

OASIS Management for Single Visit at Start of Care (SOC) or Resumption of Care (ROC)

		Comprehensive Assessment Required?	OASIS Required?	Discharge OASIS Required?	Agency Discharge (Documented Explanation) Required?
SOC	Only one visit planned & provided	Yes	<ul style="list-style-type: none"> ▪ Not required by <u>regulation</u> ▪ <u>Payer</u> may require OASIS (HHRG items) ▪ If OASIS collected for payment, and M0150 = 1,2,3, or 4, may be submitted to State system 	No	Yes
SOC	More visits planned but none provided after SOC	Yes (may not have been completed, or even started on the first and only visit)	<ul style="list-style-type: none"> ▪ Not required by <u>regulation</u> ▪ <u>Payer</u> may require OASIS (HHRG items) ▪ If OASIS collected, and M0150 = 1,2,3, or 4, OASIS data may be submitted to State system 	No	Yes
SOC	One visit made, then patient admitted for qualifying inpatient facility stay before 2 nd visit	Yes (may not have been completed or even started on the first and only visit)	<ul style="list-style-type: none"> ▪ Not required by <u>regulation</u> ▪ <u>Payer</u> may require OASIS (HHRG items) ▪ If OASIS collected, and M0150 = 1,2,3, or 4, OASIS data may be submitted to State system ▪ If SOC OASIS is collected and submitted, may also complete and submit Transfer (RFA 6 or 7), but not required to do so since SOC OASIS is not required 	No	Yes
SOC	One visit made but patient died before 2 nd visit	Yes (may not have been completed or even started on the first and only visit)	<ul style="list-style-type: none"> ▪ Not required by <u>regulation</u> ▪ <u>Payer</u> may require OASIS (HHRG items) ▪ If OASIS collected, and M0150 = 1,2,3 or 4, OASIS data may be submitted to State system ▪ If SOC OASIS is collected and submitted, may also complete and submit RFA 8 Death at Home, but not required to do so since SOC OASIS is not required 	No	Yes
SOC	Visit made but patient not taken under care	No	<ul style="list-style-type: none"> ▪ Not Required by <u>regulation</u> 	No	No
SOC	RN open (nonbillable) for one time billable therapy visit	Yes	<ul style="list-style-type: none"> ▪ Required by <u>regulation</u> ▪ More than one visit made 	Yes <ul style="list-style-type: none"> ▪ More than one visit made 	Yes

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		Comprehensive Assessment Required?	OASIS Required?	Discharge OASIS Required?	Agency Discharge (Documented Explanation) Required?
ROC	Only one visit planned & provided	Yes	<ul style="list-style-type: none"> ▪ Not required by <u>regulation</u> ▪ <u>Payer</u> may require OASIS (HHRG items) ▪ If OASIS collected for payment, and M0150 = 1,2,3, or 4, may be submitted to State system 	No	Yes
ROC	More visits planned but none provided after ROC	Yes	<ul style="list-style-type: none"> ▪ Not required by <u>regulation</u> ▪ <u>Payer</u> may required OASIS (HHRG items) ▪ If OASIS collected, and M0150 = 1,2,3, or 4, may be submitted to State system 	No	Yes
ROC	One visit made, then patient admitted for qualifying inpatient facility stay before 2 nd visit	Yes	<ul style="list-style-type: none"> ▪ Not required by <u>regulation</u> ▪ <u>Payer</u> may require OASIS (HHRG items) ▪ If OASIS collected, and M0150 = 1,2,3, or 4, OASIS data may be submitted to State system ▪ If ROC OASIS is collected and submitted, may also complete and submit Transfer (RFA 6 or 7), but not required to do so since ROC OASIS is not required 	No	Yes
ROC	One visit made but patient died before 2 nd visit	Yes	<ul style="list-style-type: none"> ▪ Not required by <u>regulation</u> ▪ <u>Payer</u> may require OASIS (HHRG items) ▪ If OASIS collected, and M0150 = 1,2,3 or 4, OASIS data may be submitted to State system ▪ If ROC OASIS is collected and submitted, may also complete and submit RFA 8 Death at Home, but not required to do so since ROC OASIS is not required 	No	Yes
ROC	Visit made but patient not taken under care	No	<ul style="list-style-type: none"> ▪ Not required by <u>regulation</u> 	No	No

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REFERENCES for Guidance:

CMS Q&As Category 2

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

A19. Any partial assessment that was completed can be filed in the patient record, but HAVEN (or HAVEN-like software) will not allow a partial assessment to be exported for submission to the State agency. In situations like this, a note explaining the circumstances for not completing the assessment should be documented in the chart. If, after the 911 call, the patient is admitted to an inpatient facility and then later returns home again, a Resumption of Care assessment would be indicated at that point. When the 911 call results in the ER treating the patient and sending the patient back home, the Resumption of Care assessment would be completed at the next agency visit.

Q23. A patient recently returned home from an inpatient facility stay. The Transfer comprehensive assessment (RFA 6) was completed. The RN visited the patient to perform the ROC comprehensive assessment but found the patient critically ill. She performed CPR and transferred the patient back to the ER where, he passed away. The ROC assessment, needless to say, was not completed. What OASIS assessment is required?

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

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

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

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

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

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

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agency would get a warning that the new assessment was out of sequence. This will not prevent the agency from transmitting that assessment, however. [Q&A EDITED 08/07]

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

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

[Q&A added 06/05] [Q&A EDITED 08/07]

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

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

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

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

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

No discharge comprehensive assessment or OASIS is required when only one visit is made. The agency would complete their own internal discharge paperwork.

[Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #4]

CMS OASIS Q&As Category 4b

Q21. M0100. For a one-visit Medicare PPS patient, is Reason for Assessment (RFA) 1 the appropriate response for M0100? Is it data entered? Is it transmitted? Is a discharge OASIS completed?

A21. Completion of a SOC Comprehensive Assessment is required, even when the patient is known to only need a single visit in the episode. While there is no requirement to collect OASIS data as part of the comprehensive assessment for a known one-visit episode, some payers (including Medicare PPS and some private insurers) require SOC OASIS data to process payment. If collected, RFA 1 is the appropriate response on M0100 for a one-visit Medicare PPS patient. Since OASIS data collection is not required by regulation (but collected for payment) in this case, the agency may choose whether or not the data is transmitted to the State system.

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

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Conditions of Participation: The Comprehensive Assessment of Patients

OASIS Collection Regulation – published January 1999

§484.55 Condition of participation:

Comprehensive assessment of patients.

(b) *Standard: Completion of the comprehensive assessment.*

(1) The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.

(2) Except as provided in paragraph

(b)(3) of this section, a registered nurse must complete the comprehensive assessment and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status.

(3) When physical therapy, speech- language pathology, or occupational therapy is the only service ordered by the physician, a physical therapist, speech-language pathologist or occupational therapist may complete the comprehensive assessment, and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. The occupational therapist may complete the comprehensive assessment if the need for occupational therapy established program eligibility.

(d) *Standard: Update of the comprehensive assessment.* The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than—

(1) Every second calendar month beginning with the start of care date;

(2) Within 48 hours of the patient's

return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests;

(3) At discharge.

[Excerpt from 64 FR 3784, Jan. 25, 1999]

www.access.gpo.gov/su_docs/fedreg/a990125c.html

OASIS-B1 (12/2002) Data Set - Approved Final Version

The Centers for Medicare & Medicaid Services (CMS) announces the approval by the Office of Management and Budget (OMB) of the proposed changes to the reduced burden OASIS in response to the Department of Health and Human Services department-wide initiative to reduce regulatory burden in healthcare.

Since the reason for assessment 2 -Start of care with no further visits planned has been eliminated, agencies should follow these recommendations if a patient needs only one visit in the episode. According to the Condition of Participation at 42 CFR 484.55, each patient must receive a comprehensive assessment.

However, in this case, the agency is not required to collect the OASIS items and the agency is not required to encode or submit that assessment. This assessment can be placed in the clinical record for documentation and planning purposes. A discharge assessment is no longer required for one-visit episodes.

If the home health agency has a Medicare fee-for-service patient and expects to receive payment for the single visit, agencies must follow the PPS payment rules.

This means, that for payment for Medicare fee-for-service patients, you must encode and submit reason for assessment 1 for patients with one-time only no further visits planned episodes

Since we have eliminated reason for assessment 10 - Discharge - no further visits after start of care, there is now no discharge indicator for the patient who had only one visit, is no longer with from the agency, and there is no possibility of completing a discharge assessment. If there is only one visit made and the patient is no longer available, no discharge assessments are required.

[Excerpt from "OASIS-B1 (12/2002) Data Set – Approved Final Version]

http://www.cms.hhs.gov/HomeHealthQualityInits/12_HHQIOASISDataSet.asp