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OASIS Alert

Survey & Certification: Agencies' Protests Lead To Assessment Clarification

Five-day window has some flexibility.

New rules mean you no longer need to struggle to fit all patient assessment updates into the last five days of the 60-day episode.

Now any patients who are exempt from OASIS are also exempt from the five-day window requirement for the update to their comprehensive assessments, the **Centers for Medi-care & Medicaid Services** clarifies in a Sept. 9 letter to surveyors (S&C-04-45).

Bottom line: Surveyors should immediately exempt Medicaid pediatric, maternity and personal care patients from the five-day window, CMS instructs. As the April CMS letter to surveyors specifies, non-Medicare, non-Medi-caid patients also are exempt.

Agencies must conduct an update to the comprehensive assessment as often as the patient's condition warrants it, and "not less frequently than the last five days of every 60 days" for all patients, regardless of payor source. But home health agencies do not have to wait until the 55th to 60th day "to perform another comprehensive assessment on non-Medicare/non-Medicaid patients, or for pediatric patients, maternity patients and those patients receiving personal care only services even when Medi-caid is the payor source," CMS stresses in the letter. Agencies can perform the assessments any time in the episode up to the 60th day.

Why: CMS issued a letter to surveyors in April saying agencies still must perform comprehensive assessments even when OASIS isn't required. After that, surveyors started citing agencies for not conducting those non-OASIS assessments in the OASIS time frames, notes **Mary St. Pierre** with the **National Association for Home Care & Hospice**. Because these patients didn't generate OASIS data, there was no reason for CMS to require the assessment in the OASIS timeframe, NAHC has argued to CMS.

Agencies cried foul once surveyors began applying the five-day window to all Medicaid patients for several reasons, notes Chicago-based regulatory consultant **Rebecca Friedman Zuber**. Many Medicaid programs have more involved requirements for recertification, such as having physicians' signatures on the orders before the recert period. In those cases, agencies need to start the recertification process with a comprehensive assessment at least a few weeks before the end of the episode, Zuber explains.

What to do: CMS requires comprehensive assessments for all patients, but CMS' Sept. 9 letter reaffirms that agencies have the right to design their own comprehensive assessment for non-OASIS patients, as well as administer the assessment on their own timeline, advises consultant **Judy Adams** with the Charlotte, NC-based **LarsonAllen Health Care Group**. Here's how to be sure your non-OASIS assessment passes the test:

1. Review the standard. Focus first on 484.55, advises **Rachel Hammon** of the **Texas Association for Home Care**. This standard requires agencies to provide "a patient specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social and discharge planning needs."

2. Keep assessments comprehensive. Comprehensive assessments typically address physical, mental, social, environmental and ADL/IADL aspects of the patient's condition, Adams suggests. The items covered should allow the

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clinical staff to develop an appropriate plan of care to meet that patient's needs. "A comprehensive assessment ought to touch on all those OASIS categories, just not in the same way," Zuber says.

3. Use standardized tools. Agencies should strive to make their assessments as objective as possible, Zuber suggests. There are many more standardized tools, such as wound care scales or physical therapy scales, clinicians now can use to assess a patient's condition. HHAs should use them when feasible, Zuber urges.

4. Create a policy. You should spell out your non-OASIS assessment in your policies and procedures and then make sure clinicians stick to it, Zuber notes. Likewise, the timeframe for the assessments should also be clear and enforced, Adams says.

Another option: Many agencies decide to retain the OASIS assessment for all their patients' comprehensive assessments, Adams notes. They may want to avoid the confusion caused by having two or more types of assessments, and the possibility of accidentally not conducting an OASIS assessment when required. And sometimes HHAs find out patients are eligible for Medicare after the episode is entirely over.

Editor's Note: The survey letter is at www.cms.hhs.gov/medicaid/survey-cert/sc0445.pdf.

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