

## Chapter 12

## Section 3

# Home Health Benefit Coverage And Reimbursement - Assessment Process

Issue Date:

Authority: 32 CFR 199.2; 32 CFR 199.4(e)(21); 32 CFR 199.6(a)(8)(i)(B); 32 CFR 199.6(b)(4)(xv); and 32 CFR 199.14(j)

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### 1.0 APPLICABILITY

This policy is mandatory for the reimbursement of services provided either by network or non-network providers, and shall apply to home health services subject to both the original 2008 case-mix system for 60-day episodes of care and the new case-mix system now called the Patient-Driven Groupings Model (PDGM) for 30-day periods of care. Therefore, this section applies to services provided both before and after January 1, 2020. Additionally, alternative network reimbursement methodologies are permitted when approved by the Defense Health Agency (DHA) and specifically included in the network provider agreement.

### 2.0 ISSUE

To describe the comprehensive patient assessment, including Outcome and Assessment Information Set (OASIS) items, to be conducted at specific points in the home care episode/period.

### 3.0 POLICY

#### 3.1 Physician's Role in the Assessment Process

To qualify for coverage of home health services, a beneficiary must be under the care of a physician who establishes the Plan Of Care (POC). The physician's fundamental role in this process is to determine the patient's health care needs and advocate for the services required to meet those needs. In order to perform this role efficiently, the certifying physicians must utilize their intimate knowledge of the patient's medical condition. As such, physicians have the following responsibilities:

##### 3.1.1 Home Health Certification

The beneficiary's physician is responsible for signing the Home Health Certification [Centers for Medicare and Medicaid Services (CMS) Form 485] upon the initiation of any POC. Home health services are required when an individual is confined to his/her home and needs skilled nursing care on an intermittent basis, or physical or speech therapy. If an individual who has been furnished home health services based on such a need -- and who no longer requires such care or therapy -- continues to require occupation therapy; a plan for furnishing such services has to be established and

periodically reviewed by the beneficiary's physician. Upon the completion of every 60-day episode/  
**period**, if the patient is receiving continuous home care from the same Home Health Agency (HHA), the beneficiary's physician is responsible for Home Health recertification.

### **3.1.2 POC Certification**

The beneficiary's physician is responsible for development of a POC-based on his/her intimate knowledge of the medical condition of the home health patient.

**3.1.2.1** The POC developed in consultation with the agency staff covers:

- Diagnoses, including mental status;
- Types of services and equipment required;
- Frequency of visits;
- Prognosis;
- Rehabilitation potential;
- Functional limitations;
- Activities permitted;
- Nutritional requirements;
- Medications and treatments;
- Safety measures to protect against injury;
- Instructions for timely discharge or referral; and
- Any other appropriate items.

**3.1.2.2** The physician's orders for services in the POC must specify the medical treatments to be furnished, as well as the type of home health discipline that will furnish the ordered services, and at what frequency the services will be furnished.

**3.1.2.3** Standardized data collection (CMS Form 485) facilitates accurate coverage decisions, helps to ensure correct payment for covered services and promotes compliance with federal laws and regulations.

**3.1.2.3.1** CMS Form 485 (the Home Health Certification and POC):

- Meets the regulatory and national survey requirements for the physician's POC certification and recertification.
- Provides a convenient way to submit a signed and dated POC.
- Refer to [Addendum D](#) for items contained in CMS Form 485.
- **For POC and physician certification/recertification requirements, refer to the CMS Internet-Only Manuals Publication # 100-02, Medicare Benefit Policy Manual, Chapter 7, Sections 30.2 and 30.5.**

**3.1.2.3.2** However, HHAs may submit any document that is signed and dated by the physician that contains all the required components of the POC.

**3.1.2.4** The POC must be signed and dated by the beneficiary's physician before the agency can submit a claim. Any changes in the plan must be signed and dated by the beneficiary's physician. If any services are furnished based on the beneficiary's physician's oral orders, the orders must be put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist responsible for furnishing or supervising the ordered services.

**3.1.2.5** The signed POC is maintained in the beneficiary's medical record at the HHA, with a copy of the signed POC available upon request when needed for medical review (MR). Providers may submit the POC electronically if acceptable to the contractor.

**3.1.2.6** Upon completion of every 60-day episode/**period**, if the patient is receiving continuous Home Health Care (HHC) from the same HHA, the beneficiary's physician is responsible for re-certification of the POC.

## **3.2 Comprehensive Assessment Requirement**

As a condition for participation under the TRICARE Program, HHAs must conduct a comprehensive assessment that identifies the patient's need for home care, and that meets the patient's medical, nursing, rehabilitative, social and discharge planning needs. The HHAs must use the most current standard core data set (i.e., the OASIS), when evaluating adult, non-maternity patients. This requirement underscores the importance of a systematic patient assessment in improving quality of care and patient outcomes. The comprehensive assessment of the patient, in which patient needs are identified, is a crucial step in the establishment of a POC. In addition, a comprehensive assessment identifies patient progress toward desired outcomes or goals of the care plan. The importance of the assessment process has been further accentuated by its critical role in calculating the appropriate prospective payment amounts for HHC.

### **3.2.1 Applicability**

**3.2.1.1** The comprehensive assessment and reporting regulations (i.e., OASIS collection, encoding, and transmission requirements) apply to any HHA required to meet Medicare conditions for participation and are applied to all patients of that HHA unless otherwise specified. This includes Medicare, Medicaid, Managed Care, and private pay patients serviced by the agencies. It also includes Medicaid waiver and State plan patients to the extent they do not fall into one of the three exception categories listed below. The comprehensive assessment and reporting regulations are required by the State to meet Medicare conditions of participation.

**3.2.1.2** Medicare's requirement to conduct comprehensive assessments that include OASIS data items applies to each patient of the agency receiving home health services, except for the following:

- Patients under the age of 18;
- Patients receiving maternity services;
- Patients receiving housekeeping or chore services only; and
- Patients receiving personal care services only.

**3.2.1.3** However, the encoding and transmission requirements for non-Medicare and non-Medicaid patients receiving skilled care are delayed until a system to mask their identity is developed and implemented. Until such a system is developed and implemented, HHAs must meet all other requirements of the comprehensive assessment regulation, including conducting start of care

comprehensive assessments and updates at the required time points on all non-Medicare and non-Medicaid patients receiving skilled services using the required OASIS data items. This means that only the requirements to encode and transmit OASIS data is delayed. The collection of OASIS data as part of the comprehensive assessment process, and updates at the required time points, are required in order to ensure quality of care for all patients and to encourage the use of OASIS as the basis for care planning.

**3.2.1.4** Due to the delay in State agency validation of transmitted OASIS data for non-Medicare/non-Medicaid patients, HHAs will only be responsible for the collection and encoding of OASIS data for TRICARE beneficiaries receiving services under a HHA's POC. Encoding will be required to generate the appropriate Health Insurance Prospective Payment System (HIPPS) code and claims-OASIS matching key output necessary to process and pay the HHA claim. Post-payment validation will be utilized to ensure that the HIPPS code generated by the Home Assessment Validation Entry (HAVEN) Grouper software is reflective of the patient's true condition, and that the services were actually rendered. Validation may be accomplished either manually through the use of The Home Health Resource Group (HHRG) Worksheet and accompanying OASIS instruction manual, or through the use of an automated accuracy protocol designed to assist medical review of home health claims submitted by HHAs who are being paid under the HHA Prospective Payment System (PPS). The Regional Home Health Intermediary (RHHI) Outcomes and Assessment Information Set Verification Protocol for Review of HHA Prospective Payment Bills (ROVER) utilizes medical records to verify that information contained in a HHA-completed OASIS is reflective of the patient's condition. Both methods will guide medical review staff through the clinical records, allowing the reviewer to document whether or not the case-mix OASIS items are validated by the information contained in the records. A HIPPS code will also be computed based on the reviewer's responses and compared to the HIPPS code assigned by the HHA. The reviewer can either accept the HIPPS billed by the provider, or adjust the claim as necessary.

**3.2.1.5** Abbreviated assessments will be required for TRICARE eligible beneficiaries who are under the age of eighteen or receiving maternity care from Medicare certified HHAs (i.e., HHAs meeting all Medicare conditions of participation [Sections 1861(o) and 1891 of the Social Security Act and part 484 of the Medicare regulation (42 CFR 484)] in order to receive payment under the HHA PPS. Refer to [Section 4, paragraph 3.4](#) for more details regarding the abbreviated OASIS data requirements for reimbursement of these beneficiary categories. The above patient categories will not be exempt from OASIS data collection if under a POC established by a physician.

**3.2.1.6** A patient who is under age 18 and turns 18 while under the care of an HHA is to receive a full comprehensive assessment (including OASIS) at the next appropriate time point.

### **3.2.2 Data Collection**

**3.2.2.1** Patient assessment data may be collected through a combination of methods, including interaction with patient/family, observation, and measurement. When used in combination, these methods provide a full picture of the patient's health status. The following [CMS website \(https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html\)](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html) provide the primary components of a home care patient assessment, along with the standard data sets used in assessing the patient's condition for reimbursement under the HHA PPS.

**3.2.2.2** Patient assessment data is required at specific time points to keep them current and useful in planning care. These time points include:

### **3.2.2.2.1 Initial Assessment Visit**

**3.2.2.2.1.1** The initial visit is performed to determine the immediate care and support needs of the patient. This visit is conducted within 48 hours of referral, or within 48 hours of a patient's return home from an inpatient stay, or on the physician-ordered start of care date.

**3.2.2.2.1.2** The initial assessment visit is intended to ensure that the patient's most critical needs for home care services are identified and met in a timely fashion. This initial assessment determines eligibility for the home health benefit under the TRICARE Program, including homebound status.

**3.2.2.2.1.3** The initial assessment visit must be conducted by a registered nurse unless rehabilitation therapy services are the only services ordered by the physician. In this care, the initial assessment would be made by the appropriate rehabilitation skilled professional.

**3.2.2.2.1.4** A comprehensive assessment is not required to be completed at this visit, although the HHA may choose to do so. The comprehensive assessment may be initiated at this visit and completed within the time frames discussed below.

### **3.2.2.2.2 Completion of the Comprehensive Assessment**

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

**3.2.2.2.2.2** This requirement does not preclude a HHA from completing the comprehensive assessment during the initial visit. This provides operational flexibility to the HHA while maintaining patient safety in ensuring that all patient needs will be identified within a standard time period.

**3.2.2.2.2.3** The comprehensive assessment must include a review of all medication the patient is currently using in order to identify any potential adverse effects of drug reactions, including ineffective drug therapy, significant side effects and drug interactions, duplicate drug therapy, and noncompliance with drug therapy.

**3.2.2.2.2.4** The comprehensive assessment describes the patient's current health status and identifies needs that subsequently are addressed in the POC. Updates of this assessment identify progress toward goals.

### **3.2.2.2.3 Update of the Comprehensive Assessment**

The comprehensive assessment, which includes the OASIS data set items, must be updated within:

- Five days immediately preceding each recertification - day 56 through day 60 of each period);
- Forty-eight (48) hours of transfer to an inpatient facility;
- Forty-eight (48) hours of resumption of care after an inpatient stay of 24 hours or more for any reason except diagnostic testing;

- Forty-eight (48) hours of discharge (discharge for this requirement means discharge to the community, transfer to another facility, or the death of the patient); and
- Forty-eight (48) hours of significant change in condition (i.e., a major decline or improvement in a patient's health status).

**3.2.2.3** The comprehensive assessment is expected to meet the patient's medical nursing, rehabilitative, social, and discharge planning needs. As such, it is an assessment of needs that might be met by a variety of disciplines. It is not expected that a single clinician conducting the assessment will perform a nursing, physical therapy, speech-language pathology, occupational therapy, and social work assessment. The assessing clinician must, however, conduct a sufficiently broad assessment of environmental, social support, functional, and health domains that effectively identify the patient's needs.

**3.2.2.4** The OASIS data set was not intended to constitute a complete comprehensive assessment instrument. It can, however, be used as the foundation for valid and reliable information for patient assessment, care planning, service delivery, and improvement efforts. The agency might want to begin with required OASIS items and add core assessment items deemed necessary to meet clinical, regulatory, or accreditation requirements. The core comprehensive assessment with OASIS items could then be supplemented with additional discipline-specific assessment items required to meet the special needs of the beneficiary.

**3.2.2.5** The OASIS data set must be incorporated into the HHA's own assessment, exactly as written. Integrating the OASIS items into the agency's own assessment system in the order presented in the OASIS form will facilitate data entry of the items into data collection and reporting software.

### **3.2.3 Encoding of OASIS Data**

**3.2.3.1** Once the assessment is completed and OASIS data items collected by the qualified skilled professional (i.e., the nurse or therapist responsible for coordinating or completing the assessment), data can be encoded directly by the skilled professional or by a clerical staff member from a hard copy of a completed OASIS. Non-clinical staff may not assess patients or complete assessment items; however, clerical staff or data entry operators may enter the OASIS data collected by the skilled professional into the computer. HHAs must also comply with requirements safeguarding the confidentiality of patient identifiable information. HHAs may take up to seven days after collection to enter it into their computer systems.

**3.2.3.2** To enter the data, HHAs will operate the HAVEN software program and run the OASIS data set through the CMS-specified edits. This process involves using HAVEN or HAVEN-like software to review the data for accuracy and consistency, making any necessary changes and finalizing the data. HAVEN will accommodate data entry of OASIS items from all required time points. Seven days are allowed to encode, edit and lock OASIS data, as that is believed to be a reasonable amount of time to expect agencies to complete this task while ensuring accuracy of data.

**3.2.3.3** The agency must enter the OASIS data and identify any information that does not pass the specified edits; that is, any missing, incorrect, or inconsistent data. Editing and locking functions are automatically performed using the HAVEN software.

**3.2.3.4** Once the OASIS information is encoded, HHAs will “lock” the data; i.e., use their software to review and edit it to create a file that will be transmitted to the State agency or other entity approved to receive this transmission. Since State agency validation of non-Medicare/non-Medicaid OASIS files have been delayed, transmission of TRICARE locked files will not be required at this time. HHAs will, however, still be responsible for the collection and encoding of OASIS data. This information will provide a mechanism for objectively measuring facility performance and quality. It will also be used to support the HHA PPS (i.e., generate the HIPPS code and claim-OASIS matching key output required on the CMS 1450 UB-04 claim form for pricing).

**3.2.3.5** Since encoded OASIS data must accurately reflect the patient’s status at the time the information is collected, HHAs must ensure that data items on its own clinical record match the encoded data.

**3.2.3.6** Refer to the CMS website (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html>) for information regarding the OASIS. The HHA may access the web site and download the required OASIS data set for each data collection time point; i.e., start of care, resumption of care following an inpatient facility stay, follow-up, discharge (not to an inpatient facility), transfer to inpatient facility (with or without agency discharge), and death at home. See CMS’ website (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HAVEN.html>) for information regarding the Home Assessment Validation and Entry (HAVEN) system.

### **3.2.4 Case Management Responsibilities**

It is recognized that while an abbreviated OASIS assessment may facilitate payment under the HHA PPS, it does not adequately reflect the management oversight required to ensure quality of care for beneficiaries under the age of 18 and obstetrical patients. As a result, the contractors will have to continue to case manage these beneficiary categories through the use of appropriate evaluation criteria as required under the specific terms of their contract to ensure the quality and appropriateness of home health services (e.g., the use of INTERQUAL criteria for managing the appropriateness of home health services). Contractor involvement will even be more critical in cases where home health services are provided in non-Medicare HHAs (i.e., those HHAs for which Medicare certification is not available due to the beneficiary categories they serve). Refer to [Section 4, paragraph 3.6](#) for the hierarchical placement and reimbursement of home health services for TRICARE eligible beneficiaries under the age of 18 or receiving maternity care.

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