INITIAL ASSESSMENT VISIT

PROCEDURE

A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status.
Interpretive Guidelines §484.55(a)(1)
The initial assessment visit is conducted to determine the immediate care and support needs of the patient.
For Medicare patients, the initial assessment visit must include a determination of the patient's eligibility for the home health benefit, including homebound status. Verification of a patient's eligibility for the Medicare home health benefit including homebound status does not apply to Medicaid patients, beneficiaries receiving Medicare outpatient services, or private pay patients. The required initial assessment visit at §484.55(a)(1) and the "initial evaluation visit" at §484.30(a) may be completed during the same visit.
See the guidelines at §484.55 above for Medicare eligibility requirements.

For patients receiving only nursing services or both nursing and therapy services, a registered nurse must conduct the initial assessment visit.

Review a case-mix, stratified sample of clinical records and make home visits according to the survey process (see §§2200 and 2202) to determine compliance with this requirement.

Probes §484.55(a)(1)

What are the HHA's policies for conducting the initial assessment?

How is Medicare eligibility and homebound status determined?

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The initial assessment visit must be held 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.

Interpretive Guidelines §484.55(a)(1)

In the absence of a physician-specified start of care date, the initial assessment visit is conducted within 48 hours of the referral. If the physician specified a start of care date,

this supersedes the 48-hour time frame. Check the intake or clinical record for documentation of a specified start of care date.

For Medicare patients, if the initial assessment indicates that the patient is not eligible for the Medicare home health care benefit, i.e., the patient is not homebound, has no skilled need, etc., and the HHA does not admit the patient, then there is no indication for the HHA to conduct a comprehensive assessment or to collect, encode, or transmit OASIS data to the State.

Probes §484.55(a)(1)

How does the HHA assure that initial visits are conducted within the required time frames?

Compare the date of the physician referral and the date of the initial assessment visit. If the initial visit is later than 48 hours or later than the physician-ordered start of care date, check the individual patient's clinical record. Sometimes a patient requests that a visit not be made until a more convenient time. That request must be documented in the clinical record as well as a notation that the physician was notified of and approves the patient's request for a delayed start of care.

If the physician orders start of care to begin after the 48-hour time frame specified in the regulations, is there an order in the patient's chart specifying this start of care date?

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§484.55(a)(2)

When rehabilitation therapy service (speech language pathology, physical therapy, or occupational therapy) is the only service ordered by the physician, and if the need for that service establishes program eligibility, the initial assessment visit may be made by the appropriate rehabilitation skilled professional.

Interpretive Guidelines §484.55(a)(2)

For non-Medicare patients, if the need for a single therapy service establishes initial home health eligibility, the corresponding practitioner, (including a physical therapist, speech-language pathologist, or occupational therapist) can conduct the initial assessment visit.

For the Medicare home health benefit, occupational therapy services provided at the start of care alone do not establish eligibility; therefore, occupational therapists may not conduct the initial assessment visit under Medicare. Patients needing only occupational

therapy services on admission to the agency may qualify for eligibility under programs other than Medicare.

These instructions are consistent with the guidance at §484.30(a), which states, "If the physician orders only therapy services, it would be acceptable for the appropriate therapist (physical therapist or speech-language pathologist) to perform the initial evaluation visit."

When physical therapy (PT), speech language pathology (SLP), or occupational therapy (OT) is the only service ordered by the physician, a PT, SLP, or OT may complete the initial assessment visit if the need for that service establishes program eligibility. See 42 CFR §484.55(a)(2).

Review a case-mix, stratified sample of clinical records and make home visits according to the survey process (see §§2200 and 2202) to determine compliance with this requirement. For a sample of patients, determine who conducted the initial assessments, if the homebound status for Medicare was identified, and the dates of the referral and initial assessments.

NOTE: A patient who requires short term nursing determined at the start of care in addition to ongoing therapy is not considered a therapy-only case, i.e., a one-time visit by a nurse scheduled to remove sutures. Therefore, the RN must do the initial assessment.

Probes §484.55(a)(2)

How does the HHA assure that initial visits are conducted within the required time frames?

Compare the date of the physician referral and the date of the initial assessment visit. If the difference is greater than 48 hours or later than the physician ordered start of care date, check the individual patient's clinical record. If a patient requests that a visit not be made until a more convenient time, the request should be reported to the physician and documented in the clinical record.

Review patient records in which therapy (occupational therapy, physical therapy, or speech language pathology) was the only skilled service provided. Determine if the appropriate discipline completed the initial assessment. According to State law, some HHA's may use RNs for initial assessments in therapy-only cases.

Interview staff to determine how therapy-only initial assessment visits are conducted.

How does the HHA ensure that the skilled disciplines completing the initial assessment are performing this task accurately?

If questions are raised through interview and record review, review the HHA's policies regarding conducting and completing an initial assessment visit.

G334

§484.55(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.

Interpretive Guidelines §484.55(b)(1)

For patients to whom OASIS applies, when a patient is admitted to the HHA, a start of care comprehensive assessment that includes certain required OASIS data items, must be completed no later than 5 calendar days after the start of care date.

Pre-Survey Activity - Review OASIS data management reports, as available, to determine if start of care comprehensive assessments are completed within the required time frame.

Onsite Activity - Identify the start of care date. For all practical purposes, the start of care date is the first billable home visit. For payers other than Medicare, the first billable visit might be a visit made by a home health aide.

Review any reasons presented for not completing the start of care comprehensive assessments within the required time frame (i.e., the HHA planned to complete the assessment within the required time frame but the patient refused the visit.). Document explanations for start of care comprehensive assessments completed outside of the required time frame.

M0090 on the OASIS data set reflects the final date the qualified clinician completed the actual patient assessment. This is usually the date of the last home visit made to complete the comprehensive assessment but may reflect a date subsequent to the onsite visit when the qualified clinician needs to follow up, offsite, with the patient's family or physician in order to complete an OASIS clinical data item. Compare the start of care date at M0030 with the date the assessment was completed (M0090). M0090 should be no more than 5 days later than M0030. The HHA has 7 additional days from the date the patient assessment is completed (M0090) to encode (data-enter), edit, and ensure the accuracy of the OASIS data and to consult with the qualified clinician who conducted and completed the comprehensive assessment for purposes of clarification or to complete missing OASIS data items such as diagnosis codes, etc., and to lock (export) the data for future submission to the State agency. (See §484.20(a)).

Probes §484.55(b)(1)

Was the start of care comprehensive assessment completed within 5 calendar days after the start of care date?

Did the HHA provide acceptable explanations and documentation for start of care comprehensive assessments completed outside of the required time frame?

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(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.

Interpretive Guidelines §484.55(b)(2)

For Medicare and Medicaid patients receiving skilled nursing services, an RN must conduct and complete the comprehensive assessment, and for Medicare patients confirm eligibility, including homebound verification, for the Medicare home health benefit. See the guidelines at §484.55 for Medicare eligibility requirements.

When nursing and therapy are both ordered at the start of care, the registered nurse performs the start of care comprehensive assessment. Either discipline may perform subsequent assessments if the discipline is still actively providing skilled services to the patient.

Probes §484.55(b)(2)

Is the appropriate clinician conducting the comprehensive assessments, i.e., RN, physical therapist, occupational therapist, or speech-language pathologist? Check the signature of the clinician who completed the start of care assessment, and verify that it is a qualified clinician.

G336

(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 establishes program eligibility.

Interpretive Guidelines §484.55(b)(3)

For a therapy-only case, it is acceptable for a physical therapist or speech language pathologist to conduct and complete the comprehensive assessment at admission to the HHA. Occupational therapists may conduct and complete the assessment when the need for occupational therapy establishes program eligibility.

NOTE: Occupational therapy alone does not establish eligibility for the Medicare home health benefit at the start of care; however, occupational therapy services only may qualify for eligibility under other programs, such as Medicaid. Therefore, occupational therapists may not conduct the start of care comprehensive assessment under Medicare. In contrast, the Medicare home health patient receiving services of multiple disciplines, i.e., skilled nursing, physical therapy, and occupational therapy, during the episode of care, can retain eligibility if, over time, occupational therapy is the only remaining skilled discipline providing care. At that time, an occupational therapist can conduct OASIS assessments, i.e., resumption of care, follow-up, transfer, and discharge assessments.

For Medicare patients, at start of care, after the eligibility of the patient has been confirmed and the need for the qualifying service is established then the sequence of therapy services provided is irrelevant. Therefore, if physical, occupational and/or speech therapies are ordered, the order in which services are delivered is at the HHA's discretion based on the patient's plan of care. Since the need for occupational therapy alone does not constitute eligibility under Medicare, the HHA must provide the qualifying service, i.e., physical or speech therapy, prior to transfer or discharge.

A qualified therapist may conduct and complete the comprehensive assessment, and for Medicare patients confirm eligibility, including homebound verification, for the Medicare home health benefit. See the guidelines at §484.55 for Medicare eligibility requirements.

For patients receiving services from multiple skilled disciplines, the comprehensive assessment, including OASIS items, may be completed by different disciplines such as a registered nurse, physical therapist or speech language pathologist at subsequent time points. The same discipline is not required to complete the comprehensive assessment at every required time point.

If an RN's entry into the case is known at start of care (i.e., nursing is scheduled, even if only for one skilled nurse visit), then the case is NOT considered to be therapy-only, and the RN must conduct the start of care comprehensive assessment. If the order for nursing is not known at start of care and originates from a verbal order after start of care, then the case is considered therapy-only at start of care, and the therapist can perform the start of care comprehensive assessment. Either discipline may perform subsequent comprehensive assessments.

In cases where state law and/or HHA policies require RNs to perform comprehensive assessments, even though therapy is the only service ordered, CMS does not require a

physician's order for an RN to perform a comprehensive assessment within the RN's nursing scope of practice and licensing laws.

If local HHA policies and/or state regulations require an RN to perform the comprehensive assessments whenever they occur or are necessary, then the RN would need to perform all assessments for the home health patient, not just the start of care assessment. This would, of course, require close communication between the therapist and the RN to assure that the patient's condition and needs are assessed "as frequently as the patient's condition warrants" as required by 42 CFR 484.55(d) Update of the comprehensive assessment. CMS does not consider this to be a multidiscipline case.

If it is the HHA's policy for the RN to perform a comprehensive assessment before the therapist's start of care visit, the nurse could perform a comprehensive assessment on or after the therapist's start of care date or the therapist could perform the start of care comprehensive assessment if this is a therapy only case. A comprehensive assessment performed BEFORE the start of care date (identified generally as being the first billable visit) cannot be entered into HAVEN (or HAVEN-like software).

Probes §484.55(b)(3)

Are the appropriate clinicians conducting the comprehensive assessments, i.e., RN, physical therapist, occupational therapist, speech-language pathologist? Check the signature of the clinician who completed the start of care assessment (only one clinician takes responsibility for an assessment, although more than one may collaborate.)