MEMORANDUM

Texas Department of Human Services * Long Term Care/Policy

TO: Long Term Care -Regulatory
Regional Directors, State Office Section Managers and
HCSSA Program Administrators

FROM: Marc Gold, Director
Long Term Care Policy
State Office MC: W-519

SUBJECT: Regional Survey & Certification Letter #01-03

DATE: May 18, 2001

The attached RS&C Letter is being provided to you for information purposes and should be shared with all professional staff.

- RS&C Letter No. 01-03 -- Outcome and Assessment Information Set (OASIS) Considerations for Home Health Agencies (HHAs) Seeking Initial Certification; Contact the OASIS Help Desk, at (512) 438-2100.

~Original Signature on File~

Marc Gold

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Division of Medicaid and State Operations, Region VI

1301 Young Street, Room 827
Dallas, Texas 75202
Phone (214) 767-6301
Fax (214) 767-0270

February 27, 2001

REGIONAL SURVEY AND CERTIFICATION LETTER NO: 01-03

To: All State Survey Agencies (Action)
All Title XIX Single State Agencies (Information)

Subject: Outcome and Assessment Information Set (OASIS) Considerations for Home Health Agencies (HHAs) Seeking Initial Certification

The purpose of this letter is to provide guidance to State survey agencies (SAs) personnel involved in the initial certification of HHAs. With the advent of the home health prospective payment system (PPS), it is imperative for the new HHA to establish a 60-day episode for its Medicare patients that is consistent with the HHA's effective date for Medicare participation.

HHAs must meet certain requirements, including enrollment and capitalization, and must provide skilled home health services to a minimum of 10 patients that is consistent with the Medicare home health Conditions of Participation (CoPs) before receiving Medicare approval. Compliance with the CoPs is determined via an onsite survey by the SA and any applicable subsequent actions or revisions required of the HHA following the initial survey. The new HHA cannot bill Medicare for payment of services to Medicare beneficiaries until the effective date for Medicare participation has been determined by the HCFA RO.

Realistically, notification of the effective date of participation may take weeks after the initial survey of the HHA. In addition, the date of official compliance may vary depending on the outcome of the onsite survey. As described in the State Operations Manual (SOM), Section 2780, the date of compliance is either:

1. The date the onsite survey is completed if, on the date of the survey the HHA meets all CoPs and any other requirements required by HCFA; or
2. If the HHA fails to meet any of the requirements as a result of the onsite survey, compliance is the earlier of:
    - the date the HHA meets all requirements; or
    - the date the HHA meets all the CoPs and submits an acceptable plan of correction for standard level deficiencies.

Services provided before the effective date for Medicare participation is not permitted under Medicare. As such, it is important that new HHAs seeking payment under Medicare establish the required 60-day episode on or after the effective date of their Medicare participation.

Instructions for Handling Medicare Patients in HHAs Seeking Initial Certification
If the HHA is confident that it has met all CoPs and all other Medicare requirements at the time the initial survey is completed, the HHA is advised to do a new start of care assessment, that is, Reason For Assessment (RFA) #1, on each of its Medicare patients at the first billable visit after the onsite survey. The HHA should delay encoding and transmitting the assessment until the Medicare provider number is assigned.

The HHA can go back and encode the collected OASIS information, obtain the necessary health insurance prospective payment system (HIPPS) codes for billing under PPS, and transmit the information to the State OASIS system as production (i.e., "live") data after the provider number has been assigned. The date of this assessment will become day 1 of the HHA's first 60-day episode under Medicare, as long as the assessment was done in conjunction with a billable visit. Warning messages related to noncompliance with timing requirements are unavoidable and are to be expected in this situation.

If compliance (i.e., the effective date) is not the date of the onsite survey, it will be based on number 2 above, as outlined in the SOM. The HHA should, again, do a new start of care assessment (RFA #1) on each of its Medicare patients at the first billable visit after the anticipated date of compliance, delay encoding and transmitting the assessment until the Medicare provider number is assigned, and continue as outlined in the paragraph above. That is, the HHA should go back and encode the collected OASIS information, obtain the necessary HIPPS codes for billing under PPS, and transmit the information to the State OASIS system as production data. As above, warning messages related to noncompliance with timing requirements are unavoidable and are to be expected in this situation.

Instructions for Handling Medicare Patients in HHAs That Recently Completed an Initial Survey
New HHAs that have been surveyed prior to February 1, 2001 are advised to use the information from the OASIS start of care (RFA #1), resumption of care (RFA #3), or follow-up assessment (RFA #4) closest to (and after) the official date of compliance to complete a new start of care assessment (RFA #1) for Medicare billing purposes. This assessment should be encoded and submitted using the newly assigned provider number and should reflect a start of care date that is consistent with the first billable visit after the effective date for Medicare participation. The first billable visit after the Medicare effective date will become day 1 of the HHA's first 60-day episode.

If the new HHA did not conduct a start of care (RFA #1), resumption of care (RFA #3), or follow-up (RFA #4) OASIS assessment during the time between the effective date for Medicare participation and the date the HHA learns of its approval, the HHA should conduct an "other follow-up" (RFA #5) OASIS assessment, as soon as possible. This assessment can be used to generate the HIPPS code used for billing under Medicare. The start of care date should reflect a

date that is consistent with the first billable visit after the effective date for Medicare participation, as stated above.

Instructions to New HHAs concerning all Other Patients
For all other patients treated by the HHA (i.e., non-Medicare patients), if a new start of care date is not required by the patient's pay source, the HHA should encode and transmit all OASIS assessments as required by current regulation that were collected after the effective date of Medicare participation. These assessments should be submitted in the production mode using the newly assigned provider number. The HHA should continue with the OASIS assessment schedule already established based on the patient's admission date. Transmissions of test data before the official date of approval will be deleted from the State OASIS system.
If you have any questions, please contact Dodjie B. Guioa at 214-767-6179 or through E-mail at dguioa@hcfa.gov.

Sincerely,

~Signature on File~

Molly Crawshaw, Chief
Survey and Certification Operations Branch