

CATEGORY 2 - COMPREHENSIVE ASSESSMENT

Q1. Are OASIS data collected on patients that are recertified or only on patients that are transferred or discharged?

A1. The condition of participation (CoP) published in January 1999 requires a comprehensive patient assessment (with OASIS data collection) be conducted for all adult, nonmaternity patients receiving skilled care at start of care, at resumption of care following an inpatient facility stay of 24 hours or longer, every 60 days or when there is a major decline or improvement in patient's health status, and at discharge or transfer to an inpatient facility.

OASIS data collection, effective December 8, 2003, is required for skilled Medicare and skilled Medicaid patients only. Section 704 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (<http://www.treas.gov/offices/public-affairs/hsa/pdf/pl108-173.pdf>) temporarily suspends the requirement that Medicare-certified home health agencies collect OASIS data on non-Medicare/non-Medicaid patients. Note that the CoP at 42 CFR sections 484.20 and 484.55 require that agencies must provide **each** agency patient, regardless of payment source, with a patient-specific comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward the achievement of desired outcomes. The comprehensive assessment must also identify the patient's continuing need for home care, medical, nursing, rehabilitative, social, and discharge planning needs. If they choose, agencies may continue to collect OASIS data on their non-Medicare/non-Medicaid patients for their own use.

A Survey and Certification Memo (#04-12) sent to surveyors on 12/11/03, further explains the requirement change. It is accessible at <http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopofPage> (Search for 04-12)

Note that a private pay patient is defined as any patient for whom M0150 Current Payment Source for Home Care does **NOT** include responses 1, 2, 3, or 4. If a patient has private pay insurance in conjunction with M0150 response 1, 2, 3, or 4 covering the care the agency is providing, then OASIS data must be collected (this includes patients for whom Medicare may be a secondary payer). [Q&A EDITED 08/07]

Q2. In my agency, we have 'maintenance' type patients. For example, in one case a monthly visit was made on March 20, 2000, and we found that a patient had been hospitalized March 2, 2000. We were not notified of that hospitalization. The patient had returned home, and no problems were noted. What would I need to do to comply with the OASIS collection requirements?

A2. In most cases, a hospitalization of 24 hours or more, which occurs for reasons other than diagnostic testing, is a significant event that can trigger changes in the patient and may alter the plan of care. When you learn of a hospitalization, you need to determine if the hospital stay was 24 hours or longer and occurred for reasons other than diagnostic testing. If the hospitalization was for less than 24 hours (or was more than 24 hours but for diagnostic purposes only), no special action is required. If the hospitalization did meet the criteria for an assessment update, complete an assessment that includes the Transfer to Inpatient Facility OASIS data items using response 6 in M0100 - Reason Assessment is Being Completed. Enter March 20, 2000, as the response to M0090 (the date you learned of the hospitalization) and March 2, 2000, in M0906 (the actual date of

the transfer). You have 2 days from the point you have knowledge of a patient's return home from an inpatient stay to complete the Resumption of Care assessment, selecting response 3 for M0100. M0090 will be the date the assessment is actually completed. The Resumption of Care Date (M0032) would be the first visit after return from the hospital, i.e., March 20, 2000 in this example. When completing the Resumption of Care (ROC) assessment, follow all instructions for specific OASIS items. For example, in responding to M0175, when the inpatient facility discharge date was more than 14 days prior to the ROC date, NA is the appropriate response. M0180 and M0190 thus will not be answered. [Q&A EDITED 08/07]

Q3. Do we have to complete an OASIS discharge on a patient who has been hospitalized over a specific time period?

A3. The agency will choose one of two responses to OASIS item M0100 when a patient is transferred to an inpatient facility for a 24-hour (or longer) stay for any reason other than for diagnostic testing:

M0100=6 - Transfer to an Inpatient Facility--patient not discharged from agency; or

M0100=7 - Transfer to an Inpatient Facility--patient discharged from agency.

The agency's internal policies should guide the decision whether or not to discharge a patient. For additional guidance on transferring Medicare PPS patients with or without discharge, see the OASIS Considerations for Medicare PPS Patients document found at the QIES Technical Support website

<https://www.gtso.com/download/OASISConsidForMedicarePPSPatRev.pdf>

[Q&A EDITED 08/07]

Q4. May an LPN, OTA, or PTA perform the comprehensive assessment?

A4. No. An LPN, OTA, and PTA are clinicians that are not qualified to establish the Medicare home health benefit for Medicare beneficiaries or perform comprehensive assessments.

Q5. What Comprehensive assessments do I need to complete on my Medicare PPS patients?

A5. You must conduct a comprehensive assessment including OASIS data items at start of care, at resumption of care following an inpatient facility stay of 24 hours or longer, every 60 days, and at discharge. When a patient is transferred to an inpatient facility or dies at home, a brief number of OASIS data items must be collected, but no Discharge comprehensive assessment is required. [EDITED 08/07]

Q6. Does information documented in OASIS have to be backed up with documentation elsewhere in the patient's records?

A6. There is no regulatory requirement that OASIS assessment data be duplicated elsewhere in the patient record. However, we expect patient needs that have been assessed in the agency comprehensive assessment would be reflected in the patient's medical record or plan of care. This is in accordance with Condition of Participation (CoP) 42 CFR 484.48, Clinical Records, requiring a clinical record containing pertinent past and current findings in accordance with accepted professional standards be maintained for every patient receiving home health services. (The CoPs can be read or

downloaded from <http://www.cms.hhs.gov/providers/hha/#oasis>, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category.)

For example, if the response for OASIS item M0250 - Therapies the patient receives at home, were 1, 2, or 3, then the medical record should reflect appropriate interventions and physician orders to provide the required intravenous or infusion therapy, parenteral, or enteral nutrition. The clinical record would also have appropriate documentation of the implementation and evaluation of the interventions. The medical record and the plan of care should reflect the aspects of care for which the HHA has responsibility, including the therapy(ies) provided at home. Documentation in the clinical record, for example, may indicate that the patient and caregiver are learning all aspects of administering the therapy, with an outline of the focus of education and assessment provided by the agency. Another patient/caregiver may be independent with providing the therapy, but the HHA is periodically re-evaluating the patient's nutritional and fluid status during this episode.

Another example would be OASIS item M0390, Vision, with a response of 1 or 2. This would mean that for response 1, the patient has partially impaired vision, i.e., the patient cannot see medication labels. Therefore, the plan of care would need to document the plan for ensuring that the patient receives the correct medications at the correct times, and the clinical record would contain documentation of the education provided and evaluation of the interventions implemented.

Q7. At Recertification, our agency collects only the Reduced Burden OASIS items. Is this sufficient to meet the CoP for the follow-up assessment?

A7. The OASIS items alone are not a complete comprehensive assessment and must also have the agency-determined components of the Follow-Up comprehensive assessment. Please refer to Appendix C of the *OASIS User's Manual* (available at <http://www.cms.hhs.gov/oasis/usermanu.asp>) for sample clinical forms demonstrating the integration of OASIS items into comprehensive assessments, one for each time point. [Q&A EDITED 08/07]

Q8 [Q&A DELETED 08/07; Duplicate of CMS Q&A Cat 4b, Q15]

Q9. Who can perform the comprehensive assessment when RN and PT are both ordered at SOC?

A9. According to the comprehensive assessment regulation, when both disciplines are ordered at SOC, the RN would perform the SOC comprehensive assessment. Either discipline may perform subsequent assessments.

Q10. Who can perform the comprehensive assessment when PT is ordered at SOC and the RN will enter 7-10 days after SOC?

A10. If the RN's entry into the case is known at SOC (i.e., nursing is scheduled, even if only for one visit), then the case is NOT therapy-only, and the RN should conduct the SOC comprehensive assessment. If the order for the RN is not known at SOC and originates from a verbal order after SOC, then the case is therapy-only at SOC, and the therapist can perform the SOC comprehensive assessment. Either discipline may perform subsequent assessments.

Q11. Who can perform the comprehensive assessment for a Medicare PPS patient when PT (or ST) is ordered along with an aide?

A11. Because no nursing orders exist, the PT (or ST) could perform the comprehensive assessment at the SOC and all subsequent assessments. [Q&A EDITED 08/07]

Q12. Who can perform the comprehensive assessment for a therapy-only case when agency policy is for the RN to perform an assessment before the therapist's SOC visit?

A12. A comprehensive assessment performed on a date BEFORE the SOC date cannot be entered into HAVEN (or HAVEN-like software). Since the regulations allow for the comprehensive assessment to be conducted by the therapist in a therapy-only case, the agency may consider changing its policies so that the therapist could perform the SOC comprehensive assessment. If the agency chooses to have an RN conduct the comprehensive assessment, the RN should perform an assessment on or after the therapist's SOC date (within 5 days to be compliant with the regulation). [Q&A EDITED 08/07]

Q13. Who can perform the comprehensive assessment when OT services are the only ones ordered for a non-Medicare patient?

A13. The Occupational Therapist (OT) can perform the assessment if OT services establish program eligibility for the non-Medicare payer. While OT cannot establish program eligibility for Medicare patients, that may not be applicable to other payers. The OT may conduct subsequent assessments of Medicare patients. [Q&A EDITED 08/07]

Q14. Who can perform the comprehensive assessment when both RN and PT will conduct discharge visits on the same day?

A14. When both the RN and Physical Therapist (PT) are scheduled to conduct discharge visits on the same day, the last qualified clinician to see the patient is responsible for conducting the discharge comprehensive assessment.

Q15. Can the MSW or an LPN ever perform a comprehensive assessment? What about therapy assistants?

A15. According to the comprehensive assessment regulation, a MSW or LPN is not able to perform the comprehensive assessment. Only RN, PT, SLP (ST), or OT is able to perform the assessment. Therapy assistants are also not able to perform the comprehensive assessment. This is no different from the previously existing Medicare conditions of participation (CoP) that set forth the qualification standards for those conducting patient assessments. The CoP can be read or downloaded from <http://www.cms.hhs.gov/providers/hha/#oasis>, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category.

Q16. How does the agency develop a SOC comprehensive assessment that is appropriate for therapy-only cases?

A16. Discipline-specific comprehensive assessments are expected to include: the OASIS items appropriate for the specific assessment (i.e., SOC, follow-up, etc.); agency-

determined 'core' assessment items (appropriate for use by any discipline performing a comprehensive assessment); and discipline-specific assessment items. The combination of these components in an integrated form would constitute a discipline-specific comprehensive assessment for the appropriate time point. Discipline-specific assessment forms are available from commercial vendors and may be available through some professional associations. This subject is discussed more fully in Chapters 4 and 7 of the *OASIS User's Manual*, available at <http://www.cms.hhs.gov/oasis/usermanu.asp>. Please refer to Appendix C of the *OASIS User's Manual* (available at <http://www.cms.hhs.gov/oasis/usermanu.asp>) for sample clinical forms demonstrating the integration of OASIS items into nursing comprehensive assessments, one for each time point. [Q&A EDITED 08/07]

Q17. Are we required to discharge patients from the agency when they are admitted to an inpatient facility?

A17. The agency may develop its own policies and procedures regarding discharging patients at the time of admission to inpatient facilities, but must be cognizant of the billing implications for Medicare PPS patients. Questions about billing must be directed to the agency's Regional Home Health Intermediary (RHHI). For guidance on transferring patients with or without discharge, refer to the OASIS Considerations for Medicare PPS Patients located at the QIES Technical Support website <https://www.qtso.com/download/OASISConsidForMedicarePPSPatRev.pdf>.

Q18. I understand that the initial assessment visit (or Resumption of Care assessment) is to be done within 48 hours of the referral (or hospital discharge). What do we do if the patient puts us off longer than that? For example, the patient says, "I have an appointment today (Friday); please come Monday."

A18. The initial assessment visit is to be done within 48 hours of the referral OR on the physician-ordered date. In the absence of a physician-ordered SOC date, if the patient refuses a visit within this 48-hour period, the agency should contact the physician to determine whether a delay in visiting would be detrimental to the plan of care. The call should be documented in the patient's chart for future reference. The ROC visit is to be done within 48 hours of the patient's hospital discharge. The agency should contact the physician to determine whether a delay in visiting will be detrimental. At the ROC, there is no regulatory language allowing the ROC to be delayed by physician order, greater than 48 hours from the inpatient facility discharge. The agency should make every effort to complete the ROC assessment within the 48 hours from the discharge home. If the patient refuses or isn't available, the ROC assessment should be completed as soon as possible, with any physician communication and circumstance details documented in the clinical record. [Q&A EDITED 08/07]

Q19. An RN visited a patient for Resumption of Care following discharge from a hospital. The nurse found the patient in respiratory distress and called 911. There was no opportunity to complete the Resumption of Care assessment in the midst of this situation. What should be done in this situation?

A19. Any partial assessment that was completed can be filed in the patient record, but HAVEN (or HAVEN-like software) will not allow a partial assessment to be exported for submission to the State agency. In situations like this, a note explaining the circumstances for not completing the assessment should be documented in the chart. If,

after the 911 call, the patient is admitted to an inpatient facility and then later returns home again, a Resumption of Care assessment would be indicated at that point. When the 911 call results in the ER treating the patient and sending the patient back home, the Resumption of Care assessment would be completed at the next agency visit.

Q20. Can you clarify the difference between the 'initial assessment' and the 'comprehensive assessment?'

A20. The initial assessment visit is conducted to determine the immediate care and support needs of the patient and, in the case of Medicare patients, to determine eligibility for the home health benefit including homebound status. If no reimbursable service is delivered, this visit is not considered the SOC and does not establish the SOC date. The SOC comprehensive assessment must be completed on or within 5 calendar days after the SOC date and in compliance with agency policies. In the interest of cost-effectiveness, many agencies have combined the initial assessment with the delivery of skilled service(s), assuming the patient is eligible for home care. This would make the initial assessment and the SOC the same date. Also in the interest of efficiency, many agencies also encourage the admitting clinician to complete the SOC comprehensive assessment on this initial visit as well. In this case the SOC date (M0030) is the same as the date the assessment is completed (M0090). These protocols and procedures are a matter of agency choice and agency policy, as long as the regulatory time requirements are met. [Q&A EDITED 08/07]

Q21. For a discharge assessment, does the clinical documentation need to include anything other than the OASIS discharge items?

A21. The exact content of the discharge comprehensive assessment documentation (other than the required OASIS items) is left to each agency's discretion. To fulfill the comprehensive assessment requirement, agencies should remember that the OASIS data set does not, by itself, constitute a comprehensive assessment. HHAs should determine any other assessment items needed for a discharge assessment and include these in their comprehensive discharge assessment.

Q22. If a patient died before being formally admitted to an inpatient facility, do I collect OASIS for Death at Home?

A22. The OASIS discharge due to death is used when the patient dies while still under the care of the agency (i.e., before being treated in an emergency department or admitted to an inpatient facility). A patient who dies en route to the hospital is still considered to be under the care of the agency and the death would be considered a death at home. A patient, who is admitted to an inpatient facility or the hospital's emergent care center, regardless of how long he/she has been in the facility, is considered to have died while under the care of the facility. In this situation, the agency would need to complete any agency-required discharge documents (e.g., a discharge summary) and a transfer assessment (RFA 7, Transfer to Inpatient Facility, Patient Discharged) to close out the OASIS episode. [Q&A EDITED 08/07]

Q23. A patient recently returned home from an inpatient facility stay. The Transfer comprehensive assessment (RFA 6) was completed. The RN visited the patient to perform the ROC comprehensive assessment but found the patient critically ill. She performed CPR and transferred the patient back to the ER where,

he passed away. The ROC assessment, needless to say, was not completed. What OASIS assessment is required?

A23. The Transfer assessment completed the requirements for the comprehensive assessment. The patient did not resume care with the HHA. The agency's discharge summary should be completed to close out the clinical record.

Q24. Is it ever acceptable for an LPN to complete the OASIS? For example, could an LPN complete the OASIS if she/he were the last to see a patient prior to an unexpected re-hospitalization?

A24. The comprehensive assessment and OASIS data collection must be conducted by an RN, PT, OT or SLP as described in the regulations. This is no different from the previously existing Medicare conditions of participation (CoP) that set forth the qualification standards of those conducting patient assessments. Patient assessment is not included in the duties of an LPN. The CoP can be read or downloaded from <http://www.cms.hhs.gov/providers/hha/#oasis>, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category. [Q&A EDITED 08/07]

Q25. Do you have any information on what agencies are to do if the beneficiary refuses to answer OASIS questions? For example, some patients felt it was an invasion of their privacy to address question M0300 (about current residence). Are agencies not to admit, based on the refusal?

A25. The OASIS items should be answered as a result of the clinician's total assessment process, not administered as an interview. Conducting a patient assessment involves both interaction (interview) and observation. Many times the two processes complement each other. Interaction and interview (i.e., report) data can be verified through observation - observation data adds to the information requested through additional interview questions. Many clinicians begin the assessment process with an interview, sequencing the questions to build rapport and gain trust. Others choose to start the assessment process with a familiar procedure such as taking vital signs to demonstrate clinical competence to the patient before proceeding to the interview. We suggest that agencies that seem to report a high degree of difficulty with specific OASIS items might be well advised to review with their staff the processes of performing a comprehensive assessment, because all OASIS items are required to be completed. Sometimes such difficulties indicate that clinical staff might benefit from additional training or retraining in assessment skills. The OASIS Web-Based Training (WBT) includes considerable information to help clinicians with assessment processes and can be accessed online at <http://www.oasistraining.org/>. Remtech Services, Inc. (RSI), the contractor that developed the WBT, has mailed a CD-ROM to all Medicare certified agencies. If your agency cannot locate its copy, and would like to order one, go to <http://www.oasistraining.org/> and click on 'Reference', then on 'Contacts'. In addition, a list of supplemental references regarding patient assessment is included in Chapter 4 of the *OASIS User's Manual*, available at <http://www.cms.hhs.gov/oasis/usermanu.asp>. The Privacy Act Notices are available at: http://www.cms.hhs.gov/OASIS/03_Regulations.asp#TopOfPage.

Q26. What Privacy Act statements are required since MMA 2003 temporarily suspended OASIS data collection for non-Medicare/non-Medicaid patients?

A26. For non-Medicare/non-Medicaid patients in agencies that temporarily suspended OASIS items in their comprehensive assessment, the Notice about Privacy for Patients Who Do Not Have Medicare or Medicaid Coverage (Attachment C) is not currently required.

For non-Medicare/non-Medicaid patients in agencies that continue to include OASIS items in their comprehensive assessment, the Notice about Privacy for Patients Who Do Not Have Medicare or Medicaid Coverage (Attachment C) is required.

For all Medicare and Medicaid patients receiving skilled services, the Statement of Patient Privacy Rights for Medicare and Medicaid patients (Attachment A) and the Privacy Act Statement (Attachment B) are required.

The Privacy Act Notices are available at http://www.cms.hhs.gov/OASIS/03_Regulations.asp#TopOfPage

Q27. What should we do about OASIS when a patient refuses?

A27. Remember that the regulations require that a comprehensive patient assessment be conducted at specified time points, which for some patients includes the use of standardized data items as part of the assessment. These items, of course, are the OASIS data set. To discuss patient refusal, we must first address the components of a patient consent process. Typically, patient consent forms (which must be signed by the patient or their designated representative) include 4 components: a consent to be treated by the HHA; a consent for the HHA to bill the pay source on behalf of the patient; a consent to release patient-specific information to the physician, the patient's insurance carrier or other payer, etc.; and acknowledgement that the patient has been informed of his or her rights and has received written information about these rights. Consenting to treatment (#1) would include the performance of a comprehensive assessment that is necessary to develop a plan of care/treatment; releasing information to the payer source (#3) would include transmitting data to the State agency as a representative of Medicare/Medicaid; and acknowledgement of patient rights (#4) would include the receipt of the Privacy Act statements regarding patient rights. What then is the patient 'refusing,' and what is the HHA's response? Does the patient refuse to be assessed (i.e., refuse to be treated)? Most agencies have written policies (based on input from legal counsel) about how to handle such situations, and whether or not to provide care to a patient who refuses to agree to be treated. Does the patient refuse to have his/her information released (to the physician, to the payer, etc.)? How does the HHA obtain physician orders if no patient-specific information can be released? What information can be provided to the fiscal intermediary (or other pay source) requesting patient records to verify the provision of services, patient eligibility for services, etc.? Again, most HHAs will have obtained a legal opinion and promulgated written policies about providing services to a patient who refuses to consent to release of information.

During the comprehensive assessment, does the patient refuse to answer a specific interview question -- for example, "What is your birth date?" In this case, please recall that the OASIS items are not an interview, but rather request standardized information on each HHA patient. Nearly all OASIS items can be obtained through observation of the patient in the normal assessment process, or through review of discharging facility paperwork or caregiver interview. Many items that can ONLY be obtained by interview have a response option of 'unknown' at SOC. Two exceptions to this include the

patient's Medicare number (M0063), and the patient's birth date (M0066). These data typically are obtained for billing purposes, so we feel confident that HHAs can find other ways to obtain the information. If a patient refuses to answer an interview question, the clinician must assess the patient and record the appropriate response to the OASIS item. Note that all (appropriate) OASIS items must be answered for a specific assessment, or the assessment cannot be transmitted. In the experience of HHAs that used the OASIS data items as part of a comprehensive assessment for well over 3 years during the national demonstration, the items were already part of their clinical documentation -- which means that the clinicians were already assessing patients for these very factors. [Q&A EDITED 08/07]

Note that the Privacy Act statements (to be provided to the patient) are informational in nature. It is expected that they will be presented to (and discussed with) the patient in a way similar to the other patient rights information currently required by the Medicare conditions of participation.

Q28. How are we to handle physical, speech or occupational therapy-only patients when these disciplines do not assess for the same elements as skilled nursing? The data set seems skewed toward nursing issues.

A28. OASIS data items are not meant to be the only items included in an agency's comprehensive assessment. They are standardized health assessment items that must be incorporated/integrated into an agency's own existing assessment processes. For a therapy-only case, the primary therapist may conduct the comprehensive assessment using the comprehensive assessment data items incorporated into their form that includes whatever other inquiries the agency currently makes for therapy-only cases. Refer to Chapters 4 and 7 in the *OASIS User's Manual* for additional discussion of this issue. The manual is available at <http://www.cms.hhs.gov/oasis/usermanu.asp>.

Q29. We have integrated OASIS data items into our current assessment questions. Staff feels strongly that they need the admission OASIS information as a reference point. My understanding was that staff was NOT to have the original set of OASIS items as a reference.

A29. Your understanding is correct. The instructions about not using previous OASIS data as reference for a later assessment are to decrease the likelihood of clinicians becoming biased in their item response selection or simply 'carrying data forward' rather than actually performing a new assessment. Careful training of your clinical staff, emphasizing the importance of actually conducting a new assessment (rather than recording the same response as before without performing an assessment), is important. Clearly the admission assessment data are useful in reviewing patient progress throughout the care episode. After the follow-up (or discharge) assessment has been performed and the findings documented, reviewing the admission assessment assists the clinician to see exactly what progress has occurred. You might request clarification from your staff as to how they are using the admission data -- and then reinforce the importance of a completely new assessment at the follow-up time point, if necessary. It is important for agencies to keep the big picture in mind, i.e., OASIS is but the first step toward an outcome management paradigm. As such, it is imperative that the clinician collects OASIS data at the required time points with no preconceptions. In this way, she/he is able to accurately document her/his observations of the patient's status at the

time of assessment. It is critical for staff to understand how inaccurate data will affect the agency's outcome reports, as well as the legal clinical record. [Q&A EDITED 08/07]

Q30. For how long a period may agencies place a patient on 'hold' status when the patient has been hospitalized?

A30. At this time, CMS is not defining policy relating to an agency's hospitalization of patients. The agency should carefully consider the requirements for collecting assessment information on patients who are transferred to an inpatient facility for 24 hours or longer (and occurs for reasons other than diagnostic testing). The agency should review their current transfer and discharge policies to determine how the data collection requirements can best be met for transfer to an inpatient facility, resumption of care, and discharge assessments. Bear in mind that certain considerations should be made for your Medicare PPS patients. Refer to the information on the OASIS Considerations for Medicare PPS Patients located at the QIES Technical Support website <https://www.qtso.com/download/OASISConsidForMedicarePPSPatRev.pdf> for suggestions in keeping your assessments in sync with Medicare billing. [Q&A EDITED 08/07]

Q31. Does OASIS data collection have to be initiated on the very first contact in the home (the initial assessment visit), or is it OK to begin OASIS data collection on the start of care visit, if these two visits are at different times?

A31. The Start of Care OASIS items, which must be integrated into your agency's own comprehensive assessment, must be completed in a timely manner, but no later than five calendar days after the start of care date. The comprehensive assessment is not required to be completed on the initial visit; however, agencies may do so if they choose. [Q&A EDITED 08/07]

Q32. Does the medication list need to be reviewed by an RN if the patient is only receiving therapy services?

A32. The standard for the drug regimen review is not new; it was included in the previous conditions of participation (CoP) under the plan of care requirements. The comprehensive assessment must include a review of all medications the patient is using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects and drug interactions, duplicate drug therapy, and noncompliance with drug therapy. The scope of the drug regimen review has thus been narrowed from the previous CoP. Each agency must determine the capabilities of current staff members to perform comprehensive assessments, taking into account professional standards or practice acts specific to your State. No specific discipline is identified as exclusively able to perform this assessment.

Q33. For patients who are discharged after a hospital stay or a visit to the doctor, is it necessary to complete the discharge assessment? We will not be able to make a home visit after the discharge order is obtained.

A33. The patient who is discharged after a hospital stay will have had OASIS data reported at the point of transfer to the inpatient facility. No additional assessments or OASIS data collection are expected in this situation unless a resumption of care occurs. Therefore, the agency will complete any agency-required discharge documents (e.g., a

discharge summary), but no further OASIS data are collected or reported. If the physician determines at an office visit that the patient does not need additional visits and requests discharge, the agency must report the patient status at the last qualifying visit prior to this date (e.g., the last visit performed by a clinician qualified to conduct a comprehensive assessment). When agency staff are aware that the patient's needs for home care are decreasing and that a physician visit is imminent, the possibility of such discharge must be considered. It would be appropriate to update the physician on the progress seen in the home and suggest that it may be time to discharge the patient. Close attention to the details of the comprehensive assessment thus can be incorporated into the home visit scheduled prior to the physician visit. [Q&A EDITED 08/07]

Q34. Is it possible to have two home health agencies independently provide services to a patient, and if so, does each agency complete a comprehensive assessment, including the OASIS data items?

A34. Two participating agencies providing home health services under a Medicare home health plan of care is not allowed under PPS. One agency is the primary provider, whereby the primary provider reimburses the secondary agency under mutually agreed-upon arrangements. In this case, the primary agency is responsible for making sure that comprehensive assessments (including OASIS items) are conducted when due and submitted under the primary agency's name.

Q35. The patient's payer source changes from Medicare to Medicaid or private pay (or vice versa). The initial SOC/OASIS data collection was completed. Does a new SOC need to be completed at the time of the change in payer source?

A35. There is a discussion of payer source change in Chapter 8 of the *OASIS User's Manual*. Different States, different payers, and different agencies have had varying responses to payer change situations, so we usually find it most effective to ask, "Does the new payer require a new SOC?" HHAs usually are able to work their way through what they need to do if they answer this question. If the new payer source requires a new SOC (Medicare is one that DOES require a new SOC), then it is recommended that the patient be discharged from the previous pay source and re-assessed under the new pay source, i.e., a new SOC comprehensive assessment. The agency does not have to re-admit the patient in the sense that it would normally admit a new patient (and all the paperwork that entails a new admission). If the payer source DOES NOT require a new SOC, then the schedule for updating the comprehensive assessment continues based on the original SOC date. The HHA simply indicates that the pay source has changed at M0150. OASIS data collection and submission would continue for a Medicare/Medicaid patient changed to another pay source until the patient was discharged. Because the episode began with Medicare or Medicaid as a payer, the episode continues to be for a Medicare/Medicaid patient. Transmittal 61, posted January 16, 2004, includes a section on special billing situations and can be found in the *Medicare Claims Processing Manual*. Go to <http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf>; scroll to page 94 of the document to read "Section 80 - Special Billing Situations Involving OASIS Assessments." Questions related to this document must be addressed to your RHHI. [Q&A EDITED 08/07]

Q36. Could you explain what the term 'start of care' actually means? Is it related to payment?

A36. One of the interesting things about home care is the definition of when the patient is admitted and when the patient is discharged. In contrast to an inpatient setting, where the 'exterior walls' dictate admission and discharge, home care has many variations. Therefore, defining SOC is not as easy as it appears. Start of care currently relates to the 'first billable visit.' The 'first billable visit' approach was selected largely because of the Medicare payment requirements and the fact that the first billable visit defines SOC and the start of the episode for Medicare purposes. A strong case can be made to maintain congruence of the episode dates with the comprehensive assessment requirements. All payers clearly define what is considered a billable visit. However, not all payers require that a skilled provider conduct the first billable visit. For example, an aide might make the first visit (SOC), followed by the RN within the 5-day SOC window, and be perfectly acceptable for that payer. In this example, the episode of care would begin with the aide's billable visit. It has been suggested that we use the agency's initial patient contact as the date of the first assessment, however, it must be noted that the first entry of any care provider into the patient's home may not always occur in close proximity to the episode beginning. For now, SOC will remain linked to the first billable visit.

Q37. Please discuss dealing with 'unplanned or unexpected' discharges.

A37. In providing patient care that focuses on achievement of outcomes, the HHA assumes responsibility for monitoring patient progress and for coordinating care among all participating providers. The agency thus is responsible for planning, coordinating, and communicating about improvement in patient status that can indicate the need for less frequent visits or even discharge. Agencies that do this well will have relatively few 'unexpected' discharges, though such events can occur (for example, when a patient unexpectedly moves out of the service area). To meet the various requirements for the comprehensive assessment, as well as collection and use of OASIS data, the following requirements must be met:

1. the discharge assessment must report patient status at an actual visit (i.e., the clinician must be able to assess the patient, not merely report on patient status from a telephone call);
2. the comprehensive assessment must be conducted by a qualified clinician (RN, PT, SLP, OT);
3. the encoded OASIS data must accurately reflect the patient's status at the time of the assessment; and
4. the HHA's clinical record must contain documentation matching the encoded data sent to the State.

Situation: The nurse conducts a routine visit (not SOC) for Mr. N on August 4. An aide visits August 5 and August 7. On August 8, the physician calls the agency and unexpectedly discontinues home care. What OASIS data are reported? What dates are used for M0090, M0903, and M0906? How does the agency note the patient's status at discharge?

The general principle to follow in these cases is to report the patient's status on the last visit by the clinician qualified to complete the comprehensive assessment with OASIS. We suggest the following approach:

1. All OASIS data required for discharge must be reported. Response 9 for M0100-Reason Assessment is Being Completed will indicate that the patient is being discharged from the agency, but NOT to an inpatient facility.
2. M0090 would be noted as August 8, the date the agency completes the assessment after learning of the need to discharge. (This is the date to be used for compliance with the completion of the discharge assessment and data transmission requirements. Note: Regulation allows up to two calendar days after identification of need to discharge for completion of the discharge assessment.) M0903 - Date of Last (Most Recent) Home Visit would be noted as August 7. M0906 - Discharge/Transfer/Death Date would be reported as August 8 (if your agency defines discharge date as the date the agency is notified of the need to discharge.)
3. To be compliant with the discharge comprehensive assessment requirement, the qualified clinician that last saw the patient should complete the agency's discharge documentation as completely as possible, based on the patient status at that provider's last visit -- in this example, August 4. The clinician should note on this documentation that this is a situation of an unexpected discharge and the discharge assessment is 'based on the visit of mm/dd/yyyy.' The OASIS data from this assessment will be encoded and transmitted. The agency will thus have a discharge assessment recorded and a clinical record document that matches the OASIS data transmitted to the State.

Variation 1: What if the same dates apply to the nurse's visit (August 4) and the date the physician calls the agency to discontinue services (August 8), but there have been no aide visits? What, if anything, is different from the situation described above?

Only one difference exists between this situation and the one described above. That is the date recorded in M0903 - Date of Last (Most Recent) Home Visit. In this variation, the date would be August 4, the date of the nurse's visit.

Variation 2: The situation is the same as Variation 1, but agency policy requires the discharge date to be the date of the last visit. What, if anything, is different from the situation in Variation 1?

The date recorded in M0090 - Date Assessment Completed would be August 8, the date that the agency completed the assessment after learning of the need to discharge. M0903 - Date of Last (Most Recent) Home Visit again would be August 4. Agency policy would dictate the date to be recorded in M0906 - Discharge/Transfer/Death Date, which would be recorded as August 4 (the last actual visit). This will produce a warning message in HAVEN or other data entry software, because the assessment was completed more than two days after the discharge. The warning will not hinder locking and transmission of data.

Variation 3: What if the visits on August 5 and August 7 were made by an LPN (or therapy assistant)? What, if anything, is different from the situation described above?

There is no difference from the initial situation described earlier. The LPN (or therapy assistant) is not qualified to perform the comprehensive assessment, therefore the recorded assessment must describe the patient's status at the nurse's (or qualified therapist's) visit. If the LPN/therapy assistant made the last visit before the MD

discontinued services, the LPN/therapy assistant's last visit date would be recorded for M0903. In this case, that date would be August 7.

Variation 4: What if the nurse's August 4th visit was the SOC assessment, followed by the aide visits on August 5 and August 7? What, if anything, is different from the initial situation?

There is no difference from this situation and the initial one described. The HHA must report the patient's status from an actual visit -- in this case, the only possible visit would be the SOC assessment. The qualified clinician must complete the agency's discharge documentation as noted above, with the note that the assessment is 'based on the visit of mm/dd/yyyy.'

Variation 5: What if the nurse makes a visit on August 4, expecting this to be the discharge visit pending a final check with the patient a few days later? A telephone call to the patient on August 8 confirms that the patient is doing well, and the agency discharges the patient. What, if anything, is different from the situations described above?

There are some subtle differences from the situations described above. Because the nurse is expecting the discharge to occur, it is recommended that a complete assessment be recorded on August 4. However, the regulations will require an assessment congruent with the discharge date of August 8. The agency must assure the presence in the clinical record of a discharge assessment completed on (or within 48 hours of) the date recorded in M0090 (August 8 in this example). The HHA has two options for this precise situation: (1) To conduct a (most likely nonreimbursed) visit on or after August 8 to complete another discharge assessment, or (2) To follow the procedures for recording a discharge assessment dated August 8, based on the patient status of August 4 (and so noted in the clinical documentation). Possibly a better option would be to place the telephone call to the patient within 48 hours of the August 4 visit, thus placing the discharge assessment and the discharge date within 48 hours of each other.

Variation 6: The RN's last visit to the patient was July 3, the SOC date. Since then the LPN has been following the patient and her last visit was August 4, with aide visits on August 5 and 7, before the physician called to order the discharge on August 8 because the patient no longer wanted care. Would the RN be allowed to complete the discharge assessment based on the LPN's last visit?

The conditions of participation (CoP) require that a comprehensive assessment (including OASIS items) be conducted at the time of discharge. The CoP (and many state licensing laws) do not include "assessment" as a duty of the LPN. The CoP can be read or downloaded from <http://www.cms.hhs.gov/providers/hha/#oasis>, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category. The RN could not create an assessment as if it were fact without seeing a patient. In such a situation the RN did not inspect the patient's skin, observe the patient's performance of activities, or collect much of the non-OASIS data needed in a comprehensive assessment (e.g., vital signs, breath sounds, etc.). This makes evident some legal issues involved for the nurse and the agency. When a licensed clinician signs an assessment, he/she is attesting that the documentation contained therein is correct. It would be difficult to make such an assertion if the clinician signing the document had not

assessed the patient. Lastly, there is the issue of the agency's responsibility for managing patient care. When an agency admits a patient, the agency has a responsibility to ensure that a LPN's care is supervised by a RN. CoP 484.30(a) states that the "registered nurse makes the initial evaluation visit, regularly reevaluates the patient's nursing needs, initiates the plan of care and necessary revisions..." This scenario is concerning because apparently the supervising RN did not know that the patient did not want further care or why. It would be important for the agency to evaluate the care and supervision provided. Were there truly no indications that the patient wanted or needed to be discharged? If such information had been reported to the RN, perhaps the RN could have completed a reassessment to determine if discharge or a change in care plan was appropriate. The agency would not know whether discharge was appropriate at this time or if there was another reason for the patient's request. In this situation, a registered nurse from the agency should complete a discharge assessment by visiting the patient.

For a more in-depth explanation of the rationale behind this response go to page 3768 (middle column) of the *Federal Register* posted January 25, 1999, where this was specifically addressed in the preamble to the statement of the Condition of Participation (CoP), 484.55. CMS pointed out that in the CoP (prior to 1999), patient evaluation is listed in the duties of the registered nurse at 484.30(a) and therapy services at 484.32, but not in the duties of the LPN at 484.30(b). Many State regulations also stipulate that patient evaluation and comprehensive assessment are duties of the registered nurse, not a licensed practical nurse. You can read or download the above-mentioned regulation in the *Federal Register* at http://www.cms.hhs.gov/OASIS/03_Regulations.asp#TopOfPage, scroll down to the heading, "OASIS Collecting and Reporting Regulations," and click on the link to view the final "collection" regulation.

HHAs who discover a large number of unplanned or unexpected discharges must be aware that retrospective data reporting can negatively impact the agency's outcome report in two ways: (1) the clinician's recall of patient status information is likely to be less accurate than the information recorded immediately upon assessment, and (2) the patient's status at time of discharge may actually be better (i.e., improved) than it was at the time of the visit conducted by the RN, PT, SLP, or OT. [Q&A EDITED 08/07]

Q38. I assume that a patient who is no longer receiving skilled care but continuing to receive personal care only will cease OASIS data collection at the end of skilled care. Is this correct? If it is, how should OASIS items M0100, M0870, and M0880 be answered in the discharge assessment?

A38. We encourage HHAs to complete a discharge assessment at a visit when a patient receiving skilled care no longer requires skilled care, but continues to receive unskilled care. While this is not a requirement, conducting a discharge assessment at the point where the patient's skilled need has ended provides a clear endpoint to the patient's episode of care for purposes of the agency's outcome-based quality monitoring (OBQM) and improvement (OBQI) reports. Otherwise, that patient will not be included in the HHA's OBQM and OBQI statistics. It will also keep that patient from appearing on the HHA's roster report (a report you can access from your State's OASIS system that is helpful for tracking OASIS start of care and follow-up transmissions) when the patient is no longer subject to OASIS data collection. In this case, OASIS item M0100 (Reason for Assessment) should be marked with Response 9 (Discharge from agency). OASIS item

M0870 (Discharge Disposition) should be marked with Response 1 (Patient remained in the community), and item M0880 should be marked with Response 3 (yes, assistance or services provided by other community resources). (If Response 2 also applies to M0880, it should also be marked.) We realize the wording for M0100 and M0880 is somewhat awkward in this situation; clinicians should note in their documentation that the agency will be continuing to provide only personal care services.

Q39. [Q&A DELETED 08/07; Duplicate of CMS Q&A Cat. 4b Q #21]

Q40. [Q&A DELETED 08/07; Duplicate of CMS Q&A Cat. 4b Q #16]

Q41. When a patient is transferred to a hospital, but does not return to the agency, what kind of OASIS assessment is required?

A41. No assessment is required at that point. The agency's last contact with the patient was at the point of transfer to the inpatient facility, so the transfer data conclude the episode from the point of OASIS data collection. If the agency had not already discharged the patient, there presumably would need to be some documentation placed in the clinical record to close the case for administrative purposes.

Q42. What should agencies do if the patient leaves the agency after the SOC assessment (RFA 1) has been completed and further visits were expected?

A42. Completion of a SOC Comprehensive Assessment is required, even when the patient only receives a single visit in an episode. Effective December 2002, there is no requirement to collect OASIS data as part of the comprehensive assessment for a single-visit episode. Some payers (including Medicare PPS and some private insurers) require SOC OASIS data to process payment. If collected, RFA 1 is the appropriate response on M0100 for a one-visit Medicare PPS patient. Since OASIS data collection is not required by regulation (but collected for payment) in this case, the agency may choose whether or not the data is transmitted to the State system.

If OASIS data is required for payment by a non-Medicare/non-Medicaid payer (M0150 response does not include Response(s) 1,2,3, or 4), the resulting OASIS data, which may just include the OASIS items required for the PPS Case Mix Model, may be provided to the payer, but should not be submitted to the State system. Regardless of pay source, no discharge assessment is required, as the patient receives only one visit. Agency clinical documentation should note that no further visits occurred. No subsequent discharge assessment data should be collected or submitted. If initial SOC data is submitted and then no discharge data is submitted, you should be aware that the patient's name will appear on the data management system (DMS) agency roster report for six months, after which time the patient name is dropped from the DMS report. If the patient were admitted again to the agency and a subsequent SOC assessment submitted, the agency would receive a warning that the new assessment was out of sequence. This would not prevent the agency from transmitting that assessment, however. [Q&A EDITED 08/07]

Q43. Since RFAs 2 and 10 were eliminated in December 2002, what should we do if only one visit is made at Resumption of Care? All the references I've seen address only the issue of one visit at SOC.

A43. Because the RFA 10 response originally stated, "after start/resumption of care," we advise you to follow the same instructions you would after only one visit at SOC (i.e., the ROC comprehensive assessment is required, but OASIS data collection is not required). No discharge comprehensive assessment or OASIS is required when no additional visits are made after the ROC visit. Agency clinical documentation should indicate that no additional visits occurred after the ROC assessment, and internal agency documentation of the discharge would be expected. You should be aware that the patient will continue to appear on the agency's roster report as an incomplete episode. The patient's name will appear on the data management system (DMS) agency roster report for six months, after which time the patient name is dropped from the DMS report. If the patient were admitted again to the agency and a subsequent SOC assessment submitted, the agency would get a warning that the new assessment was out of sequence. This will not prevent the agency from transmitting that assessment, however. [Q&A EDITED 08/07]

Q44. What type of comprehensive assessment is required for pediatric, maternity, and patients requiring only personal care, housekeeping or chore services?

A44. All pediatric, maternity, and patients requiring only personal care, housekeeping or chore services are exempt from the OASIS data collection requirements. For pediatric, maternity, or personal care patients, the HHA will need to complete an agency-developed comprehensive assessment at the required time points. The agency may develop its own comprehensive assessment and tailor it to the needs of the patients of their case-mix. An HHA is not required to conduct a comprehensive assessment for individuals where HHA services are entirely limited to housekeeping or chore services. [Q&A edited 06/05]

Q45. [Q&A DELETED 08/07; Duplicate of CMS Q&A Cat 2 Q #39]

Q46. Home health patients may return to the hospital after a single visit. Some HHAs treat these as one-visit only episodes, do not collect OASIS data, and do not bill the Medicare program. Is this acceptable? In many instances, it appears that the patients were prematurely discharged from the hospital.

A46. Yes, this is acceptable. This scenario appears to fit the criteria for one-visit only episodes for Start of Care or Resumption of Care that became effective December 16, 2002. Each patient must receive a comprehensive assessment. The agency is not required to collect the OASIS items, nor encode and submit the assessment. This assessment can be placed in the clinical record for documentation and planning purposes. [Q&A added 06/05] [Q&A EDITED 08/07]

Q47. For discharge assessments done on therapy-only cases (or when therapy is the last skilled service in the home), could a nurse visit the patient within 2 days of the therapy discharge and perform the comprehensive assessment? The date of discharge would be the date the therapist actually discharged the patient, while the date the assessment was completed (M0090) would be the date the nurse actually completes the comprehensive assessment.

A47. CMS regulations at 42 CFR 484.55(b) allow the therapist to conduct the discharge assessment at the discharge visit in either a therapy-only case or when the therapist is the last skilled care provider. If the agency policy is to have the RN complete the comprehensive assessment in a therapy-only case, the RN can perform the discharge

assessment after the last visit by the therapist. This planned visit should be documented on the Plan of Care. The RN visit to conduct the discharge assessment is a non-billable visit. The date of the actual discharge is determined by agency policy. When the agency establishes its policy regarding the date of discharge, it should be noted that a date for M0906 (Discharge/Transfer/Death Date) that precedes the date in M0903 (Date of Last/Most Recent Home Visit) would result in a fatal error, preventing the assessment from being transmitted. [Q&A added 06/05]

Q48. If the RN is admitting and completing the initial and SOC comprehensive assessment for a Medicare case with orders for PT and home health aide (no nursing skill or orders), can the home health aide establish the SOC by making a visit on the same day as the RN admits. And if so, what time requirements would apply to when the PT must make his/her evaluation visit?

A48: The case as described is a therapy-only case, thus the RN or the therapist can conduct the initial assessment to determine the immediate care and support needs of the patient and to determine eligibility for the Medicare home health benefit, including homebound status. Once patient eligibility has been confirmed, and the plan of care contains physician orders for the qualifying service as well as other Medicare covered home health services, the qualifying service does not have to be rendered prior to the other covered home health services ordered in the plan of care. If a covered service is provided, the SOC date is established and the visit is Medicare billable. A start of care comprehensive assessment cannot be performed prior to the SOC date. Thus, in the situation described, the RN or the PT can make the initial assessment. However this is not a billable visit and should not be included in the therapy visits. The home health aide who provides a covered service can be the first billable (SOC) visit. If it is the HHA's policy for the RN to conduct the SOC assessment, this would follow the home health aide visit. The RN's SOC assessment should be completed on or within five days after the SOC date (or according to agency policy). The timing of the PT evaluation visit is not specifically defined by the Conditions of Participation, except to say that the practice must comply with accepted professional standards and principles. Reference: Interpretive Guidelines G336 [Q&A ADDED 08/07 Previously CMS OCCB 03/05 Q&A #1]

Q49. When initial orders exist for nursing and PT, can the PT make an evaluation visit and establish the start of care, with the RN subsequently visiting to conduct the initial assessment visit and to complete the SOC comprehensive assessment?

A49: No. When initial orders exist for nursing and PT, the Conditions of Participation require that the RN conduct the initial assessment visit to determine the immediate care needs of the patient, and for Medicare patients, to establish program eligibility including homebound status. When nursing orders are present at the SOC, the RN is allowed up to five days after the SOC date to complete the SOC comprehensive assessment. The PT may conduct the PT evaluation visit after the initial visit by the RN and during the five-day period while the SOC comprehensive assessment is completed. Reference: Interpretive Guidelines G331 [Q&A ADDED 08/07 Previously CMS OCCB 03/05 Q&A #2]

Q50. One of the time requirements outlined in the CoPs for the initial assessment visit is that it must be conducted "within 48 hours of referral". Does "referral" mean referral from a physician, or referral from anyone (e.g., the patient, family,

assisted living facility)? Sometimes when we are contacted by the patient or family member, physician's orders for home care may not exist. Does the "clock" for the 48 hours start when the patient/family contacts the agency requesting services, or when the physician provides orders?

A50: "Referral" refers to the referral from a physician (or designee) for home care evaluation and/or services. The referral may come in the form of initial contact by the physician's office, a hospital discharge planner or even the patient or family member, who may be in possession of the written physician's orders for home care.

If a patient or family member makes initial contact with the agency and has not discussed and/or received home care orders from the physician for a referral for home care, then this is not considered a "referral" for the purposes of determining compliance with conducting the initial assessment visit. In this case, the agency should contact the physician to obtain necessary orders, and then conduct the initial assessment visit within 48 hours of that referral, within 48 hours of the patient's discharge from an inpatient facility, or on the physician's ordered start of care date. [Q&A ADDED 08/07; previously CMS OCCB 07/06 Q&A #1]

Q51. Start of Care visit - If both nursing and therapy are ordered at SOC, does the RN have to visit the patient before the therapist? If this is required and the PT visits before the RN, what is the impact on the agency?

A51: The Condition of Participation, 484.55, Comprehensive Assessment of Patients found at www.access.gpo.gov/su_docs/fedreg/a990125c.html stipulates that a registered nurse must conduct the initial assessment unless it is a therapy only case. Since "initial" means first, when nursing orders exist at Start of Care, the RN must be the first person to see the patient and complete the initial assessment requirements.

The Conditions also require that if nursing orders exist at SOC, the RN must complete the SOC comprehensive assessment including the OASIS. This does not necessarily mean that the SOC comprehensive assessment must be completed by the RN on the SOC date or that the initiation of therapy must be delayed until the RN completes the comprehensive assessment. Federal guidelines state the SOC comprehensive assessment including the OASIS must be completed within 5 days after the SOC date. (See the OASIS Assessment Reference Sheet, <http://www.cms.hhs.gov/OASIS/Downloads/OASISRefSheet.pdf>). Of course, if your agency policies are more restrictive (e.g., require earlier completion), you must follow your policy.

You also asked what is the impact to the agency if the PT visits the patient before the RN when both nursing and PT are ordered at SOC. Your agency will be out of compliance with the Medicare Conditions of Participation when you allow the therapist to make the initial assessment visit when there are also nursing orders. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #2]

Q52. First scenario: A home care agency receives an order for RN and PT for a patient. The SN does the SOC OASIS assessment on the first billable visit of 1/1/07. The Physical therapist does his initial eval on 1/3/07 and upon review of the RN's SOC OASIS documentation, it is discovered that the patient's functional status documented on the OASIS differs from the PT evaluation.

Should the PT discuss his findings with the RN and, if agreed upon, make changes to the SOC OASIS completed on 01/01/07? Does another visit have to occur jointly? Is there a certain time frame this can happen?

A52: While the comprehensive assessment must be completed by only one clinician, it is an excellent idea for all the disciplines caring for a patient to discuss assessment findings and their plans of care. The RN who performs the SOC comprehensive assessment on the SOC date, 1/1/07, has up to 5 days after the SOC (the date of the first billable visit) to complete the SOC OASIS assessment. When conferring with the PT regarding his 1/3/07 visit assessment findings, the RN may discover the SOC OASIS responses chosen do not reflect the assessment findings of the therapist. The RN and PT should further discuss the patient's status to determine if:

- 1) The differences noted in the patient's status or ability would be considered **normal progression of disease or recovery based on the time that lapsed** between the two assessments, (e.g. the RN noted the patient required assistance of another at all times to ambulate on 1/1/07 due to weakness after hospital discharge. The PT conducted his evaluation on 1/3/07 and the patient's weakness had greatly improved and only needed supervision of another to ambulate at night when she was tired.) In this case, the differences noted can be attributed to normal progression of recovery and do not indicate that the 1/1/07 findings were necessarily inaccurate.
- 2) The differences noted in the patient's status were due to a **misunderstanding of the OASIS scoring guidance**, (e.g. the RN believed that M0680 Toileting included the patient's ability to transfer on and off the toilet and clothing management.) After discussion, if the RN believes her original score was inaccurate because she inappropriately applied her assessment findings when selecting an OASIS response, changing her response to M0680 within the 5 day time period allowed for completing the assessment is acceptable. The M0090 date will be changed to reflect the date the assessment was completed.
- 3) The differences noted were due to a **difference in the interpretation of assessment findings**, (e.g. The RN observed the patient ambulating while holding onto furniture and walls and believed the patient was independent and needed no assistance. The PT made the same observation but understood the walls and furniture represented the patient's need for assistance for safe ambulation.) If after discussion, the RN believes her original score was inaccurate because she inappropriately interpreted her assessment findings, changing her response to M0700 within the 5 day time period allowed for completing the assessment is acceptable. The M0090 date will be changed to reflect the date the assessment was completed.
- 4) The differences noted were due to a **difference (or adequacy) in the assessment approach**, (e.g. The RN asked the patient if he could dress himself. The PT asked the patient to demonstrate gathering his clothes and putting on and removing select clothing items.) The RN should not base or change her assessment scores based solely on the assessment of the PT, if such assessment findings were not observed by the RN. If after discussion the RN questions the accuracy of her score because she believes she may not have gathered sufficient information necessary to determine the patient's ability to dress, the RN may choose to make another visit during the 5 day assessment time frame and further observe and assess the patient. The RN may determine that her original OASIS response is accurate and leave the assessment as originally completed.

Or, the RN may select a different score based on the subsequent visit findings and report the new score as part of the SOC assessment. If the subsequent visit provides any information that is used to complete the comprehensive assessment, then the M0090 date should be changed to reflect the date the assessment was completed.

5) The differences, after discussion, **cannot be reconciled**. The RN's observations are not consistent with the PT's evaluation. The RN may choose to make another visit during the 5 day assessment time frame and further observe and assess the patient. The RN may determine that her original OASIS response is accurate and leave the assessment as originally completed. Or, the RN may select a different score based on the subsequent visit findings and report the new score as part of the SOC assessment. If the subsequent visit provides any information that is used to complete the comprehensive assessment, then the M0090 date should be changed to reflect the date the assessment was completed. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #3]

Q53. A patient is recertified on 2/21/07 for a new cert period starting 2/26/07. The patient goes into the hospital on 2/23/07 and is discharged from the hospital on 2/26/07. We go back out to see her on 1st day of new episode 2/26/07. Would she require a ROC or a SOC OASIS?

A53: Special guidance applies when the patient returns home from the inpatient facility on day 60 or 61. You will need to complete the ROC assessment and then make a decision based on the HIPPS code. If it did not change from the recert assessment, then you submit the ROC, as it is considered a continuous episode. If the HIPPS code did change from the recert assessment, home care would not be considered continuous and you would perform a "paper billing" discharge and then submit the assessment as a SOC. More details related to this guidance can be found in the Medicare Claims Processing Manual, Section 80-Special Billing Situations Involving OASIS Assessments located at <http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf> (see excerpt below)

"2. Beneficiary is Discharged From the Hospital on Day 60 or Day 61

A hospital discharge may occur on day 60 or day 61 and the HHA performs a Resumption of Care assessment which DOES NOT change the HIPPS code from a recertification assessment performed in the last 5 days (days 56-60) of the previous episode. In this case, home care would be considered continuous if the HHA did not discharge the patient during the previous episode. (Medicare claims processing systems permit "same-day transfers" among providers.) The RAP for the episode beginning after the hospital discharge would be submitted with claim "from" and "through" dates in FL 6 reflected day 61. The RAP would not report a new admission date in FL 17. The HIPPS code submitted on the RAP would reflect the recertification OASIS assessment performed before the beneficiary's admission to the hospital. This OASIS assessment would also be reflected in the claims-OASIS matching key in FL 63. This OASIS assessment would be submitted to the State Agency, as would the Resumption of Care assessment.

A hospital discharge may occur on day 60 or day 61 and the HHA performs a Resumption of Care assessment which DOES change the HIPPS code from a recertification assessment performed in the last 5 days (days 56-60) of the previous episode. In this case, home care would not be considered continuous and HHAs must discharge the beneficiary from home care for Medicare billing purposes. The RAP for the episode beginning after the hospital discharge would be submitted with claim "from" and "through" dates in FL 6 that reflected the first date of service provided after the hospital

discharge. The RAP would also report a new admission date in FL 17. The HIPPS code submitted on the RAP would reflect the OASIS assessment performed after the patient returned from the hospital. This OASIS assessment would also be reflected in the claims-OASIS matching key in FL 63. This OASIS assessment would be changed to indicate a Start of Care assessment prior to submission to the State Agency.” [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #4]

Q54. For a Medicare patient, a recert visit is done April 16th, which was the last day of the first cert period. The patient is hospitalized on April 18th, the second day of the new cert. No home care visits were provided in the new cert period before the hospitalization. Which assessments should be completed and is discharge required?”

A54: If the Medicare PPS patient had a recertification assessment visit during the last five days of the episode, and then experiences a qualifying hospitalization in the new episode, the agency should complete a transfer assessment. This is true whether or not any home care visits have been made in the new episode. The agency may select RFA 6 or 7, depending on agency policy and practice.

If the agency selects RFA 7, then when the patient returns to home care services, a new SOC should be completed.

If the agency selects RFA 6, then when the patient returns to home care services within the episode, a SOC/ROC comprehensive assessment should be completed. In order to determine if this assessment should be reported as a SOC or a ROC, the HHRG/HIPPS code resulting from the assessment responses should be determined. If the resulting HHRG/HIPPS code is the same as from the recertification assessment performed in the last 5 days of the previous episode, then the two episodes are considered continuous. In this case the assessment should be reported as a ROC, no discharge is required, and the care continues on under the original certification periods. This is an example of a situation in which the first visit in a new certification period could be the Resumption of Care visit.

If the resulting HHRG/HIPPS code is not the same as from the recertification assessment performed in the last 5 days of the previous episode, then the two episodes would not be considered continuous. In this case the patient should be discharged through completion of agency discharge paperwork or process, and the new assessment should be reported as a SOC, establishing a new episode with a new certification period. All assessments completed (the SOC and recertification assessments completed in the previous episode, the transfer, and the SOC or ROC assessment in the next episode) should be transmitted to the State Agency. A discharge OASIS assessment under the previous episode is not required, and if the home health agency completed an RFA 6 upon transfer and the episodes were eventually determined to not be continuous (under the conditions explained above), the agency does not need to “correct” the RFA 6, (by changing to an RFA 7, indicating discharge). The submission of the assessment sequence (SOC RFA 1, Recert RFA 4, Transfer RFA 6, SOC RFA 1...) will be accepted by the State Agency, and the documentation contained within the clinical record(s) should clarify the events.

More details related to this guidance can be found in the Medicare Claims Processing Manual, Section 80-Special Billing Situations Involving OASIS Assessments located at <http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf>, (see excerpt below)

3. Beneficiary is Admitted to Hospital on Day 61 Prior to Delivery of Services in the Episode

A beneficiary may be hospitalized in the first days of an episode, prior to receiving home health services in the new episode. These cases are handled for billing and OASIS identically to cases in which the beneficiary was discharged on days 60 or 61. If the HIPPS code resulting from the Resumption of Care OASIS assessment is the same as the HIPPS code resulting from the recertification assessment, the episode may be billed as continuous care. If the HIPPS code changes, the episode may not be billed as continuous care. The basic principle underlying these examples is that the key to determining if episodes of care are considered continuous is whether or not services are provided in the later episode under the recertification assessment performed at the close of the earlier episode. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #5]

Q55. In the new Q&As that were posted in May 2007 it states that if an agency has done a recert and then the patient goes to the hospital and the agency does a transfer without dc, then when the patient comes back the clinician does the comprehensive assessment. Depending on the HIPPS code would depend on if they did a ROC or a SOC. But what if the agency had not done the recert and the patient went to the hospital on day 58. When the patient comes out would they do a new SOC? (Since there is no HIPPS code to match up with).

A55: If a patient is transferred to the hospital on day 58, before the recertification assessment was completed, and the stay in the inpatient facility met the criteria for a Transfer, the agency would complete a Transfer OASIS. When the patient returns home, if it is on 59 or 60 and they have not been discharged from the home care agency, a Resumption of Care (RFA 3) assessment would be completed, and would satisfy both the ROC and the recertification requirements. If the patient's stay extends beyond the end of the current certification period, a SOC would be completed. The agency would also need to perform a "paper" discharge from the previous episode, (no OASIS DC required). [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #3]

Q56. If a patient converts to a payer requiring a new SOC, is it OK to do the SOC OASIS on next visit (under the new pay source) even if that visit isn't scheduled for up to a week after the last visit under the old payer?

A56: When a patient is changing pay sources to a payer which requires a new SOC, then the agency must provide an initial assessment visit within 48 hours of the time of referral or on the physician's ordered Start of Care date. If the orders for the new episode are for SN to begin on a date a week away, then the initial assessment visit and SOC Comprehensive Assessment may be completed one week after the discharge visit under the old pay source, if that meets the physician's ordered start of care date. Alternatively, the agency may have completed the initial assessment requirements (determined immediate care and support needs, and eligibility for the home health benefit if appropriate) at the last visit under the old pay source, in which case the SOC comprehensive assessment may still be conducted at the next visit (in a week), noting that if the patient were to develop problems and require services in between the visits,

the SOC may need to be completed sooner. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #1]

Q57. Has there been any regulatory changes that prohibit a nurse from doing the initial SOC OASIS if only therapy is ordered?

A57: There have not been any regulatory changes to the Condition of Participation (CoPs), 484.55, Comprehensive Assessment of Patient Standard (a) Initial assessment of patients. But the Standard does not prohibit a nurse from performing the initial assessment visit when there are therapy only orders. It states that the RN must complete the initial assessment visit when nursing orders exist at SOC. If there are therapy only orders, no nursing at all, the appropriate therapist may complete the initial assessment visit. Agencies are at liberty to develop policies that are more restrictive than the CoPs (e.g., policies that allow or require the RN to perform the initial assessment visit during a non-billable visit when there are no nursing orders at SOC). [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #2]

Q58. Medicare patient goes to hospital, agency completes RFA 6, Transfer, patient not discharged. Patient returns home with orders for one PT visit to evaluate new equipment. PT does eval and determines no further visits are necessary. Should HHA complete ROC, even though no further visits are going to be provided? And if the HHA completes the ROC, would they complete a DC on the same day?

A58: In responding to the question, it will be assumed that the single PT visit conducted at the resumption of care was a skilled and covered visit, that the resumption of care visit occurred within the existing 60-day episode, and that we are discussing a Medicare PPS patient.

A comprehensive assessment must be completed when the patient returns home from an inpatient stay of 24 hours or greater for any reason other than diagnostic tests, even though there will only be the one PT visit. The Conditions of Participation 484.55 Comprehensive Assessment of Patients, Standard (d) states:

The comprehensive assessment must be updated and revised within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests.

However, since 2002, OASIS is not a required part of the comprehensive assessment for known one-visit patient episodes. CMS Q&A Cat 2 Q43 clarifies that a ROC comprehensive assessment is required, even if it is the only visit conducted after the inpatient discharge, but that the assessment should be treated like a one-visit only episode at the start of care (i.e., comprehensive assessment is required, but OASIS data collection is not required). While there is not a regulatory requirement to collect OASIS as part of these assessments, there may be a reimbursement requirement by the payer to do so.

No discharge comprehensive assessment or OASIS is required when only one visit is made. The agency would complete their own internal discharge paperwork. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #4]