

## CATEGORY 1 – APPLICABILITY

**Q1. To whom do the OASIS requirements apply?** [Q&A EDITED 06/14 incorporating Previous CMS Qtrly 01/14 Q&A#1]

A1. The comprehensive assessment and OASIS data collection requirements apply to Medicare certified home health agencies (HHAs) and to Medicaid home health providers in States where those agencies are required to meet the Medicare Conditions of Participation. The comprehensive assessment requirement currently applies to all patients regardless of pay source, including Medicare, Medicaid, Medicare managed care (now known as Medicare Advantage), Medicaid managed care, and private pay/including commercial insurance. The comprehensive assessment must include OASIS items for all skilled Medicare, Medicaid, and Medicare or Medicaid managed care patients with the following exceptions: patients under the age of 18, patients receiving maternity services, patients receiving only chore or housekeeping services. Section 704 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 temporarily suspended OASIS data collection for non-Medicare and non-Medicaid patients. (The December 2003 notice detailing this temporary suspension can be accessed at <http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopofPage>, click on Policy & Memos to States and Regions, then look for Memo 04-12 on the list for 2004. OASIS requirements for patients receiving only personal care (non-skilled) services have been delayed since 1999. The transmission requirement currently applies to Medicare and Medicaid patients receiving skilled care only.

If care provided by the home health agency is billed to the Medicare Administrative Contractor (MAC) as traditional fee-for-service Medicare (M0150 #1) or billed to a State Medicaid Agency as traditional fee-for-service Medicaid (M0150 #3), OASIS data collection is required.

Likewise, if care provided by the home health agency is billed to an insurance company who has contracted with the Federal Agency (Medicare managed care – M0150 #2) or State Medicaid Agency (Medicaid managed care– M0150 #4), to pay for home health services with Federal Medicare or State Medicaid funds as a managed care plan, OASIS data collection is required.

If care provided by the home health agency is billed to a non-insurance company entity (an organization coordinating and/or providing patient care services; or providing case management services; reported as M0150 #6, #9, or #11), then OASIS data collection is not required, as funds, including those from Medicare/Medicaid sources, have been paid specifically to the non-insurer coordinating organization, and may not be specific to home health services.

Note: When Medicare PPS is the payer for a patient otherwise excluded from the OASIS requirements (i.e., pediatric or maternity patients), the OASIS payment items must be collected in order to calculate a HIPPS code required for inclusion on the claim. While required for billing, the OASIS data for these excluded patients is not required to be submitted to the OASIS system.

**Q1.1. We are a pediatric Medicaid certified home healthcare agency. We are currently collecting OASIS data on several clients over the age of 18. If we were not Medicare certified, would we need to continue to collect OASIS on these clients?** [Q&A EDITED 06/14; ADDED 09/09; Previously CMS OCCB Q&A 04/09 Q&A #1]

A1.1. First, if you are solely a Medicaid home health provider and not a Medicare certified provider, you would only be required to collect OASIS if your state requires you to meet the Medicare Conditions of Participation.

If, as an organization, you are required to collect and submit OASIS because your state requires you to meet the Medicare Conditions of Participation, you must do so on all skilled Medicare and Medicaid patients except those under the age of 18, maternity patients, and personal care only patients .

**Q1.2. A patient turns 18 while in the care of an HHA -when do we do the first OASIS assessment?** [EDITED 06/14; Formerly Q&A #8]

A1.2. If the patient is under age 18 and the home care is covered under Medicare PPS, the HHA must complete the comprehensive assessment, including the OASIS, to obtain a Medicare PPS (HHRG/HIPPS) code. The HHRG/HIPPS code is submitted on the request for advance payment (RAP). The OASIS data would not be submitted to the OASIS system. For a skilled Medicare/Medicaid patient who turns 18 while under the care of an HHA, the comprehensive assessment with OASIS data collection and submission to the OASIS system would occur the first time one of the following events takes place: 1-When patient returns home from a qualifying inpatient stay -Resumption of Care, i.e., RFA#3; 2-When patient is transferred to an inpatient facility for 24 hours or longer (for a reason other than diagnostic tests) -Transfer to an Inpatient Facility -RFA#6 if not discharged from the HHA or RFA#7 if discharged from the HHA; 3-When the 60 day recertification is due, i.e., the last five days of the certification period -Follow-up, i.e., RFA#4; 4-When there is a major decline or major improvement in the patient's condition to update the care plan -Other follow-up, i.e., RFA#5; or 5-On death of the patient at home, or when the patient is discharged from the agency i.e., RFA#8 -death or RFA#9 -normal discharge.

If the patient is not a Medicare or Medicaid patient, other regulations apply. Effective December 8, 2003, OASIS data collection for non-Medicare/non-Medicaid patients was temporarily suspended under Section 704 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. Note that the Conditions of Participation (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. To access the CoP, go to <http://www.cms.hhs.gov/center/hha.asp>, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category.

A memo was sent to surveyors on 12/11/03, "The Collection and Transmission of the Outcome and Assessment Information Set (OASIS) for Private Pay Patients," which you can access by going to the CMS OASIS web site at <http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopofPage>, click on Policy & Memos to States and Regions, then look for Memo 04-12 on the list for 2004.

**Q1.3. It is my understanding that OASIS collection is not required for Medicare patients under the age of 18. How do you submit a claim with the appropriate HIPPS/HHRG if you do not complete the OASIS assessment? If you do complete an OASIS assessment, can it be submitted to the OASIS system? Where would I search on the website for this type of information?** [Q&A EDITED 06/14; ADDED 09/09; Previously CMS OCCB Q&A 10/07 Q&A #1]

A1.3. The Conditions of Participation do not require OASIS data collection on pediatric patients. However, if Medicare is the payer, at least the payment OASIS items would have to be collected in order to generate the payer requirement of a HHRG/HIPPS code. HAVEN or other software may be used to generate the HIPPS/HHRG code. This code would be submitted to the

Medicare Administrative Contractor (MAC) for billing purposes only. The data should not be submitted to the OASIS system. The OASIS system will reject any incomplete assessments or any data submitted for patients younger than 18 years of age.

For further information regarding data submission, contact your OASIS Automation Coordinator (OAC). Contact information is available at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/AutomationCoord.html>. For further information about coverage or billing, contact your MAC.

2. [Q&A RETIRED 09/09; REDUNDANT TO GUIDANCE FOUND IN Q&A #2.1]

**Q2.1. Do we need to collect OASIS on a patient admitted to home health with post-partum complications? If we open a patient 2-3 months after a C-section for infection of the wound, do we collect OASIS, or do we consider this "maternity"? What is the definition of "maternity" and when do we collect OASIS on these patients?** [Formerly Q&A #11; EDITED 09/09; ADDED 08/07; Originally CMS OCCB Q&A 05/07 Q&A #1]

A2.1. The Conditions of Participation do not require OASIS data collection for patients receiving only maternity-related services. If the patient was a Medicare PPS patient, the OASIS data would be required in order to generate an HHRG/HIPPS code for payment under PPS.

Post-partum complications and a wound infection in the C-section incision are only possible in maternity patients. Maternity patients are patients who are currently or were recently pregnant and are receiving treatment as a direct result of the pregnancy.

**Q3. How do the OASIS regulations apply to Medicaid HHA programs? Do the OASIS regulations apply to HHAs operating under Medicaid waiver programs?** [Q&A EDITED 06/14]

A3. The OASIS regulations apply to HHAs that must meet the home health Medicare Conditions of Participation (CoP). An agency that currently must meet the Medicare CoP under Federal and/or State law will need to meet the CoP related to OASIS and the comprehensive assessment. If an HHA operates under a Medicaid waiver, and if that State's law requires HHAs to meet the Medicare CoP in order to operate under the Medicaid waiver, then OASIS applies. If an HHA operates under a Medicaid waiver, and if that State's law does not require that the HHA meet the Medicare CoP in order to operate under the Medicaid waiver, then OASIS does not apply. HHAs should be aware of the rules governing HHAs in their State. Currently, OASIS requirements apply to all patients receiving skilled care reimbursed by Medicare, Medicaid, and Medicare or Medicaid managed care patients with the following exceptions: patients under the age of 18, patients receiving maternity services, and patients receiving only chore or housekeeping services. OASIS requirements have been delayed for patients receiving only personal care (non-skilled) services.

**Q4. We are an HHA that also provides hospice services. Do the OASIS requirements apply to our hospice patient population? What if they are receiving 'hospice service' under the home care agency (not the Medicare hospice benefit)? Would OASIS apply?** [Q&A EDITED 08/07]

A4. Medicare Conditions of Participation (CoP) for home health are separate from the rules governing the Medicare hospice program. Care delivered to a patient under the Medicare home health benefit needs to meet the Federal requirements put forth for home health agencies, which include OASIS data collection and reporting for skilled Medicare and Medicaid patients. Care delivered to a patient under the Medicare hospice benefit needs to meet the Federal requirements put forth for hospice care, which do not include OASIS data collection or reporting.

However, if a Medicare patient is receiving skilled terminal care services through the home health benefit, OASIS applies.

**Q5. We have a branch of our agency that serves non-Medicare patients. Can you elaborate on whether we need to do the comprehensive assessment with OASIS for these patients? We do serve Medicaid patients from this branch --does this make a difference?**

A5. If an HHA is required to meet the Medicare Conditions of Participation (CoP), then all of the CoP apply to all branches of that agency including the comprehensive assessment and OASIS data collection. Whether the agency has different branches operating under a single provider agreement/number serving different patient populations does not matter. Some States, as a part of State licensure or certification, allow HHAs to establish completely separate entities for serving other than Medicare/Medicaid patients. If the separate entity does not have to comply with the Medicare CoP for any reason (e.g., they do not have to meet the Medicare CoP to compete for managed care contracts, etc.) and the individual State does not require Medicare compliance, then none of the CoP applies. To be considered a separate entity, several requirements must be met, including separate incorporation for tax and business purposes, separate employer IDs, separate staff, separate billing and cost reporting systems, etc. If this separate entity is not meeting the Medicare CoP, then it cannot be using Medicare certification for any reason, including payment or competing for contracts.

**Q6. Does the patient's payer source matter? Should we collect OASIS data on private pay patients who are only paying for aide service? What about a patient receiving therapy services under Medicare Part B? [Q&A EDITED 06/14]**

A6. Effective December 8, 2003, OASIS data collection for non-Medicare/non-Medicaid patients was temporarily suspended under Section 704 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. Note that the Conditions of Participation (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 in fiscal year 2004)

If the agency provides services to a private pay patient paying for personal care services only, e.g. aide services the agency would be required to conduct a comprehensive assessment, excluding OASIS, of the patient. A comprehensive assessment is not required if only chore or housekeeping services are provided.

If care provided by the home health agency is billed to a non-insurance company entity (an organization coordinating and/or providing patient care services; or providing case management services; reported as M0150 #6, #9, or #11), then OASIS data collection is not required, as funds, including those from Medicare/Medicaid sources, have been paid specifically to the non-insurer coordinating organization, and may not be specific to home health services.

The Medicare home health benefit exists under both Medicare Part A and Medicare Part

B. Patients receiving skilled therapy services under the Medicare home health benefit that are billed to Medicare Part B would receive the comprehensive assessment (including OASIS items) at the specified time points if care is delivered in the patient's home. If a Medicare patient receives therapy services at a SNF, hospital, or rehab center as part of the home health benefit simply because the required equipment cannot be made available at the patient's home, the Medicare Conditions of Participation apply, including the comprehensive assessment and collection and reporting of OASIS data. However, if the services are provided to a patient RESIDING in an inpatient facility, then these are not considered home care services, and the comprehensive assessment would not need to be conducted.

If a Medicare beneficiary receives outpatient therapy services from an approved provider of outpatient physical therapy, occupational therapy, or speech-language pathology services under the Medicare outpatient therapy benefit (as opposed to the Medicare home health benefit), then OASIS requirements would not apply. Bear in mind that under PPS, if the patient is under a home health plan of care, the outpatient therapy is bundled into the prospective payment rate and is not a separate billable service. See our February 12, 2001 Survey and Certification memorandum (#3 for 2001) at

<http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopofPage>, "The Application of OASIS Requirements to Medicare Beneficiaries...", for more information on the applicability of OASIS to Medicare beneficiaries.

**Q7. When a nurse visits a patient's home and determines that the patient does not meet the criteria for home care (e.g., not homebound, refuses services, etc.), is the comprehensive assessment required? What about OASIS data collection?** [Q&A EDITED 06/14]

A7. If the individual was determined to not be eligible for services, the patient would not be admitted for care by the agency, and no comprehensive assessment or OASIS data collection would be required. No data would be transmitted to the OASIS system.

**Q8.** [Q&A RENUMBERED; now Q&A #1.2]

**Q9. Can you explain the term 'skilled service'?** [Q&A EDITED 08/07]

A9. Skilled services covered by the Medicare home health benefit are discussed in the Medicare Benefit Policy Manual. This publication can be found on our website at: <http://www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf>.

**Q10. What is the current status of OASIS applicability to patients receiving only personal care services?**

A10. The applicability of OASIS to patients receiving only personal care services is delayed and will remain so until a new Federal Register notice is published that announces otherwise.

**Q11.** [Q&A RENUMBERED; now Q&A #2.1]