CMS OASIS Q&As: CATEGORY 2 - COMPREHENSIVE ASSESSMENT

Q1. [Q&A RETIRED 11/24; REDUNDANT to guidance in OASIS Manual chapter 1].

Q2. In my agency, we have 'maintenance' type patients. For example, in one case a monthly visit was made on March 20, 2021, and we found that a patient had been hospitalized March 2, 2021. 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 10/23; EDITED 05/22; 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 an 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 24 hours or more 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 for Assessment is Being Completed. Enter March 20, 2021, as the response to M0090 - Date Assessment Completed (if that was the date you completed the data collection after learning of the hospitalization) and March 2, 2021, in M0906 - Discharge/Transfer/Death Date (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 last date that information used to complete the comprehensive assessment and determine the OASIS coding was gathered by the assessing clinician and documentation of the specific information/responses was completed. The Resumption of Care Date (M0032) would be the first visit after return from the hospital, i.e., March 20, 2021 in this example. When completing the Resumption of Care (ROC) assessment, follow all instructions for specific OASIS items. For example, in responding to M1000 - Inpatient Facilities, 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 for a specific number of days? [Q&A EDITED 10/23; EDITED 05/22; EDITED 01/11]

A3. The agency will choose one of two responses to OASIS item M0100 - Reason for Assessment (RFA) 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 - Transferred to an inpatient facility--patient not discharged from agency; or

M0100 - 7 - Transferred 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 reason for

assessment (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 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. Discharge should be made at the end of the 60-day certification period in all cases if the beneficiary has not returned to the HHA. If the beneficiary returns to HH after an inpatient stay that spans the end of the certification period, Medicare requires a new Start of Care assessment.

Q4. [Q&A RETIRED 05/22]

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 Q&A 01/15 Q3]

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. [Q&A RETIRED 05/22]

Q6. [Q&A RETIRED 05/22]

Q7. At Recertification, our agency collects only the OASIS items. Is this sufficient to meet the CoP for the follow-up assessment? [Q&A EDITED 10/23; EDITED 05/22; EDITED 09/09]

A7. Each patient must receive a patient-specific comprehensive assessment that accurately reflects that patient's status, and must include, at a minimum: the patient's current health, psychological, functional, and cognitive status, as well as their strengths, goals, and care preferences, continuing need for home care, medical, nursing rehabilitative, social and discharge planning needs, a review of all medications the patient is currently taking and the patient's primary caregiver(s), if any as described in the Conditions of Participation. The OASIS items alone are not a complete comprehensive assessment.

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

Q9. [Q&A RETIRED 05/22]

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 Start of Care (SOC) comprehensive assessment including OASIS? Or since nursing services are not necessary, can the PT complete the SOC comprehensive assessment including OASIS on or within 5 days after the PT establishes the start of care? [Q&A EDITED 11/24; EDITED 10/23; ADDED 04/15; Previously CMS Qtrly Q&A 10/14 Q1]

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 Start of Care (SOC) will not be established by that visit. A comprehensive assessment performed on a date BEFORE the SOC date does not meet the Medicare HH CoPs. 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 including OASIS (if the PT will be establishing the SOC that day), return for a non-billable visit to complete the SOC comprehensive assessment including OASIS on or within 5 days after PT establishes the start of care, OR have the PT complete the SOC comprehensive assessment including OASIS.

Q10. Who can perform the comprehensive assessment when physical therapy (PT) is ordered at SOC and the registered nurse (RN) will enter 7-10 days after SOC? [Q&A EDITED 10/23; EDITED 05/22; REVIEWED 12/12]

A10. If nursing is ordered in the initial referral, then the case is NOT therapy-only, and the RN should conduct the Start of Care (SOC) comprehensive assessment including OASIS. If there is no order for nursing in the initial referral then the case is therapy-only at SOC, and the therapist can perform the SOC comprehensive assessment including OASIS. Either discipline may perform subsequent assessments.

Q10.1. The physical therapist (PT) provides the start of care visit and completes the OASIS and identifies a need for nursing to address medication management and wound care. An order is obtained from the physician for SN service, and the registered nurse (RN) visit is made days after start of care. What document does the RN need to complete to initiate nursing care? Is the RN to complete an OASIS follow up document, or a Start of Care (SOC) document, or something else? [Q&A EDITED 10/23; ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 07/18 Q3]

A10.1. You describe a situation where the physical therapist (PT) provides the start of care (SOC) visit and completes the comprehensive assessment including OASIS and identifies a need for nursing to address medication management and wound care.

The type of document that the RN would complete is dependent upon the patient situation and agency policies. The following are some options that an agency may use in the situation described to document the nurse's first visit:

- Since the SOC comprehensive assessment including OASIS had already been completed by the PT, the RN could document the nursing visit with a non-OASIS nursing evaluation form or other agency documentation form.
- If the RN visit is within the 5-day SOC assessment timeframe, the RN may complete another SOC comprehensive assessment including OASIS form. Only one SOC OASIS can be submitted.
- If the circumstances surrounding the patient's need for nursing met the agency's policy/criteria for a major decline or improvement in health status, then an RFA 5 - Other follow-up assessment would be required, and the RN could complete that assessment form to document the nursing visit.

Q11. Who can perform the Start of Care (SOC) comprehensive assessment including OASIS for a Medicare PPS (PDGM) patient when PT (or ST) is ordered along with an aide? [Q&A EDITED 10/23; EDITED 05/22; EDITED 08/07]

A11. Because no nursing orders exist, the PT (or ST) could perform the comprehensive assessment including OASIS 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 start of care (SOC) visit? [Q&A EDITED 10/23; EDITED 05/22; EDITED 09/09]

A12. A comprehensive assessment performed on a date BEFORE the SOC date does not meet the requirements of the regulations. If the agency chooses to have an RN conduct the comprehensive assessment, the RN should perform an assessment on or within 5 days of the therapist's SOC date.

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 start of the 60-day certification period and the 30-day payment period ("From" Date) Sunday or Monday? [Q&A EDITED 05/22; ADDED 09/09; Previously CMS OCCB Q&A 04/08 Q1]

A12.1. 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 60-day certification period and the 30-day PDGM payment period (From Date) begin on the date the first billable service is provided. In your scenario, the episode (certification period and payment period) begins on Monday when the PT provides a billable service.

Q12.2., Q13., Q13.1 [Q&As RETIRED 05/22]

Q14. [Q&A RETIRED 10/23]

Q14.1. An RN goes to a patient's home for an anticipated discharge visit. The patient agrees to discontinuing home care services but declines going through the full assessment of items on the OASIS. May this clinician still complete the discharge OASIS in collaboration with other disciplines that have seen this patient within the past 5 days prior to the date of this visit? [Q&A EDITED 10/23; ADDED 05/22; Previously CMS Qtrly Q&A 10/21 Q1]

A14.1. The Discharge comprehensive assessment requires a patient encounter and assessment from a qualified clinician.

The RN may complete the discharge comprehensive assessment including OASIS document based on information from their 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. The "last 5 days that the patient received visits" are defined as the date of the last patient visit, plus the four preceding days.

Q15. [Q&A RETIRED 05/22]

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 (ROC) assessment is completed? Is there a timeframe in which care (by an LPN or others) can be provided prior to the completion of the ROC assessment? [Q&A EDITED 10/23; EDITED 10/18; Q&A ADDED & EDITED 9/09; Previously CMS OCCB Q&A 01/09 Q5]

A15.1. It is not required that the Resumption of Care (ROC) comprehensive assessment including OASIS 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. 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 on-call nurse visit.

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 EDITED 10/23; EDITED 05/22; ADDED to Cat. 2 01/12; ADDED to Cat. 4b 08/07 as Q23.3; Previously CMS OCCB Q&A 07/06 Q5]

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 the transfer and ROC assessment should be completed within 2 calendar days of the agency's knowledge of the qualifying 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.

Q15.1.2. A 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 an 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 EDITED 10/23; EDITED 05/22; ADDED 10/16; Previously CMS Qtrly Q&A 07/16 Q1]

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 OASIS (RFA 6 – Transferred to an inpatient facility – patient not discharged from agency) would be completed to end the patient's

quality episode with the M0906 – Discharge/Transfer/Death Date being the date the patient transferred to the hospital, and the M0090 - Date Assessment Completed would be the last day that information used determine OASIS coding was gathered by the assessing clinician and documentation of the specific information/responses was completed.

Q15.2. [Q&A RETIRED 05/22]

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, M2401 - Intervention Synopsis)? [Q&A EDITED 10/23; EDITED 05/22; EDITED 10/18; Q&A ADDED 01/11; Previously CMS OCCB Q&A 04/10 Q1]

A15.3. The comprehensive assessment including OASIS 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, 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 the 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.

Q15.3.1. [Q&A RETIRED 11/24]

Q15.3.2. After reviewing the Expansion of the One Clinician Convention Q&A, I have a question for clarification. Does the statement "other agency staff" refer to staff within our agency? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 04/18 Q3]

A15.3.2. Yes, the statement “other agency staff” in the context of the collaboration refers to staff within the assessing clinician’s home health agency, including staff contracted by the agency.

Q15.3.3. Can you please guide on how the General OASIS Item Convention that “the time period under consideration includes the 24 hours immediately preceding the visit, plus the time in the home for the comprehensive assessment” works with using collaboration within the assessment timeframe? [Q&A EDITED 10/23; ADDED 05/22; Previously CMS Qtrly Q&A 07/19 Q3]

A15.3.3. When collaboration is used, other agency staff may provide information to the assessing clinician on what they assessed during a visit conducted during the assessment timeframe. Each person collaborating may provide information that was collected utilizing the existing conventions, including the “day of assessment.” For example, if desired, the PT who visited on Wednesday may provide information that was relevant to the PT’s “day of assessment” (the 24 hours that proceeded the PT’s visit, and the time the PT was in the home) to the RN for consideration when coding the SOC/ROC assessment items.

Q15.3.4. The aide who visited the patient on Monday discovered the patient had been hospitalized for two days and discharged home on Sunday. The RN visits the patient on Tuesday to do the Resumption of Care (ROC) assessment and the PT visits on

Wednesday, and the OT visits the patient on Thursday. Based on collaboration guidance, could the nurse use information from the aide and the PT and OT visits to complete ROC OASIS items? [Q&A EDITED 10/23; ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 04/18 Q2]

A15.3.4. At Resumption of Care (ROC), the assessing clinician may supplement their assessment with information from visits conducted by other agency staff within the assessment timeframe. A ROC comprehensive assessment including OASIS, if applicable, must be completed within 2 calendar days of facility discharge, or knowledge of the patient's return home, or the physician's ordered ROC date. In this scenario, the M0032 - ROC date is Monday (the date of the first visit following a qualifying inpatient stay) and the assessment must be completed by Wednesday (2 calendar days of agency knowledge of the patient's return home). If desired, the nurse may use the information from the three visits that occur within the assessment timeframe (i.e., the HHA visit on Monday, the RN assessment on Tuesday, and the PT visit on Wednesday) to complete the ROC assessment. The OT visit on Thursday is outside the assessment timeframe and information from that visit may not be considered when determining OASIS responses.

Q15.3.5. With the expansion of the One Clinician Convention, information gathered during the last 5 days that visits were provided can be used to contribute to completion of an unplanned discharge. Can this 5-day collaboration lookback also be used for Resumption of Care (ROC), Recert, or a *planned* discharge OASIS? [Q&A EDITED 10/23; ADDED 05/22; Previously CMS Qtrly Q&A 07/18 Q1]

A15.3.5. For a planned or unplanned discharge, the assessment must be completed within 2 days of the discharge date, and information from the last five days the agency provided visits may be considered by the assessing clinician when selecting OASIS responses. The "last 5 days that the patient received visits" are defined as the date of the last patient visit, plus the four preceding calendar days. For a Resumption of Care (ROC), the current data collection guidance states that the assessment timeframe (the maximum number of days in which the assessment must be completed) is within two days of the inpatient facility discharge, or knowledge of the discharge, or the physician-ordered ROC date; and the time period under consideration (the period of time in which the patient's status can be considered when selecting a response) for most items is the "day of assessment", which is defined as "24 hours immediately preceding the visit and the time spent in the home." For a Recertification, the assessment timeframe is the last five days of the certification period, and the time period under consideration for most items is the "day of assessment," which is defined as "24 hours immediately preceding the visit and the time spent in the home."

Q15.3.6. We have a situation with an unplanned discharge. The nurse who was the last qualified clinician to see the patient is out on maternity leave. How do we complete the OASIS discharge? [Q&A EDITED 10/23; ADDED 05/22; Previously CMS Qtrly Q&A 07/18 Q2]

A15.3.6. In the case of an unplanned discharge (an end of home care where no in-home visit can be made), the last qualified clinician who saw the patient may complete the discharge comprehensive assessment document based on information from their last visit. The assessing clinician may supplement the OASIS items on 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 unplanned discharge. The "last 5 days that

the patient received visits" are defined as the date of the last patient visit, plus the four preceding calendar days.

In your situation, the last qualified clinician who saw the patient is not available. Follow these steps:

1. If possible, send another clinician out to visit the patient and perform the Discharge comprehensive assessment visit.
2. If not possible to visit the patient, look back in the notes to find another qualified clinician who saw the patient (preferably as close to the time of discharge as possible), and who could complete the discharge comprehensive assessment based on their 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 unplanned discharge.
3. If the clinician on leave was the only qualified clinician to see the patient and it is impossible to make an additional visit to the patient, it may not be possible to complete a Discharge comprehensive assessment. The Discharge comprehensive assessment requires an in-person patient encounter and assessment from a qualified clinician. A supervisor or other agency clinician who has not visited the patient cannot complete a discharge comprehensive assessment compliantly using only 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 unplanned discharge.

Q15.3.7. We have an RN that no longer works for the agency. They performed a discharge assessment on May 8th but did not complete any OASIS items. Physical therapy was also involved in care but had performed a discipline-specific discharge on April 26th. How do we proceed with this patient? [Q&A ; EDITED 10/23; ADDED 05/22; Previously CMS Qtrly Q&A 10/19 Q4]

A15.3.7. A Discharge comprehensive assessment including OASIS is required within two days of the patient's discharge date. The Discharge comprehensive assessment requires an in-person patient encounter and assessment from a qualified clinician. If a Discharge comprehensive assessment including OASIS is missed, the agency should complete the discharge assessment as soon as the oversight is identified. There may be situations in which this is not possible (i.e., the discharging clinician does not have sufficient assessment information to complete the discharge assessment and an additional home visit is not possible within two days of the discharge date, or the missed OASIS is not identified until greater than two days after the discharge date). After the discharge assessment timeframe, a missed discharge OASIS may not be created based on previous visits/visit notes.

Failing to complete a discharge assessment should be avoided, as not completing a timely discharge assessment represents non-compliance with the comprehensive assessment update standard (of the CoP). For the Medicare PPS (PDGM) patient, payment implications may also arise from a missed assessment based on the QAO threshold calculation. Any questions about payment implications may be directed to your agency's Medicare Administrative Coordinator (MAC).

Q15.3.8. We are completing an unplanned discharge for a patient who was receiving nursing services only. All recent home health visits have been provided by an LPN, with the last RN visit being 2 weeks prior to this unplanned discharge. When the RN completes the discharge assessment document, should events such as emergent care use and falls that occurred since the last RN visit be reported on the Discharge OASIS? [Q&A EDITED 10/23; ADDED 05/22; Previously CMS Qtrly Q&A 10/18 Q2]

A15.3.8. Yes, whether the discharge is planned or unplanned, all events that have occurred during the quality episode (at the time of or any time since the most recent SOC/ROC assessment) should be reported. This is true regardless of when the last qualifying clinician conducted a visit.

Q15.3.9. An in-person discharge visit is not always possible (e.g., patient moves out of the area or refuses a discharge visit). When is a "non-visit" discharge comprehensive assessment with OASIS allowed? [Q&A EDITED 10/23; ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 04/20 Q1]

A15.3.9. There is no OASIS guidance that allows for a "non-visit" discharge comprehensive assessment with OASIS. The OASIS Guidance Manual coding instructions for M0100 - Reason for Assessment, Response 9 - Discharge state: "This comprehensive assessment is conducted when a patient is discharged from the agency for any reason other than transfer to an inpatient facilityor death at home". The discharge comprehensive assessment with OASIS requires an in-person patient encounter and assessment from a qualified clinician.

For details on how to complete a discharge assessment in the case of an unplanned discharge, see additional guidance in Category 2 Q15.3.6.

Q15.4. [Q&A RETIRED 10/18]

Q16. How does the agency develop a Start of Care (SOC) comprehensive assessment that is appropriate for therapy-only cases? [Q&A EDITED 10/23; EDITED 05/22; EDITED 10/16; EDITED 04/15]

A16. Each patient must receive a patient-specific comprehensive assessment that accurately reflects that patient's status, and must include, at a minimum: the patient's current health, psychological, functional, and cognitive status, as well as their strengths, goals, and care preferences, continuing need for home care, medical, nursing rehabilitative, social and discharge planning needs, a review of all medications the patient is currently taking and the patient's primary caregiver(s), if any as described in the Conditions of Participation.

In addition to any required OASIS items, an agency may determine what other assessment items will be included in the agency's comprehensive assessment(s) to meet regulatory, coverage and clinical needs.

Q17. [Q&A RETIRED 05/22]

Q17.1. During the start of care (SOC) visit, the nurse completed all consents, OASIS, etc. and was nearing the end of the 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 11/24; EDITED 10/23; EDITED 05/22; EDITED10/16; ADDED 09/09; Previously CMS OCCB Q&A 10/07 Q2]

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 (SOC). If the OASIS assessment was not completely finished and the criteria for a Transfer was not met, the assessing clinician would have up to 5 days after the SOC date to complete the RFA 1, SOC comprehensive assessment. 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 SOC date was not established and a new SOC would be completed upon return home from the inpatient facility.

OASIS data collection and submission is not required when only one visit is made in a quality episode. However, to bill Medicare PPS (PDGM) for a single visit in a quality episode, OASIS data must be collected and submitted 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 quality episodes.

Questions related to coverage and billing for Medicare patients are addressed in the Medicare Policy Benefit Manual and the Claims Processing Manual.

Q17.1.1. An initial assessment with a reimbursable service Start of Care (SOC) was performed on 1/24 (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 10/23; EDITED 05/22; EDITED 10/18; Q&A ADDED 06/14; Previously CMS Qtrly Q&A 04/14 Q1]

A17.1.1. In your case, the initial assessment visit was made, a billable service was provided establishing the Start of Care (SOC) date 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 timeframe, the 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 last date that information used to complete the comprehensive assessment and determine the OASIS coding was gathered by the assessing clinician and documentation of the specific information/responses was completed.

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 Resumption of Care (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 - Reason for Assessment 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 EDITED 05/22; ADDED & EDITED 09/09; Previously CMS OCCB Q&A 04/09 Q4]

A17.2. If you need to discharge a patient from Medicare home health when they elect the Medicare Hospice benefit, you are required to complete the discharge comprehensive assessment including the OASIS. M2420 - Discharge Disposition, will be Response 3 - Patient transferred to a non-institutional hospice.

Q18. I understand that the initial assessment visit (or resumption of care visit) 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 10/23; 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 (ROC) 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 ROC assessment in the midst of this situation. What should be done in this situation? [Q&A EDITED 10/23; EDITED 05/22; EDITED 10/18; Q&A EDITED 10/16]

A19. Any partial OASIS assessment that was completed can be filed in the patient record, but a partial OASIS assessment cannot be submitted.

- If, after the 911 call, the patient is admitted to an inpatient facility and then later returns home again after a qualifying inpatient stay, a Resumption of Care visit 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 10/23; EDITED 05/22; 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 start of care (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

including OASIS 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 Q&A 01/09 Q1]

A20.1. The Comprehensive Assessment of Patients Condition of Participation (CoP) §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.) communicate with the patient by phone prior to the initial assessment visit to gather or impart some of the information related to patient rights and services as part of the intake process, 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? [Q&A EDITED 05/22; REVIEWED 09/09]

A21. To fulfill the comprehensive assessment requirement, agencies should remember that the OASIS data set does not, by itself, constitute a comprehensive assessment. Home Health agencies should refer to the Conditions of Participation to determine the expected scope of the comprehensive patient 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 10/23; EDITED 05/22; EDITED 08/07]

A22. Yes, The OASIS RFA 8 - Death at home is completed when the patient dies at home or anywhere other than after being admitted for a qualifying inpatient stay. A patient who dies en route to the hospital would be considered a death at home. A patient who dies after being admitted to the hospital's emergency department (ED), regardless of how long they have been in the ED, is considered to have died at home. A patient who dies less than 24 hours after being admitted to an inpatient facility is considered to have died at home. A patient who dies while being held for observation is considered to have died at home.

Q22.1. [Q&A RETIRED 10/23]

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 EDITED 05/22; ADDED 01/12; Previously CMS OCCB Q&A 01/11 Q2]

A22.2. An RFA 8 - Death at home is completed when the patient dies at home or anywhere other than after being admitted for a qualifying inpatient stay. This includes a patient who expires during outpatient surgery or in the care of the recovery room after outpatient surgery.

Q22.3. Our patient was transported to the hospital and was placed in observation where they expired. Would we complete the RFA 7 - Transferred to an inpatient facility - patient discharged from agency or RFA 8 - Death at home? [Q&A ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 04/22 Q2]

A22.3. When a patient dies anywhere other than after being admitted for a qualifying inpatient stay complete an RFA 8 - Death at home OASIS. A qualifying inpatient stay is defined as a patient being admitted to an inpatient facility for 24 hours or more for reasons other than diagnostic testing.

Only use RFA 7 - Transferred to an inpatient facility - patient discharged from agency when a patient is transferred from your agency for a qualifying inpatient stay and return to your agency is not expected.

Q23. A patient recently returned home from an inpatient facility stay, and our agency is resuming care. The RN visited the patient to perform the ROC comprehensive assessment but found the patient critically ill. The RN performed CPR and transferred the patient back to the ER where they passed away. The ROC assessment, needless to say, was not completed. What OASIS assessment is required? [Q&A EDITED 05/22; EDITED 09/09]

A23. The Transfer completed the OASIS requirements, and no further OASIS data collection is expected. 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 RFA 6 - Transferred to inpatient facility - patient not discharged from agency 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 05/22; EDITED 06/14; ADDED 09/09; Previously CMS OCCB Q&A 10/07 Q3]

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 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.

Q23.100. I have a question about completing an RFA 8 - Death at home. We completed a Resumption of Care with Recert (ROC/Recert) in the last 5 days of a patient's first certification period after they returned home from a qualifying inpatient stay. The patient expired at home in the new certification period, and no visits had been provided since the ROC/Recert visit. What is the correct course of action in terms of OASIS completion? Should we complete an RFA 8 - Death at home and transmit as the final OASIS in the sequence? Or because no care was rendered during the subsequent certification period, should we not complete/submit the RFA 8 - Death at home and have the final OASIS submission be the ROC/Recert OASIS? [Q&A EDITED 10/23; ADDED 05/22; Previously CMS Qtrly Q&A 04/22 Q1]

A23.100. In situations where only one visit was performed in a quality episode, such as the situation described, the OASIS does not have to be submitted to the OASIS system. Therefore, it is acceptable to not submit the ROC/Recert assessment to the OASIS system, but rather to maintain the completed ROC/Recert assessment in the patient's clinical record, with documentation explaining the situation. It would also be acceptable to submit the ROC/Recert and Death at Home assessments to the OASIS system.

The Death at home OASIS is never mandated in situations of single visits in a quality episode (SOC/ROC date to DAH).

Q24. [Q&A RETIRED 05/22]

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 05/22; EDITED 04/15]

A25. The OASIS items should be answered based on the clinician's total assessment, not administered as an interview. A patient assessment includes (but is not limited to) interaction and observation.

Q26., [Q&A RETIRED 11/24]

Q27. What should we do about OASIS when a patient refuses? [Q&A EDITED 10/23; EDITED 05/22; 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 OASIS data items as part of the assessment. 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 their 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 and treated? Most agencies have written policies (based on input from legal counsel) about how to handle such situations. Does the patient refuse to have their 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 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. The information required to complete nearly all OASIS items can be obtained through observation of the patient in the normal assessment process, and/or through review of discharging facility paperwork and/or caregiver interview. Many items that can ONLY be obtained by interview have a response option of 'unknown' at SOC. 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.

Note that the Privacy Act statements (to be provided to the patient) are informational in nature. CMS expects these will be presented to (and discussed with) the patient in a way similar to that used for other patient rights information currently required by the Medicare Conditions of Participation.

Q28. [Q&A RETIRED 05/22]

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 10/23; EDITED 05/22; EDITED 10/18; EDITED 10/16]

A29. For OASIS items intended to 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 without referring back to prior assessments or documentation of status from a prior care setting.

For OASIS 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.

Q29.1. There has been guidance that states when there is a decline in patient status within the assessment timeframe to not update the assessment to reflect the decline. The example given was related to dysphagia following an ER stay. I am questioning now if we can identify other "updates" within the 5-day assessment timeframe such as new signs of infection with a surgical incision (M1342), development of a UTI (M1600), etc.? We have understood that at Start of care (SOC, the 5-day assessment timeframe allows us to update as we gather more data and that would also update M0090 - Date Assessment Completed.

Are there situations in which we are able to update the OASIS items within the assessment timeframe, and situations when this would not be allowed? [Q&A ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 07/21 Q1]

A29.1. Each OASIS item should be considered individually and coded based on the guidance provided for that item.

Unless otherwise specified in item guidance, information collected by the assessing clinician during the timeframe for the specified assessment type may be used to inform OASIS coding.

Note item guidance does specify special rules for coding pressure ulcer/injury and GG Function items at Start of care/Resumption of care (SOC/ROC). To support consistency of data collection related to pressure ulcers/injuries and GG function data across all post-acute care (PAC) providers, cross-setting guidance directs coding for pressure ulcers/injuries to be based on the "first skin assessment" and coding for GG0130 - Self-Care and GG0170 - Mobility items should be based on a functional assessment that occurs at or soon after the patient's SOC/ROC, and reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your agency staff.

Q30., Q31. [Q&As RETIRED 05/22]

Q32. Does the medication list need to be reviewed by an RN if the patient is only receiving therapy services? [Q&A EDITED 05/22; EDITED 01/11]

A32. The Condition of Participation standard for the drug regimen review states the comprehensive assessment must include a review of all medications the patient is using 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. 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. 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 drug therapy, or compliance issues? [Q&A EDITED 05/22; EDITED 10/18; EDITED 01/11; ADDED 09/09; Previously CMS OCCB Q&A 01/09 Q6]

A32.1. It is acceptable for an RN in the office to collaborate on the drug 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., Q34. [Q&As RETIRED 05/22]

Q34.1. We admit a patient for BID wound care and several days after our start of care (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 will not be continuing to provide care for this patient and will be closing the case? [Q&A EDITED 11/24; EDITED 10/23; EDITED 05/22; EDITED 06/14; ADDED 09/09; Previously CMS OCCB Q&A 10/07 Q7]

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., For guidance related to Medicare patients, refer to the Medicare Claims Processing Manual, Chapter 10, Section 10.1.5.1 - More Than One Agency Furnished Home Health Services, 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 Start of Care (SOC) including OASIS data collection was completed. Does a new SOC need to be completed at the time of this change in payer source? [Q&A EDITED 11/24; EDITED 10/23; EDITED 05/22; EDITED 10/16]

A35. Different States, different payers, and different agencies have 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 can 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 reassessed 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). When transitioning from a skilled Medicare or Medicaid patient to a situation not requiring OASIS (e.g., moving from skilled Medicare to personal care only), CMS encourages HHAs to complete a discharge OASIS assessment at the last visit under the Medicare or Medicaid pay source. While this is not a requirement, conducting a discharge OASIS assessment at the point where the patient’s skilled need has ended provides a clear endpoint to the patient’s quality episode for purposes of the agency’s quality initiatives.

Q35.1. We were billing a commercial pay source and then the business office discovered mid-episode that the patient qualified for Medicare eight months ago. The clinician providing the care no longer works at our agency and there are no other clinicians that saw the patient, with the exception of one clinician several months prior. How would we complete the OASIS in this situation? Would we need a Start of Care (SOC) and Discharge OASIS? [Q&A EDITED 10/23; ADDED 05/22; Previously CMS Qtrly Q&A 07/19 Q1]

A35.1. The Start of Care (SOC) and Discharge comprehensive assessments are based on an in-person patient encounter and assessment from a qualified clinician (which may include collaboration). If the qualified clinician that no longer works for the agency was the only qualified clinician to see the patient since the patient qualified for Medicare, it may not be possible to complete a SOC or Discharge comprehensive assessment.

In addition to OASIS completion, other regulatory and payer requirements may be affected by a payer source change.

- Questions related to home health regulations and compliance may be sent to the Home Health Survey Mailbox at hhasurveyprotocols@cms.hhs.gov
- Questions regarding general information about the Home Health Prospective Payment System (HH PPS) may be sent to: HomeHealthPolicy@cms.hhs.gov

Q36. [Q&A RETIRED 05/22]

Q36.1. I understand the comprehensive assessment cannot be completed before the Start of Care (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 EDITED 10/23; EDITED 05/22; ADDED 06/14; Previously CMS OCCB Q&A 01/08 Q1]

A36.1. The Start of Care (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 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 to meet the requirements of an initial assessment visit and 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. [Q&A RETIRED 10/18]

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

Q37.3. We are seeking guidance related to the following scenarios:

A) A qualified clinician completes the visit for the initial assessment 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?

[Q&A EDITED 10/23; EDITED 05/22; EDITED 10/18; EDITED 04/15; ADDED 09/09; Previously CMS OCCB Q&A 01/09 Q2]

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 complete the comprehensive assessment including OASIS. This comprehensive assessment can be completed with or without allowed collaboration, including review of the departed clinician's documentation.

B & C) The comprehensive assessment, including OASIS, is a legal document and when signed by a clinician, the signature is an attestation that all information 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. When a potential inconsistency is identified within the assessment timeframe and the assessing clinician is not available to approve the suggested edits then the original OASIS responses selected by the assessing clinician on the completed OASIS would be submitted.

For additional guidance related to the CMS OASIS Correction Policy refer to the State Operations Manual, Chapter 2.

Q37.4. Our clinician reported an ostomy as a surgical wound in M1340 - Surgical Wound item. The clinician no longer works for the agency, so we cannot contact them about the error. Can this OASIS change be made by the DON without speaking to the clinician?
[Q&A EDITED 10/23; EDITED 05/22; EDITED 10/18; ADDED 04/15; Previously CMS OCCB Q&A 07/11 Q2]

A37.4. You have described a situation where an OASIS 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 OASIS 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 assessing 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 assessing clinician 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 and HHRG. 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.

Q37.5. We have a situation where a clinician has left the agency and there are several OASIS assessments that our QA department had questions on, regarding the OASIS codes that were selected by the assessing clinician. Since the clinician is no longer available to provide their input, how should the identified discrepancies be handled? Can the OASIS reviewer change the codes even if the assessing clinician cannot give their approval? [Q&A ADDED 10/23; Previously CMS Qtrly Q&A 07/23 Q2]

A37.5. When a potential inconsistency is identified within the assessment timeframe and the assessing clinician is not available to approve the suggested edits then the original OASIS responses selected by the assessing clinician on the completed OASIS would be submitted.

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. When the original assessing clinician is not available to correct the true error, the clinical supervisor or quality staff may make the correction of the validated error following the agency’s 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.

Please note that the comprehensive assessment, including OASIS, is a legal document and when signed by a clinician, the signature is an attestation that all information contained in the document is truthful and accurate.

Q37.6. A third-party external auditor consistently states that our OASIS functional status items are “underscored” and recommends changing the responses to the OASIS items. Is the assessing clinician required to accept the auditor’s recommendations? [Q&A Added 11/24; Previously CMS Qtrly Q&A 04/24 Q1]

A37.6. While a home health agency may use third party external auditors to review OASIS coding and make recommendations, the assessing clinician is responsible for determining OASIS coding based on their assessment.

Each OASIS item should be considered individually and coded based on the guidance provided for that item.

When a potential inconsistency is identified within the assessment timeframe (including inconsistencies identified by a vendor/consultant/third-party reviewer), the assessing clinician may consider available input from these other sources and determine if any revisions to OASIS item responses is warranted, within the assessment timeframe and consistent with OASIS guidance.

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 - Reason for Assessment and M2420 - Discharge Disposition be answered in the discharge assessment? [Q&A EDITED 05/22; EDITED 10/16]

A38. We encourage HHAs to complete a discharge OASIS assessment for a patient who no longer requires skilled care but continues to receive personal care only. While this is not a requirement, conducting a discharge OASIS assessment at the point where the patient's skilled need has ended provides a clear endpoint to the patient's quality episode for purposes of the agency's quality initiatives. In this case, OASIS item M0100 - Reason for Assessment should be marked with Response 9 (Discharge from agency). While the patient may continue to receive personal care services from a Medicare-certified home health agency, since the services are not skilled, OASIS item M2420 - Discharge Disposition should be marked with Response 1 - Patient remained in the community (without formal assistive services).

Q39. [Q&A RETIRED 08/07; Duplicate of CMS Q&A Cat. 4b Q21]

Q40. [Q&A RETIRED 08/07; Duplicate of CMS Q&A Cat. 4b Q16]

Q41. When a patient is transferred to a hospital, but does not return to the agency, what kind of OASIS assessment is required? [Q&A EDITED 05/22; REVIEWED 09/09]

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 OASIS data conclude the quality 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 Q20.1]

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 10/23; EDITED 05/22; EDITED 06/14]

A42. Completion of a comprehensive patient assessment is required, even when the patient only receives a single visit in a quality 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/DAH). However, to bill Medicare PPS (PDGM) for a single visit quality 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 quality episodes.

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

For a single visit episode if OASIS data is required for payment by a non-Medicare/non-Medicaid payer (M0150 – Current Payment Sources 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, the Discharge comprehensive assessment including OASIS should NOT be collected or submitted, as the patient received only one visit. Agency clinical documentation should note that no further visits occurred. 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's name is dropped from the DMS report. If the patient were admitted again to the agency and a subsequent SOC OASIS assessment submitted, the agency would receive a warning that the new OASIS assessment was out of sequence. This would not prevent the agency from transmitting that OASIS 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 05/22; EDITED 06/14; ADDED 09/09; Previously CMS OCCB Q&A 04/09 Q5]

A42.1. You have described a situation where more than one visit was made - RN or therapist performs SOC comprehensive visit and then an MSW (or aide) visits. Two visits were made. In this situation a Discharge comprehensive assessment including OASIS 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 - Discharge from agency? [Q&A EDITED 11/24; EDITED 05/22; ADDED 01/12; Previously CMS OCCB Q&A 10/11 Q2]

A42.1.1. 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, the comprehensive assessment including OASIS is required for both the SOC (RFA 1) and DC (RFA 9). 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 date (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 quality 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 quality episode, and OASIS wouldn't even be required by policy for this single visit episode. [Q&A EDITED 05/22; ADDED 06/14; Previously CMS Qtrly Q&A 01/13 Q2]

A42.1.2. The quality episode begins on the SOC/ROC (M0030/M0032) date which is defined as the date of the first billable service. In the case where the PT makes only one visit and the visit is billable this is the SOC date. The nurse provides a second visit (nonbillable) within the 5 days after the SOC to complete the SOC comprehensive assessment including the OASIS. Both the OASIS SOC and a Discharge comprehensive assessment including OASIS would be required, as two visits were made in the quality episode.

Q42.2., Q43. [Q&As RETIRED 05/22]

Q44. What type of comprehensive assessment is required for pediatric, maternity, and patients requiring only personal care, housekeeping or chore services? Do these patients require an OASIS to be completed as well? [Q&A EDITED 05/22; 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 including OASIS 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 for whom the payer requires OASIS data collection. Our pediatric/maternity nurses are having difficulty answering many of the OASIS items. Do you have any insight or recommendations on how to complete these items when assessing a newborn? [Q&A EDITED 05/22; ADDED 06/14; Previously CMS Qtrly Q&A 01/13 Q1]

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]

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 10/23; EDITED 05/22; EDITED 06/14; ADDED 06/05]

A46. Yes, this is acceptable. This scenario appears to fit the criteria for single visit quality episodes for Start of Care or Resumption of Care that became effective December 16, 2002. The Conditions of Participation require that each patient 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 (PDGM) for a single visit payment period, 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 quality episodes. When a patient is discharged after only one visit (a single visit quality episode), a Discharge OASIS should NOT be collected or submitted.

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

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 10/23; EDITED 05/22; EDITED 06/14; ADDED 09/09; Previously CMS OCCB Q&A 07/09 Q3]

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 (PDGM) for a single visit payment period, 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 quality episodes. When a patient is discharged after only one visit (a single visit quality episode), a Discharge OASIS should NOT be collected or submitted.

If the agency elected not to submit the OASIS data collected during the SOC assessment when the patient was admitted to the inpatient facility, an internal agency discharge (not OASIS) would be appropriate. No Transfer OASIS would be required as there was only one visit in the 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 (PDGM) 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 including OASIS would be completed.

If, after completing the initial assessment visit and the SOC comprehensive assessment including OASIS (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 complete the RFA 6 Transfer, and then complete a Resumption of Care (ROC - RFA 3) upon the patient's return home, assuming the ROC assessment is completed within the current certification period.

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 05/22; EDITED 10/18; EDITED 01/11; ADDED 06/05]

A47. CMS regulations allow the therapist to conduct the discharge comprehensive assessment including OASIS (if applicable) 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 discharge comprehensive assessment including OASIS in a therapy-only case, the RN can perform this 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 comprehensive assessment including OASIS should be completed within 2 days of the discharge date. The M0090 - Date Assessment Completed, is the last date that information used to complete the comprehensive assessment and determine OASIS coding was gathered by the assessing clinician and documentation of the specific information/responses was completed.

Q48. If the RN is admitting and completing the initial and comprehensive assessment including the SOC OASIS 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? And if so, what time requirements would apply to when the PT must make their evaluation visit? [Q&A EDITED 10/23; EDITED 05/22; ADDED 08/07; Previously CMS OCCB Q&A 03/05 Q1]

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 including OASIS cannot be performed prior to the SOC date. Thus, in the situation described, the RN can make the initial assessment visit to determine the immediate care and support needs of the patient and to determine eligibility for the Medicare home health benefit. However, this is not a billable visit. 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 comprehensive assessment, including OASIS, this would be completed on or within five days after the SOC date (or according to agency policy, if more restrictive). 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.

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 EDITED 05/22; ADDED 08/07; Previously CMS OCCB Q&A 03/05 Q2]

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 determine program eligibility including homebound status. 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 yet completed the SOC comprehensive assessment including OASIS.

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 ROC comprehensive assessment and OASIS for PT-only patients. 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 05/22; EDITED 10/18; ADDED 09/09; Previously CMS OCCB Q&A 04/09 Q3]

A49.1. Assuming there is not a specific physician-ordered Resumption of care (ROC) date, the ROC comprehensive assessment including OASIS 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 including OASIS (RN, PT, OT, SLP) may complete the ROC comprehensive assessment including OASIS, following the agency's policy.

In a PT only ROC, there is no requirement that the PT complete the comprehensive assessment and ROC OASIS on the first visit. It would be compliant with the Condition of Participation, §484.55, for the PT to perform a discipline-specific re-evaluation and then an RN complete the ROC comprehensive assessment including OASIS on a non-billable subsequent visit as long as the comprehensive assessment including the OASIS 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, is the last date that information used to complete the comprehensive assessment and determine OASIS coding was gathered by the assessing clinician and documentation of the specific information/responses was completed. The dates would not be the same if the RN visited and completed the ROC comprehensive assessment including ROC OASIS 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 EDITED 05/22; ADDED 08/07; Previously CMS OCCB Q&A 07/06 Q1]

A50. "Referral" means the referral from a physician/allowed practitioner (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 date, within 48 hours of the patient's discharge from an inpatient facility, or on the physician's ordered start of care date.

Q51. 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 10/23; EDITED 05/22; EDITED 12/12; ADDED 08/07; Previously CMS OCCB Q&A 05/07 Q2]

A51. The Condition of Participation, §484.55, 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 the RN will complete this on the SOC date or that the initiation of therapy must be delayed until the RN completes the SOC comprehensive assessment including OASIS. Federal guidelines state the SOC comprehensive assessment including the OASIS must be completed within 5 days after the SOC date. Of course, if your agency policies are more restrictive (e.g., require earlier completion), you must follow your agency policy.

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. [Q&A RETIRED 05/22]

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 the patient is already under the care of the agency. [Q&A EDITED 10/23; EDITED 05/22; EDITED 10/18; ADDED 09/09; Previously CMS OCCB Q&A 07/08 Q1]

A51.2. It is acceptable for the RN to make a non-billable visit in a PT only case to complete the ROC comprehensive assessment including OASIS if applicable within 48 hours of discharge. The PT may visit to evaluate the patient before or after the RN 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 ROC 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 comprehensive assessment including OASIS is completed on that first visit.

Q52. [Q&A RETIRED 10/18]

Q53. A patient is recertified on 2/21 for a new cert period starting 2/26. The patient goes into the hospital on 2/23 and is discharged from the hospital on 2/26. We go back out to see them on 1st day of new episode 2/26. Would they require a ROC or a SOC OASIS? [Q&A EDITED 10/23; EDITED 05/22; ADDED 06/14; Previously CMS OCCB Q&A 05/07 Q4]

A53. An agency should discharge a patient in all instances when a qualifying inpatient stay spans the end of a 60-day certification period. If the patient then returns to agency after an inpatient stay that spans the end of the 60-day certification period, CMS requires that the agency complete a new Start of Care (SOC) assessment.

Q53.1. On December 31st we recertified a patient, planning for a new 60-day certification period that started on January 3rd. Later in the day, on the 31st, the patient was admitted to the hospital and returned home on January 2nd. We completed a transfer (RFA 6) when they went to the hospital but now don't know if we should complete a Resumption of care (ROC) or complete a new Start of care (SOC), since the inpatient stay didn't extend into the new certification period. [Q&A EDITED 11/24; EDITED 10/23; ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 01/22 Q3]

A53.1. In a situation where the recertification had been completed, the patient experiences a hospitalization in the current 60-day certification period, and now the comprehensive assessment including OASIS is being completed upon the patient's return home from the qualifying inpatient stay, if the M0090 - Date Assessment Completed is between days 56-60, complete an RFA 3 (ROC). If the M0090 - Date Assessment Completed is after day 60 (M0090 date falls in the subsequent certification period) complete an RFA 1 (SOC).

Q53.2. Please provide guidance on the following scenario: A patient was recertified between days 56-60 and then in the new 60-day certification period, prior to any home health visits being made, the patient is admitted to the hospital for a qualifying inpatient stay. Should the agency complete the RFA 6 - Transferred to an inpatient facility, patient not discharge from agency and a Resumption of Care when the patient returns? Or should an RFA 7 - Transferred to an inpatient facility, patient discharged from agency be completed and a new Start of Care be completed? [Q&A EDITED 11/24; ADDED 10/23; Previously CMS Qtrly Q&A 10/22 Q1]

A53.2. If the patient had a recertification assessment visit during the last five days of the episode, and then experiences a qualifying hospitalization in the new 60-day certification period, 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 RFA 7, depending on whether the agency anticipates the patient will be returning to service or not.

When an RFA 6 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 your internal agency discharge process would occur (with no OASIS collection).

Q54., Q54.1., Q54.2., Q55., Q55.1., Q56., Q57., Q58. [Q&As RETIRED 05/22]

Q58.1. A patient has orders for 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 05/22; EDITED 06/14; ADDED 09/09; Previously CMS OCCB Q&A 10/07 Q4]

A58.1. The Conditions of Participation state completion of a comprehensive patient assessment is required, even when the patient is known to only need a single visit in the quality 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 TRN/DC). However, to bill Medicare PPS (PDGM) for a single visit payment period, 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 quality episodes.Agency clinical documentation should note that no further visits occurred. No subsequent discharge comprehensive assessment including OASIS should be collected or submitted.

Q59. [Q&A RETIRED 05/22]

Q60. 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 EDITED 05/22; ADDED 09/09; Previously CMS OCCB Q&A 07/09 Q2]

A60. The comprehensive assessment, including the OASIS and all subsequent home care visits should be completed in the physical presence of the patient in their home or place of residence.

Q60.50. Since PDGM uses 30-day payment periods rather than 60-day certification periods as the unit of payment, do the 30-day PDGM payment periods affect when OASIS needs to be collected? [Q&A ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 10/19 Q2]

A60.50 While the PDGM case-mix adjustment is applied to each 30-day period of care, other home health requirements will continue on a 60-day basis. Specifically, certifications and recertifications continue on a 60-day basis and the comprehensive assessment will still be completed within 5 days after the start of care date and completed no less frequently than during the last 5 days of every 60 days beginning with the start of care date, as currently required by the Condition of Participation §484.55.

Q60.100. Which OASIS items are used to determine if the admission source category is community or institutional for PDGM? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 10/19 Q3]

A60.100. The OASIS assessment will not be utilized in evaluating for admission source information. Information from the Medicare claims processing system will determine the appropriate admission source for final claim payment.

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 11/24; EDITED 06/14; ADDED 12/12; Previously CMS Qtrly Q&A 01/12 Q1]

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.

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,) 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 11/24; EDITED 06/14; ADDED 12/12; Previously CMS Qtrly Q&A 01/12 Q2]

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.

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) 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. CMS OASIS Q&As state "...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, (i.e.,M0030, M0090,) with indifference to the actual condition of the patient at (or close to) the time of the new SOC date? [Q&A EDITED 11/24; EDITED 05/22; EDITED & ADDED 12/12; Previously CMS Qtrly Q&A 04/12 Q1]

A61.2. Yes.

Q61.3. [Q&A RETIRED 05/22]

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 Q&A 04/12 Q3]

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 Q&A 04/12 Q4]

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 EDITED 11/24; ADDED 06/14; Previously CMS Qtrly Q&A 04/12 Q5]

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, (i.e.,M0030, M0090)

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 EDITED 11/24; ADDED 06/14; Previously CMS Qtrly Q&A 04/12 Q6]

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 (i.e., M0030, M0090). When the HHA resubmits these assessments, they will then be linked to the new SOC assessment.

Q61.8. [Q&A RETIRED 05/22]

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 Q&A 04/12 Q8]

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 Q&A 04/12 Q9]

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 Q&A 04/12 Q10]

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 their 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 their lower body? Is it ever appropriate to rely on clinical

judgment when selecting a response for OASIS data items? [Q&A EDITED 10/23; ADDED 04/15; Previously CMS Qtrly Q&A 01/15 Q1]

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.