DEPARTMENT OF HEALTH & HUMAN SERVICES
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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-04-26

DATE: **April 8, 2004**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Clarification of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 for Non-Medicare/Non-Medicaid Patients in Home Health Agencies (HHAs)

Letter Summary

- Effective December 8, 2003, section 704 of the MMA of 2003 temporarily suspended the requirement that Medicare-approved HHAs collect Outcome and Assessment Information Set (OASIS) data on non-Medicare/non-Medicaid patients.
- The statute does not suspend any other aspects of the Comprehensive Assessment regulation.
- The time frames specified in 42 CFR §484.55 are not OASIS specific and have not been suspended by MMA.

The purpose of this memorandum is to promote a full understanding of Section 704 of the MMA of 2003 with regard to the collection of OASIS data for non-Medicare/non-Medicaid patients.

Background

The Medicare Conditions of Participation at 42 CFR sections 484.20 and 484.55 require that HHAs:

- Complete a comprehensive assessment for all patients, including: patients under age 18, patients receiving maternity services, and patients receiving only chore and housekeeping services,
- Use a standard core assessment data set (OASIS) when evaluating all patients, and
- Electronically transmit all patients' OASIS assessment data to CMS.

Discussion

- Section 704 of the MMA temporarily suspends the requirement that Medicare-approved HHAs collect OASIS data on non-Medicare/non-Medicaid patients. That provision has the narrow effect of suspending the provisions in 42 CFR. §484.55 relating to OASIS requirements for non-Medicare/non-Medicaid patients. However, Section 704 of the MMA does not affect any other provision of §484.55.

- The statute does not suspend any other aspects of the Comprehensive Assessment regulation. The time frames specified in §484.55 are not OASIS specific and therefore have not been suspended by the MMA. Consequently, each Medicare and Medicaid patient receiving skilled services from an HHA must receive comprehensive assessments according to the requirements established in §484.55. The HHA may develop its own comprehensive assessment for each time point for patients whose services are not paid by either Medicare or Medicaid.

- Section 484.55 continues to require that each patient (including non-Medicare/non-Medicaid patients) receives an initial assessment either within 48 hours of referral or within 48 hours of the patient's return home, or on the physician-ordered start of care date. The comprehensive assessment must be completed no later than 5 days after the start of care, and according to §484.55(d), the comprehensive assessment must be updated:

  > 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) The last five days of every 60 days 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 another than diagnostic tests, [and] (3) At discharge.

- The phrase "not less frequently than the last five days of every 60 days beginning with the start-of-care date" does not mean that HHAs must wait until the 56^{th} – 60^{th} day to perform another comprehensive assessment on non-Medicare/non-Medicaid patients. The assessment may be performed any time up to and including the 60^{th} day. The timetable for the subsequent 60-day period would then be measured from the completion date of the most recently completed assessment. Another way of stating this clarification is to observe that clinicians may perform the comprehensive assessment for non-Medicare/non-Medicaid patients more frequently than the last 5 days of the 60-day episode without conducting another comprehensive assessment on day 56-60, and remain in compliance with §484.55(d). For example, if a non-Medicare/non-Medicaid patient's payer source requires a revised plan of care on day 50 of the episode, the clinician could conduct the follow-up assessment earlier than day 50 without conducting a second assessment on day 56-60.

For questions on this memo, please contact Mary Weakland at (410) 786-6835 or e-mail at mweakland@cms.hhs.gov.

Effective Date: December 8, 2003

Training: The information contained in this announcement should be shared with all survey and certification staff, their managers, the state/RO training coordinator, all OASIS coordinators, and all home health agencies.

Sincerely,

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)