DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations / Survey and Certification Group

Ref: S&C-04-45

DATE: **September 9, 2004**

FROM: Director
Survey and Certification Group

TO: State Survey Agency Directors

SUBJECT: Home Health Agencies (HHAs)**:** Clarification of Timing Requirements For Conducting The Comprehensive Assessment On Pediatric And Maternity Patients As Well As Those Patients Receiving Personal Care Services Only.

Letter Summary

- This memorandum clarifies that HHAs may develop their own comprehensive assessment for each required time point under the regulations at 42 CFR 484.55 for pediatric patients, maternity patients and those patients receiving personal care services only regardless of payor source.
- The assessment may be performed any time up to and including the 60th day from the most recently completed assessment.

Background: The comprehensive assessment requirement at 42 CFR 484.55 requires HHAs to complete the comprehensive assessment no later than five days after the start of care, and to update the comprehensive assessment:

> 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. (See §484.55(d))

Since the implementation of the Outcome and Assessment Information Set (OASIS) in 1999, all pediatric and maternity patients have been exempt from the OASIS data collection requirements. Similarly, the OASIS data collection requirements do not currently apply to patients receiving **only** personal care services, regardless of payment source.

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 56th – 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 Medicaid is the payor source.

The assessment may be performed any time up to and including the 60th day. The timetable for the subsequent 60-day period would then be measured from the completion date of the most recently completed assessment. Clinicians may perform the comprehensive assessment for these patients more frequently than the last five days of the 60-day episode without conducting another comprehensive assessment on day 56-60, and remain in compliance with §484.55(d). The HHA would need to complete the comprehensive assessments (as applicable) at the required time points for these patients (regardless of payor source). The agency may develop its own comprehensive assessment for each time point. For further discussion on this topic, refer to memorandum S&C-04-26.

For questions concerning this memorandum, please contact Mavis Connolly at (410) 786-6707 or e-mail at mconnolly@cms.hhs.gov.

Effective Date: Immediately. The state agency should disseminate this information within 30 days.

Training: This memorandum should be shared with state agency and regional office supervisory and training staff.

/s/
Thomas A. Hamilton

cc: Survey and Certification Regional Office Management