CMS OASIS Q&As: CATEGORY 2 - COMPREHENSIVE ASSESSMENT

Q1. When are we required to collect OASIS? [Q&A EDITED 10/18; EDITED 06/14]

A1. OASIS reporting regulations apply to all Home Health Agencies (HHAs) required to meet the Medicare Conditions of Participation and are applied to all skilled Medicare and Medicaid patients of that HHA, with some exceptions. Skilled Medicare and/or Medicaid patients who are excluded from the OASIS requirements include:

- Patients under the age of 18
- Patients receiving pre- & post-partum maternity services
- Patients receiving personal care only

Per regulatory requirements, patient's requiring OASIS will be identified on **M0150 - Current Payment Source** by one or more of the following responses:

- 1 – Medicare (traditional fee for service)
- 2 – Medicare (HMO/managed care/Advantage plan)
- 3 – Medicaid (traditional fee for service)
- 4 – Medicaid (HMO/managed care).

OASIS data collection time points are described in OASIS Guidance Manual instruction for **M0100 Reason for Assessment**, and include:

- Start of Care (SOC)
- Resumption of Care (ROC)
- Recertification (Follow-up)
- Major decline or improvement in patient's health status (Other Follow-up)
- Transfer to an Inpatient Facility
- Discharge (DC)
- Death at Home (DAH)

Based on CMS policy, OASIS data collection is not required when only one visit is made in a quality episode (SOC/ROC to TRN/DC/DAH), and OASIS data collection at discharge is never mandated in these situations of single visits in a quality episode.

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. What would I need to do to comply with the OASIS collection requirements? [Q&A EDITED 10/18; EDITED 06/14, M number updated]

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 (if that was the date you completed the data collection after learning 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, or on the physician-ordered Resumption of Care date to complete the Resumption of Care visit, 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 M1000, when the inpatient facility discharge date was more than 14 days prior to the M0032 ROC date, NA is the appropriate response.

Q2.1. [RETIRED 10/18]

Q2.2. [RETIRED 10/18]

Q3. Do we have to complete an OASIS discharge on a patient who has been hospitalized over a specific time period? [Q&A EDITED 01/11]

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.

When a patient is transferred to the inpatient facility, it should be assessed if the agency anticipates the patient will be returning to service or not. If the HHA plans on the patient returning after their inpatient stay or if the patient's return to service is unsure, the RFA6 should be completed. There will be times when the RFA7 is necessary to use, but only when the HHA does NOT anticipate the patient will be returning to care. There are several reasons why the RFA7 may be used, including these examples: the patient needs a higher level of care and no longer appropriate for home health care, the patient's family plans on moving the patient out of the service area, or the patient is no longer appropriate for the home health benefit.

The Claims Processing Manual clarified this issue in July 2010 and directs providers to not discharge a patient when goals are not met at the time of a transfer. If a provider does discharge and readmit within the same payment 60-day episode, a Partial Episodic Payment (PEP) adjustment will be automatically made.

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.qtso.com/hhadownload.html

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.

Q4.1. Are Social Workers permitted to review and/or audit OASIS documents and provide guidance to the qualified assessing clinician/agency? [Q&A ADDED 04/15; Previously CMS Qtrly 01/15 Q&A #3]

A4.1. CMS defines a qualified clinician for the purpose of collecting and documenting accurate OASIS data as a Registered Nurse, Physical Therapist, Speech-Language Pathologist, or Occupational Therapist. The qualifications of individuals doing a quality review of the comprehensive assessment, including OASIS items, and/or providing education and instruction related to OASIS data collection should be defined by agency policy.

Q5. What comprehensive assessments do I need to complete on my Medicare PPS patients? [Q&A EDITED 12/12]

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, when there has been a major change in the patient's health status, and at discharge. When a patient is transferred to an inpatient facility for 24 hours or longer for reasons other than diagnostic testing or dies at home, a brief number of OASIS data items must be collected, but no Discharge comprehensive assessment is required.

Q6. Does information documented in OASIS have to be backed up with documentation elsewhere in the patient's records? [Q&A EDITED 10/18; Q&A EDITED 12/12]

A6. There is no regulatory requirement that OASIS assessment data be duplicated elsewhere in the patient record.

Q7. At Recertification, our agency collects only the Reduced Burden OASIS items. Is this sufficient to meet the CoP for the follow-up assessment? [Q&A EDITED 09/09]

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.

Q8. [Q&A RETIRED 08/07; Duplicate of CMS Q&A Cat. 4b, Q&A #15]

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.

Q9.1. We received an order for nursing and PT. The nurse conducted the initial assessment visit and determined that the patient did not have any justifiable nursing need, but did have a need for PT services. Because there was an order for nursing present with the original orders, is the RN required to complete the SOC comprehensive assessment? Or since nursing services are not necessary, can the PT complete the SOC comprehensive assessment on or within 5 days after the PT establishes the start of care? [Q&A ADDED 04/15; Previously CMS Qtrly 10/14 Q&A #1]

A9.1. Since an order for nursing existed at the time of the initial referral, the RN must complete the initial assessment visit. If it is determined during the initial assessment visit, that the patient either did not have a need for nursing services and/or the patient declined all nursing services, the SOC will not be established by that visit. The RN can notify the physician that nursing will not be involved in the patient's care, and either continue on to complete the SOC comprehensive assessment (if the PT will be establishing the SOC that day), OR have the PT complete the SOC comprehensive assessment on or within 5 days after the PT establishes the start of care.

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? [Q&A EDITED 08/07]

A11. Because no nursing orders exist, the PT (or ST) could perform the comprehensive assessment at the SOC 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? [Q&A EDITED 09/09]

A12. A comprehensive assessment performed on a date BEFORE the SOC date cannot be entered into HAVEN (or HAVEN-like software) and does not meet the requirements of the regulations. 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).

Q12.1. If an agency sends an RN out on Sunday to provide a non-billable initial assessment visit for a PT only case and the PT establishes the Start of Care on Monday by providing a billable service, is the 60-day payment episode (485 "From" Date) Sunday or Monday? [Q&A ADDED 09/09; Previously CMS OCCB 04/08 Q&A #1]

A12.1. The Medicare Benefit Policy Manual explains: "10.4 - Counting 60-Day Episodes (Rev. 1, 10-01-03) HH-201.4 A. Initial Episodes The "From" date for the initial certification must match the start of care (SOC) date, which is the first billable visit date for the 60-day episode. The "To" date is up to and including the last day of the episode which is not the first day of the subsequent episode. The "To" date can be up to, but never exceed a total of 60 days that includes the SOC date plus 59 days."

The "To" date (the 60th day of the payment episode) marks the end of the payment episode for the purposes of determining if a subsequent episode is adjacent or not for M0110 Episode Timing.

The Start of Care is established when a service is provided that is considered reimbursable by the payer. If an agency sends a clinician to the patient's home to provide a non-billable service, it does not establish the Start of Care. The Medicare PPS 60 day payment episode (485 From Date) begins on the date the first billable service is provided. In your scenario, the episode begins on Monday when the PT provides a billable service.

This guidance can be found in the Medicare Benefit Policy Manual

http://www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf

Q12.2. M0080. Can a speech therapist do a non-bill admission for a physical therapy only patient? [Q&A EDITED 01/12; ADDED to Cat. 2 01/11; EDITED 09/09; Previously CMS OCCB 04/08 Q&A #3; Also in Cat 4b Q&A #13.1]

A12.2. The Comprehensive Assessment of Patients Condition of Participation (484.55) states in Standard (a) (2) "When rehabilitation therapy service (speech language pathology, physical therapy, or occupational therapy) is the only service ordered by the physician, and if the need for that service establishes program eligibility, the initial assessment visit may be made by the appropriate rehabilitation skilled professional." Some agencies' policies make this practice more restrictive by limiting some of the allowed disciplines (i.e., PT, OT, and/or SLP) from completing the initial assessment visit and/or comprehensive assessment, and require an RN to complete these tasks, even in therapy only cases where the therapy discipline establishes program eligibility for the payer. While not necessary, it is acceptable for agencies to implement this type

of more stringent/restrictive practice. Even though there are no orders for nursing in a therapy only case, the RN may complete the initial assessment visit and the comprehensive assessment, as nursing, as a discipline, establishes program eligibility for most, if not all payers.

In a case where PT is the only ordered service, and assuming physical therapy services establish program eligibility for the payer, the PT could conduct the initial assessment visit and the SOC comprehensive assessment. Likewise, assuming skilled nursing services establish program eligibility for the payer, the RN could complete these tasks as well, even in the absence of a skilled nursing need and related orders. If speech pathology services were also a qualifying service for the payer, it would be acceptable, although not required, for the SLP to conduct the initial assessment visit and/or complete the comprehensive assessment for the PT only case, even in the absence of a skilled SLP need and related orders. Likewise, a PT could admit, and complete the initial assessment visit and comprehensive assessment for an SLP-only patient, where both PT and SLP were primary qualifying services (like the Medicare home health benefit).
It should be noted that under the Medicare home health benefit (and likely under other payers as well), the visit(s) made by the RN, (or SLP, or PT, etc.) solely to complete the initial assessment and comprehensive assessment tasks (there is no medically-necessary need for the discipline) would not be reimbursable visits, therefore would not establish the start of care date for the home care episode.

Q13. Who can perform the comprehensive assessment when OT services are the only ones ordered for a non-Medicare patient? [Q&A EDITED 08/07]

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.

Q13.1. Can an OT establish the plan of care and perform the SOC assessment when a Medicare Advantage plan is the payer? [Q&A ADDED 01/11; Previously CMS OCCB 04/10 Q&A #2]

A13.1. OT does not establish eligibility for the Medicare Traditional Home Health benefit. Therefore, an OT may not perform the initial assessment or complete the SOC comprehensive assessment on Medicare traditional fee-for-service (PPS) patients. Other payers, such as Medicaid, Medicare Advantage plans, or private insurers, may have different coverage guidelines that would allow OT to establish eligibility for each respective home health benefit. It will be necessary to contact the payer to find out if the Occupational Therapy discipline establishes program eligibility for that payer, to determine if OT may perform the initial assessment visit and the SOC comprehensive assessment.

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? [Q&A EDITED 12/12]

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/center/hha.asp, click on "Conditions of Participation 484.55, Comprehensive Assessment of Patients" in the "Participation" category.

Q15.1. My patient was released from the hospital and needed an injection that evening. The case manager was unavailable and planned to resume care the following day. Could the on-call nurse visit and give the injection before the resumption of care assessment is completed? Is there a time frame in which care (by an LPN or others) can be provided prior to the completion of the ROC assessment? [Q&A EDITED 10/18; Q&A ADDED & EDITED 9/09; Previously CMS OCCB 01/09 Q&A #5]

A15.1. It is not required that the ROC comprehensive assessment be completed on the first visit following the patient's return home. OASIS guidance states that the Resumption of Care comprehensive assessment document must be completed within 2 calendar days of the facility discharge date, knowledge of patient's return home, or within 2 calendar days of a physician-ordered ROC date. The clinician that completes the ROC comprehensive assessment document must be an RN, PT, OT or SLP.

Q15.1.1. What do we do if the agency is not aware that the patient has been hospitalized and then discharged home, and the person completing the ROC visit (i.e., the first visit following the inpatient stay) is an aide, a therapist assistant, or an LPN? [Q&A ADDED to Cat. 2 01/12; ADDED to Cat. 4b 08/07 as Q&A #23.3; Previously CMS OCCB 07/06 Q&A #5]

A15.1.1. When the agency does not have knowledge that a patient has experienced a qualifying inpatient transfer and discharge home, and they become aware of this during a visit by an agency staff member who is not qualified to conduct an assessment, then the agency must send a qualified clinician (RN, PT, OT, or SLP) to conduct a visit and complete both the transfer (RFA 6) and the ROC (RFA 3). Both assessments should be completed within 2 calendar days of the agency's knowledge of the inpatient admission. The ROC date (M0032) will be the date of the first visit following an inpatient stay, conducted by any person providing a service under your home health plan of care, which, in your example would be the aide, therapist assistant, or LPN.

The home health agency should carefully monitor all patients and their use of emergent care and hospital services. The home health agency may reassess patient teaching protocols to improve in this area, so that the patient advises the agency before seeking additional services.

Q15.1.2. Patient admitted to home health services under Medicare payer in December and discharged January. During the episode the patient was in the hospital for observation, according to the HH medical record, so no Transfer nor Resumption of care OASIS assessments were completed. The patient was seen by a RN the day following return home from the 'observation' stay. Now, months later, the hospital informed us that Medicare shows the patient had an open home health episode, so the hospital claim is being denied by Medicare. Their records indicate the patient was in fact admitted, not kept in observation stay. What is the proper action – if any - at this point to correct the OASIS for this episode? [Q&A ADDED 10/16; Previously CMS Qtrly 07/16 Q&A #1]

A15.1.2. When an agency is notified that a patient has had a qualifying inpatient facility admission, a missed Transfer and Resumption of Care assessment would be completed as soon as the agency becomes aware of the missed assessment(s), recognizing that in some situations (as with a patient discharge, death, relocation, etc.) a home visit to conduct the Resumption of Care assessment visit may not be possible. In the scenario cited, even if the Resumption of Care assessment is not able to be completed because necessary data to complete the assessment is not available, the Transfer assessment (RFA 6 – Transfer without

agency discharge) would be completed to end the patient's quality episode with the M0906 date being the date the patient transferred to the hospital, and the M0090 Data Assessment Completed would be the day the agency completes the transfer data collection.

Q15.2. Who can complete the OASIS data collection that occurs at the Transfer and Death at Home time points? Can someone in the office who has never seen the patient complete them? Does it have to be an RN, PT, OT or SLP? [Q&A EDITED 04/15; ADDED 09/09; Previously CMS OCCB 01/09 Q&A #4]

A15.2. Since the Transfer and Death at Home OASIS time points require data collection and not actual patient assessment findings, any RN, PT, OT or SLP may collect the data, as directed by agency policy. The OASIS Guidance Manual, under M0100, explains that a home visit is not required at these time points. As these time points are not assessments and do not require the clinician to be in the physical presence of the patient, it is not required that the clinician completing the data collection must have previously visited the patient. The information can be obtained over the telephone by any RN, PT, OT or SLP familiar with OASIS data collection practices. This guidance applies only to the Transfer and Death time points, as a visit is required to complete the comprehensive assessments and OASIS data collection at the Start of Care, Resumption of Care, Recertification, Other Follow-up and Discharge.

Q15.3. Would it be acceptable if we have the clinician complete the discharge comprehensive assessment in the home for those items that require direct observation and/or interview of the patient and then ask office-based staff to research and document those items requiring only a review of the record, (e.g., M2005 Medication Intervention, M2016 Patient Caregiver Drug Education Intervention, M2401 Intervention Synopsis)? [Q&A EDITED 10/18; Q&A ADDED 01/11; Previously CMS OCCB 04/10 Q&A #1]

A15.3. The comprehensive assessment is the responsibility of one clinician. The assessing clinician responsible for completing the comprehensive assessment may work collaboratively and elicit feedback from other agency staff, in order to complete any or all OASIS items integrated within the Comprehensive Assessment. This may include collaborating with others in the office to allow completion of items.

All staff, including professional assistants or non-clinical staff functioning within the scope of their practice and state licensure as applicable, may perform a record review and communicate the findings to the assessing clinician, who would be responsible for confirming and validating that information used to complete the assessment. In these collaborative situations, it is the single assessing clinician who will complete the comprehensive assessment after any appropriate collaboration has occurred.

Q15.4. [RETIRED 10/18]

Q16. How does the agency develop a SOC comprehensive assessment that is appropriate for therapy-only cases? [Q&A EDITED 10/16; EDITED 04/15]

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 Appendix A of the OASIS Guidance Manual located at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html under "Downloads".

Q17. Are we required to discharge patients from the agency when they are admitted to an inpatient facility? [Q&A EDITED 01/11]

A17. When a patient is transferred to the inpatient facility, it should be assessed if the agency anticipates the patient will be returning to service or not. If the HHA plans on the patient returning after their inpatient stay, the RFA 6 should be completed. There will be times when the RFA 7 is necessary to use, but only when the HHA does NOT anticipate the patient will be returning to care. There are several reasons why the RFA 7 may be used, including these examples: the patient needs a higher level of care and no longer appropriate for home health care, the patient's family plans on moving the patient out of the service area, or the patient is no longer appropriate for the home health benefit.

The Claims Processing Manual clarified this issue in July 2010, and directs providers to not discharge a patient when goals are not met at the time of a transfer. If a provider does discharge and readmit within the same payment 60-day episode, a Partial Episodic Payment (PEP) adjustment will be automatically made.

Q17.1. During the SOC visit, the nurse completed all consents, OASIS, etc. and was nearing the end of her visit. The patient developed symptoms which required transport to the ER. The patient was kept overnight for observation and then sent home. Do we have a Start of Care? Can we bill for the visit? If we don't bill, do we still have to do the SOC OASIS? [Q&A EDITED 10/16; ADDED 09/09; Previously CMS OCCB 10/07 Q&A #2]

A17.1. In the scenario presented, you describe a case in which an initial assessment was conducted, it was determined the patient met the payer's eligibility and your agency's admission criteria and a comprehensive assessment was begun, if not completed. If a reimbursable service was provided, it would have established the Start of Care. If the OASIS assessment was not completely finished and the criteria for a Transfer to Inpatient was not met, the same clinician would have up to 5 days after the SOC date to complete the RFA 1, SOC comprehensive assessment. If the same clinician was unable to complete the SOC comprehensive assessment, a second clinician could visit the patient and start and complete a new SOC assessment within 5 days after the SOC date. The SOC date was established when the first reimbursable service was provided.

If no billable service was provided before the patient was transported to the ER, the Start of Care was not established and a new SOC would be completed upon return home from the inpatient facility.

Based on CMS policy, OASIS data collection and submission is not required when only one visit is made in a quality episode (SOC/ROC date to TRF/DC). However, to bill Medicare PPS for a single visit payment episode, OASIS data must be collected and submitted to the OASIS system, and used to calculate a HIPPS code for inclusion on the Medicare claim. If you choose NOT TO BILL Medicare for the single visit provided, there is no requirement to collect and transmit OASIS data for single visit episodes.

Questions related to coverage and billing are addressed in the Medicare Policy Benefit Manual which is located at: http://www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf and the Claims Processing Manual located at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c10.pdf

Q17.1.1. An initial assessment with skilled service Start of Care (SOC) was performed on 1/24/14 (the SOC comprehensive assessment with OASIS was begun, but not completed). Later in the day, the patient was admitted to the hospital and returned home on 1/26. The comprehensive assessment with OASIS data collection was completed on 1/26, within the 5 day window. Since the comprehensive assessment was completed after the

hospital admission, we did not do a Transfer or ROC. Was this correct? [Q&A EDITED 10/18; Q&A ADDED 06/14; Previously CMS Qtrly 04/14 Q&A #1]

A17.1.1. In your case, the initial assessment visit was made, a billable service was provided establishing the SOC and the SOC comprehensive assessment was begun but not completed before the qualifying stay in the inpatient facility. When the patient returned to your care on 1/26 which was within the allowed 5 day SOC assessment time frame, the same assessing clinician could complete the SOC comprehensive assessment that was begun on the first visit. M0030, Start of Care Date, remains the date of the first billable visit. M0090, Date Assessment Completed, is the actual date the assessing clinician completed the SOC assessment document.

Unless it had already been completed by someone else, the clinician who completes the SOC assessment on 1/26 may also complete the RFA 6-Transfer. The agency would then complete the ROC assessment within 2 calendar days of the patient's inpatient facility discharge date. This ROC assessment may also be completed on the 1/26 visit, by the same clinician who completes the SOC assessment and the OASIS Transfer data collection.

Q17.2. How do I handle a discharge on a Medicare patient who decides they are going to receive hospice in their home? M0100 only gives the option to transfer if it is to an inpatient facility not if the patient is opting to receive Hospice in the home which is not an inpatient facility. [Q&A ADDED & EDITED 09/09; Previously CMS OCCB 04/09 Q&A #4]

A17.2. If you need to discharge a patient from Medicare home health when they move to the Medicare Home Hospice benefit, you are required to complete the RFA 9, Discharge comprehensive assessment. M2420, Discharge Disposition, will be Response "3-Patient transferred to a noninstitutional hospice."

Q18. I understand that the initial assessment visit (or Resumption of Care) is to be done within 48 hours of the referral (or inpatient 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." [Q&A EDITED 10/18; Q&A EDITED 06/14]

A18. The initial assessment visit at SOC (or the Resumption of Care visit) must be completed within 48 hours of the referral, within 48 hours of the patient's return home OR on the physician-ordered SOC/ROC date. In the absence of a physician-ordered SOC/ROC date, if the patient refuses a visit within this 48-hour period, the agency may contact the physician to determine whether a delay in visiting would be detrimental to the plan of care and request a change in the SOC/ROC date.

Q19. An RN visited a patient for Resumption of Care following discharge from a hospital on March 2nd. 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? [Q&A EDITED 10/18; Q&A EDITED 10/16]

A19. Any partial assessment that was completed can be filed in the patient record, but jHAVEN (or jHAVEN-like software) will not allow a partial assessment to be exported for submission to the OASIS system.

- If, after the 911 call, the patient is admitted to an inpatient facility and then later returns home again after a qualifying inpatient transfer, a Resumption of Care assessment would be indicated within 48 hours of the hospital discharge or on a Physician-Ordered Resumption of Care date, if applicable.

- If the 911 call results in the ED treating the patient and sending the patient back home, the Resumption of Care assessment would be completed within 2 calendar days of the patient's March 2nd discharge from the inpatient facility.

Q20. Can you clarify the difference between the 'initial assessment' and the 'comprehensive assessment?' [Q&A EDITED 01/11]

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. If the admitting clinician was able to complete the SOC comprehensive assessment on this initial visit as well, 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.

Q20.1. Can our agency send out a non-clinical person to be the initial contact with a patient, to explain forms, collect signed consent forms, HIPAA forms, patient rights forms, etc, and collect demographic information to pass on to the assessing clinician who will visit the patient at some point after this "intake visit" to conduct the initial assessment visit, and the comprehensive assessment? Does this practice violate the need to have an RN, PT, OT or SLP conduct the initial assessment visit? Would the answer change if the person going to the home first to do the "intake visit" was an LPN? [Q&A ADDED 09/09; Previously CMS OCCB 01/09 Q&A #1]

A20.1. The Comprehensive Assessment of Patients Condition of Participation (484.55) requires that the initial assessment visit must be completed by an RN, if nursing orders exist at the SOC and by an appropriate, qualified therapist if no nursing orders exist. It would not meet the requirements of the Condition for an individual who is not qualified to perform assessments to enter the home before the skilled clinician who will be performing the initial assessment. This requirement is designed to ensure that the patient's immediate needs can be assessed and met. If an agency allowed a non-clinical person to enter the home to collect demographic information and explain rights and responsibilities, etc, it is possible that a potentially life threatening condition may not be assessed and treated. LPNs are not qualified to complete assessments so therefore it would not be compliant with the Condition to allow an LPN to conduct the initial assessment.

The agency may have a non-clinical person (or LPN, etc.) contact the patient by phone prior to the initial assessment visit to gather or impart some of the information related to patient rights and services, but the actual first visit to the home constitutes the initial assessment visit and must follow conditions outlined in the CoPs.

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? [Q&A EDITED 08/07]

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.

Q22.1. If a patient dies in the ER or after being admitted to the inpatient bed, but has not yet met the criteria for a true transfer situation (24 hrs or more, for reasons other than diagnostic tests) the guidance states we should perform an RFA 7. What if the patient receives care in the ER and dies after they have been transferred to floor for observation under one of the outpatient observation service G codes? [Q&A ADDED 01/12; Previously CMS OCCB 01/11 Q&A #1**]**

A22.1. An RFA 7, Transferred to an Inpatient Facility - patient discharged is completed.

Q22.2. Which OASIS do we complete if the patient expires during outpatient surgery or in the care of the recovery room after outpatient surgery? [Q&A ADDED 01/12; Previously CMS OCCB 01/11 Q&A #2]

A22.2. An RFA 7, Transfer to Inpatient Facility; patient discharged is completed.

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? [Q&A EDITED 09/09]

A23. The Transfer assessment completed the requirements for the comprehensive assessment. No further OASIS data collection is required. The patient did not resume care with the HHA. The agency's discharge summary should be completed to close out the clinical record.

Q23.1. During a therapy-only episode, the patient had an accidental fall and was hospitalized. An OASIS Transfer without discharge (RFA 6) was completed. Upon return from the hospital, the patient refused to have therapy continued and requested to be discharged from home health. We did the Discharge OASIS instead of a Resumption of Care (ROC) on the 1st day upon return from the inpatient facility but when transmitted, we get a sequencing error message. [Q&A EDITED 06/14; ADDED 09/09; Previously CMS OCCB 10/07 Q&A #3]

A23.1. The reason you are getting the sequencing error is because you completed a Transfer OASIS and then submitted a Discharge OASIS. When a Transfer OASIS is submitted, the next expected submission would be a Resumption of Care (ROC) - RFA 3. If the patient did not resume services at your agency, then an internal agency discharge (with no OASIS collection) would be expected.

It is not clear whether or not you made a visit when the patient returned home from the hospital. If the patient returned home from the hospital and refused further visits, the Transfer OASIS would be the last OASIS data collection required. You would not need to complete an OASIS Discharge, just your agency's internal agency discharge paperwork.

If the patient returned home from the hospital and you made one visit (the ROC visit) and then the patient refused further visits, you are not required to collect and submit the ROC OASIS data to the OASIS system for one visit episodes (quality episodes). You are required by the Conditions of Participation (484.55) to perform a comprehensive assessment when resuming care of a patient following an inpatient stay of 24 hours or longer for reasons other than diagnostic tests, but OASIS is not required when only one visit is made at the ROC.

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? [Q&A EDITED 12/12]

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/center/hha.asp, click on "Conditions of Participation 484.55, Comprehensive Assessment of Patients" in the "Participation" category.

Q25. Do you have any information on what agencies are to do if the beneficiary refuses to answer OASIS questions? Are agencies not to admit, based on the refusal? [Q&A EDITED 04/15]

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. A list of supplemental references regarding patient assessment is included in Appendix A of the OASIS Guidance Manual, available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html under "Downloads". The Privacy Act Notices are available at: http://www.cms.hhs.gov/center/hha.asp

Q26. What Privacy Act statements are required since MMA 2003 temporarily suspended OASIS data collection for non-Medicare/non-Medicaid patients? [Q&A EDITED 12/12]

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/center/hha.asp

Q27. What should we do about OASIS when a patient refuses? [Q&A EDITED 06/14]

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 OASIS system 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.

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. [Q&A EDITED 04/15]

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 Appendix A in the OASIS Guidance Manual for additional discussion of this issue. The manual is available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html under “Downloads”.

Q29. We have integrated OASIS data items into our current assessment questions. Staff feels strongly that they need the SOC OASIS information as a reference point to complete a subsequent assessment. My understanding was that staff was NOT to have the original set of OASIS items as a reference. [Q&A EDITED 10/18; EDITED 10/16]

A29. For assessment items that reflect a patient's current status on the day of assessment, like M1830, Bathing or M2020, Management of Oral Medications, clinicians should select a response based on the patient's ability on the day of assessment.

For items that require a look back to the time of or at any time since the most recent SOC/ROC assessment, like M2401, Intervention Synopsis, the "look back" is required to determine if specific assessments were completed, what the results of such assessments were, and/or what actions (e.g., orders, interventions implemented) resulted.

Q30. For how long a period may agencies place a patient on 'hold' status when the patient has been hospitalized? [Q&A EDITED 10/16]

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. When a patient is transferred to the inpatient facility, it should be assessed if the agency anticipates the patient will be returning to service or not. If the HHA plans on the patient returning after their inpatient stay, the RFA6 should be completed. There will be times when the RFA7 is necessary to use, but only when the HHA does NOT anticipate the patient will be returning to care. There are several reasons why the RFA7 may be used, including these examples: the patient needs a higher level of care and is no longer appropriate for home health care, the patient’s family plans on moving the patient out of the service area, or the patient is no longer appropriate for the home health benefit.

Refer to the information on the OASIS Considerations for Medicare PPS Patients located at the QIES Technical Support website https://www.qtso.com/hhadownload.html 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 (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? [Q&A EDITED 01/11]

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.

Q32. Does the medication list need to be reviewed by an RN if the patient is only receiving therapy services? [Q&A EDITED 01/11]

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. Only RNs, PTs, OTs and SLPs are qualified to perform comprehensive assessments.

Q32.1. For therapy only cases where the therapist is completing the comprehensive assessment, is it acceptable practice to have an office based RN complete the medication review by reviewing the med profile completed by the therapist during the home visit, and making telephone contact with the patient/caregiver for any necessary discussion of side effects, interactions, duplicate or compliance issues? [Q&A EDITED 10/18; Q&A EDITED 01/11; ADDED 09/09; Previously CMS OCCB 01/09 Q&A #6]

A32.1. It is acceptable for an RN in the office to collaborate on the medication regimen review in a situation where a therapist completes the comprehensive assessment. If areas of concern are identified, the agency must notify the physician and as appropriate obtain orders for any nursing intervention to further assess and resolve issues and educate the patient regarding medication changes and management.

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. [Q&A EDITED 10/18; Q&A EDITED 01/12]

A33. The patient who is discharged after a qualifying inpatient 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 home health visits and requests discharge, the last qualified clinician who saw the patient may complete the discharge comprehensive assessment document based on information from his/her last visit. The assessing clinician may supplement the discharge assessment with information documented from patient visits by other agency staff that occurred in the last 5 days

that the patient received visits from the agency prior to the unexpected discharge. The “last 5 days that the patient received visits” are defined as the date of the last patient visit, plus the four preceding days. If desired, agencies may continue to limit the OASIS to only that data directly assessed and collected by the single assessing clinician.

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.

Q34.1. We admit a patient for BID wound care and several days after our SOC, we are made aware by our own staff that it appears that the patient had been open to another home care agency 2 weeks prior to and at the time of our agency's SOC. What are the OASIS requirements for this Medicare patient assuming that our agency is closing? [Q&A EDITED 06/14; ADDED 09/09; Previously CMS OCCB 10/07 Q&A #7]

A34.1. You are asking which OASIS is required for a patient who is already open under an active plan of care at another home health agency when taken under care by your agency. When more than one agency provides care to a patient simultaneously, one agency is considered primary and is responsible for the billing and OASIS data collection requirements. In your situation, it appears that your agency was not aware that the patient was already open under a primary agency, and that no arrangement existed between your agency and the primary agency. There is no OASIS data collection that will resolve your problem. It is a billing issue and you should refer to the Medicare Claims Processing Manual, Chapter 10, Section 10.1.5.1 - More Than One Agency Furnished Home Health Services, located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf and contact your Medicare Administrative Contractor (MAC) for guidance.

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? [Q&A EDITED 10/16]

A35. 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). When transitioning from a skilled Medicare or Medicaid patient to a payer not requiring OASIS, CMS encourages HHAs to complete a discharge assessment at the last visit under the Medicare or Medicaid pay source. 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), outcome-based quality improvement (OBQI), and process measure reports.

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

A36. The start of care is established on the date the first billable service is provided.

Q36.1. I understand the comprehensive assessment cannot be completed before the SOC date. Does that mean it's OK to start it at the initial assessment as long as it is not completed until on or after the SOC date? [Q&A ADDED 06/14; Previously CMS OCCB 01/08 Q&A #1]

A36.1. The SOC is established on the day the first billable service is provided. The SOC comprehensive assessment must be completed on or within 5 days after the start of care date. An initial assessment may be performed prior to the SOC date, (e.g. RN admitting for a therapy only case). If agency policy is for the RN to perform the initial assessment during a non-billable visit in order to meet the Condition of Participation (484.55) time requirement of 48 hours for the completion of the initial assessment, and the RN does not provide a billable service, the SOC is not yet established. If the PT does not visit that same day, the date of the RN's initial assessment visit is not the SOC date. If the PT visits the next day, the SOC date is the day the PT visits and provides a billable service. While the RN likely conducted at least part of a comprehensive assessment in order to meet the requirements of an initial assessment visit to determine immediate care and support needs of the patient, any information collected on that date may not contribute to the SOC comprehensive assessment, as it was collected prior to the SOC date. The SOC comprehensive assessment that will include the OASIS data that will be transmitted to the OASIS system as the SOC assessment must be collected on or within 5 days after the SOC date, not before.

Q37. [RETIRED 10/18]

Q37.1 & 37.2. [RETIRED 01/11. Information edited and included in Q&A #37]

Q37.3. We are seeking guidance related to the following scenarios: [Q&A EDITED 10/18; Q&A EDITED 04/15; ADDED 09/09; Previously CMS OCCB 01/09 Q&A #2]

A) A qualified clinician completes the visit for the initial visit and comprehensive assessment, however before finishing the documentation of the corresponding OASIS, the clinician quits. The other pieces of the comprehensive assessment documentation are complete. What are the appropriate steps to complete the OASIS?
B) The qualified clinician completes an OASIS and then quits. During review of the documentation, a clinical supervisor notes a discrepancy between an OASIS response and other clinical documentation. What are the appropriate steps to correct the OASIS assessment?
C) Are there any other circumstances when it is appropriate for the director or supervisor to make a correction to an OASIS answer in lieu of the assessing clinician?

A37.3.

A) If the comprehensive assessment for a patient requiring OASIS data collection was not completed and the assessing clinician is no longer available to finish the comprehensive assessment, the agency may send another qualified clinician out during the allowed assessment timeframe (e.g., within 5 days after the Start of Care (SOC) date), to start and complete an entire comprehensive assessment, not just the OASIS items. This comprehensive assessment can be completed with or without allowed collaboration, including review of the departed clinician’s documentation.

B & C) The comprehensive assessment is a legal document and when signed by a clinician, the signature is an attestation that all contained in the document is truthful and accurate. If an error is discovered upon review by a supervisor or other auditing staff and it can be validated that it is a true error and not just a discrepancy (a difference between two data items without knowledge of which data item is correct), that error should be corrected following the agency's correction policy and established professional medical record documentation standards.

For additional guidance related to the CMS OASIS Correction Policy refer to the State Operations Manual, Chapter 2, located at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c02.pdf.

Q37.4. Our clinician reported an ostomy as a surgical wound in the OASIS M1340, Surgical Wound item. The clinician no longer works for the agency, so we cannot contact her about the error. Can this OASIS change be made by the DON without speaking to the clinician? [Q&A EDITED 10/18; Q&A ADDED 04/15; Previously CMS OCCB 07/11 Q&A #2]

A37.4. You have described a situation where an OASIS scoring error was discovered during the audit process. The assessment was complete. Documentation reported that the patient had an ostomy and no surgical wounds.

HHAs should have a policy and procedure for correcting errors that involves the assessing clinician. The policy should follow established clinical record professional practice standards and guidance found in relevant CMS regulations and guidance. A correction policy may allow the auditor who found the error to contact the clinician, discuss the discrepancy in the medical record and make the correction. Correction of an error will not impact the M0090, Date Assessment Completed.

When the original documenter is not available, the clinical supervisor or quality staff may make the correction to the documentation following the correction policy. The supervisor may document why the original assessing clinician is not available to make the correction and how the error was identified and validated as an error. When corrections are made to assessments submitted to the OASIS system, consider the impact of the correction on the POC, HHRG, the Plan of Treatment, and RAP. CMS urges HHAs to make corrections and/or submit inactivations as quickly as possible after errors are identified so the OASIS system will be as current and accurate as possible, as the data may be used for quality measurement or payment purposes.

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 and M2420 and be answered in the discharge assessment? [Q&A EDITED 10/16]

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), improvement (OBQI) and process measure reports. Otherwise, that patient will not be included in the HHA's OBQM, OBQI, and process measure (PBQI) statistics. It will also keep that patient from appearing on the HHA's roster report (a report you can access from the 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 M2420 (Discharge Disposition) should be marked with Response 2 - Patient remained in the community (with formal assistive services).

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

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

Q41.1. [Q&A MOVED 06/14 to Cat. 4b Q&A #20.1]

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? [Q&A EDITED 06/14]

A42. Completion of a comprehensive patient assessment is required, even when the patient only receives a single visit in an episode. Based on CMS policy, OASIS data collection and submission is not required when only one visit is made in a quality episode (SOC/ROC date to TRF/DC). However, to bill Medicare PPS for a single visit payment episode, OASIS data must be collected and submitted to the OASIS system, and used to calculate a HIPPS code for inclusion on the Medicare claim. If you choose NOT TO BILL Medicare for the single visit provided, there is no requirement to collect and transmit OASIS data for single visit episodes.

If collected, RFA 1 is the appropriate response on M0100 for a one-visit Medicare PPS patient.

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 by the payer, may be provided to the payer, but should not be submitted to the OASIS 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.

Q42.1. What do we do when the patient refuses more visits after just one nursing or therapy visit at the SOC/ROC and one MSW visit? Would a Discharge OASIS need to be completed? The information would match what was in the original SOC or ROC visit since MSWs cannot complete OASIS assessments. What if the RN visits once and the HHA visits once. [Q&A EDITED 06/14; ADDED 09/09; Previously CMS OCCB 04/09 Q&A #5]

A42.1. You have described a situation where more than one visit was made - RN or therapist performs SOC comprehensive visit and then a MSW (or aide) visits. Two visits were made. In this situation a Discharge comprehensive assessment is required.

Q42.1.1. If nursing performs a non-billable admit for a PT only case, the PT goes the same day completing an evaluation only, and there is no further need for therapy, are we required to complete the RFA 9 OASIS Discharge? [Q&A ADDED 01/12; Previously CMS OCCB 10/11 Q&A #2]

A42.1.1. For skilled Medicare and skilled Medicaid patients, OASIS data collection is required if more than one visit was made in a quality episode. In your scenario, the nurse made one visit and the PT made one visit. Therefore both the SOC (RFA 1) and DC (RFA 9) comprehensive assessments are required. This is true even if one of the visits was non-billable.

Q42.1.2. For a situation of a one-time only PT case, the PT conducts the initial assessment visit and establishes the SOC (M0030), but the nurse later performs a non-billable visit to complete the comprehensive assessment and collect OASIS sometime within the 5 days after the SOC date. Does the outcome episode start with the PT's SOC visit or with the RN's completion of the OASIS assessment (M0090)? If it starts with the M0090 date, then technically the RNs non billable visit is the ONLY visit in the outcome episode, and OASIS wouldn't even be required by policy for this single visit episode. [Q&A ADDED 06/14; Previously CMS Qtrly 01/13 Q&A #2]

A42.1.2. The quality episode begins on the SOC/ROC (M0030/M0032) date. In the case where the PT makes only one visit, establishes the SOC date by providing a billable service during their initial assessment visit and then the nurse makes a non-billable visit within the 5 days after the SOC to complete the SOC comprehensive assessment, both an OASIS SOC and a Discharge comprehensive assessment would be required, as two visits were made in the quality episode.

Q42.2. We were told by our intermediary at an educational session that OASIS is now a requirement for payment by Medicare. Does this mean we must collect and submit OASIS data even when there has been just a single visit at the start of care? If submission is mandated for single visits, how does this impact the guidance on the Management of Single Visits from CMS, which stated we didn't have to collect or submit the OASIS for the single visit, nor perform a discharge OASIS assessment? [Q&A EDITED 06/14; ADDED 01/12; Previously CMS OCCB 10/10 Q&A #1]

A42.2. Based on CMS policy, OASIS data collection and submission is not required when only one visit is made in a quality episode (SOC/ROC date to TRF/DC). However, to bill Medicare PPS for a single visit payment episode, OASIS data must be collected and submitted to the OASIS system, and used to calculate a HIPPS code for inclusion on the Medicare claim. If you choose NOT TO BILL Medicare for the single visit provided, there is no requirement to collect and transmit OASIS data for single visit episodes.

The discharge OASIS is never mandated in situations of single visits in a quality episode (SOC/ROC date to TRF/DC).

With these changes to the conditions for payment, the Single Visit Management document is being retired.

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. [Q&A EDITED 01/11]

A43. If only one visit is made at the ROC, OASIS data collection and submission 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.

Q44. What type of comprehensive assessment is required for pediatric, maternity, and patients requiring only personal care, housekeeping or chore services? [Q&A EDITED 06/05]

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.

Q44.1. We have been receiving an increased number of TRICARE pediatric/newborn patient referrals who require OASIS documentation. Our pediatric/maternity nurses are having difficulty answering many of the M items. Do you have any insight or recommendations on how to complete these items when assessing a newborn? [Q&A ADDED 06/14; Previously CMS Qtrly 01/13 Q&A #1]

A44.1. The OASIS data set was not developed for use with children. If a payer requires OASIS data collection on children, the assessing clinician must use clinical judgment and select the best possible response for each OASIS item, with an understanding that the response may not accurately represent the true status of the child. Clinical documentation will detail the true status of the child and why the OASIS was completed, e.g. payer required a data collection instrument designed for adults to be completed on a child.

Q45. [Q&A RETIRED 08/07; Duplicate of CMS Q&A Cat 2 Q&A #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. [Q&A EDITED 06/14; ADDED 06/05]

A46. Yes, this is acceptable. This scenario appears to fit the criteria for single visit episodes for Start of Care or Resumption of Care that became effective December 16, 2002. Each patient must receive a comprehensive assessment. Based on CMS policy, OASIS data collection and submission is not required when only one visit is made in a quality episode (SOC/ROC date to TRF/DC). However, to bill Medicare PPS for a single visit payment episode, OASIS data must be collected and submitted to the OASIS system, and used to calculate a HIPPS code for inclusion on the Medicare claim. If you choose NOT TO BILL Medicare for the single visit provided, there is no requirement to collect and transmit OASIS data for single visit episodes. The discharge OASIS is never mandated in situations of single visits in a quality episode (SOC/ROC date to TRF/DC).

Q46.1. [Q&A RETIRED 10/16; Duplicate of CMS Q&A Cat 2 #46.2]

Q46.2. If a patient was admitted to the hospital after the initial admission/SOC OASIS, but before another visit was completed, it is my understanding that we do not need to

transmit that OASIS. When they are discharged from the hospital after more than a 24 hour stay, do we complete a new SOC assessment and use that as the SOC date and transmit that OASIS? If this is the case, what do we do with the initial OASIS? [Q&A EDITED 06/14; ADDED 09/09; Previously CMS OCCB 07/09 Q&A #3]

A46.2. You are correct that in situations where only one visit was performed in a quality episode, the OASIS does not have to be submitted to the OASIS system. The OASIS data collection instrument was originally developed so that home health agencies could calculate patient outcomes as part of their quality improvement initiatives. In order to produce end result outcomes, patient level data collected at SOC/ROC are compared to the data collected at discharge. When only one visit is made, it is impossible to calculate end result outcomes. Therefore, since the December 2002 OASIS burden reduction initiatives, home health agencies have not been required to collect and/or submit OASIS data for one-visit episodes.

If you admit a patient to your home health agency and then become aware that for whatever reason no additional visits will be made after the first visit, by CMS policy you are not required to collect, or submit any already-collected, OASIS data to the OASIS system for that patient episode. However, to bill Medicare PPS for a single visit payment episode, OASIS data must be collected and submitted to the OASIS system, and used to calculate a HIPPS code for inclusion on the Medicare claim. If you choose NOT TO BILL Medicare for the single visit provided, there is no requirement to collect and transmit OASIS data for single visit episodes. The discharge OASIS is never mandated in situations of single visits in a quality episode (SOC/ROC date to TRF/DC).

If the agency elected not to submit the OASIS data collected during the SOC assessment, discharging the patient upon admission to the inpatient facility (internal discharge, not OASIS DC), would be appropriate. No Transfer OASIS would be required as there was only one visit in a quality episode. The agency would file the pre-hospitalization SOC assessment in the patient's record and may bill for the visit if the eligibility, coverage and billing requirements of the payer were met. (Note: For a Medicare PPS patient, if OASIS data were not collected and submitted for this single visit patient, billing requirements would not have been met.) When the patient returns home and to the agency's service, a SOC comprehensive assessment would be completed.

If after completing the initial assessment visit and SOC comprehensive assessment (in conjunction with a reimbursable visit), the patient was admitted to an inpatient facility before a 2nd visit was provided, but you expected a return of the patient, or the return status wasn't known, the agency would select an alternative process involving transferring the patient upon eligible inpatient admission, and resuming care (ROC - RFA #3) upon the patient's return home. When completing a Transfer assessment, assuming the patient was a skilled Medicare/Medicaid patient, submission of the assessments to the OASIS system would be expected.

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? Is it true 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? [Q&A EDITED 10/18; Q&A EDITED 01/11; ADDED 06/05]

A47. CMS regulations 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. The RN visit to conduct the discharge assessment is a non-billable visit. The date of the actual discharge is determined by agency policy. The Discharge assessment should be completed within 2 days of the discharge date. The M0090 Date assessment completed is the date the nurse actually completes the discharge assessment document.

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? [Q&A ADDED 08/07; Previously CMS OCCB 03/05 Q&A #1]

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

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? [Q&A ADDED 08/07; Previously CMS OCCB 03/05 Q&A #2]

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, even if the RN has not completed the SOC comprehensive assessment. Reference: Interpretive Guidelines G331

Q49.1. When a PT only patient comes home from the hospital, can the PT go out within 24 hours of the patient's return from the hospital and then the RN complete the OASIS ROC the next day. This would keep the RN within the 2 day window. Our administrative policy requires that an RN make a non-bill visit to perform the comprehensive assessment and OASIS. The ROC date and the date on the OASIS would differ as the ROC would reflect the date of PT visit and the OASIS M0090, Date Assessment

Completed, would reflect the following day when the RN completed the visit. [Q&A EDITED 10/18; Q&A ADDED 09/09; Previously CMS OCCB 04/09 Q&A #3]

A49.1. Assuming there is not a specific physician-ordered ROC date, the ROC comprehensive assessment must be completed within 2 calendar days after the facility discharge date, or knowledge of the patient's return home. Any clinician qualified to perform comprehensive assessments (RN, PT, OT, SLP) may complete the ROC comprehensive assessment, following the agency's policy.

In a PT only ROC, there is no requirement that the PT complete the comprehensive assessment on the first visit. It would be compliant with the Condition of Participation, 484.55, Comprehensive Assessment of Patients, for the PT to perform a discipline-specific re-evaluation and then an RN complete the comprehensive assessment on a non-billable visit as long as the comprehensive assessment is completed within 2 calendar days of the facility discharge, or knowledge of the patient's return home. In this case, the ROC date, M0032, will be the date of the PT's visit (the first visit after the patient's return home) and the ROC comprehensive assessment's M0090, Date Assessment Completed, will be the date the RN completed the comprehensive assessment. The dates would not be the same if the RN visited and completed the comprehensive assessment the day after the PT visited and performed the evaluation. This still represents compliance with the regulations.

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? [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #1]

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.

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? [Q&A EDITED 12/12; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #2]

A51. The Condition of Participation, 484.55, Comprehensive Assessment of Patients, found at http://www.cms.hhs.gov/center/hha.asp,(click on "Conditions of Participation: Home Health Agencies" in the "Participation" category) 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.

Q51.1. We know that for a PT only case where the RN is doing the SOC Comprehensive Assessment that it has to be done on or within 5 days after SOC date. If it is done prior to the SOC date, we understand that it is not valid and the RN will have to go back out and redo the assessment. This recently happened but it was not discovered until way after the fact (the 5 days had lapsed). Is there anything we can do? Can the PT derive the OASIS item answers from the PT evaluation? This would be out of compliance with our policies and procedures. [Q&A ADDED 09/09; Previously CMS OCCB 04/09 Q&A #2]

A51.1. There would be no way of resolving this situation compliantly as the SOC comprehensive assessment was not done on or within 5 days after the SOC date. The situation was discovered too late to send an RN out to the home to perform a SOC comprehensive during the allowed timeframe and since the agency policy does not allow PTs to perform the comprehensive assessment at the SOC; their assessment findings cannot be utilized by the therapist to "create" a SOC comprehensive assessment.
The agency could send out an RN to perform a SOC comprehensive assessment as soon as the situation is discovered. The M0090 date, Date Assessment Completed, will be the actual date the clinician visited the home and then completed the assessment. A warning message will result from the non-compliant assessment date, but this will not prevent assessment transmission.

Alternatively, the agency could maintain the non-compliant SOC comprehensive assessment that was completed before the SOC date. Either alternative demonstrates non-compliance, as the time period to achieve compliance has passed.

Q51.2. When a nurse completes a Resumption of Care (ROC) assessment for a PT only case, can the nurse do the ROC on one day and the therapist re-eval the following day? I know this can't be done at SOC, but not sure for ROC since episode has already been established. [Q&A EDITED 10/18; Q&A ADDED 09/09; Previously CMS OCCB 07/08 Q&A #1]

A51.2. It is acceptable for the RN to make a non-billable visit in a PT only case and complete the ROC assessment within 48 hours of discharge and the PT to visit to evaluate either before or after the RN's assessment visit, as long as the PT visit timing meets federal and state requirements, physician's orders, and is deemed reasonable by professional practice standards. The resumption of care date (reported in M0032) is the first visit following an inpatient stay, regardless of who provides it, whether or not the visit is billable, and whether or not the ROC assessment is completed on that first visit.

Q52. [RETIRED 10/18]

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? [Q&A ADDED 06/14; Previously CMS OCCB 05/07 Q&A #4]

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 OASIS system, 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 OASIS system."

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?" [Q&A EDITED 06/14; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #5]

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 selects RFA 6 or 7, depending on whether the agency anticipates the patient will be returning to service or not.

If the agency selected RFA 7 because they did NOT anticipate the patient would return to their care, a new SOC should be completed when the patient returns to home care services.

If the agency selected RFA 6 because they planned on resuming care of the patient following discharge, a SOC/ROC comprehensive assessment should be completed when the patient returns to home care services within the episode. 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 OASIS system. 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 OASIS system, 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.

Q54.1. Our patient's recertification was due August 12th. The nurse completed the recertification assessment on August 8th. Later that night, August 8th, the patient fell, broke her leg and is now in the hospital on her recertification date. Do we submit the recertification assessment and continue on with paperwork including the Transfer OASIS and new Plan of Care or do we keep the Recertification paperwork and complete a

Transfer OASIS, and pick back up after the discharge from the inpatient facility as a new referral? [Q&A ADDED 06/14; Previously CMS OCCB 10/07 Q&A #5]

A54.1. The Conditions of Participation require that a follow-up comprehensive assessment be conducted during last 5 days of every 60 day episode. In your scenario, the follow-up assessment was performed during the required timeframe, but then the patient's condition changed and required what we will assume is a qualifying transfer to an inpatient facility during the recertification assessment timeframe. If your agency completed an RFA 7 - Transfer with Discharge, then regardless of when/if the patient returned to your agency, submission of the Recertification assessment would not be necessary. Therefore, it is acceptable to not submit the Recert assessment to the OASIS system, but rather to maintain the completed Recert assessment in the patient's clinical record, with documentation explaining the situation. It would also be acceptable to submit the Recert assessment to the OASIS system.

If your agency completed an RFA 6 - Transfer without Discharge, then if the patient were to return to your agency on Day 60 or 61, special instructions would apply to determine if the episode is to be considered continuous or not. In order for the episodes to be considered continuous, the HIPPS codes resulting from both the Recertification assessment and the Resumption of Care assessments would need to match, and both assessments would need to be submitted to the OASIS system.

If the conditions required for continuous episodes are not met, it is acceptable to not submit the Recertification assessment to the OASIS system, but rather to maintain the completed Recert assessment in the patient's clinical record, with documentation explaining the situation. In either case, collection and submission of the Transfer assessment would be required.

(More complete details related to this guidance, reference the prior CMS OASIS Q&As Category 2, Questions 53 – 55 and the Medicare Claims Processing Manual, Section 80-Special Billing Situations Involving OASIS Assessments located at

http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf).

Q54.2. A patient is seen monthly. On a monthly visit, which falls within the last five days of the certification period, the assessing clinician discovers the patient had a qualifying hospital admission since the last monthly visit that our agency was not aware of. Do we complete a Transfer, Resumption and Recert or just the Transfer and Resumption? [Q&A ADDED 01/12; Previously CMS OCCB 10/11 Q&A #1]

A54.2. When the agency learns of a qualifying Transfer after the patient returned home, a Transfer and Resumption is required within 2 calendar days after learning of the inpatient stay. In this situation, a Transfer is required; and, since the time frame to complete the Resumption overlaps with the timeframe to complete the Recertification, the ROC assessment should be completed, fulfilling both the ROC and Recert requirements.

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). [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #3]

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).

Q55.1. If there was a need for continuing services into the next certification period, but the clinician missed completing the recertification assessment between day 56-60 and on the first visit in the new episode it was determined the patient had reached goals and needed to be discharged, do I have to complete both the Recert and the Discharge OASIS? [Q&A ADDED 01/12; Previously CMS OCCB 07/11 Q&A #4**]**

A55.1. Yes. When a Recertification assessment is missed it should be completed as soon as possible. In the situation described, you needed to recertify for the visit that was needed and justified by the patient's condition in the new episode of care. The recertification comprehensive assessment supports the patient's need for services, and the recertification OASIS drives the payment for that episode. If the clinician determined the patient was ready for discharge on the first visit in the new episode, the Discharge comprehensive assessment is also required. The discharge is the endpoint of the quality episode, which is not captured with a recertification assessment.

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? [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #1]

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.

Q57. Has there been any regulatory changes that prohibit a nurse from doing the initial SOC OASIS if only therapy is ordered? [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #2]

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).

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? [Q&A EDITED 10/18; Q&A EDITED 01/11; ADDED 08/07; Previously CMS OCCB 07/07 Q&A #4]

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 ROC 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.

OASIS data collection, as part of the mandated comprehensive assessment at ROC, is not required when only one visit is made at the ROC. No discharge comprehensive assessment or OASIS Discharge is required when only one visit is made. The agency would complete their own internal discharge paperwork.

Q58.1. A patient is ordered and needs only a single Physical Therapy visit (no other disciplines ordered/needed). Is a SOC OASIS required? If the SOC OASIS is required, is a D/C OASIS also required? [Q&A EDITED 06/14; ADDED 09/09; Previously CMS OCCB 10/07 Q&A #4]

A58.1. Completion of a comprehensive patient assessment is required, even when the patient is known to only need a single visit in the episode. Based on CMS policy, OASIS data collection and submission is not required when only one visit is made in a quality episode (SOC/ROC date to TRF/DC). However, to bill Medicare PPS for a single visit payment episode, OASIS data must be collected and submitted to the OASIS system and used to calculate a HIPPS code for inclusion on the Medicare claim. If you choose NOT TO BILL Medicare for the single visit provided, there is no requirement to collect and transmit OASIS data for single visit episodes.

Agency clinical documentation should note that no further visits occurred. No subsequent OASIS 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.

Q59. Both PT and RN evaluations are ordered by the referring physician. The patient's diagnosis by history and physical, discharge summary, and operative report indicate the primary reasons for home care are needs that can be met by the PT. Example: patient d/c from inpatient care status post uncomplicated hip replacement; patient with discharge diagnosis of L CVA with fractured tibia and fibula, and/or patient discharged status post ORIF. If the agency obtains an MD order stating PT may open, is it permissible for the PT to do the Initial Assessment? [Q&A ADDED 09/09; Previously CMS OCCB 07/09 Q&A #1]

A59. If orders for nursing exist at the SOC, the RN must perform the initial assessment visit and comprehensive assessment. If, upon review of the referral documentation, the agency calls the physician and the order for nursing is cancelled, it is no longer a PT and nursing referral and the PT could perform the initial assessment visit.

Q60. We provide skilled services to a Medicaid patient during the day while they are at an adult day care center. Our state Medicaid program does not require that skilled services

be provided in the patient's home. Can we perform the comprehensive assessment, including the OASIS, in the adult day care center or must it be completed in the patient's home? [Q&A ADDED 09/09; Previously CMS OCCB 07/09 Q&A #2]

A60. The comprehensive assessment, including the OASIS, involves collecting data on multiple aspects of the patient and their environment. The interrelated aspects of patient and environment all influence current and future health status. It is important that the clinician collects data on environmental characteristics (such as safety features) through first-hand observation rather than relying exclusively on report, therefore the assessment including the OASIS must be performed in the physical presence of the patient in their home or place of residence.

Q61. F2F. If the F2F does not occur within 30 days after the SOC, but it does occur, for example, on the 35th day, how should OASIS data be collected and submitted? [Q&A EDITED 06/14; ADDED 12/12; Previously CMS Qtrly 01/12 Q&A#1]

A61. If the F2F encounter does not occur within the 90 days prior to the SOC, or within 30 days after the SOC, then the Medicare HH eligibility criteria have not been met and the episode is not covered or billable as a Medicare HH episode. Assuming all other Medicare eligibility criteria are met, the F2F encounter (occurring on day 35 in the given scenario) would represent a pay source change to the Medicare HH benefit. Longstanding guidance in Section 80 of Chapter 10 of the Medicare Claims Processing Manual states that in certain instances, a new start of care OASIS assessment can be generated that reflects a start of care date equal to the start of the beneficiary's change to Medicare FFS. A prior OASIS can be used to generate the new SOC OASIS. The manual allows for this OASIS completion flexibility in targeted situations, to meet both Medicare billing and eligibility rules. A late face-to-face encounter is another of these targeted situations which justifies OASIS completion flexibility.

Specifically, where a face-to-face encounter did not occur within the 90 days prior to the start of care or within 30 days after the start of care, a provider may use an existing OASIS assessment to generate another OASIS with a reported start of care date equal to the first visit date after all Medicare HH eligibility criteria are met. If multiple OASIS assessments exist, the data from the assessment conducted closest to the date of Medicare eligibility should be used. This could be a SOC, ROC, or Follow-up Assessment type. In this scenario, the date when all Medicare eligibility was met would be 30 days prior to the F2F encounter (with the F2F encounter date counted as day 0). The (M0090) Date Assessment Completed should be reported as the actual date the new OASIS assessment is being generated, even if no visit is provided on that date. Timing warnings from the OASIS system may be generated based on the difference between the start of care date and the date the assessment was completed (> 5 days), but these warnings may be unavoidable in these situations and can be disregarded.

Based on the new certification period range, it may be necessary to change the response originally reported for (M0110) Episode Timing, and/or (M2200) Therapy Need, to exclude therapy visits provided before the date of eligibility. Medicare will not pay for services provided before the date on which all Medicare HH eligibility have been met, which in the scenario described would refer to any services provided in the first five days of care. If the original OASIS assessment had already been submitted to the OASIS system, it should be deleted, and the newly generated SOC OASIS assessment (with modified M0030/M0090 dates, M0110, M2200, etc.) submitted. All assessments should be maintained in the agency clinical record, with documentation explaining the situation.

Example:

- Agency provides first skilled visit **January 1st**

- Face-to-Face encounter occurs **February 5th** (Day 35)
- Date when all Medicare eligibility was established **January 6th** (30 days prior to the F2F encounter, with F2F encounter date counted as "day 0")
- Non-covered visit period (**January 1st-5th**)
- (M0030) SOC Date on generated OASIS (The date of the first visit on or after **January 6th**)
- (M0090) Date Assessment Completed on generated OASIS (The actual date new assessment is generated – on or after the **February 5th** F2F encounter.)

Q61.1. F2F. If the F2F does not occur within 30 days after the SOC, but it does occur, for example, on the 70th day, in the next certification period, how should OASIS data be collected and submitted? [Q&A EDITED 06/14; ADDED 12/12; Previously CMS Qtrly 01/12 Q&A#2]

A61.1. If the F2F encounter does not occur within the 90 days prior to the SOC, or within 30 days after the SOC, then the Medicare HH eligibility criteria have not been met and the episode is not covered or billable as a Medicare HH episode. Assuming all other Medicare HH eligibility criteria are met, the F2F encounter (occurring on day 70 in the given scenario) would represent a pay source change to the Medicare HH benefit. Longstanding guidance in Section 80 of Chapter 10 of the Medicare Claims Processing Manual states that in certain instances, a new start of care OASIS assessment can be generated that reflects a start of care date equal to the start of the beneficiary's change to Medicare FFS. A prior OASIS can be used to generate the new SOC OASIS. The manual allows for this OASIS completion flexibility in targeted situations, to meet both Medicare billing and eligibility rules. A late face-to-face encounter is another of these targeted situations which justifies OASIS completion flexibility.

Specifically, where a face-to-face encounter did not occur within the 90 days prior to the start of care or within 30 days after the start of care, a provider may use an existing OASIS assessment to generate another OASIS with a reported start of care date equal to the first visit date after all Medicare HH eligibility criteria are met. If multiple OASIS assessments exist, the data from the assessment conducted closest to the date of Medicare eligibility should be used. This could be a SOC, ROC, or Follow-up Assessment type. In this scenario, the date when all Medicare eligibility was met would be 30 days prior to the F2F encounter (with the F2F encounter date counted as day 0). The (M0090) Date Assessment Completed should be reported as the actual date the new OASIS assessment is being generated, even if no visit is provided on that date. Timing warnings from the OASIS system may be generated based on the difference between the start of care date and the date the assessment was completed (> 5 days), but these warnings may be unavoidable in these situations and can be disregarded.

Based on the new certification period range, it may be necessary to change the response originally reported for (M0110) Episode Timing, and/or (M2200) Therapy Need, to exclude therapy visits provided before the date of eligibility. Medicare will not pay for services provided before the date on which all Medicare HH eligibility have been met, which in the scenario described would refer to any services provided in the first 40 days of care. Any original OASIS assessments which may already have been submitted to the OASIS system, (likely SOC and Recert Assessments in this scenario) should be deleted, and the newly generated SOC OASIS assessment (with modified M0030/M0090 dates, M0110, M2200, etc.) submitted. All assessments should be maintained in the agency clinical record, with documentation explaining the situation.

Example:

- Agency provides first skilled visit **January 1st**

- Face-to-Face encounter occurs **March 12th** (Day 70)
- Date when all Medicare eligibility was established **February 10th** (30 days prior to the F2F encounter, with F2F encounter date counted as "day 0")
- Non-covered visit period (**January 1st – February 9th**)
- (M0030) SOC Date on generated OASIS (The date of the first visit on or after **February 10th**)
- (M0090) Date Assessment Completed on generated OASIS (The actual date new assessment is generated – on or after the **March 12th** F2F encounter.)

Q61.2. F2F. The Late F2F CMS OASIS Q&A document states "...a provider may use an existing OASIS assessment to generate another OASIS with a reported start of care date equal to the first visit date on or after all Medicare HH eligibility criteria are met." Does the word "generate" imply that the OASIS can be copied from the previous one in its entirety except for updating specific questions mentioned, (like M0030, M0090, M0110, and M2200) with indifference to the actual condition of the patient at (or close to) the time of the new SOC date? [Q&A EDITED & ADDED 12/12; Previously CMS Qtrly 04/12 Q&A#1]

A61.2. Yes.

Q61.3. F2F. When determining if M0110 should be "Early" or "Late" when generating a new SOC OASIS due to a late F2F encounter, should the non-covered episode simply be ignored? [Q&A ADDED 12/12; Previously CMS Qtrly 04/12 Q&A#2]

A61.3 Yes, since the non-covered visits did not constitute a Medicare PPS episode, it would not be considered for M0110.

Q61.4. F2F. When a new SOC assessment is generated due to a late F2F encounter, how are we to answer M0102 and M0104? [Q&A ADDED 12/12; Previously CMS Qtrly 04/12 Q&A#3]

A61.4. A late F2F is treated as a payer change. In the specific situation where a new SOC comprehensive assessment is generated for the sole purpose of changing the payer to Medicare, M0102 – Date of Physician-ordered SOC would be "NA". For M0104 –Date of Referral, enter the day prior to the new Start of Care date.

Q61.5. F2F. When we generate the new SOC OASIS assessment for a late F2F encounter, does it have to be generated by the same clinician that completed the original OASIS? [Q&A ADDED 12/12; Previously CMS Qtrly 04/12 Q&A#4]

A61.5. No, any clinician qualified to perform comprehensive assessments may generate the new SOC comprehensive assessment from existing OASIS data. Clinical documentation should include the details of the late F2F as well as how and who generated the new SOC assessment.

Q61.6. F2F. The new F2F guidance states that we should use the OASIS assessment closest to the date of Medicare eligibility to generate a SOC OASIS in the situation of a late F2F encounter. What do we do if the F2F encounter occurred on day 70 and the OASIS assessment closest to the date of Medicare eligibility was a Recertification? What if the closest assessment was a Discharge? [Q&A ADDED 06/14; Previously CMS Qtrly 04/12 Q&A#5]

A61.6. The Recertification OASIS only includes payment items. Since an incomplete OASIS cannot be submitted to the OASIS system and you may not "create" answers, you will generate your new SOC OASIS based on the existing data from the assessment conducted closest to the date of eligibility. If the closest assessment is a Follow-Up Assessment (i.e., a Recert or Other

Follow-up), generate the new SOC using all the available Recert items first, then finish generating the assessment by using items from the SOC or ROC that was conducted closest to the date of eligibility.

If the closest assessment is a Discharge, generate the new SOC using all available Discharge items first, continue with generating the new assessment by adding additional items available from the Follow-up assessment (if any) that was conducted closest to the date of eligibility, and then finish generating the assessment by using items from the SOC or ROC that was conducted closest to the date of eligibility.

In either case, remember to update specific items, (like M0030, M0090, M0110, M2200, etc.)

Q61.7. F2F. When a new SOC OASIS assessment is generated due to a late F2F encounter, do we have to delete and resubmit additional OASIS assessments that were submitted after the original SOC assessment? [Q&A ADDED 06/14; Previously CMS Qtrly 04/12 Q&A#6]

A61.7. A SOC and subsequent OASIS assessments (Transfer, ROC, Recert, Other Follow-up and Discharge) are linked together, once submitted to the OASIS system. Since the original SOC assessment, in the case of the late F2F, must be deleted before the newly "generated" SOC assessment is transmitted to the OASIS system, all of the linked assessments must also be deleted. Once the new SOC is established, all new assessments (e.g., Transfer, ROC, Follow-up, Discharge) that occurred after the new SOC date will need to be generated and transmitted. When generating these new assessments (i.e. Transfer or ROC), copy the OASIS data from the original assessments (i.e. original Transfer or ROC data) except for updating, when appropriate, OASIS items like M0030, M0090, M0110, M2200, etc,. When the HHA resubmits these assessments, they will then be linked to the new SOC assessment.

Q61.8. F2F. When a new SOC OASIS assessment is generated due to a late F2F encounter, previous guidance states, "If the original OASIS assessment had already been submitted to the OASIS system, it should be deleted..." Yet the Medicare Claims Processing Manual (Chapter 10), under Special Situations states for a payer change to Medicare FFS, which is referenced in the Q&A document, the OASIS "...can be inactivated according to the current policies for correcting OASIS records." Which guidance is accurate in the Late F2F situation? Inactivate or Delete? [Q&A ADDED 06/14; Previously CMS Qtrly 04/12 Q&A#7]

A61.8. Delete. Since the original period of time not covered by Medicare is not billable, it can and should not be maintained in the OASIS system database. It must be deleted. There are specific steps to delete the assessment. The HHA must contact their State OASIS Automation Coordinator (http://www.cms.gov/OASIS/07_AutomationCoord.asp#TopOfPage) and get a specific form signed. This is a different situation from the one described in the Claims Processing Manual since in the manual example, the patient goes from Medicare covered managed care to Medicare covered fee-for-service. In the face-to-face example, the care during the first period of time is not covered under the Medicare benefit.

Q61.9. F2F. In the case of a late F2F, the guidance states that the new SOC date would be the date of the first visit made on or following the date after which all MC eligibility requirements were met. Does this mean the SOC date would be the first billable visit even if this visit was made by an aide, OT, or LPN? [Q&A EDITED & ADDED 12/12; Previously CMS Qtrly 04/12 Q&A#8]

A61.9. Correct, the SOC is the first billable visit by any covered service.

Q61.10. F2F. When a new SOC OASIS is generated due to a late F2F encounter, should the Plan of Care for the original (now non-covered) episode with the original certification period dates and physician verbal orders be maintained, or should a new POC be generated to "match" the new episode established by the new SOC OASIS? [Q&A ADDED 12/12; Previously CMS Qtrly 04/12 Q&A#9]

A61.10. A new Plan of Care (POC) must be developed based on the new SOC date with specific orders for services. The new Plan of Care for the now Medicare-covered episode will have a begin date/SOC date that equals the date of the first billable service provided on or after the patient became eligible for the Medicare home health benefit (30 days prior to the F2F encounter). This POC should match the SOC date on the newly generated SOC OASIS. The new Plan of Care must include all existing orders beginning with the new SOC date as well as any additional orders obtained to cover the 9-week cert period. The orders may have changed over time, and the new POC should reflect all orders relevant to the certification period of the new Medicare-covered episode.

The original POC should be kept in the clinical record for reference and documentation should be in the record explaining the late face-to-face and related actions.

Q61.11. F2F. When a new SOC OASIS is generated due to a late F2F encounter, is a Discharge OASIS recommended to end the original (now non-covered) episode as it is mentioned in the Medicare Claims Processing Manual Ch. 10 guidance for similar situations? [Q&A ADDED 12/12; Previously CMS Qtrly 04/12 Q&A#10]

A61.11. No, an OASIS Discharge is not needed, since the original SOC OASIS will be deleted. There will not be a quality episode for that patient for the first period of non-covered service.

Q62. CMS has provided multiple resources and conventions (for example, OASIS Guidance Manual, Q and A's, WOCN Wound Guidance document) for guiding the assessing clinician in selecting OASIS responses that most accurately represent his/her assessment findings. These sources cover many but not all circumstances encountered in patient situations. For instance, is a hospital bed an assistive device? How do I score lower body dressing when my patient needs help dressing with 2 of the 4 articles of clothing routinely worn on his lower body? Is it ever appropriate to rely on clinical judgment when selecting a response for OASIS data items? [Q&A ADDED 04/15; Previously CMS Qtrly 01/15 Q&A #1]

A62. Yes, in situations where a definitive answer to an assessing clinician's question is not contained in published CMS OASIS guidance (OASIS Guidance Manual, Q&As, etc.), the clinician may have to rely on clinical judgment to determine what response to select, taking into consideration all the guidance that is available, and ensuring that the response selected does not conflict with current guidance.