health services to determine adequacy
of the plan of care and appropriateness
of continuation of care.

§ 484.55 Condition of participation:
Comprehensive assessment of pa-
tients.

Each patient must receive, and an
HHA must provide, a patient-specific,
comprehensive assessment that accu-
rately 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 comprehen-
sive assessment must identify the pa-
tient’s continuing need for home care
and meet the patient’s medical, nurs-
ing, rehabilitative, social, and dis-
charge planning needs. For Medicare
beneficiaries, the HHA must verify the
patient’s eligibility for the Medicare
home health benefit including home-
bound status, both at the time of the
initial assessment visit and at the time
of the comprehensive assessment. The
comprehensive assessment must also
incorporate the use of the current
version of the Outcome and Assessment
Information Set (OASIS) items, using
the language and groupings of the
OASIS items, as specified by the Sec-
retary.

(a) Standard: Initial assessment visit.
(1) A registered nurse must conduct an
initial assessment visit to determine
the immediate care and support needs
of the patient; and, for Medicare pa-

tients, to determine eligibility for the Medicare
home health benefit including home-
bound status. The initial as-
ssessment 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.

(2) When rehabilitation therapy serv-
ence (speech language pathology, physi-
cal therapy, or occupational therapy)
is the only service ordered by the phy-
sician, and if the need for that service
establishes program eligibility, the ini-
tial assessment visit may be made by
the appropriate rehabilitation skilled
professional.

(b) Standard: Completion of the com-
prehensivistic assessment. (1) The com-
prehensive assessment must be com-
pleted in a timely manner, consistent
with the patient’s immediate needs,
but no later than 5 calendar days after
the start of care.

(2) Except as provided in paragraph
(b)(3) of this section, a registered nurse
must complete the comprehensive as-

essment and for Medicare patients, de-
termine eligibility for the Medicare
home health benefit, including home-
bound status.

(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 occu-

pational therapist may complete the
comprehensive assessment, and for
Medicare patients, determine eligi-

bility for the Medicare home health
benefit, including homebound status.
The occupational therapist may com-
plete the comprehensive assessment if
the need for occupational therapy es-

This page is from a document that is not fully visible or legible. The text appears to be discussing the requirements for comprehensive assessments in health care settings, particularly related to Medicare beneficiaries. The text outlines standards for initial and completion of assessments, drug regimen review, and updates to the assessment, with references to specific dates and conditions under which assessments must be conducted or revised. The document also mentions the use of the Outcome and Assessment Information Set (OASIS) items, which are specified by the Secretary. There are references to specific regulations and dates, such as FR 33367, Aug. 14, 1989; 66 FR 32778, June 18, 2001. The text is structured in a formal, legal style, typical of regulatory or official documents.
(e) Standard: Incorporation of OASIS data items. The OASIS data items determined by the Secretary must be incorporated into the HHA’s own assessment and must include: clinical record items, demographics and patient history, living arrangements, supportive assistance, sensory status, integumentary status, respiratory status, elimination status, neuro/behavioral status, activities of daily living, medications, equipment management, emergent care, and data items collected at inpatient facility admission or discharge only.


Subpart D [Reserved]

Subpart E—Prospective Payment System for Home Health Agencies

SOURCE: 65 FR 41212, July 3, 2000, unless otherwise noted.

§ 484.200 Basis and scope.

(a) Basis. This subpart implements section 1895 of the Act, which provides for the implementation of a prospective payment system (PPS) for HHAs for portions of cost reporting periods occurring on or after October 1, 2000.

(b) Scope. This subpart sets forth the framework for the HHA PPS, including the methodology used for the development of the payment rates, associated adjustments, and related rules.

§ 484.202 Definitions.

As used in this subpart—

Case-mix index means a scale that measures the relative difference in resource intensity among different groups in the clinical model.

Discipline means one of the six home health disciplines covered under the Medicare home health benefit (skilled nursing services, home health aide services, physical therapy services, occupational therapy services, speech-language pathology services, and medical social services).

Home health market basket index means an index that reflects changes over time in the prices of an appropriate mix of goods and services included in home health services.

Rural area means, with respect to home health episodes ending on or after January 1, 2006, an area defined in § 412.64(b)(1)(ii)(C) of this chapter.

Urban area means, with respect to home health episodes ending on or after January 1, 2006, an area defined in § 412.64(b)(1)(ii)(A) and (B) of this chapter.

(70 FR 68142, Nov. 9, 2005)

§ 484.205 Basis of payment.

(a) Method of payment. An HHA receives a national prospective 60-day episode payment of a predetermined rate for a home health service previously paid on a reasonable cost basis (except the osteoporosis drug defined in section 1861(kk) of the Act) as of August 5, 1997. The national 60-day episode payment is determined in accordance with §484.215. The national prospective 60-day episode payment is subject to the following adjustments and additional payments:

(1) A low-utilization payment adjustment (LUPA) of a predetermined per-visit rate as specified in §484.230.

(2) A partial episode payment (PEP) adjustment due to an intervening event defined as a beneficiary elected transfer or a discharge and return to the same HHA during the 60-day episode, that warrants a new 60-day episode payment during an existing 60-day episode, that initiates the start of a new 60-day episode payment and a new physician certification of the new plan of care. The PEP adjustment is determined in accordance with §484.235.

(3) An outlier payment is determined in accordance with §484.240.

(b) Episode payment. The national prospective 60-day episode payment represents payment in full for all costs associated with furnishing home health services previously paid on a reasonable cost basis (except the osteoporosis drug listed in section 1861(m) of the Act as defined in section 1861(kk) of the Act) as of August 5, 1997 unless the national 60-day episode payment is subject to a low-utilization payment adjustment set forth in §484.230, a partial episode payment adjustment set forth at §484.235, or an additional outlier.