME services, your organizations must provide durable medical equipment, prosthetics, orthotics, and/or supplies (DMEPOS) to patients either directly in their place of residence or through the mail. Organizations are also eligible for HME accreditation if they bill Medicare Part B DMEPOS, regardless of where the services are provided.

**Clinical Respiratory Services**

These are defined as the provision of health care services by respiratory therapists and/or other health care professionals to patients in their place of residence, and in conjunction with the provision of HME by the same organization. This includes, but is not limited to, performing assessments and testing, administration of treatment, medication administration, provision of clinical education, and/or monitoring of the patient’s respiratory status.

**Rehabilitation Technology**

Rehabilitation technology services may be provided as a stand-alone service or as a component of home medical equipment services. These services enhance the lifestyle of physically challenged individuals through the sale and rental of custom medical equipment and ongoing evaluation by trained rehabilitation technologists. These services include, but are not limited to, those related to customized mobility systems, seating and positioning systems, and adaptive equipment (for example, aids to daily living, artificial speech, hearing, and visual devices). These services may be provided in the patient’s home, rehabilitation clinics, schools, or the home care organization’s facility.

**Pharmacy Services**

Pharmacy Services involve the provision of pharmaceutical care and services involving the preparation and dispensing of medications, medication-related devices, and supplies by a licensed pharmacy, with or without the provision of clinical or consultant pharmacist services. These services include, but are not limited to, pharmacy services provided to a patient in his or her home, long term care pharmacy services, and ambulatory infusion as defined below; but it specifically excludes community pharmacy practice.

**Pharmacy Dispensing Services**

These services involve the dispensing of medications, medication related supplies and equipment, and other related services by a licensed pharmacy. These services also include the provision of the professional services of a pharmacist as a component of the dispensing process to ensure appropriate and safe medication use (for example,
prescription review, medication profile review, patient counseling) as mandated by law
and regulations and by standards of practice.

Clinical/Consultant Pharmacist Services
These services involve the provision of professional care and services by a qualified
pharmacist to optimize outcomes of medication therapies and minimize the adverse
effects of medications. These services include, but are not limited to, assessment of the
appropriateness of medication orders, the ongoing evaluation and review of the patient’s
medication regimen and pharmacy care plan, the ongoing monitoring of medication
effects in individual patients, the provision of drug information, oversight of the
medication use process to improve patient safety, and other related cognitive
medication-related services.

Long Term Care Pharmacy Services
These services involve the provision of pharmacy dispensing services to patients
residing in a nursing home or another long term care facility where regular nursing care
is provided.

Freestanding Ambulatory Infusion Services
These services involve the dispensing and administration of drug therapy by infusion or
inhalation, as well as related services, under the supervision of a licensed health care
professional (for example, a nurse) to ambulatory patients in a room or an office at a
home care organization site that is not an extension of a physician’s office or hospital or
part of a larger ambulatory home care organization.

How many patients do I need to be accredited?

For a particular service to be accredited it must be considered “active.” Active is defined
as having provided one or more services to 10 or more patients in the last 12 months.

Second, a minimum of 2 active patients are required at the time of your on-site survey.

There are instances where we require a larger number of “active” patients. For example,

For home health deemed status surveys, 7 active patients are required.

For hospice deemed status service, 3 active patients are required (The minimum
number of patients served for this survey option is 5 in the past 12 months. This applies
to deemed status hospice only).

If you do not have an eligible patient on service at the time of survey or do not meet the
criteria for an active service, you may apply for provisional accreditation. However you
must be providing services to an eligible patient at the time of your next survey (six
months later).
I am a start up and/or don’t have any patients yet. What are my options for accreditation?

The early survey option may be just for you. You are not required to have any active patients to be surveyed under this option. However, it is only available to organizations accredited for the first time and includes 2 onsite visits. Please call us to learn more at 630.792.5070.

If we have sites and patients in another country (i.e., Mexico, Canada, Puerto Rico), can we still be accredited?

We cannot survey sites located in other countries that are not part of the United States and its territories, unless it is owned by the United States Government. Hence, we could not survey sites located in Canada and Mexico (unless they were a US military base), but can survey sites in Puerto Rico, Guam, etc. We can survey patients located in other countries, if they are serviced from a site in the United States.

The Application Process

How do I apply for accreditation?

To request access to our online application please visit www.jointcommission.org/applicationhomecare.

Within 3 business days, you will receive an email containing a special password to access your dedicated extranet site where the online application is housed.

If you have questions on completing the application, you can contact your assigned account executive at 630.792.3007 or our home care team at 630.792.5070.

How soon after I apply can/will I be surveyed?

On the application, under the “Initial Surveys” section, new organizations can note a month by which they will be ready to have their on site survey conducted. This means, The Joint Commission will not send a surveyor to the organization prior to that time; however they can arrive anywhere thereafter.

Organizations new to Joint Commission accreditation can be surveyed as soon as four months after their completed application with deposit are processed. However, the key issue is whether you are ready to be surveyed. If your organization is just beginning to prepare for survey at the time of application, you should request to be surveyed at least four to six months later. Your application for survey is valid for 12 months from the date it is submitted.
How will I know that my completed application was successfully received?

You will receive a confirmation email with 24 hours of submitting your completed online noting it was successfully received. If you do not receive one, please call your account executive directly or at 630.792.3007.

When do I need to pay my application deposit?

A non-refundable deposit of $1700 is required to process your completed application and can be paid online from your dedicated extranet site. We suggest a deposit be made after you receive your email confirmation that your application was successfully received.

Standards/Accreditation Requirements

How soon after I submit my application and deposit can I expect to receive my free standards manual?

You will receive your free hard copy and e-dition of the most recent Comprehensive Standards Manual for Home Care approximately 3 weeks after receipt of your deposit.

Who can I call if I have a question about a standard?

To access our Standards FAQs online, go to www.jointcommission.org/standards/faqs. If you don’t find your answer there, you can call 630-792-5900 or complete our online standards form on our website.

How do I know if the services my respiratory therapists provide require that I comply with the additional Clinical Respiratory Standards?

It is the services provided, not the category of personnel that determines if clinical respiratory services are provided by an organization. For example, a respiratory therapist or nurse can deliver, set-up equipment, and educate the patient on the use of the equipment without providing clinical respiratory services.

See appendix A for a helpful decision tree and detailed examples you can use to determine if the services your therapists provide fall into our definition of clinical respiratory services.

Who determines if my organization must “monitor” a patient?

Generally, the determination of whether monitoring should be included within the scope of services provided by an organization is the responsibility of the leadership of the organization.
We would expect the organization to identify on their application if they provide clinical monitoring service (i.e., clinical/consultant pharmacy services). However, the Joint Commission will also consider the organization as providing these services under the following circumstances:

- When clinical monitoring is required by contract or written agreement.
- When clinical monitoring is being advertised as being provided by the applicant organization.
- When clinical monitoring or other clinical pharmacist functions were provided to 10 or more patients in the past 12 months.
- When Home Health Services or Clinical Respiratory Services are also provided to the patient (since our standards require these services to monitor the patient's drug therapy, and require that drug therapy monitoring be interdisciplinary and collaborative).
- When no other health care professional is monitoring the patient's drug therapy and patient is at high risk of a sentinel event as a result (i.e., receiving high dose gentamicin therapy).

Clinical monitoring is not required:

- When physician or contract so indicates.
- When monitoring would be duplicative. Such as when monitoring performed by another pharmacist or the physician during outpatient visits.
- When the drug and patient situation is considered low-risk and requires no monitoring.

### On-site Survey

**How will I know when my on-site survey will be conducted?**

Applicant organizations are advised to check their secure extranet site at 7:30 am each morning beginning at the noted “ready month” on their application to determine if a surveyor will be arriving that day.

The surveyor’s name, photograph and survey agenda will also be posted on the secure extranet site.

**How long does the on-site survey last?**

The length of your survey will depend on the number of home care services you provided, your patient volume (average daily census) for each service, the number of your sites and their distance from the main site.

On average, most home care surveys are 2 days in length. Deemed status surveys for home health and/or hospice organizations are typically 3 days in length.
How do we know which affiliated companies or joint ventures will be included in our survey?

Home care services provided through an affiliated company or a joint venture may be included in the scope of your survey if there is an organizational and functional relationship between the companies or public representation of the affiliated home care services you provide. This rule may also apply to hospitals affiliated with home care organizations as well as two home care or hospice organizations that are affiliates of each other.

Each organization’s situation is considered individually. We encourage organizations offering home care or hospice services through a joint venture or an affiliated company to contact Home Care Accreditation Services to determine if these services should be surveyed. You may also refer to the “Official Accreditation Policies and Procedures” chapter of the Comprehensive Accreditation Manual for Home Care, under “Scope of Accreditation Surveys” for a detailed description of organizational and functional relatedness.

What is a corporate system survey?

A home care corporate system is a multi-office national or regional organization with six or more eligible applicant or accredited locations sharing common governance and leadership. If your organization meets these criteria and intends to submit at least six applications for survey, you must participate in the Joint Commission’s corporate survey process.

The survey scope for your organization may include multiple sites but may not exceed one span of administrative control (your organization’s structure and the manner in which responsibility and authority are delegated to your locations and staff). You may group locations which share a common administrative, management, or supervisory component, but you are limited to one level of your administrative hierarchy.

This multi-office organization survey (corporate survey) begins with a one day survey at your corporate office. The survey is conducted by a survey team assigned specifically to your organization, led by a Joint Commission central office representative. The same team will survey all your applicant organizations. The corporate survey will focus on applicable leadership, governance and management standards, corporate policies and procedures, and organization-wide performance improvement activities.

The home care program works with your organization to plan the sequence of surveys for your offices or regions. For further information about survey fees and the corporate survey process, contact the Joint Commission at 630.792.5070.

What if patients are serviced by a department of a hospital? Is this part of the hospital survey or the home care survey?

It does not matter whether home care services (as defined by the Joint Commission) are provided by a particular department of a hospital. Survey eligibility is based on all patients within the organization. Thus, if both the home health and respiratory care
departments of a hospital separately provide eligible home care services, then both groups of patients are included in the survey process for home care.

**When will we get our final report?**

Organizations receive a summary of findings at the conclusion of their on-site survey. If your organization receives any Recommendations for Improvement (RFIs) you will then need to submit Evidence of Standards compliance (ESC) to The Joint Commission within 30 days before your final report can be issued. Your organization is retroactively accredited to the day your ESC is accepted. You may not market your accreditation until you receive the final written report.

**Contracted Services**

**How do we know which service agreements and contracted services will be included in our survey?**

For the purposes of home care accreditation, applicable services provided by organizations or individuals through written agreements or contracts are surveyed for compliance with Joint Commission standards. On the application for survey, make sure you list all contractual arrangements for services provided on your behalf.

For example, if you contract for home medical equipment (HME) services, your organization's survey will also include the contracted HME company or individual. Any recommendations resulting from the contracted organization's service delivery on your behalf become part of your organization's accreditation report and influence your organization's accreditation decision.

If you provide services on behalf of another organization, these patients will also be included in the scope of your organization's survey, but you do not need to identify these contracts on your application.

**What if these services are provided for us, but we don’t have a contract or written agreement?**

These services are still included in the scope of the survey and our standards require a written agreement for such services.

**What if our organization has a contract with an accredited organization?**

If the provider of your contracted service is already accredited or has applied for accreditation at least 120 days in advance of your survey date, we will waive the on-site survey of your contracted service. If the contracted organization is awaiting survey, this organization must be accredited within six months of your survey. If the organization is currently accredited by the Joint Commission, we will not visit the contracted organization's offices, unless there are extenuating circumstances.
However, even though we may waive the on-site survey, we will evaluate how well you manage your contracted services and the coordination of care and service between your organizations. For example, we may conduct a home visit for a patient who receives services from the contracted organization. These elements of the survey process are based on the relationship between your organization and the contracted organization.

The Joint Commission retains the right to visit the contracted provider's sites if an event during the survey indicates that this is advisable. For example, if during a home visit to a patient receiving HME services from a contracted provider, the patient complains that equipment was not operational when it was delivered, the surveyor may choose to visit the contracted organization's warehouse to review how the HME service maintains patient-ready equipment.

**Does The Joint Commission require contracted services to be accredited?**

No. Although all eligible contracted services provided on behalf of the applicant organization are included in the scope of the survey process, only unaccredited contracted services will be visited on site. Because recommendations made during site visits to contracted providers appear on the applicant organization's final report, many organizations prefer to deal exclusively with accredited providers, but this is not a Joint Commission requirement. Some contracted HME services may need accreditation to meet the Centers for Medicare and Medicaid Supplier Standards. Contact us at 630.792.5070 for further information.

**After You’re Accredited**

**What happens to my accreditation when I sell my organization or am acquired by another organization or move? If I add a new service, is it automatically accredited until the time of my next survey?**

We do not automatically transfer accreditation to new owners who acquire an accredited health care organization. Accreditation will not continue if significant changes occur from those existing at the time of the previous survey.

An accredited organization must notify us no more than 30 days after it merges, is acquired, or undergoes any major change in services, location, capacity, or corporate structure. We will extend accreditation until we can determine if a special survey is necessary. Failure to notify us of ownership and service changes can result in a loss of accreditation.

Accredited organizations are encouraged to call their account executive with questions on this topic. Their main number is 630.792.3007.

To access the online Organizational Update Form, go to: [http://www.jointcommission.org/Organization_Update_Form/](http://www.jointcommission.org/Organization_Update_Form/)
Does The Joint Commission have any tools I can use to publicize my accreditation achievement?

Yes! To view the contents of our online publicity kit, go to: http://www.jointcommission.org/accreditation/accreditation_publicity_kit.aspx. It includes downloadable images of our Gold Seal of Approval™, sample news releases, and much more!

**Quality Check Directory of Providers**

How do I find out how other health care facilities rate with the Joint Commission?

With our online Quality Check™, you can "check up" on the performance of health care facilities, by reviewing their latest Quality Report. Or visit www.qualitycheck.org.

How do I register a complaint about a health care organization?

For more information please call our Office of Quality Monitoring at 800-994-6610.
Appendix A

Is Your Organization Providing Clinical Respiratory Services?

This flyer can help you determine if the specific services your organization provides meet The Joint Commission’s definition of Clinical Respiratory Services. See the reverse side for a decision tree.

<table>
<thead>
<tr>
<th>No, Not Clinical Respiratory Services</th>
<th>Yes, Clinical Respiratory Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Respiratory Care Practitioner (RCP) fits a patient for a CPAP mask in an outpatient clinic, M.D. office.</td>
<td>The Physician orders the Respiratory therapist to set up an apnea monitor and teach the family how the monitor works to alert them that their child is not breathing. The therapist also teaches the family how to safely position the child and determine if the child’s breathing pattern indicates a need to see the doctor.</td>
</tr>
<tr>
<td>The home care technician drops off a box and then shows the patient how to put on the finger probe for an overnight pulse oximeter. The next day the box is retrieved from the patient’s home and the information is downloaded to the clinic where the doctor will interpret the results.</td>
<td>The Respiratory Care Practitioner receives an order from the physician to conduct a respiratory therapy assessment on a patient scheduled for lung transplant surgery; so that he/she can recommend to the doctor, the respiratory equipment the patient may need in his home after surgery.</td>
</tr>
<tr>
<td>The RN or Respiratory Care Practitioner (RCP) visits the patient and does a pulse oximeter (pulse ox) as part of taking the patient’s vital signs.</td>
<td>The RCP is ordered to see the patient twice a week for 2 weeks to teach the patient about sleep apnea, fit her for her CPAP and evaluate how she is progressing.</td>
</tr>
<tr>
<td>The Respiratory Therapist employed by the pharmacy instructs the patient how to use their nebulizer before they leave the facility.</td>
<td>The Respiratory Therapist visits the patient, on the order of the physician to evaluate the patient to see if the patient should be switched to a BiPAP machine.</td>
</tr>
<tr>
<td>The RCP checks the patient’s oxygen saturation using a pulse ox to ensure the patient is getting enough oxygen.</td>
<td>On the orders of the Nurse Practitioner, the RCP evaluates a patient for the use of a pulse dose system so that the patient can return to work part-time.</td>
</tr>
<tr>
<td>The home care technician teaches a patient how to switch over to their portable oxygen set up.</td>
<td>The RCP downloads and evaluates the results of an overnight oximetry that was done on a patient. The RCP calls and discusses the results with the physician who provides additional orders to change the CPAP set up and bleed in oxygen.</td>
</tr>
<tr>
<td>The Respiratory Therapist does a pulse ox to determine if the patient is getting enough oxygen. Some time later, the doctor says increase the oxygen to 3 liters per minute (LPM) and the home care technician visits to deliver additional portable cylinders and ensure the flow rate is set correctly at 3 LPM.</td>
<td>The Respiratory Therapist, on the orders of the physician, visits the patient’s home to teach the patient and family how to administer the nebulized morphine and how the medication works to alleviate the patient’s air hunger.</td>
</tr>
</tbody>
</table>

FAQ: Is a physician/licensed independent practitioner’s order required for the use of a pulse oximeter?

ANS: No, not unless required by State Law/Practice Act. Currently, there are no Federal Regulations, including FDA, that compel an appropriately licensed professional to get an order.

FAQ: Does the use of a pulse oximeter, one time or occasionally, mean that the patient is receiving clinical respiratory services?

ANS: No. Use the decision tree provided on the reverse side to determine if the individual qualifies as a patient receiving clinical respiratory services.
Is Your Organization Providing Clinical Respiratory Services?

DECISION TREE FOR CLINICAL RESPIRATORY SERVICES

Is a licensed health care professional or respiratory therapist providing services?

Yes

CRS

No

Are services provided in the patient’s place of residence?

Yes

NOT CRS

No

Are services provided in association with equipment provided by the organization?

Yes

The licensed professional (RCP, RT, RN) provides ‘respiratory care’ as defined by the State Scope of Practice under the direction of a Physician/Licensed Independent Practitioner. Examples of respiratory care services include:
- Observation and Monitoring the patient
- Teaching Disease Process
- Evaluation for the Use of an Oxygen Conserving Device

No

Are at least one of the following services provided?

Yes

No

The Sum of All Services have been Provided to 10 Patients within the last 12 Months.

For additional questions please contact us directly at 630.792.5251.