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 significant change in condition, and at discharge or transfer to an inpatient facility. The following paragraph explains the late 2003 restriction of OASIS data collection to Medicare and Medicaid patients only, which is documented on the Regulations page at http://www.cms.hhs.gov/oasis/hhregs.asp:

Effective December 8, 2003, Section 704 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) 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 memo was sent to surveyors on 12/11/03, which is accessible at http://www.cms.hhs.gov/oasis/default, scroll down and click on "Survey and Certification Policy Memoranda." It is memo #12 on the list.

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).

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. 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.

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 information on our OASIS/PPS webpage under OASIS Considerations for Medicare PPS patients found at http://www.cms.hhs.gov/oasis/oasispps.asp.

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 OASIS 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.

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. Our agency completes the Reduced Burden Recertification assessment that has only 26 items. Is this sufficient to meet the CoP for the follow-up assessment?

A7. The twenty-six OASIS items are not a complete comprehensive assessment and must also have either the agency-determined components of the Follow-Up assessment or a clinical note describing in detail the assessment results. 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.

Q8. We had a patient admitted to the hospital on April 15 and found out about it on April 19. When we enter the transfer (patient discharged) assessment (M0100 reason for assessment 7) into HAVEN, we get the following message: 'WARNING: Inconsistent M0090 date: Discharge record was not completed within HCFA timing guidelines. (M0090) date should be no earlier than (M0906) date AND no more than 2 days after M0906 date.

A8. This message is intended as a reminder that you should complete discharge assessments within 48 hours. The regulation states that the assessment must be completed within 48 hours of learning of a transfer to an inpatient facility, so in this case, the assessment has been completed in compliance. The warning will not prevent the assessment from being locked and transmitted. If you find that this warning occurs consistently, you may want to examine whether your staff are appropriately tracking the status of patients under their care.

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 when PT (or ST) is ordered along with an aide?

A11. Because this is considered a therapy-only case (i.e., therapy is the only skilled service), the PT (or ST) could perform the comprehensive assessment and all subsequent assessments.

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 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 could perform an assessment on or after the therapist's SOC date (within 5 days to be compliant with the regulation).

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. 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.

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. For those agencies that want to develop discipline-specific comprehensive assessments, we expect such assessments 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.

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

A17. For guidance on transferring patients with or without discharge, refer to the information on our OASIS/PPS page at http://www.cms.hhs.gov/oasis/oasispps.asp, scroll to the heading, OASIS Considerations for Medicare PPS Patients. 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).

Q18. I understand that the SOC (or Resumption of Care) initial 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 SOC initial assessment 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. As with the SOC, the agency should contact the physician to determine whether a delay in visiting will be detrimental.

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 skilled service is delivered, this visit is not considered the SOC nor is it considered a reimbursable visit. The SOC comprehensive assessment must be completed within 5 calendar days of 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 have made this visit the SOC comprehensive assessment. These protocols and procedures are a matter of agency choice and agency policy.

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 to close out the OASIS episode.

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 or, for therapy-only cases, any of the allowable disciplines (i.e., physical therapy, speech therapy, or occupational therapy) 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.

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, contact RSI at OASIShelp@rsihq.com to obtain a copy. 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/hhregs.asp; scroll to the "Federal Register Notices Published June 18.1999" and click on Patient Privacy Notices.

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.


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 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. Those items that can ONLY be obtained by interview all have a response option of 'unknown' at SOC. There are only two
exceptions to this, one being the patient's Medicare number (M0063), and the other 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 locked and 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.

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 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.

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 our OASIS/PPS webpage about 'OASIS Considerations for Medicare PPS Patients' found at http://www.cms.hhs.gov/oasis/oasispps.asp for suggestions in keeping your assessments in sync with Medicare billing.

Q31. Does OASIS data collection have to be initiated on the very first contact in the home, or is it OK to begin OASIS data collection on the admission 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. The comprehensive assessment is not required to be completed on the initial visit; however, agencies may do so if they choose.

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 visit prior to this date. 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.

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/104_claims/clm104c10.pdf; scroll to page 89 of the document to read "Section 80 - special Billing Situations Involving OASIS Assessments." Questions related to this document must be addressed to your RHHI.

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 learns of the discharge. (This is the date to be used for compliance with the encoding and locking period.)
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.

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 it is 'based on the visit of mm/dd/yyyy.' The OASIS data from this assessment will be encoded, locked, 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 learned of the 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](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 new 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/hhregs/asp, 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.

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. Effective December 2002, for a one-visit Medicare PPS patient, is Reason for Assessment 1 (RFA 1) the appropriate response for M0100? Should it be data entered? Should it be transmitted? Should a discharge OASIS assessment be completed?
A39. You are correct that RFA 1 is the appropriate response on M0100 for a one-visit Medicare PPS patient. The OASIS data should be encoded (data entered) to generate a Health Insurance Prospective Payment System (HIPPS) code and transmitted to the State system. 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 information must be collected or submitted, but 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.

Q40. Is the date that an assessment is completed, in M0090, required to coincide with the date of a home visit? When must the date in M0090 coincide with the date of a home visit?

A40. M0090, date assessment completed, records the date the assessment is completed. The start of care (SOC), resumption of care (ROC), follow-up, and discharge assessments (reason for assessments [RFA] 1, 3, 4, 5, and 9 for M0100) must be completed through an in-person contact with the patient; therefore these assessments will coincide with a home visit. The transfer or death at home assessments (RFAs 6, 7, or 8 for M0100) will have the date the agency learns of the event recorded here. However, in the rare instance that the clinician needs to follow up, off site, with the patient’s family or physician in order to complete a specific clinical data item that the patient is unable to answer, M0090 should reflect that date.

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. Complete the assessment, enter and submit the data, do not collect any further OASIS data. Agency clinical documentation should indicate that no additional visits occurred after the SOC assessment. 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.
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., complete the assessment, enter and submit the data, do not collect any further OASIS data). Agency clinical documentation should indicate that no additional visits occurred after the ROC assessment. 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.

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. What is required for the assessment of a non-Medicare one-time visit?

A45. No OASIS comprehensive assessment is required. However, the agency must provide an agency-determined comprehensive assessment to determine the needs of the patient.

Q46. Home health patients may return to the hospital after a single visit. Some HHAs treat these as one-time only visits, 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-time only visits for Start of Care or Resumption of Care visits that became effective December 16, 2002. Each patient must receive a comprehensive assessment. The agency is not required to assess 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]

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]